Federal Budget Battle and Implications on Health Care

Articles written for this site regarding the budget battles and impacts on our health care system are listed below in order from most recent to earliest:

Budget Battles - What's Next?

By Jeff Adams October 19, 2013

The most recent federal government shutdown is over and the debt ceiling has been raised, avoiding a government default. So what is next? There will be intense negotiation between now and mid-January in an effort to avoid another shutdown and to avoid a government default. Hopefully most of the debating will be in person with each other and not on the airwaves but, after all, it is politics. A joint committee has been given the task of producing a bipartisan plan by December 15th. The period between December 15th and January 15th will involve very stressful, intense negotiation between the sides and possibly more propaganda aimed at the public than we have heard in a long time.

The main contention-points of these budget negotiations will be entitlement programs: Medicaid, Medicare, and Social Security. Social Security reform has been discussed for years and needs to be done to protect the long-term integrity of the program, especially since Americans save less and less for retirement and, as a result, have less and less money when they retire. The percent of Americans who are retired is also increasing, putting more pressure on Social Security funding. As a health actuary I will leave it to those more knowledgeable about Social Security to comment on ways to modify the program to make it more efficient. I will note, however, that outlays for Social Security are formula-driven based on an individual's lifetime income and these outlays can be more easily predicted than health care costs in Medicare and Medicaid. Medicare and Medicaid cost increases vary from year to year, often with wide swings. These wide swings make it difficult to determine how much really needs to be cut due to the difficulty in predicting costs in any budget year. Attempts to control Medicare and Medicaid costs may also have unintended adverse effects on commercial health care costs, meaning increased costs for employers, health care funds such as union funds, and individuals seeking health care coverage.

All that being said, the purpose of this article is to discuss the health care issues that may be debated in upcoming negotiations. One main point that I would ask of those following these debates, willingly or unwillingly, is to remain objective and seek multiple points of view when one side or another sends out propaganda. Propaganda that is sent out by one side or the other may make sense on the surface but may have unforeseen major side-effects when looked at in detail. This article, and others that may follow, attempt to help understanding when new proposals are publicized if I think that I can clarify essential items in the new proposals.

The Budget Problem: Medicare and Medicaid

When I began as a health actuary in 1983 Medicare and Medicaid programs were approximately 10% of the Federal budget. According to www.whitehouse.gov these programs represent 24% of the 2013 Federal budget, increasing to 28% by 2016, although it will dip slightly in 2017 to 27%. Some of these increases are due to expansion of government programs, such as George W. Bush's Medicare Part D Prescription Drug Program, but the majority of the increase is due to overall increases in health care costs in our country. Both sides generally agree that these outlay

increases are unsustainable but, to date, have differing approaches to lessen these increases.

Democrats

The Affordable Care Act ("ACA") has elements in it that are designed to make Medicare more efficient. Affordable Care Organizations ("ACOs"), for example, are provider organizations whose payments from Medicare are based partially on a series of quality and efficient targets. I estimate that this will save 5% to 7% and increase the quality of care for those Medicare enrollees who are affected. This is not a huge amount but it is significant.

ACA has also created the Patient-Centered Outcomes Research Institute ("PCORI"). PCORI receives funding from additional charges added to insurance premiums and self-insured plan costs and uses this revenue to finance grants to various entities who perform studies on various treatments in an effort to determine effectiveness of these treatments. The goal is to increase the quality of care provided but a side-effect should be more efficient health care. This is a long-term program whose actual effectiveness will be determined in five to ten years.

In the past, in an effort to reduce Medicare costs, the Democrats and Republicans have jointly reduced per-service payments to providers. While reducing Medicare costs, this reduction actually results in the providers seeking additional revenues from payors that will be assessed to employer and individual coverage premiums. In theory the government is attempting to make providers more efficient but insurers are somewhat limited in its ability to restrict provider fee schedule increases in today's environment.

It is unclear what additional proposals, if any, that the Democrats will put forth that will result in additional cost savings beyond where we are today. I am not envisioning that the Republicans will allow a bill to be passed that does not have additional spending cuts, however. The most likely Democrat proposal would be the cut in Medicare provider payments discussed above.

It is also possible that the Democrats will propose cuts in payments to insurers for Medicare Advantage programs where insurers receive a set amount per member from Medicare and are responsible for covering all claims and administrative costs incurred by those members. The intent is to make insurers more efficient, which it might do to some extent. However, since insurer profit margins are so thin, this reduction in payment from Medicare has historically resulted in reduced benefits for Medicare enrollees, increased Senior Medicare Advantage premiums, or an insurer even pulling out of the market. There is no reason to think that these side effects would not happen again in the future.

