

Testimony Presented to the House Budget Committee:

“Fiscal Consequences of the Health Care Law”

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Mr. Chairman, Mr. Van Hollen, and members of the Committee, thank you for the opportunity to participate in this very important hearing on the fiscal consequences of the health care law.

The most serious threat to the nation’s long-term prosperity is projected large fiscal deficits over the years and decades ahead. And the main reason the nation’s budget deficits are expected to remain at dangerously high levels for the foreseeable future is because of the rapid growth of entitlement spending.

Importantly, entitlement spending was a problem even before the enactment of the Patient Protection and Affordable Care Act (PPACA). In 1975, the combined cost of Social Security, Medicare, and Medicaid was 5.4 percent of GDP. In 2009, these entitlement programs cost 10.1 percent of GDP.

That jump in spending — 4.7 percent of GDP — is the main reason it is so difficult to bring the nation’s budget closer to sustainable fiscal balance. Every year, we are spending more and more to fulfill entitlement promises made years and decades ago,

leaving less and less to finance other priorities, even as the growing levels of entitlement spending puts enormous pressure on taxpayers.

And we haven't even hit the really rough patch yet. Over the coming two decades, the United States will undergo an unprecedented demographic transformation, as the baby boom generation moves from its working years into retirement. The number of Americans age 65 and older will rise from 41 million in 2010 to 71 million in 2030. As these baby boomers enroll in Social Security and Medicare, costs will soar.

We were therefore already racing toward a budget and entitlement crisis before the health care law was considered and passed. Indeed, for the proponents of the legislation, that became a primary argument for its enactment. The president argued that his health care plan would begin to address the entitlement problem, at least from the perspective of the health programs. "Health reform is entitlement reform" was the catchphrase.

But is that really the case? Did the new health care law ease the entitlement and budget crisis, or did it make matters even worse? That is the crucial question, and this Committee should be commended for taking it up as one of the first items for discussion in this new Congress. I believe the evidence is overwhelming that the new law will make matters not better, but far worse.

The most noteworthy characteristic of the new law is that it is the largest entitlement expansion since the 1960s. So, at a time when the federal budget is already buckling under the weight of existing entitlement programs, the new law stands up three new ones which will enroll tens of millions of Americans into taxpayer-financed programs promising permanent access to uncapped benefits. Moreover, spending on these new entitlements is expected to grow at rates that are above the level of growth of the economy or general inflation.

How then does a new law which increases spending by nearly \$1 trillion over the period 2010 to 2019 reduce the federal deficit (by about \$130 billion over ten years according to the Congressional Budget Office and by a modest amount in the decade after that)? The only way is by raising taxes and cutting spending by amounts in excess of the new spending commitments. According CBO's estimate of the final legislation, spending reductions will bring the net increase in spending down to about \$430 billion over the next decade. The tax hike to pay for this spending will total about \$560 billion over the same period.

Thus, although the legislation has often been described by proponents as a deficit reduction measure, it might be more accurate to say that it is a very large spending bill, offset, at least on paper, by even larger tax increases.

But even these numbers do not tell the whole story. It is also important to look carefully at the assumptions underlying these estimates to determine if the promised

deficit reduction will occur in reality, or just on paper. There are a number of reasons to be very skeptical in this regard.

The CLASS Act

The argument that the new law reduces the federal budget deficit over the coming decade rests in large part on the supposed deficit reduction from the creation of the Community Living Assistance Services and Supports Act, or CLASS Act, which is a new long-term care insurance entitlement program. CBO's estimate assumes that \$70 billion in supposed deficit reduction through 2019 is to come from the CLASS Act.

But, in truth, the CLASS Act is another budgetary time-bomb waiting to explode, not a solution that produces deficit reduction. In the short term, because the program is brand new and no one is eligible for benefits until they have paid in for five years, premiums are collected and no benefits are paid — producing what appears to be a temporary surplus. But beyond the visible ten-year window, those premiums are needed to pay long-term care insurance claims.

Moreover, every actuarial analysis done on the program indicates it will suffer from severe adverse selection. That is, it will attract mainly enrollees who expect to need the benefit. The result is that individual premiums are likely to be quite high because too few healthy workers will enroll. Overall premiums will fall well short of what is needed to cover the implicit benefit promises. Pressure will then build for a future taxpayer

