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# Should healthy people have to pay for chronic illnesses?

Paul Ryan wants to shift the burden of health-care costs. His plan is a moral and economic failure.

By David Cutler March 17 Follow @Cutler_econ

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House Speaker Paul Ryan received a considerable dose of criticism for his comment that "the fatal conceit of Obamacare" is that "the people who are healthy pay for the people who are sick."

"This is literally how all insurance works," Charles Pierce wrote for Esquire, calling Ryan a "rube." The Huffington Post offered a lesson in "Insurance 101" for Ryan, explaining that "younger people, who tend to be healthier than older people, pay for health insurance like everyone else. They'll rely on it when they need it, probably more when they're older and there are younger, healthier people filing in behind them."

Critics were probably too quick to dismiss Ryan's remarks as ignorant. What he said reflects a long-standing vision of many on the right about who should pay for the chronically ill. Spreading the costs so that healthy people pay more than their own care likely will warrant in a given year is one option. But that's not the solution Republicans have traditionally favored. Their answer for health care, as

for old-age support, is to put a greater burden on individuals to pay for the costs they incur. In that mode of thinking, the unraveling of risk pools is a virtue, not a vice.

Even under this philosophy, though, Ryan's American Health Care Act is fatally flawed: It does nothing to address the high and rising cost of chronic illness.

Although discussions about health care often involve talk about uncertainty and risk, the reality is that a large share of medical costs are predictable. Consider the million-plus people in the United States with rheumatoid arthritis. RA, as it is known, is an autoimmune disease. It is much less common than its more prevalent namesake, osteoarthritis, but the symptoms are every bit as bad: pain, stiffness, swelling and loss of function in affected joints. There is no cure for RA, but treatment can reduce pain and improve functioning. The drugs of choice cost $10,000 to $30,000 annually (most are still patent-protected), with prices rising at double-digit rates. Not surprisingly, the cost of treating RA is soaring. More than $100 of the premium paid by every enrollee in the Affordable Care Act's exchanges goes toward treatment of inflammatory disease, including RA and related conditions.



Health care is a series of RAs: severe illnesses that are expensive and unsurprising. Eighty-four percent of medical spending is for the 50 percent of people with at least one chronic disease; half of spending is for the 16 percent

with three or more chronic conditions. People with chronic diseases know they will have them forever; those without have a low chance of contracting one in any year. Nearly half of people who are in the top 10 percent of spending in one year are in the top 10 percent the next year.

The central question for health policy is who should pay for the predictably expensive. Healthy people may be asked to pay more than their own situations warrant — through higher insurance premiums, taxes for Medicare and Medicaid, or markups on the drugs and services they receive. Doctors, hospitals and pharmaceutical companies may be asked to shoulder costs through lower payments. Or the chronically ill themselves may be asked to pay what they can — and to go without care they can't afford.

America has never had a coherent policy for the chronically ill. The elderly are covered by Medicare, which has expanded periodically in response to the growing costs of chronic disease; witness the addition of the Medicare drug benefit in 2003. In the non-elderly population, the chronically ill were historically covered through employment-based health insurance, which had all workers pay roughly equal amounts for coverage. Pooling employees is a natural way to share the cost burden — firms hire both healthy people and sick.

But as fewer businesses offered generous benefits, or any benefits at all, that model for cost-sharing went into decline. More people found themselves needing to buy health coverage on the individual market, where insurers were able to differentiate healthy people from chronically sick people and charge the sick more. It's not that insurers necessarily believe the sick should bear the bulk

of the cost burden. But if they don't offer healthy people cheaper plans, those people will leave for an insurer with a more competitive rate — or drop out of the health insurance market altogether. The result is a system very much in the conservative mold, where people mostly pay for their own care.

More-liberal states struggled against this before Obamacare but were only moderately successful. When premiums for sick and healthy were compressed, the healthy dropped out. Some states established subsidized high-risk pools for the chronically sick, but the costs for state governments were so high that most wound up putting limits on enrollment. In other cases, Medicaid and federal disability insurance became the insurers of last resort.



The Affordable Care Act is based on the idea that pooled insurance is a better way to address the chronically sick. Some of us are fortunate and others are not. If we all pay into the system, the costs for the less fortunate are spread across everyone. The ACA accomplishes this through a series of coordinated policies. First, insurers are required to cover all their customers at the same price, with reasonably generous benefits. Second, everyone is required to have coverage. The healthy are not allowed to free-ride if they happen to need care, or to avoid the costs of the less fortunate. Third, taxes on high-income people were increased so insurance premiums and out-of-pocket costs could be reduced.

Republicans reject each of these principles. Their objections to the individual mandate are long-standing, and the AHCA would repeal it.

Many Republicans also take aim at risk-pooling. Similar to Ryan's idea that the healthy shouldn't have to pay for the sick, Rep. John Shimkus (R-Ill.) questioned whether men should have to pay for health insurance that covers pregnancy. And the new administrator of Medicare and Medicaid argued in her confirmation hearings that maternity coverage should be optional. The GOP has long railed against "mandated benefits" such as requirements to cover mental health care and prescription drugs.

