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INFORMED BUDGETEER:

CBO AND HEALTH REFORM – WHAT'S THE DEAL?

Letter #1

- On June 15, in a letter to Senator Kennedy, the Congressional Budget Office (CBO) released preliminary estimates of key numbers based on specifications of a draft of Title I of the Affordable Health Choices Act, the bill currently being marked up by the Senate Health, Education, Labor and Pensions (HELP) Committee. Why use so many words to describe what most people have called "CBO's cost estimate of the Kennedy bill?" For several reasons.
- CBO issued a preliminary analysis of specifications provided by the HELP Chairman that represented his draft mark. CBO did not do a complete cost estimate of committee-reported legislative language (which is when CBO almost always does a cost estimate) because the legislation has not reached that stage. The draft language that the chairman made available to HELP Committee members (to comply with a committee rule) may or may not comport with the specifications he asked CBO to estimate.
- In any event, CBO's analysis addresses only subtitles A through D of Title I of the draft bill language provided for the Affordable Health Choices Act, which are among the major provisions of the ultimate bill. While that bill language contains six titles and a total of 31 subtitles, three major sections (employer mandate, government-run plan option, and follow-on biologics) were left blank.
- Because the language came out so close to the beginning of markup, CBO did not have time to thoroughly estimate everything in the legislative language; for example, CBO did not estimate the administrative costs of the government's implementation of the proposals.
- In addition, CBO could not estimate any budgetary effect from expanding Medicaid eligibility up to 150% of the poverty level; the chairman asserts his mark assumes Medicaid eligibility will expand, but the bill does not include any language that would accomplish that because Medicaid is in the jurisdiction of the Finance Committee. The Senate's plan appears to be to marry HELP's reported language with a bill to come out of the Finance Committee after the July 4 recess; indeed, some components of each bill probably won't make sense until combined with the other bill.
- In short, the health reform legislation is not just one, but several, moving targets, and Congress won't receive a thoroughly useful, internally consistent cost estimate until sometime after the pieces stop moving.
- In assessing the interactive effects of several broad policy changes on the number of insured people, CBO said that about 147 million people would be covered by an employment-based health plan in 2017, 15 million *fewer* than under current law. A footnote to the sentence said that the decline was "the result of several flows." CBO received several questions about this, and posted more detail in an addendum to its analysis on June 16 in the Director's Blog.
- About 10 million people *would choose* to obtain coverage through exchanges rather than their employer because the subsidy they receive under the legislation makes insurance from an exchange cheaper. Another 10 million people *would have no option but* to obtain coverage through exchanges because their employers would not offer it. Finally, about 5 million people would choose to obtain employer-provided coverage under the proposal (rather than insurance through an exchange).
- What other story do these numbers tell? At least 20 million people who are currently covered by an employment-based health plan will receive government subsidies under this legislation.
- The subsidies for individuals (up to 500% of poverty) and small businesses with low-wage employees increase spending by $1.3 trillion over the next ten years. Because of the way cost estimates are done (10 years beginning with the budget year), the CBO analysis does not reflect the real 10-year budget impact of a fully-phased in program for individual and employer health insurance subsidies. The analysis estimates only a partially phased-in program; extrapolating from the CBO estimate, once the program is fully phased in, it could cost $2.3 trillion over a decade.
- The new spending is partially offset by about $300 billion in increased revenues, most of which is due to the reduction in the number of people receiving employer-provided insurance coverage. As mentioned above, CBO concluded that 15 million fewer people will be covered by an employment-based health plan than under current law. CBO assumes that employers would continue to compensate those workers at market rates -- *taxable* compensation in the form of higher wages and salaries would replace the *non-taxable* employer-provided health insurance form of compensation and result in higher income tax collections. (For more information see Donald Marron's blog of June 17, 2009)

Letter #2

On June 16, CBO sent a letter to the Chairman and Ranking Member of the Senate Budget Committee responding to their joint request that CBO identify policy changes that have the best chance of reducing health costs over the long term.

CBO's response, comprising 16 pages in addition to the cover letter, included the following key observations:

- **Federal Budget Outlook.** "The federal budget situation is on an unsustainable path, primarily because of rapidly rising spending on health care." We don't have to wait for a long time for the imbalances to hit; they will occur within Congress' 10-year estimating window.
- On an annual basis, the federal government already pays more than $1 trillion for health care in the U.S.: $700 billion for Medicare and Medicaid; $250 billion for tax preferences for health care (exclusion of premiums for employer-based health insurance from taxes), plus more spending for health care for veterans, military, and other programs. This burden in part motivates the desire for health reform.
- **Expanding Health Coverage Would Increase Deficits Further.** Creating or expanding insurance programs would only add to already unsustainable federal costs. A "large-scale expansion of insurance coverage would represent a permanent increase of roughly 10 percent" in the level of federal spending dedicated to health care. Spending on health care in the whole economy would also increase. The cost shifting that currently occurs (from uncompensated care to private payers) would not be mitigated too much, but expanding health coverage would shift some costs currently born by the private sector (individuals, providers, employers) to the federal government.
- Even if a health reform package were scored as being "budget neutral" over the next 10 years, the near-term savings would not be guaranteed for the long run and deficit neutrality would not likely be sustained, for two reasons:
  - Because an expansion of coverage would be phased in, its full 10-year cost would be more expensive than it appears for the 2010-2019 period.