Republicans

I expect the Republicans to modify its position on Medicare between now and January 15th but currently its proposal is what is commonly called a "voucher program" whereby the Federal government will give Medicare recipients a set amount of money that they can use to purchase health care coverage on their own. The idea behind it is that by doing this the Federal government has reasonably tight control on future Medicare cost increases, so important to avoid mounting deficit issues that will increase with time.

On the surface this seems like a reasonable approach but it will ultimately make health care coverage affordable only for the higher income seniors who are not healthy and willing to pay very high premiums. For example, let us assume that Medicare payments and the "voucher" for

2014 are $10,000 per member per year (this is probably low as health care costs are much higher as an individual gets older, but is reasonable for an example). Let us also assume that health care costs for Seniors increase at a rate of 6% (not unreasonable given recent health care cost increases). Let us also assume that the Federal government increases voucher values (payments to Medicare recipients with which they can buy coverage) at 3% each year (also not unreasonable since the government would implement this to better control Medicare cost increases for budget purposes). In 10 years the average Senior would be paying more than $4,600 for health care coverage. In 14 years the average Senior would be paying $14,000 for coverage. In actuality the results would be much worse as even in a couple years, healthy Seniors would start to drop coverage leaving only sicker Seniors in the pool and driving up health care costs for those who remain in the voucher program. This could easily drive up Senior premiums for health care to $6,000 in just 10 years. The Republican proposal is an ugly scenario that would dramatically increase the number of uninsured. In order to make this voucher-style program work there needs to be elements that would allow insurers to reduce costs so these reductions could be passed on to recipients.

It is unclear as to what additional proposals the Republicans will bring up although decreased provider payments as discussed above are likely.

Commercial Employer, Health Care Fund, and Individual Coverage

Unintended side effects of budget legislation on commercial coverage is an issue. Commercial health care costs have continually increased at an unsustainable rate over the past few decades. In the 1990s, "experts" said that health care costs could not exceed 20% of the Gross Domestic Product ("GDP"), otherwise serious damage would be done to the economy. At that time, health care was 12% of GDP. Currently it is 18% of GDP and still rising. Effects on the economy are showing and uninsured rates are rising. ACA reduces the uninsured rate but it also increases employer health care costs by 5% to 10%. Also, due to the details in ACA, the uninsured rate will start to rise again in three years if commercial health care costs are not brought under control, as the Premium Tax Subsidy will start to erode as a percent of total premium. As an example, a household that gets health care coverage for $2,500 in 2014 may be forced to pay $4,000 in 2017 for coverage. Not only does the Federal government need to assure that Medicare cost savings are not made at the expense of commercial coverage, it needs to create legislation that helps control health care costs in general.

Democrats

Additional proposals on commercial health care by the Democrats are unexpected. Concentration is now on the Federal budget and the Democrats may be willing to sit back and see if the long-term elements of ACA (PCORI and Exchange CO-OPs) help to lower commercial health care cost increases. PCORI was discussed above and there is additional information in another article on PCORI on this site. It has some potential but results will not be known for years. ACA also provides funding for CO-OPs in the Exchanges. The hope is that some of the experimental payment or organization methodologies used by these CO-OPs will be effective in lowering costs while increasing quality of care. Many CO-OPs will not be in existence ten years from now but the hope is that many who survive do so because of new ideas they bring to the health care industry, making it more efficient and raising the quality of care.

Republicans

Republicans will also be concentrating on the Federal budget so it is unlikely that they will bring forth legislative proposals on commercial health care coverage. Their most recent proposal was to increase competition by allowing insurers to sell across state lines without having to follow state mandates in the state in which they sell. For example, an insurer in Delaware would be able to sell in New York without following New York mandates. The only affect on overall health care costs would be the ability to buy coverage without state mandates. Some consider this more of a benefit reduction than a cost reduction. It would also allow insurers to avoid some small group premium restrictions. For example, New York does not allow small group premium rates to be based on age. Under the Republican proposal a policy sold by an insurer in a state that allows age-rating to an employer in New York would enable the insurer to age-rate that employer group. This would not reduce health care costs, only distribute them differently between the employers.

