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The Long-Term Fiscal Impact of Health Reform: Risks and Risk Management Options

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come in above projections. Misses in either direction add to the long list of factors that buffet the federal budget. If savings are greater than forecast or spending less, the windfall, relative to what was projected when health care reform became law, leaves the health care sector, reducing the federal deficit; if savings are lower or spending more, future presidents and Congresses face additional fiscal pressure from the health sector but have no additional tools to achieve savings there.

The long-term fiscal risk depends on how underlying trends play out. One way to understand the potential impact of health reform on the long-term fiscal outlook is to create a "base case" that embodies one set of assumptions.

This paper considers a base case in which:

- New subsidies are paired with offsets. Costs and offsets initially grow rapidly as new programs are phased in, then grow at current projections for the rate at which Medicare and Medicaid will grow, and end the short-run (2019) equal. Box 1 discusses those assumptions.
- Subsidies require direct spending by the federal government. Future per participant subsidy costs depend on trends in the cost of covered services;
- After the initial ten year period, cost growth slows to the 'GDP + 1' growth rate used to make long-term projections for Medicare. Box 2 addresses the plausibility of this assumption.

Box 1

Assumptions About Future Health Care Costs

Forecasts of how much new health insurance subsidies will cost rest on assumptions about future trends in health care costs and how fast the economy will grow.

Both the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary ("the Actuary") and the Congressional Budget Office (CBO) generate projections for health care costs. Both forecast health care cost growth slowing from current levels. However, in their long-term projections, health care cost growth remains above growth of the overall economy for a long period.

Near-term outlook

New subsidies for health insurance would serve a population closer in age to the children and adults who form a majority of Medicaid's enrollment than the older population in Medicare. In the Actuary's most recent report on Medicaid costs, the cost per non-disabled, non-aged enrollee in Medicaid is projected to increase by 7.0 percent per year from Fiscal Year 2008 to 2017.[3]

Box 1 (continued)

[3] *2008 Actuarial Report on the Financial Outlook for Medicaid*. Washington: 2008.

CBO forecasts slightly slower growth in per enrollee Medicaid costs for children and non-disabled adults in a more recent projection. The CBO projection averages 6 percent per year for children and adults over 2009 to 2019.[4]

In its March 2009 economic projections, CBO projected nominal GDP will grow by 4.5 percent over 2012 to 2015 and 3.9 percent over 2016-2019. This implies per enrollee costs growing more rapidly than the economy by 1.5 percentage points in 2012 to 2015 and 2.1 percentage points in 2016 to 2019.

Longer-term forecasts

Each year the Actuary produces a seventy-five year forecast as part of the annual report of the Medicare trust fund trustees. For the first ten years, the Actuary makes separate projections for each category of service. For years eleven to twenty-our, growth rates within each category are assumed to converge to a single growth rate, and then, over years twenty-five to seventy-five, converge to the "infinite horizon" assumption of no growth in excess of GDP. That single rate begins at 1.3 percentage points faster than economic growth, a beginning point that is consistent with overall growth of one percentage point faster than GDP throughout the period.[5]

CBO has no similar official view about periods beyond the next ten years, but it considered possible paths for future trends in a November, 2007, report, "The Long-Term Outlook for Health Care Spending."

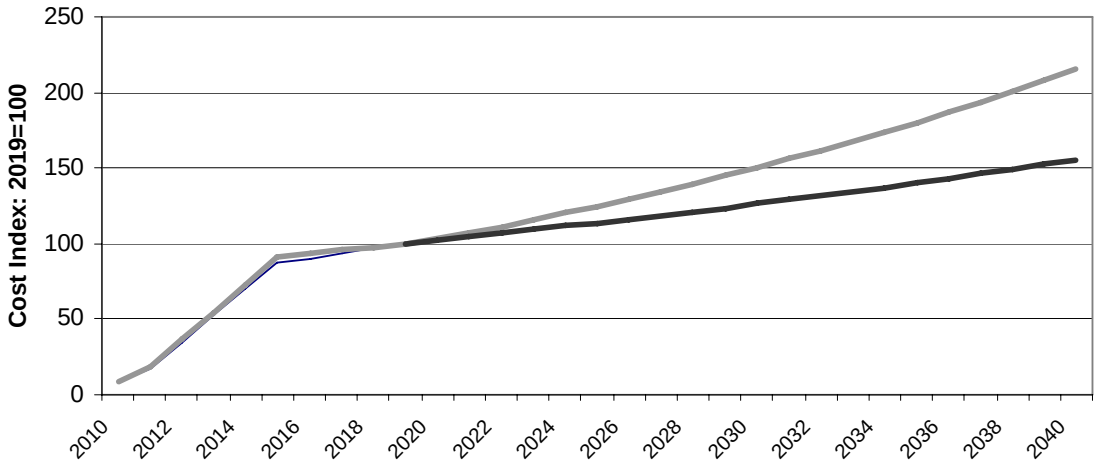
In that report, CBO said Americans would be willing to have higher health care costs up to the point that health care cost growth made fewer resources available for everything else. That is, all real growth gains would go to health care. This provides a lower constraint to long-term health care spending than the Actuary's approach.

