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Introduction

Even twenty years ago, it should have been clear that the collision of two powerful, long-term trends in our economy would eventually drive the debate on U.S. health policy to the impasse it reached in 2017. Indeed, some of us had predicted it years ago. (See, for example, "Is There Hope for the Uninsured?," *Health Affairs* [2003].[1])

The debate is conducted in the jargon of *economics* and *constitutional federal-state relations*. But it is not really about economics and the Constitution at all. Instead, at the heart of the debate is a long-simmering argument over the following question on distributive *social ethics*:

> ***To what extent should the better-off members of society be made to be their poorer and sick brothers' and sisters' keepers in health care?***

The two ominous long-term trends on which I based my dire prognosis on the uninsured are the following:

1. the rapid secular growth in the cost of American health care, in the face of
2. the growing inequality[2] in the distribution of income and wealth in this country.

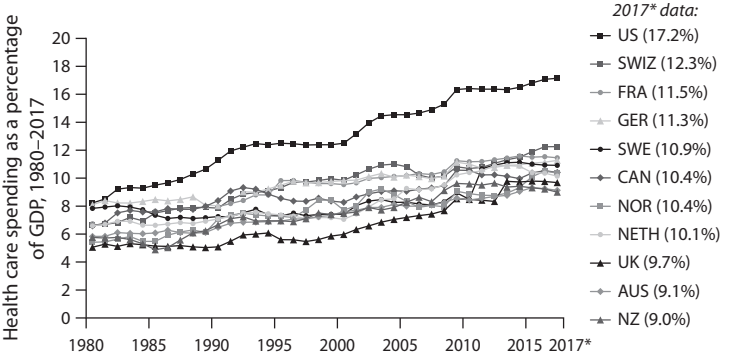

Figure I.1 Health Care Spending as a Percentage of GDP, 1980–2017 (Adjusted for Differences in Cost of Living). Current expenditures on health per capita, adjusted for current US$ purchasing power parities (PPPs). Based on System of Health Accounts methodology, with some differences between country methodologies (data for Australia uses narrower definition for long-term care spending than other countries). *2017 data are provisional or estimated.

Source: Roosa Tikkanen, *Multinational Comparisons of Health Systems Data, 2018* (Commonwealth Fund, Dec. 2018), https://www.commonwealthfund.org/publications/publication/2018/dec/multinational-comparisons-health-systems-data-2018.

Figures I.1 and I.2 give a sense of these two trends.

Over time, these two trends have combined to price a growing number of American families out of the high-quality or at least luxurious American health care that families in the higher strata of the nation's income distribution would like to have for themselves. We have now reached a pass where bestowing on a low-income American even standard medical procedures, such as a coronary bypass or a hip replacement, is the financial equivalent of bestowing on a poor patient a fully loaded Mercedes-Benz.

The American people's legendary apathy on such matters (see, for example, Uwe Reinhardt, "Taking Our Gaze away from Bread and Circus Games" [1995])[3] has facilitated the unabated growth of these trends over time.[4] The people's leaders, from

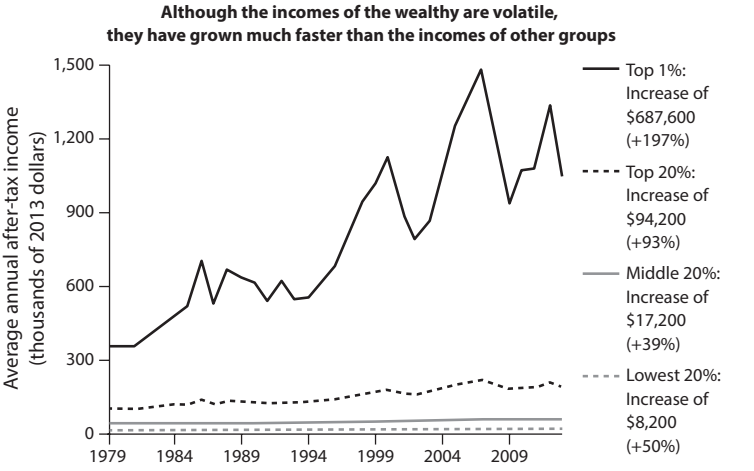

Figure I.2 Average Annual After-Tax Income (2013 Dollars). Increase calculated for 1980–2013.
Source: Congressional Budget Office, *The Distribution of Household Income and Federal Taxes, 2013*, June 2016. Compiled by Peter G. Peterson Foundation, 2016. Reprinted with permission from PGPF.

every incumbent president down,[5] simply told voters that we had the best macro economy in the world, and also the best health system in the world, bar none, and that was good enough for the general populace.

In the early postwar period and through the 1990s, the dream among health policy analysts and the policy makers they advised had been to construct for America a roughly egalitarian, universal health insurance and health care system.

