



A Briefing Paper from

Hudson Institute

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

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Summary:

Current federal commitments to health care are on a course to consume an ever larger share of the budget. New subsidies bring two forms of risk to the federal budget which could either exacerbate or moderate this trend. First, there is the financial risk that can be anticipated at the time health care reform happens. Second, there is the risk that things will turn out differently than expected.

Policy options that could be put to use to manage the long-term fiscal risk of new subsidies include fiscal federalism, a cap on total spending, a trust fund, fiscal triggers to determine the rate at which implementation proceeds, a defined benefit, and creating a discretionary rather than entitlement program.

This paper compares how these options manage fiscal risk against a set of “base case” scenarios. In these scenarios, the cost of a new entitlement is offset by savings and revenue of equal magnitude over the first decade. Thereafter, underlying growth trends in the economy and the health care system determine the rate at which costs and offsets grow. The scenarios differ in what they expect about future growth in health care costs and how much of the financing comes from reallocating existing fiscal commitments to health care. In the most optimistic scenario, all the financing for new subsidies comes from within the health care sector. The common trend between cost growth in subsidies and offsets allows health care reform to be fiscally balanced. However, where the offset pool includes new revenue, offsets slip behind costs in the long-run. If all offsets came from new revenue, costs would be one-third higher than revenue at the end of twenty years into the long-run.

New subsidies for health insurance are a component of almost all visions of health care reform. These subsidies could take a variety of forms, both in how they reach the people who get them and what long-term fiscal commitment the federal government makes. This paper considers the long-term impact of new health insurance subsidies on the federal budget and tools for managing that impact.

The initial cost of new subsidies for health insurance will be a function of who is eligible and how much each person receives. The long-term fiscal impact will depend on the rate of growth in both initial costs and the offsets that pay for those subsidies. Cost growth will depend on growth in the population, change in the share of the population who are eligible and participate, and change in the subsidy each person receives. The relationship between trends in cost and offsets will determine whether new subsidies add or take away from the pressures on the federal budget. As the Congressional Budget Office has reminded us, the cost of Medicare and Medicaid is on a path to grow from 5 percent of GDP today to 6 percent in 2019 and about 12 percent by 2050.¹

In the short-term, the “pay as you go” rules adopted by the Senate and House of Representatives require health care reform legislation to be budget neutral over the first decade. New subsidies must be paired with offsets of equal magnitude. Both savings from current federal fiscal commitments and new revenues could provide offsets. The “pay go” time horizon extends to ten years. Its end provides a definition of when the short-term ends and the long-term begins.

The Senate’s Byrd Rule adds the additional uncertainty of whether there will be a long-term. This rule, codified in 1990 as Section 313 of the Congressional Budget Act of 1974, limits the ability of the Senate to consider reconciliation legislation that would increase the deficit for periods of time beyond the budget window, currently ten years. A motion to waive the Byrd Rule requires a three-fifths vote in the Senate.² In the case of tax cuts implemented during the Bush Administration, avoiding the Byrd Rule meant ending tax cuts after ten years, avoiding fiscal impact on years after those addressed by the budget resolution. Should health care reform’s legislative path become the reconciliation route, the Byrd Rule complicates what, if anything, can last beyond ten years.

The short-term fiscal risk of health care reform stems from forecast error. One way or another, a ten year forecast will be wrong. 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

¹ “Options for Controlling the Cost and Increasing the Efficiency of Health Care.” Statement of Douglas W. Elmendorf, Director, CBO, Subcommittee on Health, House Committee on Energy and Commerce, March 10, 2009.

² Robert Keith, “The Budget Reconciliation Process: The Senate’s ‘Byrd Rule.’” Updated March 20, 2008. Congressional Research Service, Order Code RL 30862.

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-four, 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

Why Assume Health Care Costs Will Always Grow Faster than the Economy?

If health care costs grew less rapidly or just as rapidly as the economy overall, health care cost growth would not be the issue it is.

