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Principle #5: Continued Vigilance in Health Reform
March 31, 2010

Yesterday, President Obama signed into law the second of the two health care reform bills. The laws will spend a combined \$940 billion to expand insurance coverage to 32 million Americans. These costs are offset by a combination of tax increases and spending cuts, which the Congressional Budget Office (CBO) estimates will be enough to reduce deficits by about \$140 billion through 2019, and in the broad range of 0.5 percent of GDP in the following decade.

As the health reform debate began early last spring, CRFB set five principles for creating a fiscally responsible health reform plan:

- 1) Health Care Reform Should Focus on Slowing Cost Growth
- 2) New Government Health Care Spending Should be Fully Offset
- 3) Government Health Care Programs Must be Made Sustainable
- 4) The Need to Reform Health Care Does Not Displace the Need to Reform Other Areas of the Budget
- 5) Health Care Reform is a Continuous Process and Will Require Continued Vigilance from Policymakers

CRFB discussed the first four principles in previous papers (see them at crfb.org/publications/search?keywords=&document=69&issue=61&project=75). Although there may be strong disagreement among experts on whether – and the extent to which – the new health care legislation meets the first three principles, there is broad agreement that more still needs to be done.

With regard to the legislation that just passed, there are at least two reasons for continued vigilance. First, the package includes a number of tax increases and spending cuts that may be politically at risk of being watered down or repealed. Second, even with the changes, government health care programs are still unsustainable.

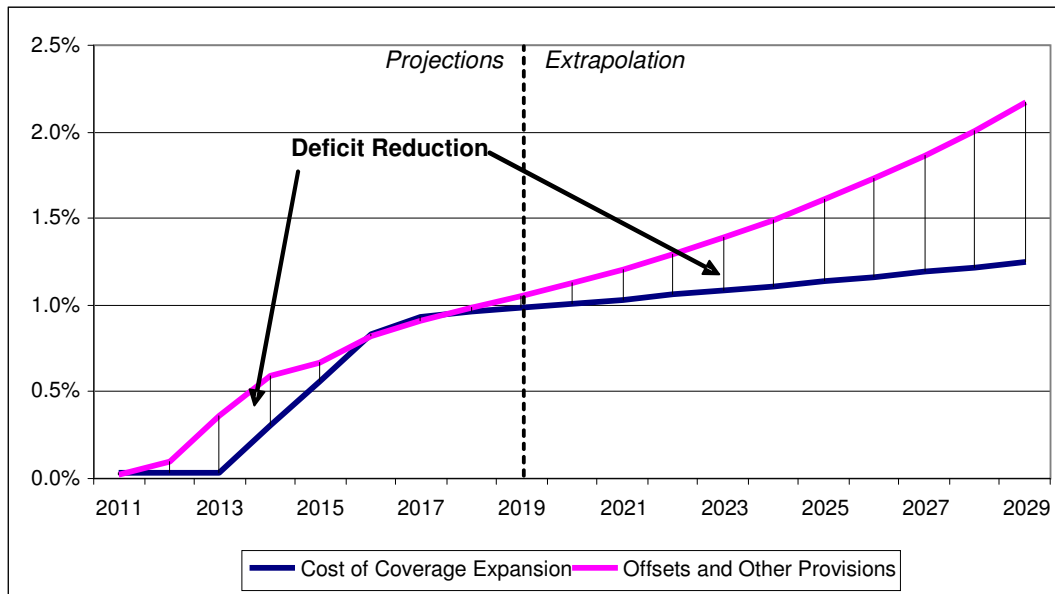
Given the immense challenges of controlling health care costs, no single reform package is likely to fully solve the problem of public and private health care cost growth. While there is widespread disagreement over the laws' effectiveness, all sides must understand that the enacted reforms are “round one,” rather than the health policy finale.

Deficit Reduction and Cost Control in the Health Reform Law

If implemented as enacted, the health reform package signed by President Obama is expected to reduce the deficit somewhat through 2019, and more significantly the following decade (see our charts and graphs here: <http://crfb.org/blogs/comparing-health-care-reform-bills-updated-charts-and-interactive-graphs>). Although projected to cost about \$940 billion for coverage expansion and \$140 billion for other initiatives, CBO estimates these costs would be more than offset by accompanying tax increases and spending cuts. In total, the legislation would reduce the ten-year deficit by \$143 billion. Excluding the savings from the CLASS Act and student loan changes, the bill would improve the ten-year deficit picture by \$54 billion, or an average of \$5 billion per year.

In the second decade, CBO estimates the legislation would reduce the deficit more substantially, by about half of a percent of GDP, or about \$1.3 trillion (plus interest).

Fig. 1: Deficit Impact of Health Reform Legislation, Extrapolated to 2030 (percent of GDP)



Source: Congressional Budget Office and Authors' Calculations and Estimations

The health care reform package also includes a number of important measures aimed at controlling overall health care costs. Perhaps most importantly, it includes an excise tax on high-cost private insurance, beginning in 2018. This tax will partially offset the effects of the current tax exclusion on employer provided health insurance, which tends to drive up health care costs. And since the tax threshold will be indexed to general inflation (which is lower than health care cost growth), it should put downward pressure on costs over time.