That dream appears to be dead. We will examine the symptoms of its demise throughout the book. Just one example is the ceaseless talk about the economic "sustainability" of Medicare and Medicaid. That argument reflects efforts by some members of Congress and their advisers to construct for the United States an *officially* sanctioned, multi-tier health system in which the

quality of health insurance and of the health care experience of low-income and lower-middle-class Americans does not have to match the health care experience of families in the upper strata of the nation's income distribution. In effect, they seek a system in which health care is rationed by income class.

The argument that U.S. spending on Medicare for the elderly and Medicaid for the poor and disabled is not "affordable" or "economically sustainable" seems to have wide currency in the arena of public opinion; but it is a highly dubious argument that calls for quick comment.

Medicare

One should always challenge anyone who declares that a trend—any trend—is "unsustainable" or "not affordable" to explain exactly what he or she means by these words. Usually the response will be vague or plainly *political*, that is, not about economics at all.

To illustrate, figure 1-8 in a 2016 report[6] by the prestigious Medicare Payment Advisory Commission (Medpac) shows that in some years Medicare spending rose faster than private health insurance spending, while in other years it was the other way around. These growth rates are reproduced in figure I.3.

If Medicare spending is not sustainable, is health spending sustainable under private health insurance, whose growth in per capita health spending in many years has exceeded the growth in Medicare spending per beneficiary?

The latest estimates by the Trustees of the Medicare program[7] indicate that Medicare currently accounts for 3.6 percent of gross domestic product (GDP) and will claim 6 percent of GDP by 2050. For 2016, that comes to a claim of 2016 per capita GDP of $2,088, leaving a non-Medicare GDP per capita of about $56,000.

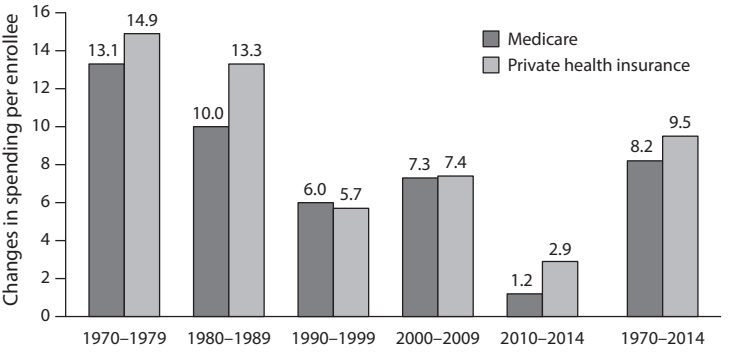

Figure I.3 Changes in Spending per Enrollee, Medicare and Private Health Insurance.
Source: Medicare Payment Advisory Commission (Medpac) Data Book "Health Care Spending and the Medicare Program," June 2016, Figure 1-8.

According to the Congressional Budget Office (CBO), real GDP is expected to grow by only 1.9 percent per year for the foreseeable future (although that number may be higher if promises made by the Trump administration come true). If we subtract from the growth of real GDP the currently projected population growth of about 0.9 percent per year, we conclude that the CBO projects real GDP per capita to grow by about 1 percent. At an annual compound growth rate of 1 percent, real GDP (in 2017 prices) will be $80,544 in 2050. After a claim of 6 percent, or $4,833, for Medicare, that leaves the contemporaries living in 2050 with $75,700 of non-Medicare GDP per capita. Thus, in 2050 the contemporaries living then will have 35 percent more real *non-Medicare GDP* per capita than we have today.[8] Figure I.4 illustrates these numbers.

So, if we could afford to take care of our elderly in 2016 with a real GDP per capita of only $58,000, why cannot the contemporaries living in 2050 take care of their elderly with a real GDP per capita of $80,500? Put another way, what do pundits and

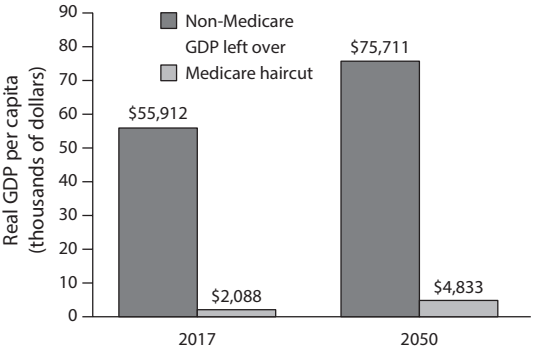

Figure I.4 Real GDP Per Capita after Medicare Haircut, 2017 and 2050.
Source: Congressional Budget Office, 2017.

politicians who proclaim that Medicare is "unsustainable" mean by that term?

Medicaid

Total Medicaid spending is determined by the number of Americans who are eligible for Medicaid coverage and the amount of spending *per Medicaid enrollee*.