Is the assumption that health care costs will grow faster than the economy *ad infinitum* a reasonable assumption? Carried out far enough, the assumption produces the prediction that the U.S. will arrive at a point where everything else gets squeezed out and the economy is nothing but health care. Such a forecast strains credulity. Health care would absorb everything else in the economy. This view of the future seems subject to the so-called “Stein’s Law,” framed by the economist Herb Stein. Things that can’t go on forever, won’t.

⁴ Congressional Budget Office. “Spending and Enrollment Detail for CBO’s January 2009 Baseline: Medicaid.” February 5, 2009.

⁵ Todd G. Caldis, “The Long-Term Projection Assumptions for Medicare and Aggregate National Health Expenditures.” Office of the Actuary, March, 2008.

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.

The ‘GDP + 1’ assumption became part of the Actuary’s view of the world after an outside technical panel review report in 2000.⁶ That panel was most influenced by the historical evidence. Looking at growth rates in real per capita Medicare costs since 1975, the panel found no interval of five or more years over which real per capita Medicare costs had grown more slowly than 1 percent above real per capita GDP.

The Actuary’s approach, which has the intuitive appeal of being consistent both with recent patterns and Stein’s Law, produces growth in Medicare costs above the ‘GDP + 1’ level through 2044, beyond the period in the base case used in this paper. While appealing to the common sense embodied in Stein’s Law, it lacks an account of how the transition from something not sustainable to something that is will be accomplished. CBO’s analysis similarly comes without an account of how, but does have a rationale for why: the American people will not accept levels of health care costs that make their non-health care standard of living fall.

Long-term projections of net costs require one more assumption. How fast will offsets grow? An earlier assumption requires offsets balance costs over the first decade. Thereafter, what happens depends on the underlying rates of growth in the sources of the offsets.

Savings from health programs are assumed to grow at the same rate as the health sector. These savings grow at the same rate as new subsidies. If all offsets came from the health sector, a subsidy scheme that was paid for at the outset of the long-run (2019) would remain paid for indefinitely. New revenues are assumed to grow at the same rate as the tax base, assumed to be the rate of growth in the economy overall.

A package of offsets that came solely from new revenue would not be able to remain “paid for” into the long run. Figures 1, 2, and 3 show three different views of the timing for when health care cost growth moderates.

In the first view (Figure 1), if cost growth does move off its historical path, it is not until well into the long-run. Health care costs would continue to follow the 2015-2019 pattern of two percentage points faster than the economy overall throughout the first generation into the long-run. In the second, health care cost growth slows to one percentage point faster than the economy over 2020 to 2040. In the third and most optimistic view, the progress made in the first decade yields health care cost growth slowing to one percentage point faster than GDP in 2020 and continues at that rate through at least 2040.

⁶ Technical Review Panel on the Medicare Trustees Reports. “Review of Assumptions and Methods of the Medicare Trustees’ Financial Projections.” December 2000.

