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Health care costs are growing at a historically rapid pace, calling into question our ability to fund our promises over the long term.

Federal Health Care Law Promises Coverage for All, But at a Price

by Jason Saving

The Patient Protection and Affordable Care Act, better known as health care reform, was signed into law last March. The measure ostensibly provides health care coverage to almost all Americans while simultaneously reducing the deficit by \$143 billion over 10 years and by a greater amount over the longer term.

Few would disagree that some type of health care reform was needed. About one-seventh of the U.S. population lacked health insurance of any kind. Health care costs are growing at a historically rapid pace, calling into question our ability to fund our promises over the long term. And U.S. health care expenditures as a percentage of gross domestic product (GDP) remain far above those of other developed nations (*Chart 1*).

Several headline-grabbing benefits for middle-class Americans attracted the most attention: Children under the age of 26 can find coverage under their parents' plans; elderly Americans with large out-of-pocket drug expenses received \$250 checks from the government; and health plans that once avoided people with preexisting conditions can no longer do so.

These provisions, while important to families, form only a small part of the great debate over how many people will be insured under the health care law—and whether it truly will “bend the cost curve,” as proponents claim.

Broadening Health Care Coverage

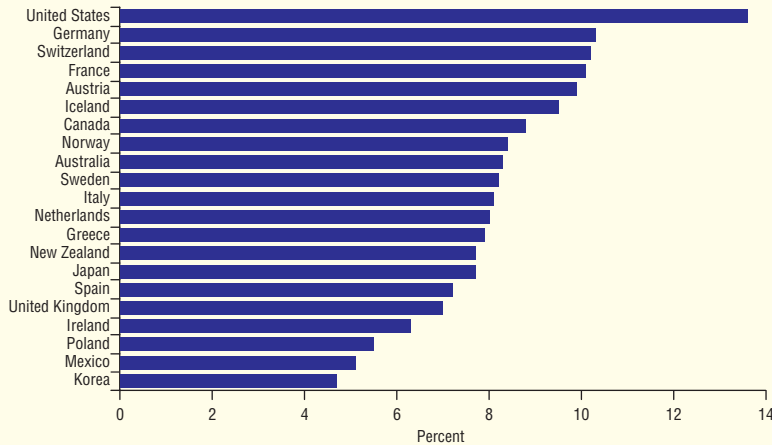
While the health care law contained many thousands of provisions, coverage was broadened in four primary areas. First, the Medicaid system was expanded to include households earning less than 133 percent of the federal poverty line, which works out to \$29,000 for a family of four. Second, health insurance exchanges will be created beginning in 2014 so



Chart 1

U.S. Spends Most for Health Care

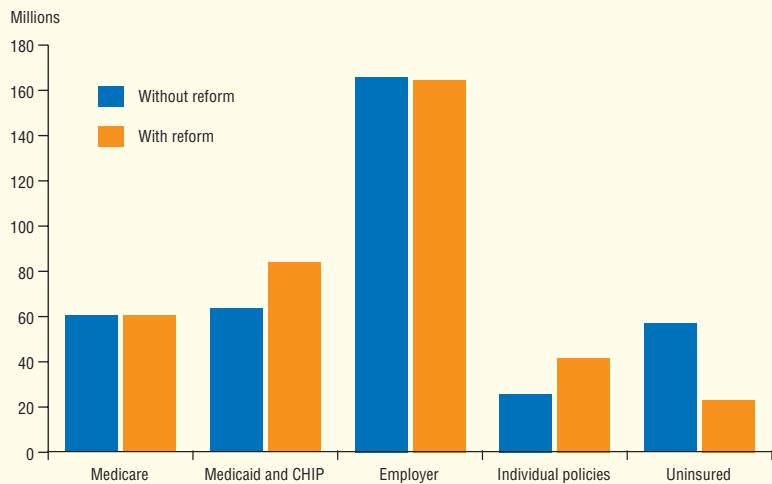
(Health care expenditures as percentage of GDP)



SOURCE: World Bank, World Development Indicators.

Chart 2

Health Coverage Shifts With Law



NOTE: Number covered in 2019 with the health care reform law versus the number that would have been covered if reform had never been enacted.

SOURCES: Congressional Budget Office; Office of Management and Budget; Centers for Medicare and Medicaid Services.

\$88,000. Finally, certain businesses will receive subsidies for providing or retaining coverage for their workers.

