By Douglas Holtz-Eakin and Michael J. Ramlet

DOI: 10.1377/hlthaff.2010.0446
HEALTH AFFAIRS 29,
NO. 6 (2010): 1136–1141

ANALYSIS & COMMENTARY

Health Care Reform Is Likely To Widen Federal Budget Deficits, Not Reduce Them

Douglas Holtz-Eakin (dholtzeakin@americanactionforum.org) is president of the American Action Forum, in Washington, D.C.

Michael J. Ramlet (ramletm@advisory.com) is a research analyst at the Advisory Board Company, in Washington, D.C.

ABSTRACT The federal government faces a daunting fiscal outlook, which makes the budgetary impact of the Patient Protection and Affordable Care Act even more important. The official Congressional Budget Office (CBO) analysis indicates modest deficit reduction over the next ten years and beyond. We examine the underpinnings of the CBO's projection and conclude that it is built on a shaky foundation of omitted costs, premiums shifted from other entitlements, and politically dubious spending cuts and revenue increases. A more comprehensive and realistic projection suggests that the new reform law will raise the deficit by more than $500 billion during the first ten years and by nearly $1.5 trillion in the following decade.

The United States faces a daunting budgetary outlook. The Obama administration's budget displays an unsustainable debt spiral over the next decade. In this context, the fiscal consequences of the newly enacted Patient Protection and Affordable Care Act are of extreme importance.

Proponents of the health care reform law point to the Congressional Budget Office (CBO) analysis, which suggests a modest contribution to deficit reduction over the budget window and beyond. Proponents also argue that the CBO understates the beneficial reductions in the pace of health care spending. Opponents suggest instead that the act will exacerbate the fiscal outlook, as politically unrealistic spending reductions and tax increases fail to offset new entitlement spending.

We briefly examine these arguments via the use of simple alternative scenarios. On balance, it is difficult to conclude that the act will not accelerate the coming fiscal crisis.

An Approaching Fiscal Train Wreck

The federal government's unsustainable long-run fiscal posture has been outlined in successive versions of the CBO's Long-Term Budget Outlook. In broad terms, over the next thirty years, the inexorable dynamics of current law will raise outlays, or committed federal expenditures, from about 20 percent of gross domestic product (GDP) to 30–40 percent of GDP.[1]

Any attempt to keep taxes at their postwar norm of 18 percent of GDP will generate an unmanageable federal debt spiral. In contrast, ratcheting up taxes to the 30–40 percent of GDP needed to match the federal spending appetite would likely be self-defeating, as it would undercut badly needed economic growth.[2]

The policy problem is that spending rises above any reasonable level of taxation for the indefinite future. The diagnosis leads as well to the prescription for action. Over the long term, the budget problem is primarily a spending problem, and correcting it requires reductions in the growth of large mandatory spending programs and the appetite for federal outlays.

This depiction of the federal budgetary future has been unchanged for a decade or more. However, the most recent administration budget shows that in part as a result the financial crisis, recession, and policy responses, the problem has become dramatically worse, and will arrive more quickly. The federal government ran a fiscal 2009 deficit of $1.4 trillion—the highest since

World War II—as spending reached nearly 25 percent of GDP and receipts fell below 15 percent of GDP. In each case, the results are unlike those experienced during the past fifty years.

Going forward, there is no relief in sight. Over the next ten years, according to the CBO's analysis of the President's Budgetary Proposals for Fiscal Year 2011, the deficit will never fall below $700 billion.[3] In 2020 the deficit will be 5.6 percent of GDP—roughly $1.3 trillion, of which more than $900 billion will be devoted to servicing debt on previous borrowing.

The budget outlook is not the result of a shortfall of revenues. The CBO projects that over the next decade the economy will fully recover and that revenues in 2020 will be 19.6 percent of GDP—more than $300 billion more than the historic norm of 18 percent. Instead, the problem is spending. Federal outlays in 2020 are expected to be 25.2 percent of GDP—about $1.2 trillion higher than the 20 percent that has been business as usual in the postwar era.

As a result of the spending binge, in 2020, public debt will have more than doubled from its 2008 level to 90 percent of GDP and will continue its upward trajectory.

Budgetary Effects Of Health Reform

In light of the fiscal threat from growing spending, the budgetary impacts of the Patient Protection and Affordable Care Act are central to any discussion of its merits. We begin by reviewing the CBO cost estimate that concludes that the act will serve to lower projected deficits over the next ten years and beyond. After our summary review, we analyze the budgetary implications of altering certain assumptions.