In addition to the excise tax, the reform package includes a number of smaller cost-control measures, including pilot programs and demonstration projects for health care

payment reforms, measures to expand and improve comparative effectiveness research, payment cuts to underperforming hospitals, new wellness initiatives, and other reforms.

Importantly, the bill also includes an Independent Payment Advisory Board (IPAB). This board will oversee automatic cuts to Medicare payments when the program grows too fast, and is expected, in the process, to suggest further reforms to Medicare that may slow economy-wide health care cost growth.

Unfortunately, the success—or even enactment—of these cost-controlling and deficit-reducing measures is both uncertain and insufficient. For those reasons, policymakers must continue to pursue cost control vigilantly.

Ensuring the Offsets and Cost Controls Stick

Whether (and the extent to which) the health care package reduces deficits will, in part, depend on if future Congresses are willing to maintain the package's deficit-reducing provisions. There will undoubtedly be strong pressure to soften or reverse many of these measures. Not surprisingly, since they are the hardest things to do, the most important parts of the bill from a fiscal perspective are those most at risk of being watered down.

For example, the excise tax on high-cost plans will not be implemented until 2018. This date has already been pushed back five years from 2013 in the first law, and considering its unpopularity—especially in the House—this date might slip further. Given the importance of this tax to both offsetting the package's new costs and controlling overall growth in health care costs, it must not be weakened.

The excise tax would also affect more people over time because the threshold is indexed only to inflation, which grows much slower than health care costs. This design is one of its strengths, but it may also be a catalyst for growing opposition to the measure. The increased payroll tax for high earners may also see mounting political opposition since the threshold for paying the higher tax is not indexed at all and will affect a growing number of individuals over time.

There are also serious concerns about the payment cuts to Medicare providers. Most notably, the legislation would modify the formulas which update payment rates to providers. Currently those formulas are calculated based on input cost growth; under the reform, that formula would subtract out economy-wide productivity gains each year. These changes should help slow Medicare cost growth significantly and will provide strong incentives to increase efficiency. Yet, based on historical evidence, providers may have difficulty sufficiently improving their own productivity. As a result, over time, a large gulf could develop between payments from Medicare and from private insurers – and this gulf may not be sustainable. According to the Medicare actuaries:

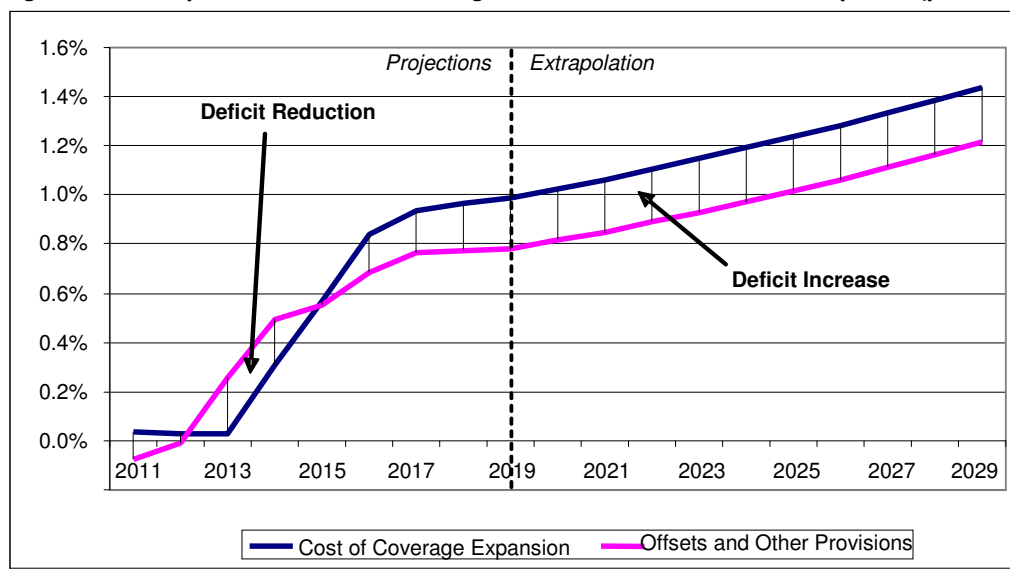
“Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the providers’ costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries). Simulations by the Office of the Actuary suggest that roughly 20 percent of Part A providers would become unprofitable within the 10-year projection period as a result of the productivity adjustments.”

The Actuaries also voice a similar concern with regards to the Independent Payment Advisory Board (IPAB), which may find it increasingly difficult to meet its Medicare savings targets. This is especially true given that many potential savings levers—such as cost-sharing rules—are not allowed to be changed by IPAB.

There is also the issue of the Sustainable Growth Rate (SGR), or “doc fix.” Under current law, physician payments under Medicare are projected to drop by 21 percent this year, and more in subsequent years. Politicians have typically prevented this drop in payments through temporary fixes – but have offset the cost of this fix more often than not. Unfortunately, since comprehensive health care reform used most of the obvious potential offsets to finance coverage expansion – and failed to address the SGR – future doc fixes are now more likely to be deficit-financed.

