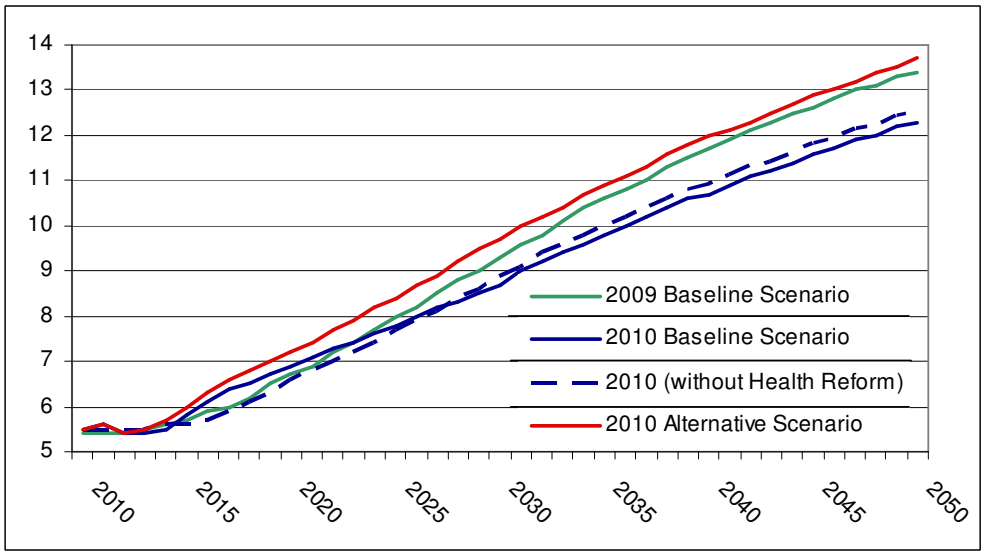
The Effect of Health Reform on the Long-Term
July 14, 2010

Last week, the Congressional Budget Office (CBO) released its Long-Term Outlook, which CRFB wrote about in detail at http://crfb.org/document/cbos-long-term-budget-outlook. A key question leading up to the release, was what CBO would conclude about the health reform bill's impact on the long-term; however, their answer is inconclusive.

Those on the right have argued the report finds that "Obamacare [Is] Unlikely to Reduce Spending on Health Care,"[1] while those on the left have suggested "CBO's Good News... [that] The Affordable Care Act Will Substantially Reduce the Deficit."[2] But CBO reaches neither of these conclusions. It simply does not have the analytical capacity to project what a complex set of new, untried policies will do decades into the future.

In this paper, we discuss how the health bill affects the long-term, how CBO estimates the effects of these changes under their two long-term scenarios, what impediments and uncertainties make it impossible to conclude too much from these estimates, and what policymakers can do to maximize the chance that health care reform will reduce long-term deficits.

Fig. 1: Major Federal Health Spending (Percent of GDP)



Changes in the Health Care Bill

CRFB has written many times before about the major policy changes embedded in the health care bill, along with their ten-year budgetary effects.[3] Over ten years, CBO estimates the bill will reduce the deficit by $143 billion—though these estimates include some troubling gimmicks, including using money from the CLASS Act, a new long-term insurance program. From a fiscal perspective, the legislation makes three broad types of changes over the first decade:

1. It increases the level of funding for low-income health care by expanding Medicaid and SCHIP and providing subsidies for individuals in the new health exchanges.

2. It decreases the level of funding for Medicare, largely by cutting Medicare Advantage and reducing payments to providers.

3. It increases the overall level of taxation by increasing and expanding the Medicare payroll tax for high earners, imposing fees on the health care industry, establishing a tax on high-cost insurance, and making other changes.

In total, these three sets of changes (along with other smaller ones) basically net against each other in 2019. Most of these changes really deal with *levels* of spending and taxation, rather than growth rates. Beyond the first decade, however, a number of provisions in the bill might begin to start really impacting *rates* of growth. These provisions include:

1. "Productivity adjustments" for Medicare's provider payment updates, designed to permanently reduce the size of these updates and therefore slow the growth of provider payments in Medicare (note that these do begin early in this decade).

2. A reduction in the growth rate of exchange subsidies, beginning in 2018, which will cause these subsidies to grow more slowly than health care costs.

3. A large number of pilot programs, demonstration projects, and smaller reforms which have the potential to slow health care cost growth (or not).

[1] The Heritage Foundation, "Obamacare Unlikely to Reduce Spending on Health Care." Blog post (*The Foundry*), July 1, 2010. http://blog.heritage.org/2010/07/01/cbo-obamacare-unlikely-to-reduce-spending-on-health-care/.
[2] Center for American Progress, "Don't Miss the CBO's Good News." June 30, 2010. http://www.americanprogress.org/issues/2010/06/cbo_health.html.
[3] For previous CRFB analyses of the health care reform bill, see http://crfb.org/publications/search?keywords=&document=69&issue=61&project=All.