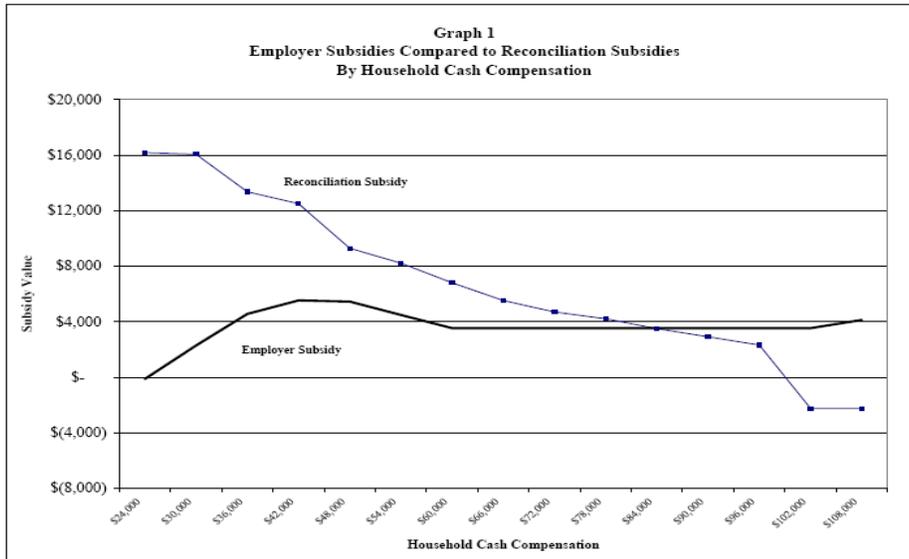
bailout to avoid imposing cuts on the vulnerable citizens who elected to enroll and pay premiums. In short, this program is not going to solve our entitlement crisis. Indeed, it is a perfect illustration of why federal entitlement spending is our central budgetary problem.

Disequilibrium in Federal Insurance Subsidies

The new law promises members of households with incomes between 135 and 400 percent of the federal poverty line new premium subsidies if they get their coverage through the new state-run “exchanges.” Census data show that today there are about 111 million Americans under the age of 65 who are living in households with incomes in that range. But CBO estimates that only 19 million people will be getting the new premium assistance in 2019. They assume the other 90 million Americans will stay in job-based plans.

If that were really to happen, it would be terribly unfair. As Stephanie Rennane and Eugene Steuerle of the Urban Institute have documented, the new premium subsidies in the exchanges are worth far more to low- and moderate-wage workers than today’s federal tax preference for employer-paid premiums (see Chart 1). For instance, a household of four with compensation of \$60,000 in 2016 would get \$3,500 more in government assistance if they moved from employer coverage to an exchange. The extra subsidies would be even more for lower wage workers.

**Chart 1:
Disequilibrium in Federal Insurance Support**



Source: "Health Reform: A Two-Subsidy System," Stephanie Rennane and C. Eugene Steuerle, Tax Policy Center, April 2010

The new law thus sets up a situation where two families with identical compensation totals from their employers can get very different levels of federal support depending on where they get their insurance.

In my judgment, that's not likely to be a politically stable situation. Pressure will build on elected leaders to treat every American equally. That is likely to lead to regulatory and legislative decisions making it easier for workers now in job-based plans to migrate to the exchanges.

Over time, what is likely to happen is that those who would be better off in the exchanges will end up there, one way or another, even as higher wage workers retain the

tax advantage for job-based coverage. As the labor market segregates, costs will soar well above the \$1 trillion in new spending over ten years currently projected for the law.

AMT-Like Bracket Creep

The new law relies heavily on tax increases to cover the new entitlement spending. According to CBO's latest long-term budget projections, by 2035, the tax increases in the new law will collect revenue equal to 1.2 percent of GDP, which is very substantial. In today's terms, that's a \$180 billion tax increase, every year.

How can that be, given that the tax hikes do not go nearly that high in the first decade? The answer is AMT-like bracket creep. The new tax on high-cost insurance plans, sometimes called the "Cadillac" tax, applies to policies with premiums for families above \$27,500 in 2018. That threshold will only grow with general consumer inflation in 2020 and beyond, not growth of health costs. Thus, by 2030, the tax will be binding on many millions of Americans' insurance plans.

Similarly, the new Medicare taxes on wages and other sources of income apply only to individuals with incomes above \$200,000 per year beginning in 2013 (\$250,000 for couples). But those income thresholds are fixed; they won't rise with inflation at all. In very short order, that means these taxes will begin hitting middle-class Americans with massive tax hikes. By 2030, inflation will have eroded the \$200,000 threshold so that it is the equivalent of \$130,000 today (assuming 2.5 percent annual inflation).

The Medicare Payment Rate Reductions

The largest spending reduction in Medicare comes from automatic reductions in the inflation updates for hospitals and other institutional providers of care. The notional rationale is that these cuts represent productivity improvement in the various institutions getting Medicare payments. The reductions, amounting to a 0.4-0.5 percentage point reduction off the normal inflation update for Medicare payments, will occur every year, in perpetuity. The compounding effect of doing this on a permanent basis would be massive savings in Medicare — if they really were implemented. CBO says the cuts will generate \$156 billion over the first decade alone.

But there are strong reasons to suspect these cuts will not be sustained. Medicare's actuarial team, led by Richard Foster, has warned repeatedly that these cuts are not viable over the medium and long-term because they would jeopardize access to care for seniors. The cuts would push average Medicare payments to levels that are below what Medicaid is expected to pay, and the network of providers willing to take care of Medicaid patients is notoriously constrained. It is hard to imagine political leaders allowing Medicare to become less attractive to those providing services than Medicaid is today.