To understand how these provisions would affect coverage patterns, it's important to first know how things worked before the bill's passage—and how they change under the new law. Health coverage in the U.S. has been provided through four main sources. The most important of them is employer-based. Pioneered by large retailers such as Montgomery Ward at the dawn of the 20th century and spurred on by World War II-era regulations that exempted fringe benefits from otherwise-strict controls on wages, employer-provided health insurance encompasses just more than half the nation's population. Other coverage sources include Medicare for the elderly and disabled, Medicaid for the poor and individual plans purchased in the private marketplace.

Over the next decade, as the law is fully implemented, two significant changes will occur. First, the expansion of Medicaid and the Children's Health Insurance Program (CHIP) will add 20.4 million people to the nation's medical welfare system. And second, the health insurance exchanges will enable 15.7 million people who would otherwise lack coverage to find affordable policies. More than 1 million fewer people will be insured through employers, and the aggregate impact of these changes will cut the ranks of the uninsured to 23.1 million from 56.9 million—a 59 percent reduction (*Chart 2*).

To get a sense of the timeline, let's examine how the ranks of the insured would change between now and 2019. Until 2014, when the main provisions of the plan kick in, there's a slight uptick as young adults and those with preexisting conditions are eligible for coverage. In 2014, as the exchanges enable virtually anyone who wants insurance to obtain it, coverage jumps by just less than 8 percentage points, leaving the ranks of the uninsured below 10 percent for the first time in history. Coverage stays at more or

individuals and small businesses can pool their purchasing power, with the goal of obtaining better coverage at lower rates. Third, families earning less

than 400 percent of the federal poverty line will receive health insurance subsidies on a sliding scale, phasing out entirely for households making



less that level for the remainder of the decade (*Chart 3*).

The Congressional Budget Office (CBO) estimates that expanding Medicaid eligibility to 133 percent of the federal poverty line carries a 10-year cost of \$434 billion. Providing individual insurance subsidies to everyone below 400 percent of the federal poverty line has a 10-year cost of \$464 billion. And a few smaller programs, such as business insurance subsidies, have a 10-year cost of \$40 billion, for a total of \$938 billion.

But there is new revenue to be found in the law as well. The largest, \$511 billion, comes from cost savings and spending cuts. Chief among them are substantial reductions in outlays for seniors who opt into the Medicare Advantage program¹, as well as the elimination of inefficiencies throughout the health care system.

Next on the revenue side is \$150 billion in penalty payments for individuals who ignore the plan's individual mandate or purchase so-called Cadillac plans. Individuals electing not to take up the subsidized insurance options available to them under the Patient Protection and Affordable Care Act must, in most cases, pay an annual fine of \$695. On the other side of the coin, individuals who obtain "too much" insurance—defined as coverage costing more than \$10,200 for individuals or \$27,500 for families on an annual basis—will pay an excise tax of 40 percent on the remaining value of the plan.

How many people will be uninsured? The best available projections suggest 23 million people—5 million undocumented immigrants, who won't be eligible for the exchanges, and 18 million others.

There are also two potentially far-reaching Medicare tax adjustments that will bring in \$210 billion over the next decade. The first is a 0.9 percentage point increase in the Medicare payroll tax for households earning more than \$250,000 per year—a step toward the progressive payroll tax pro-

posed by some as a partial solution to Medicare's unfunded liabilities.² The second is to apply this payroll tax to unearned income exceeding the same \$250,000 threshold, further straining the relationship between contributions paid and benefits received.

Another revenue component is \$110 billion in industry-specific tax increases for sectors deemed to have imposed onerous price increases on consumers in the recent past. An absolute majority of this burden comes in the form of an annual fee on health insurance providers. Other industry-based taxes include an annual fee on manufacturers and importers of brand-name drugs, a 2.3 percent excise tax on medical device manufacturers and a 10 percent excise tax on indoor tanning services.

These revenue measures and \$100 billion in other smaller enhancements produce a grand total of \$1.1 trillion in new receipts over the next 10 years (*Chart 4*). Subtracting this from the \$938 billion in previously mentioned expenditures yields net savings of \$143 billion over the next 10 years—the estimate provided by the CBO.

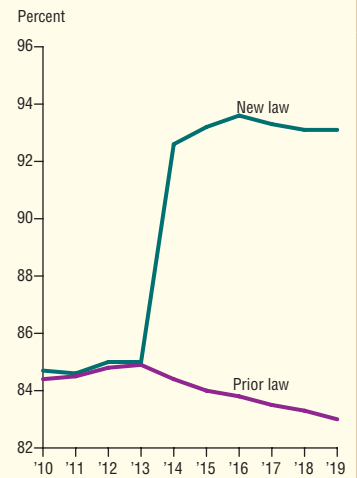
Assessing Cost Curve Issues

Under the assumptions embedded in the CBO analysis, health care reform would modestly reduce government debt relative to what otherwise would have prevailed. However, several assumptions are unlikely to hold. And in each case, the likely fiscal impact of health care reform deteriorates somewhat.

