

**EXECUTIVE OFFICE OF THE PRESIDENT
COUNCIL OF ECONOMIC ADVISERS**



**THE ECONOMIC CASE FOR HEALTH CARE REFORM:
UPDATE**

DECEMBER 14, 2009

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Over the past several months, the Council of Economic Advisers (CEA) has released a series of reports analyzing the impact of reform-induced expansions in health insurance coverage and reductions in the growth of health care spending.¹ In this update to our June report on the Economic Case for Health Care Reform, the CEA reviews the case for reform that genuinely reduces the growth rate of health care costs, and presents new findings on the economic impact of recent Congressional proposals.

The necessity of slowing the growth rate of health care costs is uncontroversial, as families, businesses, and governments at every level are struggling to cope with rapidly increasing health care costs. Each year, a larger share of workers' total compensation and of Medicare recipients' Social Security benefits is eaten up by insurance premiums. Each year, fewer businesses, and especially small businesses, can afford to offer health insurance to their workers. And each year, a larger share of spending at all levels of government goes to health care, which has led to tax increases, cuts in other programs, and higher budget deficits.

Since the release of the three CEA reports earlier this year, both the House and the Senate have made substantial progress toward passing comprehensive health reform legislation. Last month, the House passed the Affordable Health Care for America Act of 2009, and the Senate is currently debating the Patient Protection and Affordable Care Act. According to projections by the non-partisan Congressional Budget Office (CBO), both bills would provide a new measure of security and stability to those with insurance and extend health insurance coverage to more than thirty million individuals who would otherwise be uninsured. The bills would also significantly lower the Federal budget deficit in the upcoming decade, and extend the solvency of the Medicare Trust Fund by five years.²

This report presents new estimates that the Congressional proposals will reduce the growth of health care costs for individuals, businesses, and the government, and reviews the economic case for health care reform. Some of the many benefits discussed below include higher standards of living for workers, more private sector job creation, and lower government budget deficits.

¹ Executive Office of the President. Council of Economic Advisers. "The Economic Case for Health Care Reform." June 2009. <http://www.whitehouse.gov/administration/eop/cea/TheEconomicCaseforHealthCareReform/>
"The Economic Effects of Health Care Reform on Small Businesses and Their Employees." July 25, 2009. <http://www.whitehouse.gov/administration/eop/cea/Health-Care-Reform-and-Small-Businesses>.
"The Impact of Health Insurance Reform on State and Local Governments." September 15, 2009. <http://www.whitehouse.gov/assets/documents/cea-statelocal-sept15-final.pdf>.

² A recently released report from the Actuary of the Centers for Medicare and Medicaid Services suggests that the Senate bill will extend the solvency of the trust fund by 9 years. Centers for Medicare and Medicaid Services. Office of the Actuary. "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act of 2009.'" December 10, 2009.

I. HEALTH INSURANCE REFORM: WILL IT CONTROL FEDERAL HEALTH CARE SPENDING?

The President has made clear his support for health reform legislation that genuinely slows the growth rate of costs. As the Senate continues debate on its own version of health insurance reform legislation, the CEA has been investigating whether and to what extent that bill reduces the growth rate of health care spending in government programs and in the economy as a whole. To do this, we have analyzed data on projected Federal spending on Medicare and Medicaid from the CBO in each year through 2019, and combined it with data from the CBO's most recent estimates of the impact of the Senate bill.

Our findings for Medicare and Medicaid indicate that, while combined Federal spending on these two programs will initially increase (as eligibility for the Medicaid program expands), the Senate's bill will lead to a substantial reduction in the growth rate of this spending over time. These findings are consistent with the CBO score of the Senate legislation, which finds that "Medicare spending under the bill would increase at an average annual rate of around 6 percent during the next two decades -- well below the roughly 8 percent annual growth rate of the past two decades."³ More specifically, we find that:

- **By 2019, total Federal spending on the Medicare and Medicaid programs will be lower than it would have been absent reform.** These long-run savings are achieved through a reduction in wasteful spending, fraud, inefficiencies and abuse in both programs, along with a combination of delivery system reforms that gives providers an incentive to deliver high quality and efficient medical care rather than costly, inefficient care with little or no impact on quality or health.
- **From 2016 to 2019, the annual growth rate of Federal spending on these two programs will be at least 0.7 percentage point lower than it otherwise would have been.**⁴ CBO estimates suggest that the magnitude of these growth rate reductions will increase in the subsequent decade, which will substantially improve the long-term Federal budget outlook.
- **These reductions will also help lower the growth rate of Medicare recipients' Part B premiums,** which more than doubled from 2000 to 2008 and grew three times faster than did average Social Security benefits during the same period.⁵

³ Congressional Budget Office. Letter to the Honorable Harry Reid. "Patient Protection and Affordable Care Act: Cost estimate for the amendment in the nature of a substitute to H.R. 3590." November 18, 2009. See Appendix B for details on Medicare and Medicaid calculations.

⁴ We focus on 2016 to 2019 for two reasons. First, the CBO budget baseline and detailed analysis of the legislation only extends for a ten year budget window, through 2019. See Appendix B for details. Second, while the changes in spending from 2011 to 2016 reflect, in part, health insurance expansion, by 2016 most of the major provisions of health insurance expansion will be implemented. Changes between 2016 and 2019 primarily reflect the cost saving measures of the bill. We therefore view changes in spending from 2016 to 2019 as being informative for predicting the effect of health reform on the long term costs of health care spending for the Federal government

⁵ Kaiser Family Foundation. "The Social Security COLA and Medicare Part B Premium." May 2009. Appendix. <http://www.kff.org/medicare/upload/7912.pdf>.

When combined with the other provisions that are in the Senate bill, CBO estimates suggest that the Federal budget deficit will be lower by 0.25 percent of GDP in the decade following 2019 than it otherwise would have been, with the effects growing over the decade.⁶

It is worth noting that CBO projections in the past have sometimes understated the savings from delivery system reforms and revised payment policies such as those included in the Senate bill. For instance, actual savings following the Balanced Budget Act (BBA) of 1997, which changed the way skilled nursing facilities and home health services were reimbursed under Medicare, were 50 percent greater in 1998 and 113 percent greater in 1999 than CBO originally forecast.⁷ Similarly, spending on the Medicare Part D prescription drug benefit following the Medicare Modernization Act of 2003 was about 40 percent less than CBO forecast.⁸

CBO's analysis is generally limited to the Federal budget, and does not attempt to account for savings in the health care system more broadly from policies implemented through reform. For example, the CBO's "Budget Options, Volume 1: Health Care" document found only \$19 billion in Federal government savings from transitioning toward post-acute bundled payments in Medicare. However, **recent research published in the *New England Journal of Medicine* suggests that bundled payments for chronic diseases and elective surgeries could reduce health care spending by as much as 5.4 percent from 2010 to 2019.** Even if such savings applied to only half of spending in the health care sector, the result would be more than \$900 billion of savings over the decade, according to CEA estimates.⁹ If bundled payments were expanded beyond post-acute care and even half of the potential savings from bundled payments were realized in the Medicare program during the upcoming decade, these savings would translate to an additional 0.2 percent per year reduction in program expenditures, or more than \$190 billion between 2010 and 2019.

Similarly large reductions in Federal health care expenditures are plausible from the combination of other delivery system reforms, including accountable care organizations (a group of primary care physicians, specialists, and one or more hospitals that coordinate the care of and accept joint responsibility for the quality and cost of care of their group of patients) and incentives to reduce hospital-acquired infections. The CBO estimates of the savings from these provisions are

⁶ Congressional Budget Office. Letter to the Honorable Harry Reid. "Patient Protection and Affordable Care Act: Cost estimate for the amendment in the nature of a substitute to H.R. 3590." November 18, 2009. http://www.cbo.gov/ftpdocs/107xx/doc10731/Reid_letter_11_18_09.pdf.

⁷ While an underestimate of the BBA's impact accounted for a portion of these additional savings, other factors such as heightened anti-fraud activities also contributed. See Congressional Budget Office. Statement of Dan L. Crippen, Director, Congressional Budget Office. "Impact of the Balance Budget Act on the Medicare Fee-for-Service Program." Statement before the Committee on Commerce, U.S. House of Representatives. September 15, 1999. <http://www.cbo.gov/ftpdocs/15xx/doc1553/091599.pdf>.