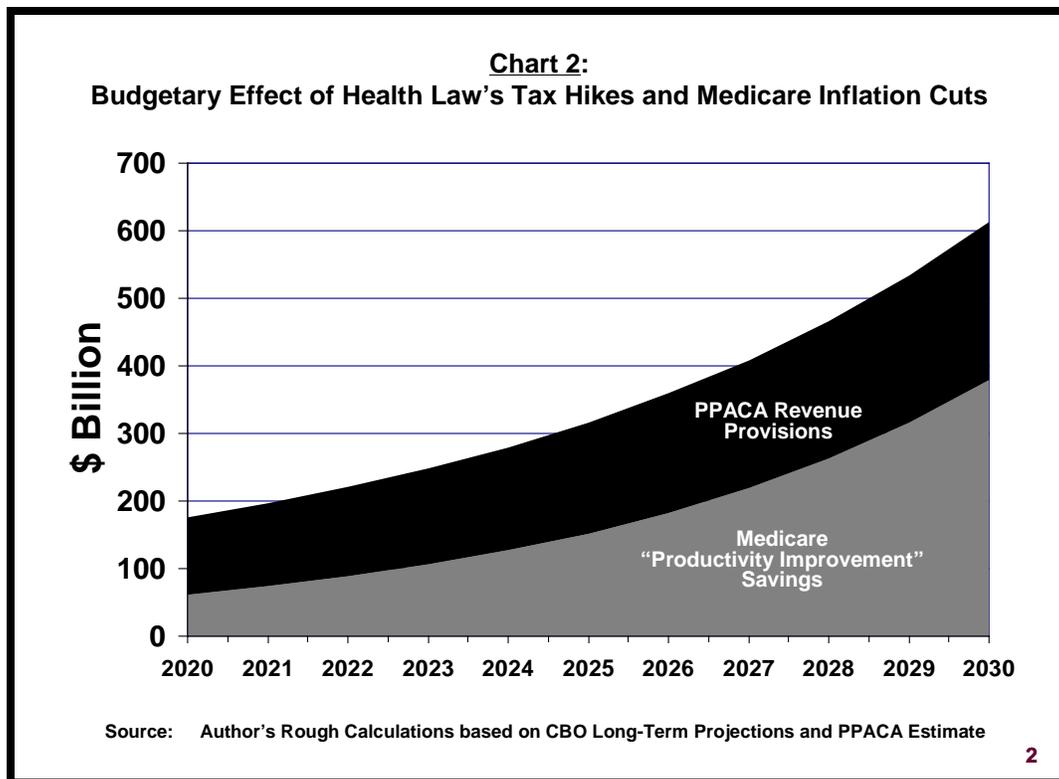
It's worth noting here that these cuts in payment rates do not constitute "delivery system reform," which the administration has often stated is what it is trying to achieve

with the Medicare changes in the new law. These cuts in inflation updates will hit every institution equally, without regard to whether or not the institution is treating its patients well or badly. The savings that are expected from other reforms, such as Accountable Care Organizations, are minor by comparison.

The Budgetary Effect of Tax Hikes and Medicare Cuts in a Second Decade

The administration and others have noted frequently that CBO's cost estimate indicates the possibility of modest deficit reduction in the second decade after 2019 (although CBO notes that such an estimate carries more uncertainty than its ten-year projections). But the expectation of long-term deficit reduction is entirely dependent on huge spending reductions from the Medicare inflation cuts and from more and more middle-class Americans paying higher taxes under the new law's tax provisions.

As shown in Chart 2, the tax hikes from the new law plus the savings from the "productivity adjustment" in Medicare would generate about \$180 billion in "offsets" in 2020. By 2030, the spending cuts and tax hikes from these provisions will have more than tripled, to over \$600 billion. If these taxes and spending cuts do not materialize, the new law will be a budget-buster of significant proportions.



Debt Subject to Limit

Both CBO and the Medicare actuaries have both noted that the Medicare cuts and payroll tax hikes which are supposed to improve the solvency of the Medicare hospital trust fund in the new law can only be counted once, not twice. Here is how CBO put it in a Director's blog post from December 2009:

“To describe the full amount of HI trust fund savings as both improving the government's ability to pay future Medicare benefits and financing new spending outside of Medicare would essentially double-count a large share of those savings and thus overstate the improvement in the government's fiscal position.”

In other words, these taxes and cuts in Medicare either improve the government's ability to pay future Medicare claims, or they pay for a new entitlement program — but not both.

One way to see that clearly is by looking at the impact of the health care law on debt subject to limit. According to CBO, the new law will increase that debt, by about \$230 billion over the coming decade, because the Medicare tax hikes and spending cuts are double-counted instead of devoted to deficit reduction.

Conclusion

Mr. Chairman, you and your colleagues on this committee face a daunting challenge. The nation is rushing rapidly toward a fiscal crisis, driven by excessive borrowing and debt. Even before the health law was enacted, it was necessary to reform the nation's entitlement programs to bring spending commitments more in line with what the country can afford. Now, with enactment of the health law, the climb to a balanced budget got much steeper.

The solution is to start by unwinding what was just passed and replacing it with a program that constitutes genuine entitlement reform.