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

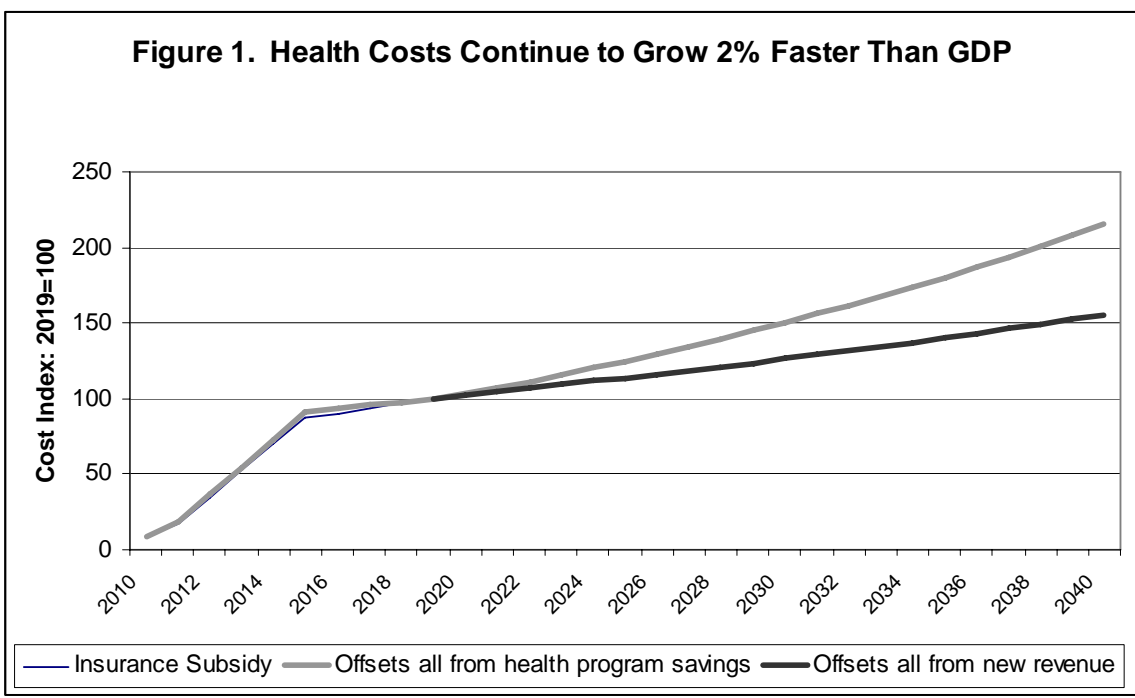
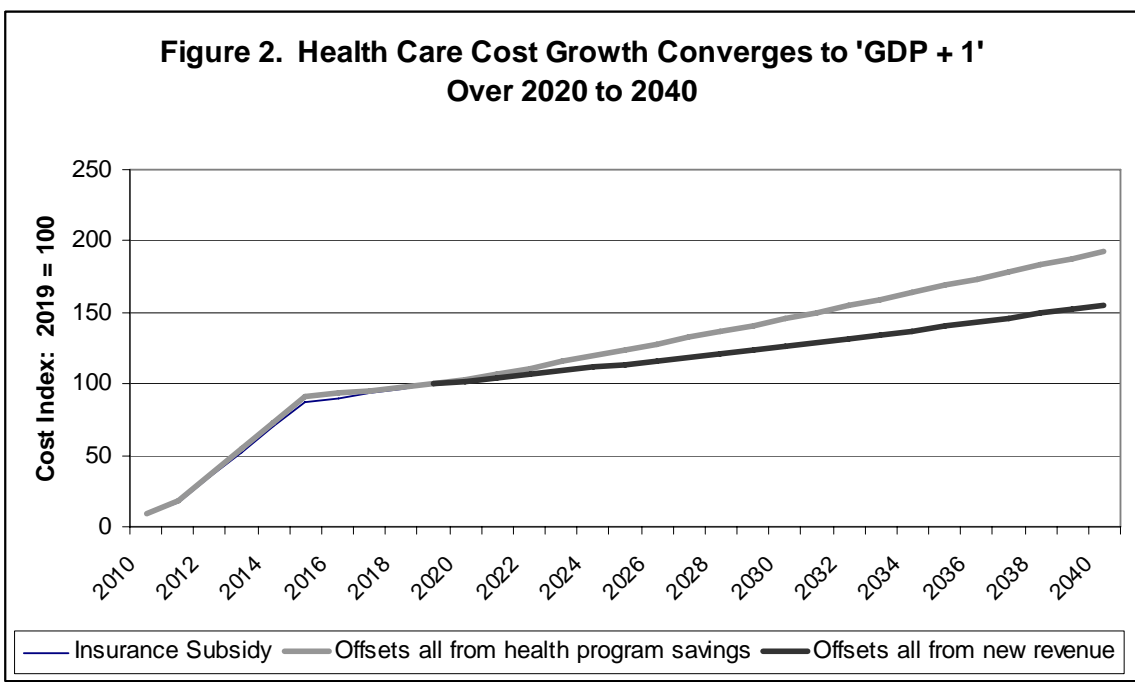
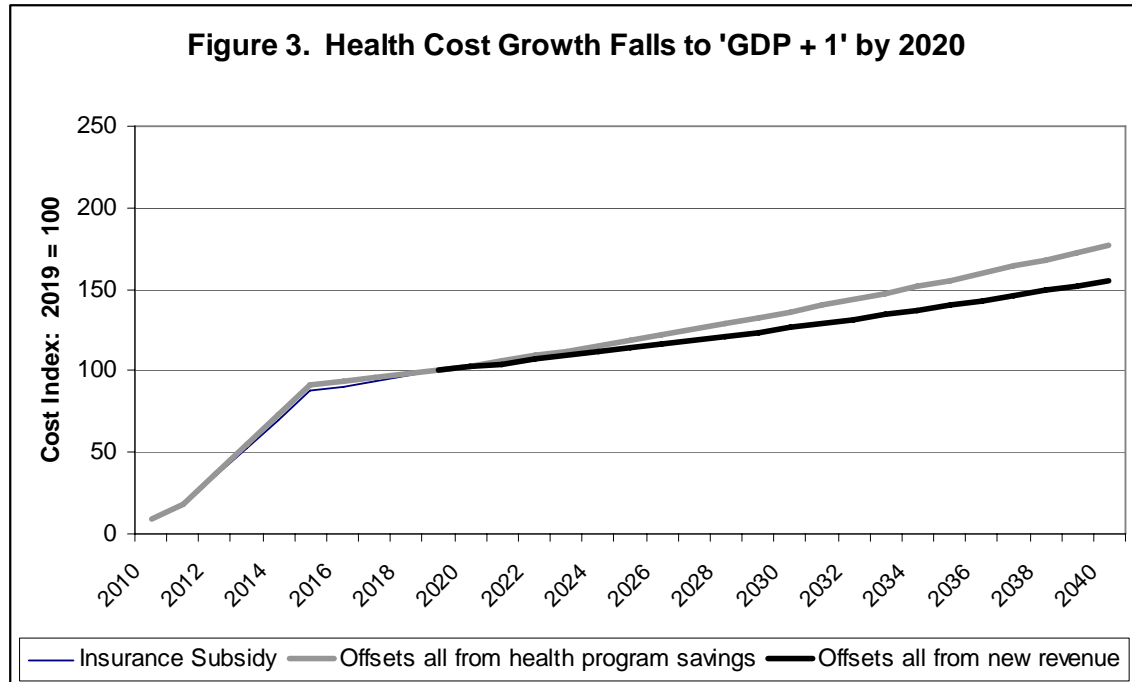