The growth in Medicaid enrollment is driven primarily by the growing income inequality in this country, which tends to increase the number of low-income Americans and with it enrollment in Medicaid, especially during recessions. Indeed, there is now a debate about how long this growing income inequality is politically sustainable, not only in the United States but also in other modern democracies.[9]

The *level* of Medicaid spending *per enrollee* is determined in part (1) by the high cost of U.S. health care in general[10] and (2) by the fact that the Medicaid population tends to be sicker and

is more disabled than is the low-income, privately insured population. After a careful review of the literature on Medicaid spending, the Kaiser Family Foundation[11] concluded:

> Spending *per enrollee* is lower for Medicaid compared to private insurance after controlling for differences in socio-demographic and health characteristics between the two groups. Given the significant health and disability differences between Medicaid enrollees and those who are privately insured, the most rigorous research examining differences in *per-enrollee* spending has focused primarily on regression-adjusted comparisons that control for these underlying differences in the need for health care. (Italics added.)

There are no proposals to impose *global* budgets on per capita U.S. health spending in general. In the Congressional Republican reform proposals of 2017, on the other hand, spending on the poor and disabled in Medicaid is to be constrained by converting the current federal assistance to Medicaid, Federal Medical Assistance Percentages (FMAP),[12] into a block grant or per capita cap arrangement whose future growth is to be constrained to the growth merely of the urban Consumer Price Index. That index, however, has always risen more slowly over time than overall per capita health spending in the United States, as figure I.5 shows.

An argument often made by the proponents of constraining Medicaid spending in this way is that actually we are not talking about real cuts, but merely cuts from some imaginary projected future spending path. First, the argument goes, the data are already adjusted for future growth in Medicaid enrollment, because future Medicaid spending is anchored in a block grant. Second, the argument continues, general price inflation (as measured

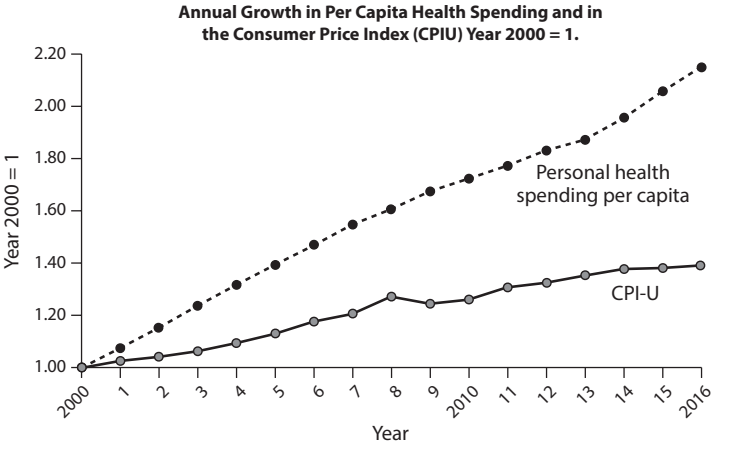

Figure I.5 Annual Growth in Per Capita Health Spending and in the Consumer Price Index (CPIU) Year 2000 = 1.
Sources: For health spending, Department of Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS), "National Health Expenditure Accounts," available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html. For the inflation rate, Inflation Data.com, Tim McMahon, "Historical Consumer Price Index (CPI-U)," October 13, 2017. https://inflationdata.com/Inflation/Consumer_Price_Index/HistoricalCPI.aspx?reloaded=true. Last viewed October 20, 2017.

by the CPI-U) always does rise, and therefore so will future Medicaid spending per capita. In a nutshell, the argument concludes, there will be no future *cuts* to the Medicaid program.

An interesting experiment here would be to see how members of Congress themselves would react if the tough constraints proposed for future per capita Medicaid spending were to be applied also to the public subsidies the federal government routinely grants health insurance for members of Congress and their staff.

Because even after a lively debate on the matter, we will never be able to reach a political consensus on the fundamental question raised above—to what extent we should become our

poorer brothers' and sisters' keepers when they fall ill. All that is left for health policy makers is the construction of an administratively more stable multi-tier health care system that facilitates rationing by income class. Chapters 9 and 10 of this book, which examines the various health reform plans debated during the summer of 2017, shed further light on this issue.

That is the long and short of it.

In the rest of the book, I begin with an overview of U.S. health spending and the factors that drive our high health spending. I argue that these spending trends already are pricing more and more American families in the lower part of the nation's income distribution out of health insurance and health care as families in the upper half of the distribution know it. I then focus on a number of bizarre quirks in our health system that are unique to the United States, explain who actually pays for health care in the United States, and explore the question whether from an international perspective Americans get adequate value for their high health spending.

Part II of the book is devoted to the ethical questions that the current situation in the United States raises for health policy makers. I explain the different distributive ethics different nations impose on their health care systems and how the United States is different from the majority of the rich nations in Europe and Asia in that it has never been able to reach a politically dominant consensus on a distributive ethic for American health care. This is followed by an explanation, from an ethical perspective, of the mechanics of commercial health insurance, which accounts for over a third of the total health spending in the United States. I then turn to focus on health reforms and the ethical precepts that underlay the reforms in recent years. The book ends with a brief novel proposal of my own for the next health reform in the United States.

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