The final score of the Patient Protection and Affordable Care Act with reconciliation amendments was released publicly 20 March 2010. The CBO and the Joint Committee on Taxation estimated that the act would lead to a net reduction in federal deficits of $143 billion over ten years, with $124 billion in net reductions from health reform and $19 billion derived from education provisions.[4] An annualized summary of the health care provisions in the act by total subsidies, total cost savings, and total tax revenues can be found in Exhibit 1.

Total subsidies in the act exceed $1 trillion over ten years. They include insurance exchange tax credits for individuals, tax credits for small employers, the creation of reinsurance and high-risk pools, and expansions to Medicaid and the Children's Health Insurance Program (CHIP). To finance the subsidies and reduce the deficit, total cost savings are projected to be nearly $500 billion based on reductions in annual updates to Medicare fee-for-service payment rates, Medicare Advantage rates, and Medicare and Medicaid disproportionate-share

EXHIBIT 1

Congressional Budget Office (CBO) Final Score Of The Health Care And Education Reconciliation Act Of 2010 (HR 4872)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010–14	2010–19
	CBO PROJECTIONS ($ BILLIONS)											
Total subsidies	4	11	13	9	70	125	181	204	219	236	106	1,072
Total cost savings	2	−2	−11	−18	−43	−51	−59	−75	−91	−109	−70	−455
Total tax revenues	0	−8	−15	−43	−77	−90	−114	−123	−131	−141	−140	−739
Net change in deficit[a]	6	1	−14	−50	−48	−15	7	6	−3	−13	−104	−124
Percent of GDP	0.04	0.01	0.09	0.31	0.28	0.09	0.04	0.03	0.02	0.07	0.61	0.65
	2020	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2020–24**	**2020–29**
	CBO PROJECTIONS EXTRAPOLATED[b] ($ BILLIONS)											
Total subsidies (3.4% CAGR)[c]	244	252	261	270	279	288	298	308	319	330	1,306	2,850
Total cost savings (10.0% CAGR)[d]	−120	−132	−145	−160	−176	−193	−212	−234	−257	−283	−732	−1,911
Total tax revenues (2.51% CAGR)[e]	−145	−148	−152	−156	−160	−164	−168	−172	−176	−181	−760	−1,620
Net change in deficit[a]	−20	−28	−36	−46	−56	−68	−82	−97	−114	−134	−186	−681
Percent of GDP	0.10	0.14	0.18	0.22	0.26	0.31	0.36	0.42	0.48	0.55	0.87	2.82

SOURCES Congressional Budget Office (CBO); Joint Committee on Taxation; and authors' analysis of previous CBO health care budget scores. **NOTES** Components may not sum to totals because of rounding. CAGR is compounded annual growth rate. [a]Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit. [b]Extrapolations for 2020–2029 calculated using CBO estimated compounded annual growth rates. [c]The CBO estimates spending growth to be at the rate of increase in gross domestic product (GDP) per capita plus one percentage point. [d]Savings from changes to the Medicare program are estimated to increase at 10–15 percent per year [e]The CBO pegs tax revenues to the rate of general inflation. U.S. Breakeven 20-Year Inflation Rate between normal bonds and inflationary bonds was 2.51 percent (accessed via Bloomberg, 9 April 2010).

hospital (DSH) payments.

The act also raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk-adjustment collections; various penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions.

To gain a rough feel for the longer-run impacts, we extrapolated the impacts to the years 2020–2029 using the CBO's estimated compounded annual growth rates. Under this crude approach, the act is expected to yield an additional $681 billion in deficit reduction.

The prospect of these savings is important given the daunting fiscal outlook. But the scenario raises an important question: Is it really likely that a large expansion of public spending will reduce the long-run deficit? The answer, unfortunately, hinges on provisions of the legislation that the CBO is required to take at face value and not second-guess.

Alternative Budgetary Scenarios

A more realistic assessment emerges if one strips out gimmicks and budgetary games and reworks the calculus. As shown in Exhibit 2, a wholly different picture emerges: The act would raise, not lower, federal deficits, by $554 billion in the first ten years and $1.4 trillion over the succeeding ten years.