Figure 2. Health Care Cost Growth Converges to 'GDP + 1' Over 2020 to 2040





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

many more assumptions. As a practical matter, microsimulation methods have not been used to model future health care expenses. Box 3 considers their potential. Neither a single assumption about growth rates or an approach built on many assumptions is necessarily better. The single assumption has the advantage of being clear about what drives the result.

Box 3

Can We Do Better in Forecasting the Future?

Macro models, like those used by the Actuary to forecast future Medicare costs, can be characterized as having a small number of variables that fluctuate in the short run and then reach a steady state that goes on forever. The assumption that the best guess about the future comes from the recent past does not allow for understanding how the future could be different.

Future costs could also be forecast from the bottom up, specifying a large number of variables and subgroups or even individual level data as in the microsimulation models used to make projections of impacts of policy change in the tax code or income transfer programs.

The single-assumption approach can be faulted for not explicitly modeling technology, widely viewed as the most important source of cost growth. Researchers at the RAND Corporation have developed a detailed model, called the Future Elderly Model.⁷ This model incorporates expectations about changes in treatment and health status. New cancer treatments, for example, will bring higher costs.⁸ Higher levels of obesity will also increase costs.⁹

The Future Elderly Model is limited when compared to the Archimedes Model developed by an eponymous group of health care modelers.¹⁰ The model takes into account physiology, diseases, interventions, and healthcare systems. Its hundreds of equations that represent human disease do not include the cost of delivering health care. A model with this degree of complexity could also be used to derive future forecasts of health care expenses.

Any model will only be as good as its ability to adopt assumptions that hold up. Whether a model that uses hundreds of equations can outperform a model with only one or two assumptions is unknown.

⁷ Dana P. Goldman et al., Health status and medical treatment of the future elderly: Final Report. Report report TR-169-CMS. August 2004.

⁸ Jay Bhattacharya, et al. "Technological Advances in Cancer and Future Spending by the Elderly," *Health Affairs*. Published online, 26 September 2005.