4. An Independent Payment Advisory Board (IPAB), or Medicare Commission, required to make certain types of cuts to Medicare whenever the program grows more than one percentage point faster than GDP.

5. An excise tax on high-cost insurance plans, which is indexed in a way so that it will cover an increasing amount of income and number of health care plans over time. (Specifically, the bill sets a dollar threshold above which the tax applies, but then indexes that threshold to the CPI after 2020 -- though health care costs are likely to grow far more quickly.)

In theory, all other things equal, these provisions should reduce deficits by increasing amounts over time. Whether they do in reality, and the extent to which they do, is far more uncertain.

CBO Estimates of the Health Care Bill

In designing the Extended-Baseline and Alternative Fiscal Scenarios in its Long-Term Outlook, CBO must make some assumptions about what impact health reform will have over the longer-run—despite not having a really solid analytical basis for doing so (see the next section for an explanation).

Before even making these assumptions, CBO made a few changes to its long-term health model from last year. First, CBO reduced its estimate of economy-wide excess health care cost growth (growth beyond GDP) from 1.9 percent to 1.7 percent, and its initial excess cost growth rate of Medicare from 2.5 percent to 1.7 percent. Second, CBO equalized excess cost growth rates among programs, rather than having Medicare grow at a faster rate than Medicaid.

Both these technical changes were made independently of the health care bill—though we can't help but note that the health care bill should tend to trend health spending as CBO now estimates it since the legislation will likely reduce Medicare growth rates down toward those of Medicaid.

CBO also lowered their estimates of the *level* of economy-wide health care spending over the next decade to account for new data, and they assume excess cost growth declines linearly over time rather than through a more complex methodology. As a result of these technical changes, total public and private health care spending is projected to be about 5 percent of GDP lower in 2035, and a similar amount in 2080, than under last year's projections. Note that basically all the reduction in health care spending in CBO projections are not the result of health care reform, but rather technical changes to CBO's methodology.

Under CBO's Extended-Baseline Scenario, the health reform bill does far more to reduce the deficit than under its Alternative Fiscal Scenario. The main difference is assumptions over whether Congress will stick to the deficit-reducing mechanisms in the bill. This manifests itself mainly on the revenue side, as opposed to on the spending side.

As we explain in the sections below, some of these cost-savings measures may not be politically, or even economically, sustainable over the longer-term. Therefore, CBO's two scenarios reflect different assumptions about how long lawmakers keep them in place. Moreover, CBO is not well equipped to assess the spending impact of the bill beyond 2030, and therefore relies on a simple mechanical calculation which is unlikely to accurately capture the legislation's full effect.

Fig. 2: Effects and Assumptions of Health Care Reform under CBO's Extended-Baseline and Alternative Fiscal Scenarios

	Baseline-Extended Scenario	Alternative Fiscal Scenario
First Decade	Spending and revenue provisions play out as written in law	Spending and revenue provisions play out as written in law
Deficit Impact in 2020	**0.1 percent of GDP reduction**	**0.1 percent of GDP reduction**
Second Decade	Federal health spending grows at slowed rate based on estimated "broad growth rates" of provision in health legislation	Federal health spending grows at rates estimated absent reform, under the assumption that policy makers will not allow certain cost-controlling measures to continue
	Tax provisions play out as written into law	Overall revenue levels will remain fixed percent of GDP^
Deficit Impact in 2030	**1 - 1.3 percent of GDP reduction**	**0 - 0.1 percent of GDP reduction**
Beyond Second Decade	Federal health spending grows at rates estimated absent reform (though from a lower level)	Federal health spending grows at rates estimated absent reform
	Tax provisions play out as written into law	Overall revenue levels will remain fixed percent of GDP
Deficit Impact in 2080	**4 - 5 percent of GDP reduction**	**0.3 percent of GDP *increase***

Note: Deficit impacts exclude interest savings and are measured relative to their respective baselines, excluding the health care bill. The Alternative Fiscal Scenario also assumes continued "doc fixes" at a cost of 0.3 percent of GDP in 2020, however this would be true whether or not health reform had passed.
^ CBO's Alternative Fiscal Scenario assumes revenues stay fixed as a percent of GDP after 2020, so here CRFB assumes that health care revenues also remain fixed as a percent of GDP.