The list of budgetary features shown in Exhibit 1 begins with the fact that the act front-loads revenues and back-loads spending. That is to say, the taxes and fees it calls for are set to begin immediately in 2010, but its new subsidies are largely deferred until 2014. This contributes to the illusion that the act reduces the deficit. Note that if revenues were delayed to start in 2014, the act's 2010–19 net deficit impact would be $66 billion lower.

Other dubious budgetary provisions fall into four scenarios: unachievable savings, unscored budget effects, uncollectible revenue, and already reserved premiums. Exhibit 2 summarizes the annual impact of each scenario and extrapolates fiscal impact to 2029.

UNACHIEVABLE SAVINGS The first scenario removes spending cuts that we believe the Centers for Medicare and Medicaid Services (CMS) will ultimately be unable to implement. These are composed of cost reductions through Medicare

EXHIBIT 2

Summary Of Analyses Of Reform Scenarios, Billions Of Dollars

Alternative scenarios	**2010–14**	**2010–19**
Official CBO score	−104	−124
Unachievable savings[a]	36.5	253.5
Unscored budget effect[b]	75.5	274.6
Uncollectable revenue[c]	−8.0	78.0
Premiums reserved[d]	24.1	70.2
Net deficit effect[e]	24.1	554.3
Percent of GDP	0.14%	2.90%
Extrapolated scenarios[f]	**2010–14**	**2020–29**
Subsidies (3.4% CAGR)[g]	1,306.0	2,849.5
Cost savings (10% CAGR)[h]	−63.8	−166.5
Tax revenue (2.51% CAGR)[j]	−577.7	−1,231.7
Net deficit effect[e]	664.4	1,451.3
Percent of GDP	3.09%	6.00%

SOURCES Congressional Budget Office (CBO); Joint Committee on Taxation, U.S. Congress; and authors' analysis of previous CBO health care budget scores. **NOTES** Components may not add to totals because of rounding. CAGR is compounded annual growth rate. [a]Centers for Medicare and Medicaid Services (CMS) unable to achieve cost reductions through Medicare market-basket updates, the Independent Payment Advisory Board, Medicare Advantage interactions, or the lower Part D premium subsidy for high-income beneficiaries. [b]Accounting for unscored budget effects related to health care reform including the Medicare Physician Payment Reform Act, the discretionary cost to the Internal Revenue Service of enforcing reform, the discretionary cost to the CMS of implementing changes to federal health care programs, and the explicit authorizations for various health care grant programs. [c]The excise tax on high-premium health plans and the associated effects of coverage provisions on revenues prove politically and operationally infeasible to collect. [d]Community Living Assistance Services and Supports (CLASS) Act premiums are reserved for the future payouts to beneficiaries who enroll in the new long-term care insurance plans and are not counted toward the deficit effect of health care coverage expansion. [e]Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit. [f]Extrapolations for 2020–29 calculated using CBO estimated compounded annual growth rates. [g]The CBO estimates spending growth to be at the rate of increase in gross domestic product (GDP) per capita plus one percentage point. [h]Savings from changes to the Medicare program are estimated to increase at 10–15 percent per year. [j]The CBO pegs tax revenues to the rate of general inflation. U.S. Breakeven 20-Year Inflation Rate between normal bonds and inflationary bonds was 2.51% (accessed via Bloomberg, 4 April 2010).

Massachusetts and Tennessee provide recent examples of cases where insurance coverage expansion has led to cost increases instead of savings.

market-basket updates, the Independent Payment Advisory Board, Medicare Advantage interactions, and the lower Part D premium subsidy for high-income beneficiaries.

Although the specifics of each differ, these provisions share two features. First, the act itself does not automatically reform Medicare in such a manner that will permit it to operate at lower budgetary cost. Accordingly, when the time comes to implement these savings, or those developed by the Independent Payment Advisory Board, the CMS will be faced with the possibility of strongly limited benefits, the inability to serve beneficiaries, or both. As a result, the cuts will be politically infeasible, as Congress is likely to continue regularly to override scheduled reductions.

A vivid example is the Medicare physician payment updates. Each year since 2002 the "sustainable growth rate" formula in current law has imposed cuts in payments to physicians under Medicare.[5] And each year, Congress has overridden these cuts.

