

# Will Health Care Reform Increase the Deficit and National Debt?

## Timely Analysis of Immediate Health Policy Issues

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The Patient Protection and Affordable Care Act (PPACA) expands coverage to over 30 million uninsured Americans through Medicaid expansions and tax credits. Reduced Medicare payments to providers will partially offset the new spending. The rest will be offset by revenues from an excise tax on high-cost health plans, increased payroll taxes on earned and unearned income, taxes on insurers and drug and medical device manufacturers, penalties on uninsured individuals, and assessments on medium and large employers whose employees obtain subsidies through the exchanges.

The Congressional Budget Office (CBO) projects that health reform will reduce the deficit over the first 10 years (2010–2019) and will continue to do so in the following decade. The CBO estimates that the deficit will

*The ultimate effect of reform on the nation's debt level is uncertain, but policymakers retain a wide range of tools to contain costs if CBO estimates prove too optimistic.*

decline by \$143 billion over the first 10 years and, beginning in 2020, by 0.5 percent of gross domestic product (GDP) each year, on average.<sup>1</sup> Relative to 2010 GDP, this would amount to about \$75 billion a year. Over the 10-year period beginning in 2020, the health reform will, as projected by CBO, result in cumulative deficit reduction of about \$1.5 trillion.

As shown in the table below,<sup>2</sup> the CBO estimates that new spending from the Medicaid expansion will cost \$434 billion over the 2010–19 period. Subsidies to individuals and families and to small firms will amount to

\$464 billion and \$40 billion, respectively. Penalties on uninsured individuals and employers and the excise tax on high-cost plans will provide about \$150 billion in offsets. Cuts in Medicare and Medicaid (and some other provisions) will amount to \$511 billion. Various new taxes on earned and unearned income, drug and medical device manufacturers, and insurers will generate revenue of an additional \$420 billion. This accounts for the projected \$143 billion in deficit reduction between 2010 and 2019. One could argue that if Congress just enacted the Medicare cuts without expanding coverage, there would be much more deficit reduction, but the affected providers would have opposed the payment reductions much more vigorously if there were to be no increase in coverage which will increase their revenues and reduce uncompensated care costs.

Beginning in 2019, the law will change the indexing of subsidies so that they will grow more slowly than they will in the preceding years. This will reduce the projected cost of these subsidies to government, and shift more costs to individuals and families (with the possibility that more people will be exempted from the

<b>Federal Spending and Revenues in Health Reform, 2010 - 2019</b>	
	\$ (billions)
Medicaid and CHIP	434
Exchange Subsidies and Related Spending	464
Small Employer Tax Credit	40
<b>Gross Cost of Coverage Provisions</b>	<b>938</b>
Penalties on Uninsured Individuals and Employers	(69)
Excise Tax on High Cost Insurance Plans	(32)
Other	(48)
<b>Net Cost of Coverage Provisions</b>	<b>788</b>
Medicare Payment Reductions and Other Changes	(511)
Increases in Revenues	(420)
<b>Deficit Reduction</b>	<b>(143)</b>

Source: The Congressional Budget Office, Letter to the Honorable Nancy Pelosi providing estimates of the spending and revenue effects of the reconciliation proposal, March 20, 2010.

requirement to obtain coverage). In addition, the premium threshold above which the excise tax would be imposed on health insurance premiums will be indexed to general inflation rather than to 1 percentage point above inflation, as it is in 2018 and 2019. This provision will increase taxes obtained from the excise tax, or if individuals cut back on the comprehensiveness of their employer-based coverage, they should have higher wages and salaries than otherwise and thus pay higher income and payroll taxes, which will bring in more revenue. In either case, the effect will be to reduce the deficit.

### Did the CBO Get the Estimates Right, or Was It Too Optimistic?

Supporters and opponents of health reform have both spent significant time projecting the impact of reform on the nation's bottom line—not surprisingly, with divergent views. No one can quantify precisely what the financial effect of health reform will be over time. Making estimates of expenditures and revenues is inherently difficult, and there are several uncertainties regarding the estimates. The CBO may have been optimistic in its assumptions but probably not significantly so. It projects a baseline of uninsured of 54 million in 2019,<sup>3</sup> assuming that the number of uninsured does not increase substantially relative to current levels. In our calculations of coverage changes over the next decade, we estimate 57 million uninsured in 2019 in the best case, and 65 million in the worst case.<sup>4</sup> If the CBO has been too optimistic on the future number of uninsured absent reform, they may have underestimated the number of individuals who would qualify for and need Medicaid or subsidies in order to obtain health insurance. Therefore,