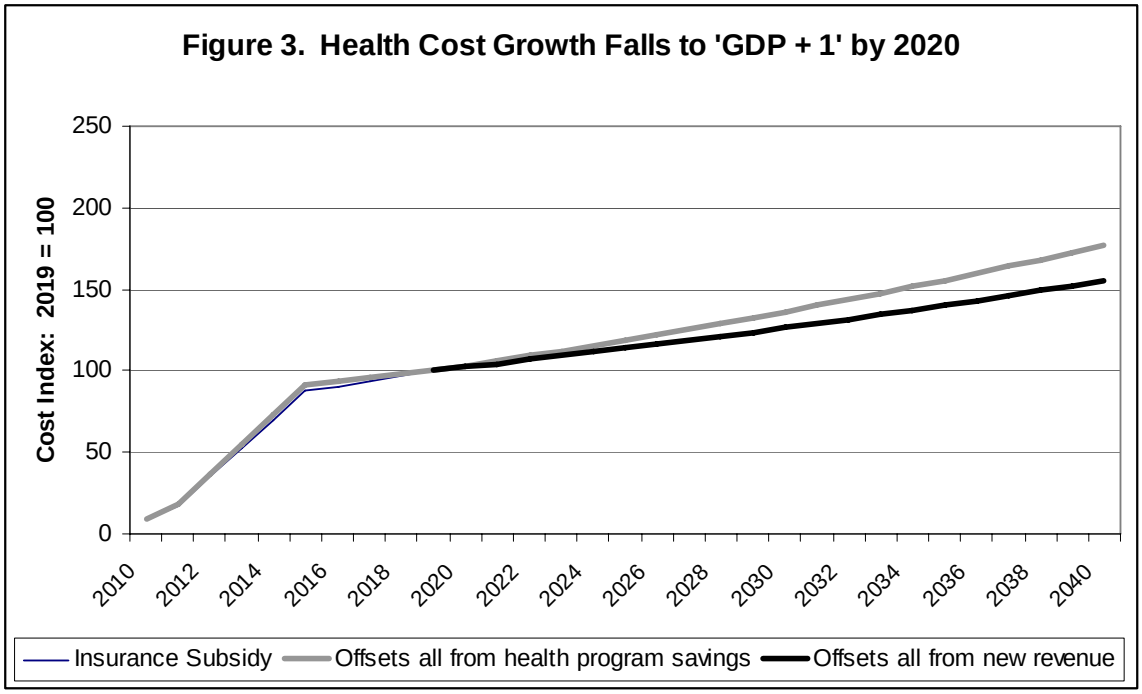
Box 2

Box 2 (continued)

The CMS Actuary has grappled with the tension between the long-term pattern of higher medical costs and the seeming impossibility that health care will become the entire economy and come to this accommodation: health care costs will grow more rapidly than the economy for a while, but eventually cannot.

Figure 1. Health Costs Continue to Grow 2% Faster Than GDP





The base case provides a common starting point: costs and offsets that initially ramp up, then follow the growth rate of Medicare and Medicaid per capita costs over the balance of the short-run (2009 to 2018) and then begin the long-run (2019) at the same level.