⁸ "New Research Finds Congressional Budget Office Has Underestimated Savings and Overestimated Costs from Health Policy Changes." The Commonwealth Fund. August 2009.

⁹ Hussey, Peter S., Eibner, Christine, Ridgely, M. Susan, McGlynn, Elizabeth A. "Controlling U.S. Health Care Spending – Separating Promising from Unpromising Approaches." *New England Journal of Medicine*. 2009 361: 2109-2111. For the \$900 billion figure, see data on projected national health care costs from Table 3 of <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf>. To estimate total spending for 2019, we assume that for 2018-2019, costs will grow at the same rate that they grew for 2017-2018. These estimates suggest that total spending from 2010 – 2019 would be more than \$35 trillion. 5.4 percent of half of \$35 trillion is more than \$900 billion.

relatively small, which may simply reflect the paucity of evidence of the real-world impact of such policies, especially when done in concert and on a national scale. When there are not historical examples for the effect of a possible reform, the CBO estimate is often very close to zero, despite the potential for significant expenditure reductions from reforms. Savings are also plausible from certain features that could spur innovation in cost-saving and quality-improvements, thereby accelerating the cost savings still further. For instance, health information technology adoption could facilitate cost-saving advances in payment methods. Additionally, provisions for administrative simplification in reform legislation – which require the standardization and streamlining of paperwork and create standards for electronic transaction – will help cut down on the \$23-\$31 billion time cost to medical practices of interacting with health plans and their administrators.¹⁰

Another potentially significant cost saver within the Senate bill is the Independent Medicare Advisory Board (IMAB). The IMAB would recommend changes to the Medicare program that would both improve the quality of care and also reduce the growth rate of program spending. Absent Congressional action, these recommendations would be automatically implemented, which would give it much greater authority than the current Medicare Payment Advisory Commission (MedPAC). The CBO score of the Senate bill estimates that the IMAB would reduce Medicare spending by \$23 billion from 2015 to 2019, with the savings likely to continue in the subsequent decade. An additional benefit of the IMAB is that it has the potential to increase the savings from many of the delivery system reforms described above, which may not be fully captured by the CBO estimates for the reasons previously mentioned.

Taken together, the combination of Medicare- and Medicaid-related provisions in the Senate’s Patient Protection and Affordable Care Act are estimated to reduce the annual growth rate of Federal spending on both programs by 1.0 percentage point in the upcoming decade and by an even greater amount in the subsequent decade. These savings would increase national savings and improve the long-run performance of the U.S. economy.

II. HEALTH INSURANCE REFORM: WILL IT CONTROL PRIVATE HEALTH CARE SPENDING?

The CBO score makes clear that the Senate’s Patient Protection and Affordable Care Act will relieve significant pressure on the Federal budget in the years ahead. But will it also reduce the growth rate of costs in the private sector? An examination of the projected revenues from just one provision in the bill – the excise tax on high-cost insurance plans – strongly suggests that the answer is yes. This tax will be levied only on the most expensive private sector plans. It will, however, provide health insurers with a powerful incentive to reduce their premiums and provide a high-value package of benefits. According to estimates from CBO and from the Joint Committee on Taxation (JCT), the resulting reduction in premiums will lead employers to pay substantially higher wages to affected employees, with this effect growing over time.

¹⁰ Casalino, Lawrence P., S. Nicholson, D.N. Gans, T. Hammons, D. Morra, T. Karrison and W. Levinson. “What does it cost physician practices to interact with health insurance plans?” *Health Affairs*, 2009, 28(4): w533-w543. <http://content.healthaffairs.org/cgi/content/full/28/4/w533>.

Using data from CBO and JCT, **CEA estimates that the excise tax on high-cost insurance plans will reduce the growth rate of annual health care costs in the private sector by 0.5 percentage point per year from 2012 to 2018.**¹¹ To the extent that insurers in the private sector mimic the delivery system reforms that are included in the Senate bill, the reduction in the growth rate of costs is likely to be even greater. This is especially true for bundled payments, as the potential savings to Medicare from this provision are smaller than in the private sector because inpatient care is already largely bundled in Medicare.¹² And it is worth noting that the transition to bundled, inpatient care generated considerable savings to the program.¹³