Massachusetts and Tennessee provide recent examples of cases where insurance coverage expansion has led to substantial cost increases instead of savings. In 1994, Tennessee implemented a massive Medicaid expansion, eventually covering 500,000 additional residents. A decade later, the state abandoned the experiment after costs more than tripled, from $2.5 billion in 1995 to $8 billion in 2004, consuming one-third of the state budget. When the experiment unraveled in 2005, 170,000 enrollees were dropped. More recently, in April 2010, Tennessee announced that because of cost overruns, the program would need to cut an additional 100,000 people from the Medicaid rolls.[6]

In Massachusetts, the state's Special Commission on the Health Care Payment System has produced payment recommendations in the wake of passing an individual insurance mandate and coverage expansions. But the commission's recommendations have not yet been enacted into law, so overall costs, which are growing 8 percent a year in Massachusetts, have not been slowed.[7] It is likely that recommendations from the federally empaneled Independent Payment Advisory Board would follow a similar trajectory, notwithstanding requirements that would force Congress to adopt the recommendations or find comparable savings.

UNSCORED BUDGET EFFECTS The second scenario highlights acknowledged costs that are not included in the CBO score. As shown in Exhibit 2, to operate the new health care programs over the first ten years, future Congresses will need to vote for $274.6 billion in additional spending. This unbudgeted spending includes discretionary costs of $7.5 billion for the Internal Revenue Service (IRS) to enforce and $7.5 billion for the CMS to administer insurance coverage. It also includes $50.0 billion in explicitly authorized health care grant programs and $209.6 billion for the Medicare Physician Payment Reform Act, which would revise the sustainable growth rate formula for physician reimbursement. All of these provisions are noted with caveats in the CBO's final reports to Congress, but none of them was factored into the final score of the act.

UNCOLLECTABLE REVENUE Scenario three questions the political will of Congress and directly refers to the excise tax on high-premium, "Cadillac" health plans. This tax was supposed to start immediately, according to the Senate's version of the reform law. After intense lobbying by organized labor, Congress relented and pushed the tax back to 2018. This raises the possibility that it will prove politically infeasible ever to implement the tax, as was the case with the Medicare Physician Payment updates explained in scenario one. Thus, the scenario shows the impact of not collecting the associated tax revenue of $78 billion over the next ten years.

RESERVED PREMIUMS Scenario four focuses on Community Living Assistance Services and Supports (CLASS) Act premiums for long-term care insurance and the potential increase in Social Security receipts. In principle, if Social Security and CLASS were to be "funded" programs rather than pay-as-you-go programs, these receipts should be reserved to cover future payments and not be devoted to short-term deficit reduction. Specifically, the scenario shows the implications of reserving the $70 billion in premiums expected to be raised in the first ten years for the legislation's new long-term care insurance.

In addition to this accounting sleight of hand, the legislation uses $53 billion for deficit reduc-

tion from an anticipated increase in Social Security tax revenue. The CBO estimates that outlays for Social Security benefits would increase by only about $2 billion over the 2010–19 period, and that the coverage provisions would have a negligible effect on the outlays for other federal programs. If Social Security revenues do rise as employers shift from paying for health insurance to paying higher wages, we should move Social Security into more of a "funded" program, and the extra money raised from payroll taxes should be preserved for the Social Security trust fund.

BOTTOM LINE What is the bottom line? Removing the potentially unrealistic annual savings, reflecting the full costs of implementing the programs, acknowledging the unlikelihood of raising all of the promised revenues, and preserving premiums for the programs they are intended to finance produces a radically different bottom line. The act generates additional deficits of $562 billion in the first ten years. And because the nation would be on the hook for two more entitlement programs rapidly expanding as far as the eye can see, the deficit in the second ten years would approach $1.5 trillion.

Conclusion

The stakes could not be higher. As documented in CBO analyses, the federal deficit is expected to exceed $700 billion every year over the next decade, doubling the national debt to more than $20 trillion.[1] By 2020, the federal deficit is projected to be $1.2 trillion, $900 billion of which represents interest on previous debt.

In this environment, the anticipated impact of the act is to reduce the deficit by a modest $124 billion over the next ten years. However, this projection is built on a shaky foundation of omitted costs, premiums shifted from other entitlements, and politically dubious spending cuts and revenue increases.

Of course, this is not the only source of budgetary uncertainty. Proponents point toward the possibility that the act will "bend the curve" more than anticipated, thereby reducing health care spending in federal programs and beyond. In this light, it is important to note that if federal subsidies do not grow at all between 2020 and 2029—a herculean reduction in annual spending growth of 3.4 percentage points—it will reduce outlays by under $500 billion. That is, extraordinary success in bending the cost curve amounts to less than one-third of the downside budgetary risks embedded in the act.