Summary

As discussed previously on this site, the US health care system has serious issues. Independent studies have shown that the quality of care in the US is in the middle of the pack as compared to the quality of care in other developed countries. Studies also show that, by any measure, the cost of health care is substantially higher than the cost of health care in any other country in the world. We are not getting what we pay for and I see advertisements for colleges saying that health care is the fastest growing industry in the country. Something has to change.

The deadlines for resolving the budget issue are too tight to allow for meaningful overall reform to our health care system. The changes between now and January 15th will likely be Band-Aid approaches that force more costs on to the commercial market. It is unclear as to when the Federal government will negotiate on meaningful health care reform but it is unlikely in the next couple years.

Why a Voucher-Style Program Will Decimate Medicare

By Jeff Adams August 12, 2013

This article is designed to be a non-partisan, objective assessment of the impact of the proposed voucher-style program for controlling Medicare costs. In this current politicized world of health care, it is difficult to deliver facts and ideas to try to educate the public. Any facts or opinions that do not match one party or the other's agenda results in the originator being labeled as partisan. Health care is 17%, or over one-sixth, of the United States' economy so there will be frayed nerves at any suggestion of changing this sector. Additionally, almost every citizen would be affected by changes in health care since if an individual is sick or injured they may have no choice but to go to the doctor or hospital. If it is feared that changes in health care may affect the citizens' access to or quality of care then there will be some agitation in the population.

The Issue

A main issue in the health care debate is big government versus small government. Republicans are proponents of smaller, more efficient governments that allow citizens to keep more money and make the decisions that affect their lives. Democrats believe in a more centralized approach with programs designed to help citizens left in difficult situations due to unfortunate situation in

their lives.

Health care is an important battleground with issues that require bipartisan cooperation to avoid major budget issues in the Federal, state, and local governments. Medicare and Medicaid represent approximately 24% of the Federal budget. It was not too long ago when only 12% of the Federal budget went for Medicare and Medicaid. The implication of this doubling of health care costs as part of the Federal budget is that the Federal budget has 12% less to spend on programs other than health care. This means that many popular programs needed to be cut or reduced due to these excess health care costs. Compounding this issue is the additional interest on government debt that needs to be paid as part of the Federal budget due to unfunded prior Medicare and Medicaid costs.

Compounding the health care problem is that health care costs for the private sector have increased substantially over recent decades. Every year many employers are forced to drop coverage for its employees, with the number of employees purchasing coverage through their employers decreasing each year for this same time period.

Modifying Medicare and Medicaid cannot be done without considering the impact on private insurance. Often, short-sighted attempts to control government health care costs only serve to push these cost "savings" on to the private sector, resulting in higher employer premiums or higher individual premium rates. An example would be reducing Medicare payment schedules to hospitals. This would theoretically reduce Medicare payments to hospitals. The easiest method for hospitals to make up for this lost revenue is to negotiate with insurance companies for increased payments for the non-Medicare and non-Medicaid business. The Federal government has much more leverage in setting payment schedules than do employers and insurance companies.

The Voucher-Type Program

One proposal to control Medicare costs is to give Medicare enrollees a certain amount of money and let them choose a private policy. By doing this the Federal government will be able to better control Medicare costs since it can control precisely the costs for the Medicare enrollees, regardless of actual health care cost incurred by the individual. For example, the government may determine that it will pay Medicare enrollees $800 per month and these enrollees would then use that $800 to help pay for insurance premiums from health insurers. If the health insurer charges $1,200 a month for premium then the enrollee would have to pay $400 per month for coverage. In the following year the Federal government may determine it will increase its payment to the enrollee by 3% to $824 while the insurance premium may increase by 7% to $1,284. This would result in the retiree having to pay $460, a 15% increase over the previous year.

This type of program is commonly called the "voucher program". Proponents of this proposal do not agree with the term but it is roughly an accurate description.

Proponents point to the control over spending and say that insurers will need to control premium increases or lose enrollment. The situation with escalating employer premiums points to the fact that insurers will not reduce premiums to keep membership if it means smaller profits, no profits, or losses. In an ideal world the insurer would like to increase enrollment as long as they do not

lose money as a corporation. If it is a choice between losing enrollment or losing money then the insurer would, like any business, generally choose to lose enrollment.

A Reasonable Scenario

A very reasonable scenario would be the Federal government starting off this program giving the retiree a voucher that would, on average, allow a Medicare enrollee to purchase coverage at the same cost of obtaining coverage today, namely the Part B Premium of $104.90 per month or, roughly, $1,200 per year. This would imply that the "value" of the voucher would be, roughly, $800 per month or $10,000 per year since average health care costs for Medicare enrollees are in excess of $900 per month, or $11,000 per year.