In the long-run, at one generation out, total costs would be 2.2 times higher than where they began the long-run if health costs continued to grow two percentage points faster than the economy, 1.9 times higher if cost growth converged to 'GDP+1' by the end of a generation into the long-run, and 1.8 times higher than they started if 'GDP+1' was the growth rate at the beginning of the long-run.

Regardless of which view of health cost growth obtains, offsets from new revenue would be the same. Offsets from new revenue would not keep up with program cost. One generation out, if offsets all came from new revenue, offsets would cover only 72 percent of subsidies with health costs continuing to grow two percentage points faster than the economy, 81 percent with costs reaching 'GDP+1' at the end of a generation and 88 percent if health costs began the long-run growing one percentage point faster than the economy overall.

In this analysis, assumptions about growth rates determine the results. The growth rate assumption stems from looking backwards and thinking the future will look a lot like the past. A microsimulation model could provide a richer analysis of the factors that create demand for health care services and that the services that are available to meet those needs. The detailed assumptions in such a model stand in contrast to the single, stable growth rate assumption used in long-term projections. A microsimulation model built on individual behavior would provide a more subtle analysis. It would also require

The base case considers subsidies that would add to current fiscal commitments that include Medicare, Medicaid and the favored tax treatment of employer-provided and some non-employer health insurance. As CBO has observed about current commitments, "[F]ederal spending on health care would eventually reach unsustainable levels."[11]

To the extent that offsets come from savings in existing health programs, new health insurance subsidies will not reduce aggregate pressure on the federal budget from health care costs. Rather, it would reallocate costs from current programs to new subsidies. By doing more with the same amount, it would make for greater productivity in the government's health spending. However, aggregate pressure on the federal budget from health care costs would remain the same.

The base case shows what results from one set of assumptions about where health care cost trends will lead in the long-term. During the first ten years, the fiscally most important may be the number who will be eligible, the fraction who will participate, and the per participant cost. Thereafter, a "steady state" prevails. Box 4 identifies assumptions and risks beyond the central risk considered here that might make the steady state unsteady.

[11] Congressional Budget Office, "The Long-Term Outlook for Health Care Spending." November 2007.

Box 4

Risks Beyond Health Care Cost Trends

The rate at which future health care costs grow is one component of the fiscal path new health insurance subsidies would follow. Other risks include:

- *Demography*

The deterministic health cost trend assumption also has imbedded in it an assumption that the age and health structure of the population will remain constant. Immigration and a birth rate that continues above the replacement rate will bring population growth. The US population is aging. The best predictor of an individual's health care costs is his or her age. An older population could mean higher health care costs. However, the total disease burden at each specific age may grow, remain the same or fall. Changes in family structure could also have an impact on cost trends. Change in the household structure and living arrangements could influence how many people live in units which have incomes low enough to qualify for health insurance subsidies.

- *Participation rates*

The share of the population eligible for subsidies may change. Over the past decade, the share of the under sixty-five population with employment-related health insurance has declined, in part reflecting structural change in the economy, as employment has grown in the service sector where health insurance coverage rates are lower. If the economy continued to evolve in a manner that produced relatively larger job growth in sectors where health insurance was less common, then demand for subsidies may increase.

- *Income structure*

If the amount of subsidy depends on a person or family's income, then changes in the share of households which have incomes at or below the level that qualifies for subsidies will have an impact on the share of the population that is eligible to participate and, presumably, total costs. Part of this uncertainty is demographic (which individuals combine into households) and part is economic (what is the distribution of earnings across jobs and what decisions will households make about who looks for work.)

- *Technology*

While aging and income growth account for some of the growth in health care costs, the remainder is usually ascribed to "technology."[12] Technology change could be cost increasing or cost decreasing. Vaccines, for example, are a cost-decreasing technology. Cardiovascular drugs could decrease the number of future cardiovascular procedures. Other new technologies could allow treatment of conditions which today have no effective treatment. Many cancer drugs have

Options and Their Fiscal Impact

New subsidies for health insurance pose fiscal risks. Those risks could be managed in advance or they can be addressed as time unfolds and potential risk turns into certainty.

How subsidies are structured determines how much fiscal risk health care reform today will impose on future federal budgets. New subsidies for health insurance could take a variety of different fiscal forms that would have very different impacts on the federal budget. Their ordering here reflects the probability that they would be more fiscally constrained than the base case, beginning with the option least likely to be more fiscally constrained.