⁹ Darius N. Ladkawalla, Dana P. Goldman and B. Shang, "The Health and Cost Consequences of Obesity among the Future Elderly," *Health Affairs*. Published online, 26 September 2005.

¹⁰ <http://archimedesmodel.com/index.html>

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 this feature. They would both increase capabilities and costs. Technology also leads to higher costs as it becomes used more widely, both geographically and in more populations (e.g., improved surgical technique making possible procedures on older and more physically compromised individuals.) Technology could be a source of future shocks that if sufficiently disruptive make the recent past a poor predictor of the future.

¹² Joseph P. Newhouse, "Medical Care Cost: How Much Welfare Loss?" *Journal of Economic Perspectives*. Vol. 6, no. 3, 1992.

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 over offsets than in the base case. Adds to existing pressure on the federal budget from health care costs.
- Health care’s share of the federal budget will increase more rapidly.

Make new subsidies part of Medicaid. Medicaid is a joint state-federal program. The state share on average is 43 percent. The formula gives states with relatively lower income levels a higher federal share. New health care subsidies could be administered through the Medicaid program or a parallel program that follows Medicaid’s fiscal structure.

Expanded eligibility for subsidies could be optional or mandatory for states. Past expansions have followed both models. For example, the Omnibus Budget Reconciliation Act (OBRA) of 1986 gave states the option of providing Medicaid coverage to children up to age five in families with incomes up to 100 percent of the federal poverty level. States have also been required to expand eligibility. The OBRA of 1989 required states to provide Medicaid coverage to pregnant women and children under age six who live in families with incomes below 133 percent of the federal poverty line and the OBRA of the following year required states to phase in coverage of older children in poor families, reaching age eighteen in 2002.

The impact on state budgets from a larger Medicaid program could be avoided if the federal government took on a larger share of the program's cost. Using Medicaid would make the long-term fiscal impact of new health care subsidies a joint product of federal and state decisions. For example, while the federal government might require states to cover certain groups or income levels, the cost would depend on the vigor with which states sought to enroll the newly eligible.

Even if expansion came as a funded mandate, states might not pursue enrollment. In the Supplemental Nutrition Assistance Program, formerly the Food Stamp program, states administer the program with all costs borne by the federal government. Nationally, 67 percent of those eligible participated in 2006. Across states, the point estimate of participation rates ranged from 98 down to 50 percent.¹³

Canada offers an example of how universal coverage can be achieved through fiscal federalism. While Canada's governmental health plan is called medicare, its fiscal structure more closely resembles Medicaid in the US. The national government makes a transfer to the provinces. The provinces hold responsibility for administering the program limited by those features which are national.¹⁴ Keeping costs in line with fiscal circumstances is the joint responsibility of the national and provincial governments.

Fiscal impact:

- The pressure on state budgets could lead to state governments responding more rapidly to cost growth than would the federal government;
- While the base case assumes a steady rate of economic growth, there could be economic fluctuations. States face constitutional restraints to balance their budgets, and this constraint could impose additional fiscal discipline.
- While states may have a stronger interest in cost containment than the federal government, both CBO and the Actuary project trends in per participant

¹³ USDA Food and Nutrition Service, "Reaching Those in Need: State Food Stamp Participation Rates in 2006." November 2008.
<http://www.fns.usda.gov/ora/menu/Published/snap/FILES/Participation/Reaching2006.pdf>, accessed April 28, 2009.

¹⁴ Gerard Boychuk, *National Health Insurance in the United States and Canada*. Washington: Georgetown University Press, 2008.

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.