There are several additional sources of savings that would accrue to the private sector as a result of the provisions included in the House and Senate bills. For example, the legislation passed by the House of Representatives, the Affordable Health Care for America Act, would allow individuals without access to affordable coverage and firms with 25 or fewer employees to purchase coverage through a competitive, well-regulated marketplace, or exchange, starting in 2013. By 2015, firms with up to 100 workers could cover their employees through the exchange, with even larger firms admitted in subsequent years. Recent estimates by MIT economist Jonathan Gruber and by the CBO suggest that this health insurance exchange would lead to health insurance coverage that is both more secure and comprehensive, and has lower administrative costs and premiums than comparable coverage under current law. Additionally, the CBO estimates that premiums would fall by as much as 3 percent for large firms and as much as 2 percent for small firms, even before accounting for incentives to curb high-cost policies as a result of the excise tax.¹⁴

Moreover, the CEA's earlier report described waste and inefficiency throughout the health care system which could be eliminated without adverse health consequences. Health insurance reform legislation is likely to diffuse care delivery reforms throughout the health care system. Public investments in patient-centered health research on quality-improving treatments, and in best practices such as bundling payments and accountable care organizations, will likely reduce cost growth in the private sector. Because hospitals, doctors, and other providers serve publicly and privately financed patients alike, the diffusion of efficient, quality-improving practices will lead to private sector savings on health care spending as well, amplifying the effectiveness of each individual component of reform.

Taken together, it is likely that the combination of provisions other than the excise tax could generate an additional reduction in the growth rate of private sector health care costs of 0.5 percentage point. This would imply a total slowing of private-sector cost growth of

¹¹ We start with 2012 because it is just prior to the implementation of the excise tax. We finish in 2018 because that is the last year for which CMS provides projections for private health care spending. See Appendix A for details on this calculation.

¹² Inpatient care is also frequently bundled in the private sector. However, even if one assumes this is true for all private insurers, when one considers that inpatient care accounts for a smaller share of health care spending among those with private health insurance than among their counterparts in Medicare, the potential savings from bundled payments in the private sector are still considerably larger than in Medicare.

¹³ MedPAC June 2008 Report to Congress.

¹⁴ Congressional Budget Office. Letter to the Honorable Evan Bayh. "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act." November 30, 2009. <http://www.cbo.gov/doc.cfm?index=10781>.

approximately 1.0 percentage point per year. Assuming that all of this slowing of cost growth is reflected in private health insurance premiums, an average family policy premium could be lower in 2019 by approximately \$1000 than it otherwise would have been.¹⁵

Recent research by Harvard economist David Cutler and Commonwealth Fund president Karen Davis suggests even greater savings from reform. Their estimates imply that a typical family in 2019 would pay nearly \$2,000 less in health insurance premiums than they otherwise would have paid. Combining that with lower out-of-pocket costs, total savings would be more than \$2,500.¹⁶ Research by Jonathan Gruber finds that even just a single provision – the excise tax – would increase after-tax wages by \$234 billion from 2013 to 2019.¹⁷

The effects discussed so far will slow the growth rate of spending for the health care sector as a whole. This slower spending growth will translate into lower costs for businesses and individuals, relative to what they otherwise would have been. Importantly, costs for businesses and individuals will be reduced further by tax credits that will directly subsidize the cost of health insurance. First, the House and Senate bills provide a tax credit that finances up to 50 percent of the cost of coverage for those small businesses that qualify. Second, the tax credits for families and individuals will cap the share of income that individuals pay for their coverage, with greater assistance provided to those families with greater need, and put annual limits on out-of-pocket spending.

III. ECONOMIC BENEFITS OF THE ESTIMATED EFFECTS OF HEALTH INSURANCE REFORM

As outlined in detail in the first CEA report described below, a reduction of this magnitude in the growth rate of health care costs would have enormous benefits for governments at every level, for employers, for individuals and families, and for the economy as a whole. A few of the many benefits of reducing the growth rate of health care costs by an average of 1.0 percentage point per year would include:

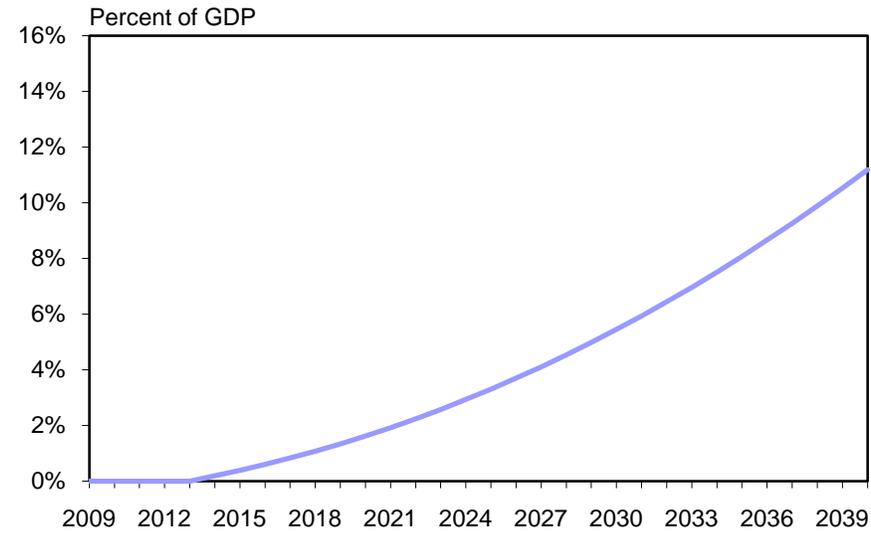
- **GDP that is 4 percent higher by 2030.** Reduced health care cost growth will free up resources and result in increased national saving and capital formation and output, contributing to increased growth of properly measured GDP. In addition, increased insurance coverage and resulting improved health care is likely to increase labor supply by reducing disability and absenteeism in the workplace, thus increasing GDP further.

¹⁵ A family policy with a premium of \$12,500 in 2013 that grew by 7 percent per year through 2019 would cost \$1,028 more in 2019 than if the same policy grew at 6 percent per year.

¹⁶ Cutler, David M. K Davis, and K. Stremikis. “Why Health Reform Will Bend the Cost Curve.” The Commonwealth Fund and The Center for American Progress Action Fund. December 2009.

¹⁷ Gruber, Jonathan. “Impacts of the Senate High Cost Insurance Excise Tax on Wages: Updated.” November 20, 2009. <http://econ-www.mit.edu/files/4895>.

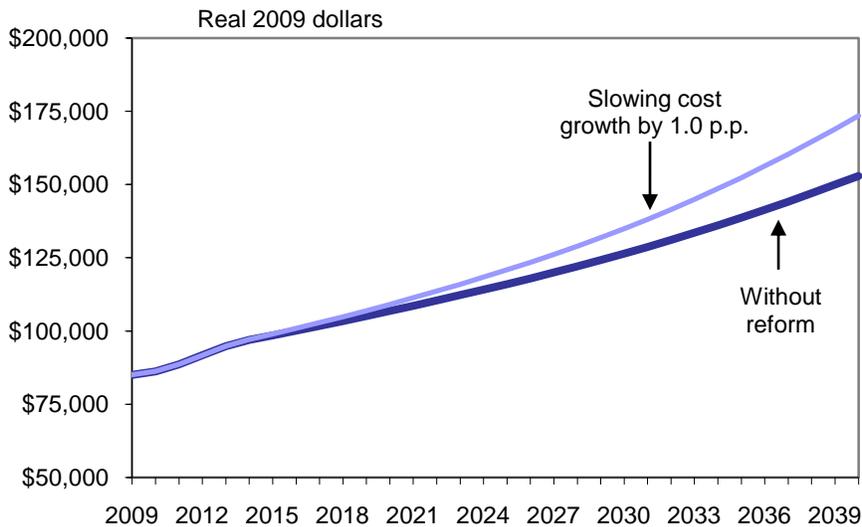
Figure 1: Percentage Increase in Properly Measured GDP from Slowing the Growth Rate of Health Care Costs by 1 p.p.



Source: CEA calculations.

- **Median family income that is \$6,800 higher by 2030.** This increase in the growth rate of GDP resulting from slowing the growth rate of health care costs translates into substantial increases in the median family income.

Figure 2: Estimated Family Income with and without Health Care Reform



Source: CEA calculations.