CBO has estimated the effect of health reform if it included a deficit-financed doc fix, a repeal of the excise tax and IPAB, and if insurance subsidies grew with the same formula after 2018 as before (under the current law, they are scheduled to slow after 2019).

Fig. 2: Deficit Impact of Health Reform Legislation Given Alternate Assumptions (percent of GDP)



Source: Congressional Budget Office and Authors’ Calculations and Estimations

In this case, instead of *reducing* the deficit by half a percent of GDP in the second decade, health reform would *increase it* by one quarter of a percentage point.

As this helps demonstrate, the very features that make these provisions difficult to sustain is also what makes them so important for bringing down costs. These provisions must be maintained or even expanded – rather than becoming victims of the political system.

We’ve Only Just Begun

But even if the legislation remains intact, it will not do enough to bring the debt under control. Despite the claim that “health reform is entitlement reform,” the health care reform package will not come close to putting Medicare on a sustainable path.

To be sure, the legislation yields significant Medicare and Medicaid savings, reducing their costs by over 8 percent (about \$110 billion) in 2019 alone. But the package uses these savings primarily to expand coverage – not to strengthen the finances of these two programs. According to our estimates, in fact, cuts in Medicare and Medicaid would likely not exceed new coverage costs for about twenty years. Even when looking at the federal government’s total budgetary commitment to health care – including tax preferences – savings do not exceed costs for well over a decade.

The legislation is able to reduce the deficit only by combining these spending reductions with a number of tax increases. And while the combination leads to deficit reduction, the improvements are modest when compared to our current fiscal path.

Fig. 3: Current Policy Deficits with and Without Health Care Legislation (billions)

	2012	2013	2014	2015	2016	2017	2018	2019	2020-2029
Deficit Without Reform	\$1,120	\$974	\$976	\$1,047	\$1,161	\$1,257	\$1,365	\$1,584	9.9% of GDP
Deficit With Reform	\$1,110	\$917	\$923	\$1,022	\$1,157	\$1,253	\$1,352	\$1,560	9.3% of GDP
Improvement	\$10	\$56	\$53	\$25	\$4	\$4	\$13	\$24	0.6% of GDP

Source: Congressional Budget Office and Authors’ Calculations and Estimations

Including interest savings, the bill only reduces the deficit by 6% (\$56 billion) in its best year and 1.5% (\$24 billion) in 2019. Even in the second decade of the legislation, when its effect is supposed to be much larger, health care—regularly described as the single biggest problem to the budget—would merely reduce average deficits from about 9.9 percent of GDP to roughly 9.3 percent.¹

Consequently, according to our estimates, reform will only lower the federal debt as a percent of GDP by about 6 percentage points by 2030. Although certainly an

¹ Note this estimate is based on CBO’s “broad range” outlook in the second decade, and thus subject to a high level of uncertainty.

improvement, this reduction will be of little comfort if our debt levels hit 130 percent of GDP, as they are projected to under current policy.

Policymakers must therefore do more to reform healthcare—as well as other areas of the budget. When policymakers move to “round two” of health care reform, they should start by revisiting some of the cost control proposals that were not included in the final package, including medical malpractice reform, broader cost sharing, and real reforms to the employer-sponsored insurance tax exclusion (as opposed to partially offsetting it through the excise tax). They will also need to consider other more direct options, including raising Medicare premiums, increasing the retirement age, and limiting certain services.

Fig. 4: Deficit Impact of Select Medicare Reforms not Enacted into Law

Option	10 Year Deficit Impact
Enact Medical Malpractice (Tort) Reform	\$54 billion
Increase all Part B Premiums from 25% to 35%	\$160 billion
Raise the Age of Eligibility for Medicare to 67	\$92 billion*
Replace ESI Exclusion with Credit Indexed to CPI (in place of excise tax)	\$770 billion
Restrict Medigap and Replace Medicare Cost-Sharing Requirements with a Unified Deductible, Coinsurance Rate, and a Catastrophic Limit	\$73 billion

Source: Congressional Budget Office, Lewin Group, and Authors' Calculations

*Policy would yield significant savings beyond the ten year budget window

But in the next round of reform, we will have one major advantage – we will have observed what worked and what didn’t under this reform package. Since the package includes important pilot programs and demonstration projects – as well as a new type of insurance market (the exchanges) – it can offer important lessons for future reforms. And important comparative effectiveness research can help guide new payment regimes which encourage the efficient provision of care.

Medicare and Medicaid remain on an unsustainable track that threatens our economy and government. The recently-enacted health care reform package will improve our fiscal picture somewhat – but *only* if policymakers can maintain (or strengthen) some of the law’s most painful provisions. And even then, the package will have only a small positive effect on addressing our overall budgetary challenges by itself, and will still leave the federal government’s commitments to health care on a dangerous and unsustainable path. Health care reform must therefore be a continuous process.