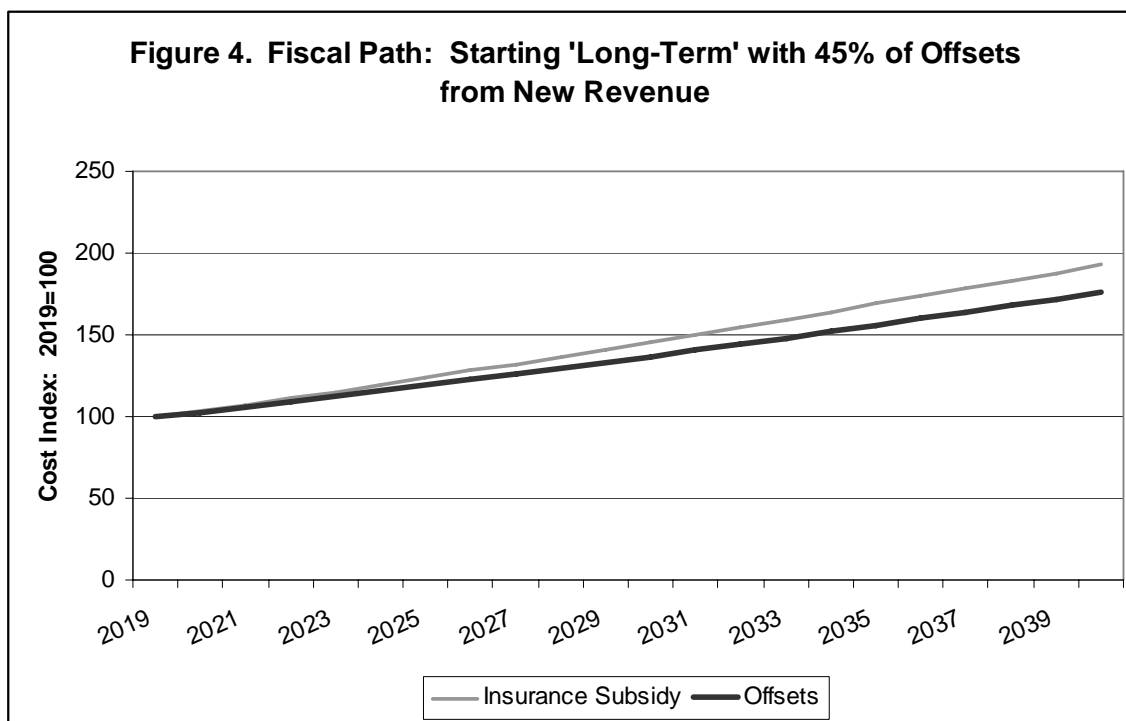
Savings from proposed changes to health programs, primarily Medicare, would ramp up more slowly and would also have more variable growth than the revenue proposal. Over the second half of the ten year FY 2009 to FY 2019 window, savings would grow by an average of 8.6 percent a year, 4.2 percentage points faster than the economy overall.

¹⁷ Author’s calculation from *General Explanations of the Administration’s Fiscal Year 2010 Revenue Proposals*. Department of the Treasury, May 2009.

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.



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

A trust fund could be structured as either an accounting device, as with the Medicare trust funds, or as a tool that would have real consequences should costs exceed expenses. The trust fund could come with answers to certain “what if” questions. For example, if costs exceeded expenses and insolvency loomed, the initial legislation could provide for

automatic reductions in health insurance subsidies, either in the dollar amount or eligibility levels.

Even if the trust fund lacked automatic, self-implementing consequences if it developed fiscal imbalances, the very existence of the trust fund would provide a framework for politicians to explain why they were taking steps to limit growth or increase revenue. The Social Security Amendments of 1983 used looming insolvency of social security trust funds to motivate changes in taxes and revenues. This experience provides an example of how trust fund insolvency can catalyze action.

The Medicare trust funds provide a different example. The many incremental changes to Medicare accomplished in various reconciliation packages enacted over the past twenty five years suggest a politically feasible path that keeps insolvency at bay using government's monopsony power to squeeze payment to providers but never gets to structural reform that provide longer-lasting guarantees of stability.

As with any federal activity that uses trust fund financing, it would still be possible for Congress to "fix" threatened insolvency by appropriating general revenue. For example, in 2008, Congress transferred about \$8 billion from the general fund to the Highway Trust Fund. (Public Law 110-318, enacted September 15, 2008.) Higher fuel prices had eaten away at trust fund revenue, putting the trust fund at the edge of insolvency. There is no limitation on Congress other than the moral force of dedicated financing to prevent a general revenue transfer.