there may be more individuals signing up for Medicaid or subsidies than CBO originally estimated. The CBO also seems to have assumed a low take-up rate in Medicaid because penalties for nonenrollment will not generally be imposed on people at Medicaid-eligible income levels. However, the actual outcome with strong outreach efforts by advocacy groups and providers could be greater Medicaid enrollment than the CBO projects.<sup>5</sup> But significant uncertainty remains, and fewer people may sign up for either Medicaid or for subsidies compared with CBO predictions. For example, there could be difficulties in developing outreach efforts and encouraging enrollment in states where there is widespread opposition to the law.

Another uncertainty is that the law has assumed that the cuts in Medicare payments to hospitals, hospices, nursing homes, and home health agencies, with payment increases below the rate of inflation, can be sustained. The assumption is that there will be ongoing “productivity improvements” in the delivery of health care that will then be returned to the taxpayer. To the extent that providers are successful at lobbying for legislation that reduces cuts of this magnitude, the savings will be reduced and the deficit will be higher than projected. Similar cuts in Medicare provider payments have been suggested by both the Medicare Payment Advisory Commission and the CBO.<sup>6</sup> It is quite likely that these cuts would have been proposed as part of a deficit reduction package in the absence of health reform. The real question is whether Medicare can pay less than the rate of growth in input prices over a decade or, as actuaries at the Center for Medicare and Medicaid Services suggest, such reductions are not sustainable.<sup>7</sup> They may be

particularly hard to sustain without serious adverse effects on program beneficiaries if there are not similar controls on the rest of the health care system.

Another issue is that private premiums may increase faster than the CBO assumes. Health care costs, and thus premiums, could grow faster for several reasons, including the consolidation in both insurer and provider markets that has occurred over the past several years. If premiums increase faster than projected, then subsidy costs will be higher. The reform ties government subsidies to the difference between premiums for the second lowest cost “silver plan” (exchanges will offer bronze, silver, gold, and platinum plans, each being increasingly comprehensive) and the percentage of family income as established by the subsidy schedule. To the extent that the silver plans (as well as others) cost more than projected by CBO, government subsidy costs will be higher since the government is responsible for the difference. But premiums could also grow more slowly than expected due to increasing competition, greater transparency and ability to price compare, removal of the least efficient carriers along with the underwriting, lower administrative costs in exchange plans, etc.

The reductions in subsidies and increases in the excise tax in 2019 and thereafter may also be difficult to sustain. The threshold at which premiums will be subject to the excise tax will increase by the rate of inflation, which will mean more and more people will be subject to this tax if, as expected, premiums continue to grow faster than inflation. This could result in increased political opposition and a change in the indexing method.

The indexing of the income-related subsidies makes them less generous relative to the cost of insurance over time. This also may not be sustainable, because it could result in insurance becoming unaffordable over time for larger numbers of low- and moderate-income Americans. There may be pressure to maintain the generosity of these subsidies to ensure low uninsurance rates. If these indexing provisions are not sustainable and additional federal financing is devoted to them, this would affect the costs of the PPACA beyond 2020.

On the other hand, the law also contains several cost-containment initiatives involving accountable health care organizations, medical homes for the chronically ill, episode-based payment, medical malpractice demonstrations, comparative effectiveness research, and prevention measures. There is increasing evidence that medical homes can generate savings for the chronically ill.<sup>8</sup> And while generalized prevention efforts seem ineffective, more targeted efforts offer more promise.<sup>9</sup> The CBO does not assume cost savings from any of these measures due to a lack of solid evidence on their effects. To the extent that these efforts do yield savings, the CBO may have significantly overestimated the cost of reform and underestimated the amount of deficit reduction.

Further, the law establishes a new office within the Center for Medicare and Medicaid Services to improve care management for the very costly

dual eligibles, including improving coordination between Medicare and Medicaid. Dual eligibles, about 10 million individuals, will account for over \$300 billion in 2010, or about 14 percent of U.S. health care spending.<sup>10</sup> Saving even a small percent on this group can yield substantial amounts. The new health insurance exchanges include a managed competition framework in which individuals, even those with subsidies, will have to pay higher out-of-pocket costs for more comprehensive coverage. This, along with the incentives the excise tax creates, should also encourage more cost consciousness and less growth in health care costs.