The following table summarizes these numbers as a possible scenario for 2013:

Total Health Care Cost Per Medicare Enrollee Per Year	$11,000
Medicare "Voucher" Per Year	$ 9,800
Medicare Enrollee Premium Payment Per Year (= 2013 Part B Premium)	$ 1,200

Under the voucher proposal there is little incentive for health insurers to control costs or increases in future premium rates. The insurers' main objective would be to have a surplus or to at least not lose money. In this scenario it is reasonable to estimate that Medicare enrollee premiums would increase by 7% each year. The 7% would include increases in health care cost due to unit cost (CPI), utilization (increase in the number of services and new procedures), and changes in the mix of services (trend towards more costly services).

As discussed, the voucher proposal allows for firmer control on Federal costs. With the current budget issues it is reasonable to assume that the value of the voucher will increase at an average rate of 3% or less. The target will probably be general CPI and eventually mirror Social Security benefit increases. Note that there continues to be downward pressure on Social Security benefit increases with the newest idea being that of the "Chain CPI".

Long-Term Results

The starting health care cost of $11.000 per year with a 7% increase each year thereafter along with a starting "voucher" amount of $9,800 with a 3% increase per year would lead to very high Medicare enrollee cost of purchasing coverage in the future.

Given this conservative scenario, the Medicare enrollee would have to pay $5,000 a year for coverage by the year 2034.and $10,000 in 2044. There will be an adverse selection spiral caused by this scenario as healthy Seniors will choose to drop Medicare coverage leaving only the sicker enrollees purchasing coverage, increasing premiums causing not so healthy people to drop coverage, increasing costs, etc. Assuming a conservative 20% adjustment for a sicker Medicare population by 2034 the Medicare enrollee would then have to pay $14,000 by 2034 and $28,000 by 2044.

Summary

Under these conservative scenarios, there will be mass exodus from Medicare over the next 20 to 30 years, adding to the 50 million uninsured in this country and decimating enrollment in

Medicare causing it to no longer be a viable program. It will, however, go a long way in controlling the Federal budget so it boils down to your preference.

There are other choices other than the voucher-style program. Many ideas about reducing the 30% to 35% of health care costs that are due to fraud and abuse have been made. Significant health care cost reductions may be obtained if the goal of reducing overweight and obesity rates in the United States is achieved. As has often been written on this site, there is no Silver Bullet solution, just a lot of hard work and many changes adding up to substantial savings.

Budget Battle - Spring 2013
By Jeff Adams April 10, 2013

Here we go again! President Barack Obama has released his budget proposal for 2014.As will be the case for the foreseeable future until our health system is fixed, his proposed budget contains cuts to Medicare totaling almost $400 billion. As stated in previous articles, these cuts will be an annual ritual to avoid Medicare taking up an increasing portion of the Federal budget.

As will be the case for a few years to come, the majority of the savings in this Band-Aid approach to controlling Medicare costs is a cut in Medicare payments to providers. Providers will need to either reduce their costs or increase revenues from commercial insurance companies to offset the reduction in revenues from Medicare. These means additional premium increases for small employers and persons purchasing individual policies from the new health insurance Exchanges. This also includes additional premiums in 2015 for persons with Premium Tax Subsidies under the Affordable Care Act.

President Obama's proposal also contains increased premium payments for wealthier individuals who are enrolled in Medicare.

My thought is that the final cuts to Medicare payments to providers after agreement by Senate Democrats and House Republicans will be at least $300 billion. The increased premiums for wealthier individuals will be debated and may be ultimately eliminated but we will wait and see.

I am also thinking that the necessary overhaul of the health care system may take place in 2017 and 2018 after several more years of the current Band-Aid approach. Only time will tell.

Budget Battle of Winter 2013

By Jeff Adams January 21, 2013

Republicans and Democrats need to come together to raise the debt ceiling by March. What will this mean for the health care system? It is too early to say but here is my guess:

The Medicare budget will be cut as part of the overall budget cuts. These cuts will be superficial cuts to segments of payors and providers in the Medicare system. As we will see for a few years to come this will be a very short-sighted plan that will not fix the underlying health care system issues of fraud, waste, abuse, and the effects of the overweight on the system.