- **Federal budget deficit lowered by as much as 2 percent of GDP by 2030.** Because the Federal government pays for a large fraction of health care through programs such as

Medicare and Medicaid, lowering the growth rate of health care costs by 1 percentage point will cause the budget deficit to be much lower than it otherwise would have been. In its June report on the Economic Case for Health Care Reform, the CEA calculated that a reduction of this scale in the growth rate of health care costs would result in a deficit that is lower by 2 percent of GDP by 2030, under the assumption that all such savings were used for deficit reduction. The CBO score of the Senate bill – which finds an average reduction in the deficit of around 0.25 percent of GDP in the second decade after reform – accounts for how the bill uses some of these savings to expand health insurance coverage to millions of Americans. The CBO estimate is also rising over that second decade. These two differences explain some of the discrepancy between the estimates.

- **An unemployment rate that is 0.16 percentage point lower and approximately 320,000 additional jobs.** Reducing the growth rate of health care costs will reduce growth in firms' non-wage compensation costs. As a result, the amount that firms raise their prices for a given growth rate of their workers' wages is lower—that is, inflation is lower. What this means is that, as long as the slower growth of health care costs is not fully reflected in workers' view of normal wage growth, the economy can operate at a lower level of unemployment for a period of time without triggering inflation.

Along with these benefits to the economy as a whole, there are certain sectors that will benefit disproportionately. Most notably and as reported in the second CEA report described below, small businesses and their employees would derive a substantial benefit from the Senate bill given the high prices that they currently pay, their risk of losing coverage if just one employee gets sick, and their lower rates of health insurance coverage. State and local governments would also benefit differentially from reform, as outlined in the third CEA report, given that they currently finance a very large fraction of uncompensated care to the uninsured and because of the enhanced Federal match rates for the reform-induced Medicaid expansion.

IV. OVERVIEW OF PREVIOUS CEA FINDINGS

In June of 2009, the Council of Economic Advisers (CEA) released a report that summarized the most important economic impacts of health care reform. The key findings from this report were that reform-induced expansions in health insurance coverage and reductions in the growth of health care spending would have enormous benefits for the U.S. economy. As outlined in this report and in the discussion above, the key benefits of slowing the growth rate of costs include:

- **An improvement in standards of living.** Slowing the growth rate of health care costs by increasing efficiency will free up resources that can be used to produce other things that people value. As a result, standards of living will be higher.
- **A substantial reduction in the long-run Federal budget deficit.** CBO projections indicate that total spending accounted for by the Medicare and Medicaid programs would

grow from 6 percent of GDP in 2009 to 15 percent by 2040 in the absence of reform.¹⁸ Health care reform that slows the growth rate of spending by increasing the efficiency of both programs would help prevent substantial increases in the future Federal budget deficit.

- **A reduction in the unemployment rate and a corresponding increase in employment.** A slower rate of growth in health care spending would allow the economy to operate at a lower level of unemployment for a period of time without triggering inflation.

As outlined in the report, the key benefits to expansions in health insurance coverage include:

- **An improvement in the health and in the economic well-being of individuals who would otherwise be uninsured.** The uninsured have significantly worse health outcomes, including much higher mortality rates, than their insured counterparts. They are also at much greater risk of bankruptcy because of their exposure to high out-of-pocket costs. Currently more than one-in-six non-elderly individuals are without health insurance and nearly half were uninsured at some point during the past decade.
- **An increase in labor supply.** Expansions of health insurance coverage would reduce absenteeism in the workplace and the prevalence of disabilities. By improving access to care, it would also enable more individuals with disabilities who might otherwise be out of the labor force to work. These effects would serve to increase economic output and reduce the budget deficit.
- **A more efficient labor market because of a reduction in “job lock”.** One impediment that many workers face to changing jobs is that insurers can place restrictions on care for the treatment of their or their family members’ pre-existing conditions. As a result, many workers remain “locked” in their current jobs rather than switching to jobs that are a better match for their interests and skills.