- "Savings generated by policy actions outside of the health care system" (e.g. proposed tax on sugary drinks or alcohol and the Administration's proposal to limit the tax rate applied to itemized deductions) would probably not grow as fast as health care spending.

- **How Can You Save Enough To Really Have An Impact?** There is enormous variation in health care spending unrelated to quality, which means there is a potential for "substantial savings." Yet all the ideas of how to make efficient practices universal in our national health system "cannot be accomplished through fiat or good intentions" or wishing it were so. But the government does control "two powerful policy levers for encouraging changes in medical" practices:
  - Changes to Medicare "payment rules could induce providers to offer higher-quality and lower-cost care (while ensuring that efficiency gains were shared by the government), and changes in the structure of benefits could give [Medicare] beneficiaries stronger incentives to choose less costly care."
  - Currently, employee compensation and benefits in the form of employer-paid premiums for health insurance are not taxed. Reducing or eliminating "the tax exclusion for employer-sponsored health insurance can affect the efficiency of health care financed by the private sector, by giving workers stronger incentives to seek lower-cost health insurance plans.

- Ideas such as switching from fee-for-service payment to paying providers for value, providing incentives to control costs, and improving decision-making by increasing information are hoped to improve efficiency. Unfortunately, "little evidence exists" about how exactly to implement such changes so that they produce the desired results.

- **Policy Options That Could Produce Savings in the Long Run.** Areas with great promise for reducing federal spending in the long run without harming people's health (note that experts don't know how best to structure these reforms, so experimentation will be needed to see what works) include:
  - Accountable Care Organizations. Groups of physicians who team together to provide coordinated care for patients would receive bonuses if they hold down the total cost services provided while meeting quality of care requirements.
  - Bundling payments to hospitals and other providers. Medicare would pay a hospital for all of the care a patient receives both while in the hospital as well as for 30 days after discharge. Rather than paying only per hospital admission, this proposal would incentivize providers to coordinate care to reduce post-hospital readmissions.
  - Comparative effectiveness. Research on the effectiveness of treatments has long lag times for yielding changes in behavior and by itself is not sufficient to reduce costs. Providers and patients must have a financial incentive to use the information.
  - Preventive and Wellness services. The evidence for the increased use of such services to reduce overall health spending is mixed; ultimately it does not appear these approaches are a magic bullet for significant savings.
  - Increase cost sharing by patients. Raising patients' deductibles and co-pays in both federal government and private health insurance would increase the efficient use of medical services.

- **Impose Ongoing Pressure, Especially on Providers, to Increase Efficiency Over Time**. Many of the reforms above would only reach fruition if we foster substantial changes in how medicine is practiced using measures such as the following:
  - Reduce Medicare payment updates automatically to allow the government to share in productivity gains.
  - Reduce Medicare payments in high spending areas.
  - Allow HHS broad discretion to makes changes in Medicare to produce savings, with a fallback mechanism of across-the-board reductions in payments to providers if administrators do not achieve a certain level of savings.
  - Require Medicare beneficiaries to pay increased premiums that reflect the growth in Medicare costs.

- For any of these approaches to work over time, Congress would have to resist pressure from providers and patients to undo reforms designed to save money. Congress' track record to date -- by ignoring the reductions scheduled under Medicare's sustainable growth rate mechanism for payments to doctors -- does not bode well for this requirement.

Letter #3

- Earlier this month, a group of health care stakeholders met with President Obama and presented him with multiple policy suggestions to back up pledges they made to reduce health care costs, strengthen quality, and improve access. The Administration touted these suggestions as evidence that health care spending could be reduced by $2 trillion over the next decade without compromising health care delivery and outcomes.

- Representative Camp as well as Senators Gregg, Enzi and Grassley asked CBO to determine whether the stakeholders' proposals would yield savings. CBO responded with a letter on June 16, noting that most of the proposals do not require the involvement of the federal government or are not specified at a sufficient level of detail to estimate savings.

- Some of the initiatives would certainly save money, like efforts to prevent infections. But such efforts are simply good medical practice and should happen in the absence of federal legislation.

- Why does it matter if the proposals do not require federal government involvement? It would be terrific if the health care industry could adopt more efficient practices and save consumers money, but those kind savings happen in the economy all the time and are not due to legislative action. CBO takes into account administrative actions, regulatory changes and industry practices when determining a baseline level of spending. In order to score savings that could be used as an offset to increase federal spending elsewhere, a proposal must change federal law and behavior must change because of the law. To the extent that certain practices would be adopted anyway, without legislation, they would not affect the budgetary scoring of a proposal.

- CBO's letter also noted that a subset of the stakeholders' initiatives could result in savings or costs that would be relevant for CBO's cost estimates for legislative proposals, including medical malpractice reform, changing Medicare payments to hospitals based on certain criteria, and extending prescription drug coverage to the entire population. But the proposals were not specified at a level of detail that would enable CBO to estimate any budgetary effects.