If the CBO's estimates are not accurate, the government can take steps to reduce the effect of reform on the deficit. The fact that government is responsible for the cost of Medicare, an expanded Medicaid program, and income-related subsidies for large numbers of low- and moderate-income Americans means that it has a much greater responsibility for health care cost containment than it has had historically. Thus, the government would likely take strong steps to restrain the growth in insurance premiums and health care costs if necessary. Steps that became politically untenable during the health reform debate in the past year—such as greater systemwide cost controls, a public plan trigger, medical malpractice reform, a stronger cap on the tax exclusion of employer health insurance contributions, and other

options—could become politically feasible.

## Conclusion

The CBO has estimated that health reform will reduce the deficit primarily because cuts in Medicare combined with new revenues will more than offset new spending, and that the deficit reduction effects will increase over time. The CBO projections may have underestimated spending growth but probably not in any significant way. There is some chance that the cost of Medicaid expansion and subsidies to individuals and families could be higher than expected. Some of the indexing provisions that begin in 2019 may be difficult to sustain. Similarly, the cuts in Medicare also may be difficult to sustain over the long-term. On the other hand, the CBO may have underestimated the effectiveness of the many cost-containment provisions in the bill—the increased competition within exchanges, the taxes on high-cost health plans, and such cost-containment initiatives as accountable health organizations, medical homes for the chronically ill, comparative effectiveness research, and many prevention measures. There will also be a major new effort to improve the management of care for dual eligibles. There are many other ways the government could strengthen cost-containment provisions if CBO estimates prove too optimistic.

## Notes

<sup>1</sup> Congressional Budget Office, “Letter to the Honorable Nancy Pelosi Providing Estimates of the Spending and Revenue Effects of the Reconciliation Proposal” (Washington, DC: Congressional Budget Office, March 20, 2010).

<sup>2</sup> Congressional Budget Office, “Letter to the Honorable Nancy Pelosi,” 2010.

<sup>3</sup> Congressional Budget Office, “Letter to the Honorable Nancy Pelosi,” 2010.

<sup>4</sup> J. Holahan, B. Garrett, I. Headen, and A. Lucas, “Health Reform: The Cost of Failure” (Washington, DC: Urban Institute, 2009).

<sup>5</sup> J. Holahan and I. Headen, “Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133% FPL” (Kaiser Commission on Medicaid and the Uninsured, 2010).

<sup>6</sup> Medicare Payment Advisory Commission, “Report to Congress: Medicare Payment Policy” (Washington, DC: Medicare Payment Advisory Commission, 2008); Congressional Budget Office, “Budget Options: Health Care” (Washington, DC: Congressional Budget Office, 2008).

<sup>7</sup> Centers for Medicare and Medicaid Services, Office of the Actuary, “Estimated Financial Effects of the Patient Protection and Affordable Care Act” (Baltimore, MD: Centers for Medicare and Medicaid Services, 2010).

<sup>8</sup> K. Grumbach, T. Bodenheimer, and P. Grundy, “The Outcomes of Implementing Patient-Centered Medical Homes: A Review of the Evidence on Quality, Access, and Costs from Recent Perspective Evaluation Studies” (Washington, DC: Patient-Centered Primary Care Collaborative, 2009).

<sup>9</sup> Diabetes Prevention Program Research Group, “The Diabetes Prevention Program (DPP): Description of Lifestyle Intervention,” *Diabetes Care* 25, no. 12 (2002): 2165–71; Diabetes Prevention Program Research Group, “Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin,” *New England Journal of Medicine* 346, no. 6 (2002): 393–403; R. T. Ackerman and D. G. Marrero, “Adapting the Diabetes Prevention Program Lifestyle Intervention for Delivery in the Community: The YMCA Model,” *The Diabetes Educator* 33, no. 1 (2008): 69–78; R. T. Ackermann, E. A. Finch, E. Brizendine, H. Zhou, and D. G. Marrero, “Translating the Diabetes Prevention Program into the Community: The DEPLOY Pilot Study,” *American Journal of Preventive Medicine* 35, no. 4 (2008): 357–63.

<sup>10</sup> Author’s calculations from data from the Medicaid Statistical Information System and the Congressional Budget Office March 2009 baseline.

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