Understanding the Uncertainty

Under both of its scenarios, CBO eventually returns to its previously estimated growth rate for federal health spending—by 2030 under the Extended-Baseline and 2020 under the Alternative Fiscal. As CBO explains, this is because "CBO does not believe it has an analytic basis for evaluating the effects of the legislation on the growth rate of spending over the very long run."

This admission of uncertainty is a completely reasonable one. For one, there are gigantic inherent uncertainties in projecting health care costs, considering the large number of factors and inputs which go into determining how these costs grow (especially way into the future). It is impossible to fully understand how the numerous major and minor changes in the health reform legislation will impact these inputs—especially considering that many of these provisions are unprecedented, and it will be years before we'll have had a chance to observe them.

Further complicating estimates is the fact that CBO already assumed health care cost growth would slow over time—so it is unclear how much of what occurs as a result of the bill would have happened absent health care reform.

Before health reform was enacted, CBO's long-term model had assumed that the private sector, states, and federal regulators would take actions to slow health care cost growth; and the savings they achieved would trickle into Medicare and Medicaid. Unfortunately, it is now impossible to disentangle the effects of the health legislation from what CBO believed might have happened anyway. This two-way cost interaction cannot easily be modeled or quantified.

And then there is the question of sustainability. CBO and other serious analysts (including the Medicare Actuaries) are highly skeptical that the provisions which slow Medicare provider payment updates (including the "productivity adjustments' and much of what IPAB would have to do) are sustainable over the long-run. The continued divergence between private and public spending to these providers could begin to represent a serious economic and political problem. As CBO explains, "*it is unclear whether that lower rate of growth can be sustained and, if so, whether it will be accomplished through greater efficiencies in the delivery of health care or will instead reduce access to care or diminish the quality of care.*"

Most analysts also think that it is quite unlikely that policymakers will continue to let revenue grow, forever, as a percent of the economy. Under CBO's Extended-Baseline Scenario, total revenues would eventually exceed 30 percent of GDP (with about 4 percent of GDP being the result of health reform) – compared to the historical average of just over 18 percent of GDP. Politicians are unlikely to let this occur.

Making the Savings Sustainable

The concern over the long-term sustainability of the savings in the health care bill is real, but it is not a certainty. As Senator Baucus argued at the release of CBO's Long-Term Outlook, "our challenge is to prove [the warnings] wrong...[and] not backslide on the savings in the bill." This is a noble goal which CRFB whole-heartedly supports. Here are some ways to make it easier:

1. **Keep Private Sector Cost Growth Down** -- The unsustainable nature of payment updates is the result of the large divergence which would likely occur between public sector and private sector payments. Slowing private sector health care cost growth can therefore make the public "curve bending" easier to sustain. Further limiting the tax exclusion on employer-provided health insurance and enacting medical malpractice liability reform are two examples of policies that might help.

2. **Spread the Pain** -- The reason provider payments have to go down so much is because they are essentially bearing all the pain from cost control (other than Medicare Advantage)—they are also basically the only ones the Medicare Commission can touch. This can be remedied by increasing premiums, changing cost-sharing rules, changing eligibility rules (for example, by raising the Medicare retirement age), and/or focusing on cuts beyond Medicare (such as Medicaid, TriCare, premium subsidies, etc). If policymakers are not willing to take on these changes directly, they could broaden IPAB's mandate to allow it to make these types of changes for them

3. **Refocus Cuts Toward Efficiency in the Second Decade**—Reducing provider payment updates is a blunt instrument which can work for awhile, but perhaps not forever. At some point, Congress or IPAB should be allowed to let updates increase somewhat faster than scheduled in exchange for targeted cuts, payment reform, or other changes. These changes should focus on actually improving the efficiency of the delivery of care, either by reducing payments on certain low-value procedures, increasing cost-sharing on those procedures, reducing payments to certain high-cost providers, or anything else.

4. **Stick to Your Guns as Long as Possible**—There is a difference between economic sustainability and political sustainability. The latter may be apt to deteriorate long before the former; we cannot afford to let it do so. Congress therefore needs to stand strong and keep in place the cost-saving measures within the bill for as long as humanly possible—and only ever remove them if they will replace them with other provisions designed to save more money.

Conclusion

At the end of the day, we don't know what health care will do. There is no real way to predict for sure the future actions of market or political actors, especially over the longer run. How these actors adjust to the new legislation will be key in determining the extent to which it has significantly improved the nation's fiscal sustainability.

Congress would be wise to proceed under conservative assumptions, especially since even the best-case outcomes on health reform would still leave us on an unsustainable fiscal path. Policymakers will need to continually revisit health reform to make sure it is doing as promised to truly slow cost growth. They will also need to address all other areas of the budget, including Social Security, defense, other domestic spending, and the revenue side of the budget.