IRET Congressional Advisory

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CBO UNDERESTIMATES COST OF THE SENATE FINANCE HEALTH BILL

The health care reform bills before Congress would raise demand for health care and raise the price of health care. Such a large industry cannot expand without experiencing rising costs as it bids scarce resources away from other uses. The price jump will be high in the short run until the supply of health care can be increased. (John Cogan, R. Glenn Hubbard, and Daniel Kessler estimate a 10% jump in premiums for family insurance plans in an op ed in the *Wall Street Journal* on September 25.) There will still be a lower but permanent long run price effect even after supply increases. Have the price increase been counted in cost estimates of the reform plans?

CBO published a report on its estimation methods in December, 2008, entitled *Key Issues in Analyzing Major Health Insurance Proposals*. It asked if the supply of health services could accommodate the new demand, especially in the short run before new doctors, nurses, and technicians could be trained, and new equipment installed. The Report discussed controlling costs through reimbursement rates negotiated or set by government agencies. It wondered, if compensation rates were reined in, would doctors and hospitals see more patients to offset lost revenue per patient, or be discouraged from working? (In our view, the latter makes economic sense; the former is wishful thinking.) CBO calls squeezing more patients into a doctor's work day "increased productivity." (We call it "having less time with your doctor" which could make the quality-adjusted "productivity gain" zero.) The ambiguity about price effects raises a question about the CBO spending estimates for the health reform bills.

The CBO scores the Senate Finance bill as reducing the federal deficit by $81 billion over ten years (letter from CBO Director Douglas Elmendorf to Senate Finance Committee Chairman Max Baucus, October, 7, 2009). The bill has a gross cost of $829 billion over the last six years of the ten year budget window, starting about 4 years out. (Taxes rise for ten years, spending does not jump until 2014.) The bill would tax high value insurance plans, which reduces the net subsidy to $628 billion. There would be other taxes on providers of medical devices and drugs, which would raise prices for consumers (including the government). The bill would impose fines on people who are deemed able to afford health insurance but who choose not to buy it. The itemized deduction for medical costs for persons under age 65 would be reduced by limiting the deduction to amounts in excess of 10% of adjusted gross income, versus 7.5% under current law.

CBO calculates that the taxes and other cost reductions from curbing Medicare Advantage payments and limiting federal payments to doctors would result in the forecast saving of $81 billion. The projected saving include $162 billion over ten years from holding payments to Medicare fee-for-service providers (other than physicians) below the growth of health cost inflation. Further savings are assumed pursuant to the recommendations of a to-be-

created Medicare Commission, whose further payment reductions are to take effect unless rejected by Congress.

CBO notes the shakiness of the assumption that such formulas and recommendations would be accepted or maintained for long. As an example, it points out the lack of enforcement of similar current law limits on the payment increases given to physicians under Medicare Part B. These Part B "sustainable growth rate" increases, or SRGs, supposedly hold annual payment increases to physicians below health cost inflation. However, Congress has allowed increases in excess of the caps repeatedly since they began to really pinch in 2002. Nonetheless, in its baseline forecast, CBO assumes another increase is allowed in 2010, followed by a return to the cap with a drop of about 25% in Part B payments in 2011, remaining at current law level thereafter. There is no way Congress would dare to enforce that cut, as it would cause many physicians to stop seeing Medicare patients.

The subsidies. The annual subsidies to health care for low-to-middle income citizens are projected at about $140 billion a year under the bill, which is about $115 billion a year discounted to 2009 health care dollars. If we subtract the insurance tax, that's about $85 billion a year in 2009 dollars. How would these subsidies affect consumer behavior and health care prices?

The government now pays directly for about $1 trillion of the roughly $2 trillion in U.S. health care spending, and allows a tax break of about $250 billion on employer-provided health care premiums. That leaves about $750 billion in out-of-pocket costs and premiums paid by individuals and businesses.

An additional subsidy of between $85 billion and $115 billion would lower the apparent cost of health care by between 11.3% and 15.3%. The reduced out-of-pocket cost should raise health care demand by 2.3% to 3.1% (if elasticity of demand is 0.2). That should raise prices by 0.7% to 0.9% (if long run supply elasticity is 0.3). The combined effects would raise spending by 3% to 4%. Short run effects would be much higher.

Federal health spending would jump by about $123 billion to $166 billion in today's dollars. These figures are $38 billion to $51 billion a year larger than the CBO estimates of about $85 billion or $115 billion in net or gross new subsidies (discounted). CBO could be underestimating the cost of the bill by about 44%, or by $278 billion (net) to $369 billion (gross) over the ten (really six) year window.

About 77% of the underestimate is from quantity. About 23% is the price effect. The higher price would not just affect the new federal subsidies; it would affect the trillion dollars the government already pays for, and the revenue cost of the tax break for insurance. The price effect alone would be about $75 billion over the last six years of the ten year budget window, and would wipe out about 90% of the projected deficit reduction forecast by the CBO. That merely assumes a long run price increase of under 1%. Furthermore, since the government is the largest payer of health care costs, it will end up paying most of the higher prices brought on by the taxes on medical devices and drugs. This bill will lose money for the government.

Other demand inducements. This analysis is based on just the voluntary effect on demand of the reduction in the average cost of insurance. There are two other considerations.

First, the *marginal* cost of health care use for the newly insured would drop by more than the subsidy of the insurance. Once they are insured and their deductibles are met, minimal copayments of 3% to 10% or 20% would buy added hospital care, doctors visits, tests, and other treatments. That is instead of the full price they are charged now. The plans offered under the health care exchanges would have zero copayments for "preventive care" treatments. The apparent marginal cost of additional care would go down for some people currently insured who

might switch to the new plans, as well as newly-covered consumers. Demand may rise by more than assumed above.

Second, the bills fine people who do not buy health insurance, which could force demand up involuntarily by more than the subsidies alone. The increase in demand, the added cost per unit, and any cost underestimate by the CBO, may be a multiple of the figures presented above.

Price increases for other federal programs. The price effect on federal outlays is mainly due to the increase in cost for health care supported by *other* federal programs. The cost of added consumption by people newly insured under the bills is not the whole cost, even if care is valued at prices that implicitly anticipate the effect of increased demand. That estimate would omit the higher price of health care for people previously insured, privately or under other federal programs such as Medicare, Medicaid, or Federal retirement. The federal portion of these cost increases should be included in the impact of the health bills on the Federal budget.

Curbing access to current consumers. The only way to avoid the price effect is to reduce demand by those currently receiving care to offset the additional demand for care by the newly insured. Cutting Medicare Advantage reduces access to some services for about a quarter of the Medicare population. CBO must have assumed that federal agencies such as the Center for Medicare and Medicaid Services can squeeze reimbursement rates for doctors and hospitals to hold price increases to those in the baseline forecast. Constraining the price path in the face of additional demand would be impossible without significantly affecting access to care.

What does the bill accomplish? The health care sector is huge. Small differences in utilization and prices have big impacts on total spending, on the federal budget, and on the cost of premiums and care paid for by individuals. The CBO letter to Chairman Baucus states quite clearly that CBO has not estimated the effect of the proposed legislation on national health expenditures. "Members have also requested information about the effect of proposals on national health expenditures (NHE)... [A]t this point, the agency has not assessed the net effect of the current proposal on NHE, either for the 10-year budget window or for the subsequent decade." Yet without considering that total, there is no way to estimate the cost per unit of care and the effect of the bill on the federal budget. More fundamentally, there is no way to tell whether the bill achieves its most basic goal of increasing access to health care.

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