Here are some possible segments that might suffer cuts and the effects on the overall health care

system:

Cuts to Medicare Advantage Payors - Insurance companies and health maintenance organizations might see a reduction in payments per enrollee. The idea is that the payors would be paid less and have to reduce its costs or profit level. This actually may have some ring of truth in the long term but in the current health care environment it will cause short-term and long-term issues.

Payor contracts with providers are negotiated in advance and can be multiple years in length. This means that a payor's costs cannot be reduced by this means on a timely basis on many or most occasions. Even if payors are able to achieve reductions through provider contracting, the providers may require that these reductions be offset by increases in the commercial (non-Medicare, non-Medicaid) contract arrangements. This would require employers to pay additional premiums to cover its employees and would increase the uninsured rate.

Reducing health care costs through increased utilization management is a means of eliminating waste, fraud, and abuse. However, payors tend to not want to add on to utilization management staff since it adds to administrative costs, increased complaints by the policyholders when services are denied or delayed, and increases complaints by providers due to additional paperwork.

The easiest method for payors to not lose money is to reduce benefits for its Medicare Advantage plans, although this is obviously bad for the policyholder. Payors are required to cover a certain minimum level of benefits but then can add elective benefits on top of the minimum benefits. It is these elective benefits that will be reduced or eliminated.

If a payor is not able to reduce its costs enough to offset the revenue decrease from the federal government and not lose money then they will probably eliminate its Medicare Advantage plans, thus eliminating a benefit option for the consumer.

Cuts to Provider Payments -

Reductions in these payments are designed to make care more efficient by limiting the amounts paid per service. Unfortunately, a large portion of the problem is that there are too many services performed and not that each service is too expensive. The unnecessary services performed adds to the providers' costs. Reducing the fee schedule does not affect the number of these unnecessary procedures performed. Fraud also adds significantly to the number of services performed. It may increase efficiencies at the provider somewhat but still fails to address the underlying problem of overutilization. Again, reducing Medicare payments to providers would cause these providers to seek additional revenue from payors' commercial business. This will cause employers and persons who have direct-pay individual coverage to have to pay higher premiums or drop coverage.

Summary

As we will see for the next few years, the congressional approaches to controlling the health care

costs in the Federal Budget will be what I call a "survival-mode" approach. With party politics there will be no willingness to compromise and get real change to the system until the situation is extremely critical. The current cutting of Medicare payments will continue to move costs to the private sector and not substantially help in eliminating the underlying issue of excessive utilization due to fraud, waste, and abuse. The fraud, waste, and abuse issue is a difficult one to track and resolve. This is made even more difficult when state governments may not want to act when specific fraud situations are pointed out.

I am hoping for a third party to develop, such as what happened in New York State. The moderate Democrats broke off and effectively formed a third party. Now the government is functioning better than it has for quite a few years. If this happens on a federal level then maybe the government will start to act more for the people's best interest than to act solely based on party politics.

Budget Battle 2012: Effects on the Health Care System
By Jeff Adams December 19, 2012

Time is running out on negotiations to avoid the Fiscal Cliff, the term used to define the expiration of the Bush-era tax cuts and the implementation of wide-spread Federal budget cuts that will most likely result in a recession in 2013 in the United States. This Fiscal Cliff would be triggered if Congress and the President cannot agree on a budget by the end of 2012 or possibly the first few days of 2013. The article that follows analyzes the impact on the United States health care system of various scenarios from this year's budget battle.

Health care costs have been one of the fastest growing parts of the economy for decades. Today, commercials for colleges still tout health care as the fastest growing sector of the economy. Two decades ago health care represented 12% of the Gross Domestic Product ("GDP"). Today, health care represents 17% of GDP. Despite this staggering growth, most objective studies show that the quality of care in the US lags other developed countries. These same developed countries spend substantially less on health care as a percent of its GDP.

In the early 1990s some health care analysts claimed that if health care as a percent of GDP topped 20% to 25% then there would be serious economic ramifications. They said that health care costs at this level would have a severe impact on Federal and state budgets and would make it extremely difficult for employers to be able to afford health care coverage to its employees. At the current 17% we are seeing signs of these issues. Medicare and Medicaid represent 24% of the Federal budget and is increasing each year, forcing Federal and state governments to eliminate other programs so that it can pay for the higher health care costs. Employers continue to drop coverage or lower benefits for its employees. The uninsured rate rises almost every year.