In a subsequent report from July of 2009, the CEA highlighted the particular benefits that small businesses and their employees would enjoy as a result of health care reform including:

- **A reduction in small businesses’ health insurance premiums.** Currently, small businesses pay up to 18 percent more for the same policy as their counterparts at larger firms, largely because of the fixed costs of administering a policy and high brokers’ fees. This high cost acts as a tax on existing small businesses and discourages the creation of new small businesses. Lower premiums would allow small businesses to pay higher wages, hire more workers, increase investment, or some combination of these.
- **An increase in health insurance coverage among small business employees.** Workers at small businesses are almost three times more likely than workers at large firms to be

¹⁸ Congressional Budget Office. The Long-Term Budget Outlook 2009. Data File. Figure 2-1. Total Spending for Health Care Under CBO’s Extended-Baseline Scenario. “Spending Under the Alternative Fiscal Scenario as a Percentage of GDP.”

without health insurance. This reduces the productivity of these workers, further disadvantaging small firms in the competitive marketplace.

- **An increase in entrepreneurship and in the incentive to work at small businesses.** Reform-induced expansions in insurance coverage would spur many talented Americans to launch their own companies. Furthermore, it would encourage more workers to join small businesses, as they would have access to more affordable health insurance.

In the third report in the series, the CEA examined the benefits of health care reform to state and local governments, which employ one-in-seven workers in the U.S., with these including:

- **A reduction in spending on uncompensated care.** State and local government currently spend billions of dollars each year on uncompensated care for the uninsured. Reform-induced expansions in coverage would reduce the need for this patchwork of programs, with the savings more than offsetting the costs of reform-induced expansions in Medicaid enrollment. This would alleviate some of the strain on state and local budgets while allowing them to direct more funds to education, public safety, and other priority areas.
- **Lower spending on employee health insurance premiums.** State and local governments pay approximately \$100 billion each year on health insurance for their 19 million employees. Reductions in the “hidden tax” of uncompensated care for the uninsured would reduce premiums for government employees, thus allowing them to pay higher wages or enjoy budget savings.

The benefits cited above are by no means an exhaustive list, but capture many of the key channels through which well-designed health care reform that expands health insurance coverage and reduces the growth rate of costs would benefit individuals, employers, and governments at every level.

V. CONCLUSION

The legislation currently working its way through Congress can deliver on its promise to substantially reduce the growth rate of health care costs in both the public and private sector in the years ahead, provided key cost containment features are preserved in the final bill. The reforms included in the legislation will improve the economic well-being of individuals, families, employers, and governments at every level.

APPENDIX A: DETAILS ON EXCISE TAX CALCULATION

The purpose of this appendix is to explain the CEA calculations of the effect of the proposed excise tax on the growth of private health care costs.

Absent reform, CMS projects third-party private expenditures of \$1.193 trillion in 2012 and of \$1.693 trillion in 2018.¹⁹ That is an annualized (real) growth rate of 6.0 percent.

Under the Senate bill, CBO projects no excise tax revenue in 2012 and \$30 billion in 2018. CBO and JCT estimate that 81.2 percent of this additional revenue is attributable to higher wages as employers shift compensation from health insurance to wages.²⁰ Thus \$24.4 billion in revenues come from that channel in 2018. If one assumes that a Federal marginal tax rate of 35 percent applies to individuals affected by the tax and that each dollar in freed-up health care spending leads to one dollar in additional wages, this implies \$69.6 billion in higher wages and thus \$69.6 billion in lower private health insurance premiums. Note that assuming a lower relevant marginal tax rate would make this reduction even higher.

It is plausible that even if individuals increase their wages by \$69.6 billion, they may not reduce health expenditures by that amount. While individuals may elect for a greater fraction of their total compensation in the form of wages, they may also select plans with higher consumer co-pays and deductibles. Thus these consumers would not reduce overall health care spending dollar-for-dollar with their increase in wages. However, it is likely that most of this shift in compensation from insurance premiums to wages would lead to a reduction in overall health care spending, as consumers reduce their use of low-value services and insurers reduce their markup factors. If one assumes that one-third of this \$69.6 billion decrease in private health insurance premiums takes the form of higher out of pocket spending, then private spending would fall by **\$46.4 billion**.

To estimate third-party private expenditures due to this tax, we assume that the tax will have no influence on these expenditures in 2012 because the government expects to collect no revenue this year. For 2018, we subtract the estimated reduction in private spending (\$46.4 billion) from the projected third-party cost absent reform (\$1.693 trillion), yielding \$1.646 trillion. The average annual growth rate from \$1.193 trillion to \$1.646 trillion over six years is 5.5 percent, and thus yields an annualized savings of **0.5 percent per year**. See Table 1.