This temptation might be greater with a trust fund not linked to a dedicated revenue source. The Obama Administration's "reserve fund" derives part of its funding from savings that arise from changes in the Medicare program. These amounts are projections based on assumptions about program costs with and without certain policy changes. It would never actually be an account in the Treasury. Its existence would end at the completion of the legislative process.

A trust fund on the books of the Treasury would require ongoing transfers. The amount of these transfers would not be tied to inflows to the Treasury. For example, savings from Medicare program changes would require administrative determinations about how much Medicare would have spent had changes not taken place. Unlike the highway trust fund, where revenues are primarily a particular federal excise tax and the income is reported every month in the Monthly Treasury Statement, the revenue for a health reform trust fund would be transfers made on the basis of estimates and projections with no ability to reconcile with actual receipts.

Fiscal impact:

- While the "pay go" tool creates no consequences after the moment Congress passes a health care reform package, a trust fund would continue as long as the program itself.

- Much would depend on Congress' willingness to be constrained by the notion of a self-sustaining trust fund. This trust fund would differ from other trusts funds by not having a single, dedicated tax that was its primary source of revenue.
- The impact would depend on how well initial projections tracked the amount of actual costs and savings. Should projections of costs be too low, the looming insolvency of the trust fund could mobilize political will; should projections be too high, accumulations in the trust fund could encourage additional subsidies or change to offsets.

Fiscal triggers. Implementation of new subsidies could be accompanied by fiscal triggers.

New subsidies could prove to be either more or less expensive than projected by the CBO at the time Congress acts. CBO provides a point estimate which can be understood as the most likely value within a range of estimates. Triggers could recognize that uncertainty and provide feedback from what occurs to the next step of the implementation process. In that way, Congress would not be defining a single future path for new subsidies but a range of paths, with the actual path depending on what happens rather than what was projected when legislation first became law.

Triggers could take a variety of forms. They could be tied to program cost or impact on the federal budget via the relative magnitude of costs and savings. If costs exceeded expectations, the next step in a phased introduction of subsidies could be postponed or income levels used in subsidy calculations could change. They could also be procedural. The brief history of triggers for Medicare enacted in 2003 (Title VIII, Cost Containment, of the Medicare Prescription Drug Improvement and Modernization Act of 2003) suggests that a trigger that produces certain procedural steps, such as submitting reports or introducing legislation, can easily be pushed aside.

Triggers could also be paired with a new trust fund. Triggers could be tied to trust fund balances. For example, new subsidies could be implemented in several tranches. Initial legislation could spell out a planned set of dates for each tranche to take effect, but the additional eligibility could be delayed if there was not a finding by an Executive Branch official that the trust fund balance was not above some level. There could also be a provision that would allow accelerating a tranche if the trust fund balance was above some level.

Triggers would provide a ready response to the almost-certain problem of forecast error during the period in which new subsidies are implemented. They would make implementation depend on the "pay go" dynamic in which new spending is balanced against savings and revenues. Triggers that slow or accelerate timing could be perceived very differently than triggers which took subsidies from those who got them last year. Taking away could result in a trigger that caused people who already receive a subsidy to lose it or receive a smaller subsidy. Taking away and delaying implementation are not

politically symmetric. Congress may be more willing to make the timetable for implementation a ministerial function of the Executive Branch contingent on particular financial landmarks.

Fiscal impact:

- Triggers could be set at any level. Depending on where triggers were set, the fiscal impact of health care reform could be above or below that in the base case.
- As with the trust fund, triggers provide a fiscal feedback mechanism that continues past the point when Congress passes and the President signs initial legislation.

Defined contribution entitlement. Rather than an entitlement to a particular insurance package, health care reform would provide an entitlement to a particular level of subsidy. Initial legislation would set the contribution level. Increases would follow a formula. This approach would narrow the sources of variability in future costs. Actual costs could still deviate from forecasts because the number who are eligible and the share who participate could differ from the forecast.

The forecast risk would take a different form than in most of the other options. In options with an open-ended commitment to a set of benefits, the federal budget bears the risk of forecast error. “Federal budget” is not an abstraction but the sum of everything government does: defense, income transfers, etc. In this option, those who receive subsidies would face the risk that health care costs will rise more rapidly than the index that adjusts the defined contribution.