Add-on. New subsidies could be implemented as a new program unconstrained by the amount of offsets Congress is willing to adopt. While both houses of Congress have adopted a rule that imposes the "pay go" constraint on new legislation, the same rule also allows circumventing the rule for emergency spending. This option would allow health care reform to proceed unconstrained by the challenge of fully specifying how it would be paid for. The failure of offsets to equal new expenses in the short-term, medium-term, or long-term would not be an impediment to Congress passing and sending to the president legislation to implement new subsidies.

The additional costs of new subsidies would become part of the budget baseline. In future years, the costs of new health care subsidies would be one additional factor for Congress to consider, along with existing direct spending for entitlement programs, when it writes a federal budget.

Compared to the base case, costs would follow the same path. Without requiring offsets as large as expenses for the short-term, the level of offsets at the outset of the long-term period (2019) would likely be lower and would grow from a proportionally lower base.

Fiscal impact:

- Greater excess of costs ov ex3DC 2ort-termfle4boaAdts to exisino preslure rmfle4 federal budge e

Medicaid costs that are similar to per participant Medicare costs over the next decade.

Capped entitlement. The amount of money available each year could be set in health care reform's implementing legislation. Initial legislation would establish amounts for an initial span of years. Congress would be required to pass new legislation to continue the subsidies past the initial period of years.

This approach follows the State Children's Health Insurance Program (SCHIP.) When passed in 1997, the legislation provided an annual allotment for participating states. States' allotments remained available for three years. After three years, unspent allocations became available to other states. In early years, when spending was below the allotment levels, Congress extended the period of time states could hold on to allotments. In more recent years, as spending exceeded new allotments, Congress shortened the period before allotments were reallocated.[15]

The fixed authorization period in the initial legislation forced SCHIP on to the legislative agenda at the expiration of the initial ten year authorization in 2007. Authorization continued on a "stop gap" basis after President Bush vetoed a reauthorization proposal in 2007. President Obama signed a ten year reauthorization on February 4, 2009, that included revenue increases, primarily an increase in the excise tax on tobacco products. CBO projected that additional federal spending totaling $73.8 billion and revenue totaling $74.8 billion over 2009 to 2019 will result.[16]

Fiscal impact:

- Compared to the base case, there would be no autopilot path. When the reauthorization period came about, and assuming the "pay go" constraint remained, Congress would face the challenge of identifying offsets equal to the then-current projection of the program's cost.

- There would be substantially less potential for actual costs to drift from projections over long periods of time. While the base case makes assumptions for decades, the capped entitlement would require assumptions only for the number of years for which funding would be provided. Each round of reauthorization would require calibrating expenses and offsetting costs. If costs prove higher than expected, relative to the offsets were provided, the reauthorization process will require some mix of lower subsidies, more narrowly drawn eligible population, or more savings or revenue increases.

New entitlement with ten years' "pay as you go" financing. New subsidies for health insurance would be paired with savings and revenues. Their magnitude would be projected to be equal for the first ten years. No further action would be required to

[15] Elicia S. Herz, Bernadette Fernandez, and Chris L. Peterson, "State Children's Health Insurance Program (SCHIP): A Brief Overview." Congressional Research Service, Report RL30473. Updated March, 2005.
[16] Congressional Budget Office, "HR 2. Children's Health Insurance Program Reauthorization Act of 2009. As cleared by the Congress and signed by the President on February 4, 2009."

continue the program in the form in which it was originally enacted beyond those ten years.

The scale of new subsidies would be limited by the scale of the "pay fors" that offset new spending. The "pay go" test applies to what Congress creates but has no impact after Congress acts. There are no consequences if actual costs prove to be more or less than projected or revenues and savings fall short or come in above projections. Misses in either direction add to the long list of factors that buffet the federal budget. If savings are greater than forecast or spending less, the federal deficit is lower than it would otherwise be. If savings are lower or spending more, future presidents and Congresses face additional fiscal pressure from the health sector but have no additional tools to achieve savings there.

Fiscal impact:

- Meeting the "pay as you go" requirement would provide for planned fiscal balance over the first ten years. However, there would be no built-in correction if what happens differs from what was projected.