¹⁹ See Table 3 from the National Health Expenditure Projections, 2008-2018, from CMS. A version of the report is available at: <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf>. The estimates presented below take the sum of private health insurance and other private funds under third-party payments. These numbers were calculated using the CBO score of the Senate bill. In this report, the CBO did not release estimates for the fiscal impact of provisions if those impacts were between -0.5 billion and +0.5 billion, so there may be some degree of rounding error. See notes to Table 1 of the November 18th score of the Senate bill.

²⁰ MIT economist Jonathan Gruber has estimated similar results for the impact of the excise tax on wages, although he computes net rather than gross wage gains. Gruber, Jonathan. "Impacts of the Senate High Cost Insurance Excise Tax on Wages: Updated." November 20, 2009. <http://econ-www.mit.edu/files/4895>

Table 1: Private Health Care Costs (Billions of \$)		
Year	Baseline	Reform
2012	1193.2	1193.2
2018	1692.8	1646.4
Annualized Growth Rate	6.0%	5.5%

Note that in the above calculation, we assume that “private health care” costs consists of the sum of spending on third-party private health insurance and other private funds, as classified by CMS. An alternative would be to assume that some fraction of the “out-of-pocket” payments is also paid by the privately insured. For example, if one-third of these costs were paid by the uninsured, one-third paid by Medicare, and one-third by the privately insured, absent health reform third-party private expenditures would increase by 5.9 percent at an annualized rate between 2012 and 2018. Under reform, the growth in cost would be 5.4 percent at an annualized rate over the same period. Hence, under this alternative scenario, reform would also reduce this rate by 0.5 percent per year.

APPENDIX B: DETAILS ON MEDICAID & MEDICARE CALCULATIONS

To estimate the effect of reform on Federal spending on Medicare and Medicaid, we first use projections from the CBO²¹ to establish baseline Federal spending on these programs of \$1.027 trillion in 2016 and \$1.236 trillion in 2019. Absent reform, these estimates suggest that Federal spending on Medicare and Medicaid will increase 6.4 percent at an annualized rate between 2016 and 2019. Table 2 outlines these baseline projections.

As mentioned in the text, the sum of Federal expenditures on these programs will initially increase as eligibility for Medicaid expands. However, reform also includes savings from eliminating waste, fraud, and abuse and from delivery system reforms. CEA calculations based on estimates from the November 18, 2009 CBO score of the Senate bill,²² summarized in Table 3, show that on net reform will both reduce the growth rate in costs and, by 2019, reduce the combined level of Federal spending on these programs. Under reform, the growth in health care costs from 2016 to 2019 is an annualized 5.6 percent, or **0.7 percentage point per year less than the baseline.**²³

Table 2: No Reform Scenario (Billions of \$)		
	Medicare and Medicaid Federal Spending	Annualized % Growth
2016	1,027	6.4%
2019	1,236	

Table 3: Reform Scenario (Billions of \$)		
	Medicare and Medicaid Federal Spending	Annualized % Growth
2016	1,037	5.6%
2019	1,222	

²¹ Congressional Budget Office. CBO’s Baseline Projections of Mandatory Spending. Table 1-4.

<http://www.cbo.gov/ftpdocs/105xx/doc10521/budgetprojections.xls>. The expenditure amounts include \$6 billion in projected CHIP spending in both 2016 and in 2019. Baseline Federal spending on Medicare, Medicaid and CHIP is calculated as the sum of lines 12 (Medicare outlays), 14 (Medicaid outlays), and 49 (CHIP outlays) less line 57 (offsetting receipts in the Medicare program).

²² See Congressional Budget Office. Letter to the Honorable Harry Reid. “Patient Protection and Affordable Care Act: Cost estimate for the amendment in the nature of a substitute to H.R. 3590.” November 18, 2009. The calculations for savings from reform include the net effect of Estimated Changes in Direct Spending and Revenues Resulting From the Patient Protection and Affordable Care Act, drawn from Table 2 of the CBO score of the legislation. These calculations include net changes in spending on Medicare, Medicaid, and CHIP.

²³ More specifically, the change is from 6.36 percent to 5.62 percent per year, which is 0.74 percent per year.