Since Republicans are trying to pass the AHCA through the budget reconciliation process, that limits the scope of the legislation to spending provisions only, and it means relatively little can be done to reduce pooling for now. The AHCA would repeal the "actuarial value" requirement that insurers have to cover a minimum share of costs, but it would leave in place the essential benefits that must be covered and the out-of-pocket maximum that insurers can make people pay. Costs would increase for people with chronic illness, but not as much as a wholesale repeal of the ACA would allow.

The limits of reconciliation bills are one of the main reasons people would lose coverage in the near term under the AHCA. Without the mandate to buy insurance, but with the requirement that insurers cover expensive people at the same rate as the healthy, the Congressional Budget Office projects that 6 million people (most of them healthy) will choose to leave the Obamacare exchange markets.

Republicans promise more changes over time to lessen the need for the healthy to subsidize the sick. The Trump administration has pledged to modify the "essential health benefits" through regulation, while Ryan has promised additional legislation to reduce mandatory risk-pooling. The CBO forecasts a return of some young and healthy people to the non-group market over time.

But reducing the payments for the healthy necessarily increases them for the sick. If insurance is allowed to exclude the "specialty drugs" taken by people with rheumatoid arthritis, people with RA could be stuck with bills of $30,000 annually. With optional maternity coverage, pregnancy might come with a $15,000 bill — a difficult way to start life with a newborn. And there is already worry that people with mental health and substance abuse disorders will be unable to access care, even as the opiate crisis continues to rage.

Without good exchange options, many of the chronically ill would probably seek to enroll in Medicaid. But here is where the third Republican objection comes in — the objection to government spending more on health care. The current version of the AHCA would cut Medicaid severely; after a decade, spending would be 25 percent lower. Already, Medicaid payments to providers are less than those for Medicare and private insurance. There is no estimate of inefficiency in Medicaid that is anywhere near this high.

Medicaid cuts would be particularly harmful to the chronically ill, who account for two-thirds of the publicly insured population. Payment rates to doctors and hospitals would fall, and eligibility criteria would be tightened. The CBO report

estimates that 14 million people would lose Medicaid coverage over the next decade.

Beyond the moral implications, the cuts to Medicaid would set up a cruel choice. With qualifying income levels for the program likely to fall and disability insurance already limited to those incapable of much work, many chronically ill will simply drop out of the labor force.

Those who remain employed will be increasingly uninsured. Of course, this does not relieve society of the problem of paying for at least some of their costs. The uninsured often receive “free care” from hospitals, doctors and some pharmaceutical companies. As even conservatives can attest, however, free care is never truly free. The insured pay for it through markups of medical bills, and tax revenue gets directed to the poor. In the AHCA, for example, there is $31 billion for additional Medicaid payments to hospitals that see a large share of low-income patients; that money was not needed under the ACA.

The only way society can avoid the annual $10,000-$30,000 for the person with rheumatoid arthritis is to reduce the cost of care, not just shift the cost from the healthy to the sick. In the case of RA, this means lowering drug costs. For diseases such as diabetes and heart disease, it means prevention as well as treatment.

The Affordable Care Act posits that cost savings can come from paying physicians not to provide more care but to provide better care. With reimbursement based on value and not volume, prevention is a way for doctors to earn more.

The AHCA would not repeal these value-related programs, but neither would it further them. The Trump administration has not said how it plans to address the value-based purchasing movement.

The most common idea for cost savings that Republicans tout is to allow insurers to sell insurance across state lines, with the idea that competitive companies will figure out how to better handle the costs of the chronically ill. Because of the rules of reconciliation, this proposal is not in the AHCA; Republicans have promised to bring it up later (with the changes in required benefits). Alas, evidence suggests that this policy would have no or minimal effect on medical spending. Indeed, it could lead to higher costs for the persistently ill, as state regulations requiring coverage of expensive medications would be overridden by federal law.

Another idea Trump supports is to lower costs by having Medicare negotiate drug prices with manufacturers. This would have an enormous impact on people with rheumatoid arthritis, a good share of whom are on Medicare. Not surprisingly, this proposal is more popular among Democrats than among Republicans, who fear the weakening of incentives for research and development of new drugs. It is unclear if Trump can get his party to reconsider its position.

Democrats and Republicans agree that we should do everything we can to reduce the prevalence of chronic illness. But beyond that, financing health care involves difficult choices. The problem with the AHCA is that by pretending everyone can have everything, it avoids the need to grapple with persistently

high costs. As any therapist can attest, avoiding trade-offs does not make them go away.

In the end, that evasion is what the CBO exposed, estimating that 24 million people would lose coverage under the GOP replacement plan in the next 10 years and millions more would face higher costs. The failure to address the persistently ill — a moral and economic failure — is the reason no amount of tinkering, regulation or subsequent legislation will ever fix what is wrong with Ryan's plan.

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