CBO assumes that Medicare costs will grow significantly more slowly than their trend growth rate over the next decade, as inefficiencies are wrung out of the system and certain categories of benefits (such as Medicare Advantage) are permanently reduced.

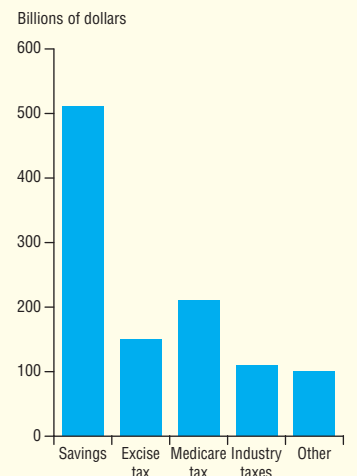
Will advances in medical technology begin to bend costs downward instead of fueling their rise? Will a new review board charged with holding down costs be up to the task? And

Chart 3
More People Gain Coverage



SOURCES: Congressional Budget Office; Office of Management and Budget; Centers for Medicare and Medicaid Services.

Chart 4
\$1.1 Trillion Savings Estimated



SOURCES: Congressional Budget Office; Office of Management and Budget; Centers for Medicare and Medicaid Services.

will policymakers allow the law's tax increases and benefit reductions to remain in place in perpetuity? If not, then the health care law moves closer to budget neutrality or even to raising the 10-year deficit tally.

Additionally, the analysis assumes that a long-delayed physician-reimbursement reduction for Medicare will be permitted to take effect this year, even though policymakers have not allowed similar reductions in past years and appear poised to continue that tradition. The 23 percent reduction scheduled to occur Dec. 1, 2010, would have brought physician reimbursements in line with a growth path agreed to in 1997 as part of the "sustainable growth rate" initiative—a previous attempt to bend the cost curve. But policymakers have balked at that growth path since its inception, creating an ever-larger divergence between what doctors actually receive and what was deemed necessary to control medical costs. With physician groups warning that queues to see doctors could lengthen dramatically if

reimbursements fell, Congress again postponed implementation of this cut and made clear it would likely never be allowed to happen. If this "doc fix" remains in place throughout the decade, the 10-year cost would be roughly \$210 billion.

A final question concerns the extent to which national health expenditures will change as a share of GDP as the health care law takes effect. Reducing the share of GDP devoted to health care was a primary objective of lawmakers.

The legislation isn't likely to achieve that, according to the most recent projection from the Centers for Medicare and Medicaid Services. Even without considering the fiscal caveats already mentioned, the health care reform law has only a negligible net impact on the size of the health care sector and its growth over time (*Chart 5*). This is not necessarily "bad," as one might reasonably expect a high-income country with high-quality upper-end care to spend a great deal on health care. But it does reinforce the point that cost control is unlikely to be the lasting legacy of the law.

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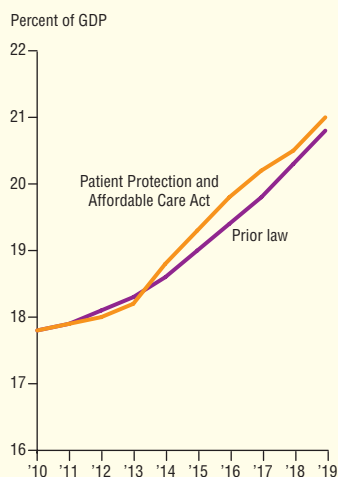
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Chart 5
Health Care Share of Economy Won't Fall



SOURCES: Congressional Budget Office; Office of Management and Budget; Centers for Medicare and Medicaid Services.

Cost of Expanding Coverage

The health care reform law was designed to expand coverage while also controlling costs. The law certainly will provide insurance for millions of currently uninsured Americans. However, it is unlikely to simultaneously "bend the cost curve." That is the more difficult task left to future policymakers to resolve.

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Note

¹Medicare Advantage is an alternative health plan choice offered by private companies approved and paid for by Medicare.

²Data from the official 2009 Medicare trustees suggest the present discounted value of these liabilities totals \$37.5 trillion over the next 75 years and \$88.6 trillion over the infinite horizon.