With this background, we enter the final days of the 2012 Budget Battle. Medicare and Medicaid are key components of this battle. This will most likely be the first of many years of very difficult negotiation within the Federal budget process regarding Medicare and Medicaid. Any agreement for this year's budget will be more of a Band-Aid approach, with no long-term solutions. It is, however, a necessary first step. It appears that both parties have come

to the understanding that rising health care costs are a huge issue. It also appears, however, that any meaningful solution is still years off. Solutions such as those described below may result from budget battles in the immediate future. Legitimate fixes to the health care system may not take place until health care costs climb to 22% to 25% of total US GDP and the situation is more of a crisis than it is today.

It is important to note a couple items in "budget-speak". "Cuts" are reductions to anticipated future spending increases. For example, if spending on a given item is $100 B in 2012 and is projected to increase 5% to $105 B in 2013, a 1% cut would result in, roughly, $104 B in spending in 2013, still a 4% increase in spending over 2012. Also, cuts are often termed in 10-year blocks, as in a $400 B Medicare cut over the next ten years, roughly $40B per year.

A significant cut to Medicare spending is likely in the final budget agreement. A $400 B cut over 10 years would be roughly $40 B each year. If Medicare spending were $500 B in 2012 and scheduled to increase to $525 B in 2013 then the $40 B cut would result in a new spending estimate for 2013 of $485 B, a $15 B actual decrease from 2012. This might cause financial issues for the health care providers (hospitals, physicians, other vendors), payors (HMOs and insurers), and policyholders as its costs increase. The budgeting issues may be exacerbated if the cuts are targeted to specific entities such as only the hospitals or the insurers.

The impact of the Medicare cuts on the health care system depends on where the cuts are made. If the cuts are made by reducing Medicare benefits to Medicare recipients then there may be angry policyholders and potential voters but there would be no major changes in the health care system as a whole. The major reason behind reducing benefits is the idea that policyholders should share in the burden of controlling health care costs. Also, deductibles and copays could be increased to reflect increases in inflation. These benefit decreases would tend to be minor.

Increases in Part B premiums would also not cause a substantial change in the landscape except that if this premium was raised high enough then seniors may not enroll in Medicare Part B, possibly leaving them uninsured. This scenario is not likely anytime soon as the Medicare Part B premium is designed to be 25% of total Part B (physician) costs but is usually less due to the political sensitivity of possibly angering the senior population.

Reductions to payments to some or all providers is a possibility. The provider may try to recover this lost revenue by obtaining better terms on its contracts with the payors on its commercial (non-Medicare, non-Medicaid) business, thus increasing costs and premiums for employer-based and individual commercial policies. The provider will also try to increase efficiencies in order to reduce costs, which would reduce overall health care costs. The provider may also try to increase utilization in order to maintain its revenue stream. This might have the impact of nullifying the intended payment reductions and cost savings.

Lowering payments to payors (insurers and HMOs) for Medicare Advantage plans is a possibility. There are two major reasons for doing this. The first reason is the theory that payors are making too much profit on Medicare Advantage plans. The second reason would be giving payors the incentive of reducing their costs so they can maintain its profit margins. Payors will attempt to reduce their costs through additional utilization management and more efficient

administration. It may also eliminate policyholder benefits to make the plan less generous. It also may try to keep payments to the providers low through better contracting for its Medicare product, but that would be subject to the same issues as stated above for the direct Medicare to provider payment reductions. Even if a payor successfully negotiates Medicare payments down with a provider, that may lead to higher payments on commercial contracts or increased utilization nullifying the anticipated payment decrease and cost reduction.

Medicaid cost-reductions will be less likely to be targeted at Medicaid recipients but will follow similar patterns as described above for Medicare. Costs are likely to be reduced for Medicaid and Medicare but there will also likely be a slight shift in cost away from these government programs into employer-based, sponsor-based, and commercial individual coverage. These additional costs to the employer-based health care plans may lead to more employers dropping coverage and a higher uninsured rate in the US. The ACA will subsidize health care for lower income persons in 2014 but its impact will be limited if health care costs increase at a higher rate than household income and the general Consumer Price Index. The reason for that is that for 2015 and after the cost of health care increases in excess of household income and CPI increases is passed on to these individuals, mitigating the impact of the subsidy. The only way that these subsidies can be maintained is for health care trends to be maintained at or below general CPI increases. Future health care regulation needs to include all components of health care and not just government programs or it will continue not to address the underlying problems in our health care system and will serve only to move health care costs from the government programs to the commercial programs.