The risk that subsidy recipients face would both interject a new element into cost containment and reframe the political challenge. A fixed contribution and the risk that future costs would exceed future contribution would create a group of consumers with a strong interest in cost containment. The political challenge would shift from the eat-your-vegetables, politically unrewarding challenge of fiscal responsibility to helping a defined constituency threatened by costs growing faster than their defined contribution amount.

Fiscal impact:

- A defined contribution itself has an ambiguous fiscal impact. The subsidy amount could be set at or below the level that would produce the fiscal path in the base case. Indexing the subsidy amount to the overall growth in prices would produce a path below that in the base case. Indexing the subsidy amount to ‘GDP + 1’ would produce the base case.
- While this approach would limit the risk posed by health care cost growth, the risk posed by change in the share of the population that would be eligible or would participate would remain.

Appropriations authorization. Health care reform would provide an authorization for future appropriations for health insurance subsidies. Subsidy amounts in future years would depend on the appropriation level.

This approach would make the actual amount available each year a result of annual trade offs in the federal budget. Subsidies would adjust to the amount appropriated, either adjusting income thresholds or the rate at which the subsidy falls between the highest income level eligible for a full subsidy and the highest income level eligible for any subsidy.

The Veterans Health Administration provides an example of responding to the health needs of a population with an annual appropriation. The VHA operates under a statutory priority list through which it matches services with resources.

Fiscal impact:

- Because there would be no direct spending, the base case for direct spending would not apply.
- The long-term fiscal impact would depend on the annual willingness of the Congress to devote domestic discretionary funds to health care compared to all other purposes that compete for domestic discretionary funds.

Conclusion

The fiscal risk from health care reform comes in two forms. The first is short-term. A package which is projected to offer offsetting subsidies and offsets over its first ten years may prove to be imbalanced as those ten years unfold. The second is long-term. A package that balances benefits and offsets in its first decade may become unbalanced thereafter. The summary table shows how each option reviewed in this paper could contribute to managing these risks.

The fiscal risk of health care reform is, by its nature, uncertain. There is some chance that the risks will resolve in a fiscally favorable manner: health care subsidies cost less than projected; the past proves to be a poor guide to what happens with health costs in the future and costs grow more slowly than in the past; or technologies emerge that are less costly substitutes for current technologies. There is also some chance that costs will prove to be higher than expected: the economy does worse than expected and more people are eligible for subsidies; health care costs do not converge towards the rate of growth of the economy overall or move more slowly in that direction; or more new technologies add to costs than take away from them.

One option is to ignore the risk. There are few political rewards for delivering a new set of subsidies that come with the warning that they might be scaled back or telling health care providers that the offsets imposed in the initial package may not be the last.

Another option is to wait. Forecasts for more distant time periods are more variable than those for near periods. As each year in the future draws nearer, forecast accuracy increases. This option favors strategies such as a capped entitlement and fiscal triggers.

A final option is to create mechanisms to address fiscal imbalance at the same time as the potential sources of imbalance are created. We are now forty four years past the creation of Medicare and almost as many years into dealing with its fiscal imbalances. With health care reform today there is the opportunity to act in advance.

Summary

Approach	Consequences of Forecast Error	Fiscal Risk Relative to Base Case
A new, add-on entitlement	None	Higher in initial ten years; thereafter same trend but starting at a higher level
Fiscal federalism	None at federal level; potential for state response	Similar
Capped entitlement	Writes the forecast into statute. Legislative action required if forecast understates demand	Depends on where capped entitlement is set relative to base case spending level
New entitlement under 'pay go' limitation for ten years	None	Potential for lower than expected expenditure, could do better to the extent offsets come from savings rather than revenue
Trust Fund	Forced action if higher expense/lower revenue renders trust fund insolvent	Base case path
Fiscal triggers	Triggers hit if cost exceeds initial forecast	Base case path, with potential for beating base case depending on where triggers are set
Defined contribution entitlement	Potential for exceeding cost if index used to update contribution grows faster than initially forecast. No consequences	Lower, equal, or higher than base case depending on index used to set contribution
Appropriations authorization	No error	Depends on level at which annual appropriations are set