The future of the Patient Protection and Affordable Care Act is likely to be even more important than its passage. In light of the precarious state of federal fiscal affairs and the enormous downside risks presented by the act, one can only hope that every future effort is devoted to reducing its budgetary footprint. ■

The authors thank Don Metz, Cameron Smith, and Hiten Patel for valuable comments. All errors are the authors' responsibility alone. These views are those of the authors and not those of the American Action Forum.

NOTES

1 Congressional Budget Office. The long-term budget outlook. Washington (DC): CBO; 2009 Jun.

2 See, for example, Skinner J, Engen E. Taxation and economic growth. N Tax J. 1996;49(4):617–42.

3 Congressional Budget Office. An analysis of the President's Budgetary Proposals for Fiscal Year 2011. Washington (DC): CBO; 2010 Mar.

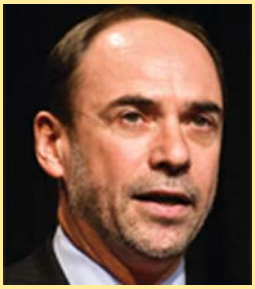
4 To analyze the fiscal impact of health care reform, we have removed the education revenues from the government takeover of all federally financed student loans.

5 Congressional Research Service. Medicare physician payment updates and the sustainable growth rate (SGR) system. Washington (DC): CRS; 2009 Nov.

6 Wadhwani A. Tennessee removes about 100,000 people from Medicaid rolls. Kaiser Health News [serial on the Internet]. 2010 Apr 8 [cited 2010 May 10]. Available from: http://www.kaiserhealthnews.org/Stories/2010/April/08/TennCare.aspx?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+khn+%28All+Kaiser+Health+News%29

7 Kowalczyk L. Pay for care a new way, state is urged. Boston Globe. 2009 Jul 19.

ABOUT THE AUTHORS: DOUGLAS HOLTZ-EAKIN & MICHAEL J. RAMLET



Douglas Holtz-Eakin is president of the American Action Forum.

Douglas Holtz-Eakin is president of the American Action Forum, a conservative think tank in Washington, D.C. From 2003 to 2005 he served as director of the nonpartisan Congressional Budget Office, where he led efforts to develop cost estimates for federal legislation, including the 2003 Medicare Modernization Act. He was chief economist for the President's Council of Economic Advisers under President George W. Bush.

He currently serves on the Financial Crisis Inquiry Commission, a ten-member commission that Congress established to investigate the causes of the financial crisis and the collapse of major financial institutions.

From 2007 until the 2008 election, Holtz-Eakin was director of domestic and economic policy for the presidential campaign of Arizona Republican Sen. John McCain. In that capacity, he helped shape McCain's health reform proposals, which at the time included a plan to repeal the tax exclusion of health insurance and replace it with a system of fixed credits to help all Americans buy health insurance.

Holtz-Eakin earned his Ph.D. in economics from Princeton University. He has held academic appointments at Columbia and Princeton Universities and was Trustee Professor of Economics at the Maxwell School, Syracuse University. At the Maxwell School, he served as chair of the Department of Economics and associate director of the Center for Policy Research.

Holtz-Eakin believes that the recently enacted Patient Protection and Affordable Care Act is "dramatically more expensive than it seems to be on the surface, and that's dangerous for a country in this financial condition." Looking ahead, he says, the public must take an active role in pushing for greater cost controls even before the law is fully implemented in 2014. For his part, Holtz-Eakin plans to influence debate through more research and development of policy solutions, along with getting the word out through various appearances and think-tank work.

Michael J. Ramlet is a research analyst at the Washington, D.C.–based Advisory Board Company, which provides best-practice research, executive training, management consulting, and business intelligence technology to more than 2,700 hospitals and health systems. He conducts quantitative analyses for the Financial Leadership Council, which serves hospital chief financial officers and finance departments.

Michael J. Ramlet is a research analyst at the Advisory Board Company.

His research interests include private insurance markets and the future of accountable care organizations. He graduated summa cum laude from the University of Minnesota's Carlson School of Management with a bachelor of science in business and public policy; he completed a health care thesis under the direction of Stephen Parente. Ramlet plans to purse a doctorate in health care management.

Ramlet used Congressional Budget Office scores and estimates from Congress's Joint Committee on Taxation to analyze the long-term costs of the new health care law, which supported the analytical underpinnings of the article he coauthored with Holtz-Eakin in this issue of *Health Affairs*.