- The long-term fiscal impact would depend on the relative share of offsets from revenue and from program savings. A lower share of savings from offsets implies higher risk of increasing the long-term deficit. (Box 5 shows a projection based on the mix identified in the President's budget.)

Box 5

Impact of the Savings/Revenue Mix In the President's Reserve Fund

The president's budget identifies savings in federal health programs, primarily Medicare, and new revenues to offset the cost of new subsidies and other fiscal implications of health care reform.

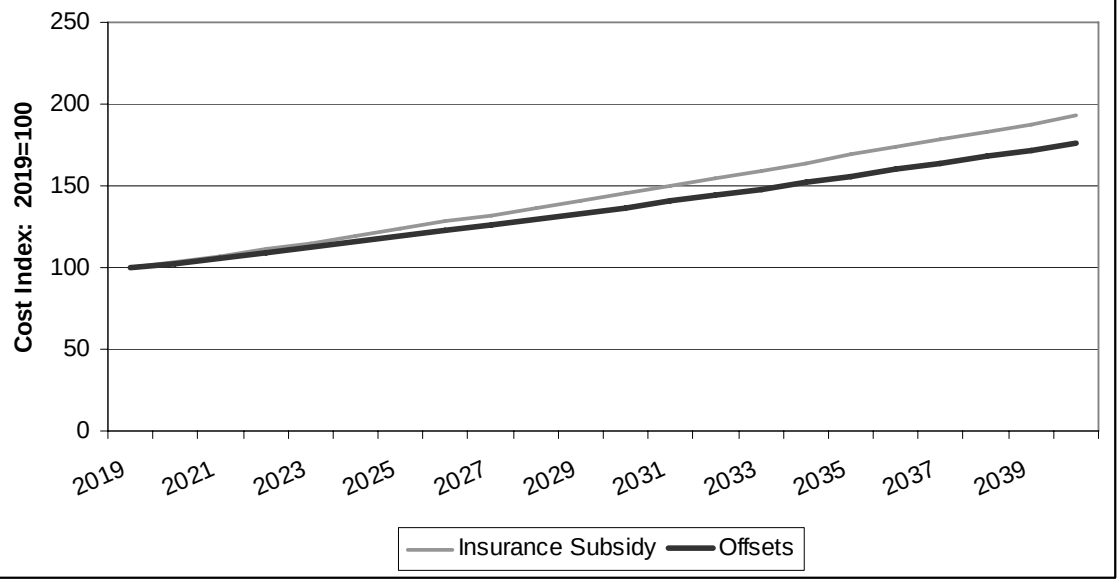
The revenue proposal in the budget, limiting the tax rate for itemized deductions for taxpayers with incomes over $250,000, would take effect in 2011. Revenue from this change would initially grow rapidly and then grow more slowly, averaging 5.6 percent annually over FY 2015 to 2019. This proposal accounts for 83 percent of the revenue identified for the health care reserve fund. Other revenue items identified for that pool would grow more slowly, averaging 4.0 percent over FY 2015 to 2019. Altogether the revenue proposals would grow by 5.3 percent over FY 2015 to 2019.[17] Over the same period the President's budget projects nominal GDP growth of 4.4 percent. Thus the revenue side would grow .9 of a percentage point faster than GDP.

Box 5, continued

The difference in growth rates between the revenue and savings proposals shows the forces at work that create long-term fiscal risk. The revenue side of an offset package grows at a rate close to that of the economy overall. The program savings side grows faster. The 8.6 percent growth rate exceeds the 7 percent growth rate projected by CBO for Medicaid acute care costs over FY 2009-2019.

At the outset of the 'long-term' in 2019, the example shown in the President's budget would derive 45 percent of its offsets from revenues and 55 percent from savings in current programs. As Figure 4 shows, the 45/55 mix has too high a share coming from revenue to maintain long-term fiscal balance. At the end of a generation into the long-run, costs would be 10 percent higher than offsets.

Figure 4. Fiscal Path: Starting 'Long-Term' with 45% of Offsets from New Revenue



Trust fund. Health care reform's fiscal impact would be tracked as fiscal inflows and outflows from a "Health Care Subsidies Trust Fund."

Summary

Approach	Consequences of Forecast Error	