



Perspective

The Cost Implications of Health Care Reform

Jonathan Gruber, Ph.D.

On March 23, 2010, President Barack Obama signed into law the most significant piece of U.S. social policy legislation in almost 50 years. There is little disagreement over the premise that

the Patient Protection and Affordable Care Act (ACA) will dramatically expand health insurance coverage. But there is concern about its implications for health care costs. These concerns have been heightened by a recent report from the actuary at the Centers for Medicare and Medicaid Services (CMS), which shows that health care reform will cause an expansion of national health care expenditures.

The ACA includes a major investment in the affordability of health insurance for low-income families: under the law, all individuals with family incomes below 133% of the poverty line (i.e., below about \$30,000 for a family of four) are eligible for free public insurance, and there are tax

credits to help make health insurance affordable for families with incomes of up to 400% of the poverty level. At the same time, the ACA incorporates a number of fund-raising mechanisms, including a reduction in the overpayment to Medicare Advantage insurers, a reduction in the update factor for Medicare hospital reimbursement, an increase in the Medicare tax (and extension to unearned income) for high-income families, an assessment on employers whose employees use subsidies rather than employer-sponsored insurance, and the “Cadillac tax” (an assessment on the highest-cost insurance plans). The Congressional Budget Office estimates that these revenue increases will exceed the new spending,

reducing the federal deficit by more than \$100 billion in the first decade and more than \$1 trillion in the second decade.¹

Some have questioned the likelihood of this deficit reduction, claiming, for example, that the numbers are “front loaded” because some of the revenue-raising mechanisms begin before 2014, whereas the majority of spending doesn’t start until after 2014. But the trend under the law will actually be toward larger deficit reduction over time; indeed, the reduction in the deficit is expected to increase in the last 2 years of the budget window. The cuts in spending and increases in taxes are actually “back-loaded,” with the revenue increases rising faster over time than the spending increases, so that this legislation improves our nation’s fiscal health more and more over time.¹

Others have raised the possibility that the cuts that provide much of this financing will never

take place, and they point to the physician-payment cuts required by the Balanced Budget Act of 1997, which have been repeatedly delayed by Congress. But as Van de Water and Horney have highlighted,² Congress has passed many Medicare cuts during the past 20 years, and the physician-payment cut is the only one that has not taken effect.

With U.S. health care spending already accounting for 17% of the gross domestic product (GDP) and growing, there is also concern about policies that increase this spending. And, as the CMS actuary points out, the ACA will increase national health care expenditures. At the peak of its effect on spending, in 2016, the law will increase health care expenditures by about 2%; by 2019, the ACA-related increase will be 1%, or 0.2% of the GDP.

However, these increases are quite small relative to the gains in coverage under the new law. There are currently 308 million insured Americans, and the CMS predicts that 34 million more will be insured by 2019. The agency also estimates that without this reform, health care costs would grow by 6.6% per year between 2010 and 2019. So we'll be increasing the ranks of the insured by more than 10% at a cost that is less than one sixth of 1 year's growth in national health care expenditures.

Alternatively, consider the fact that under this legislation, by 2019, the United States will be spending \$46 billion more on medical care than we do today. In 2010 dollars, this amounts to only \$800 per newly insured person — quite a low cost as compared (for example) with the \$5,000 average single premium for employer-sponsored insurance.³

U.S. spending on health care is very high and a source of great concern, but it is the growth rate of medical spending, not the level of spending, that ultimately determines our country's financial well-being. If current trends persist, we will be spending an unsustainable 38% of our GDP on health care by 2075, as the growth rate of health care costs continues to outstrip the growth rate of the overall economy. In this environment, whether annual health care costs rise or fall by 1% or even 5% is irrelevant — all we do is move the day of reckoning less than 1 year closer or farther away. Clearly, the key to the long-term viability of our health care system is to lower the rate of cost growth, often referred to as “bending the cost curve.”

On this count, the CMS actuary's news is good: although the ACA will boost medical spending somewhat, its incremental impact on spending will decrease over time (from 2% in 2016 to 1% in 2019). These declining estimates imply that by the second decade, the ACA will have reduced national health care spending. This effect is due to provisions such as the Cadillac tax, for which the definition of a high-cost plan is indexed to the growth in overall prices in the economy, not to the (higher) growth in health insurance premiums. As a result, an increasing proportion of plans will be taxed, and more people will shift into lower-cost insurance options in order to avoid paying the tax, thus reducing national health care expenditures.

Yet the real question concerns how far the ACA will go in slowing cost growth. There is great uncertainty, mostly because there is such uncertainty in general about how to control the rate of

growth in health care costs. There is no shortage of good ideas for ways of doing so, ranging from reducing consumer demand for health care services, to reducing payments to health care providers, to reorganizing the payment for and delivery of care, to promoting cost-effectiveness standards in care delivery, to reducing pressure from the threat of medical malpractice claims. There is, however, a shortage of evidence regarding which approaches will actually work — and therefore no consensus on which path is best to follow.

Given this uncertainty, it is best to cautiously pursue many different approaches toward cost control and study them to see which ones work best. That is exactly the approach taken in the ACA, which includes provisions to reduce consumer demand through the Cadillac tax, to reduce provider payments by appointing a depoliticized board to make up-or-down recommendations to Congress on changes to Medicare's provider payments, to run dozens of pilots to test various approaches to revamping provider-payment incentives and organizational structure, to invest hundreds of millions of dollars in new comparative-effectiveness research, and to launch pilot programs to assess the impact of various reorganizations of the medical malpractice process. None of these is guaranteed to work, but together they represent a significant step toward fundamental cost control.

In summary, analysis by both the Congressional Budget Office and the CMS actuary show that the ACA will substantially reduce the federal deficit, only slightly increase national medical spending (despite an enormous

expansion in insurance coverage), begin to reduce the growth rate of medical spending, and introduce various new initiatives that may lead to more fundamental reductions in the long-term rate of health care cost growth. The ACA will not solve our health care cost problems, but it is a historic and cost-effective step in the right direction.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Massachusetts Institute of Technology, Cambridge, MA.

This article (10.1056/NEJMp1005117) was published on May 12, 2010, at NEJM.org.

1. Letter from Douglas W. Elmendorf to House Speaker Nancy Pelosi, March 18, 2010. (Accessed May 6, 2010, at [\[.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf\]\(http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf\).\)](http://www</p></div><div data-bbox=)

2. Van de Water PN, Horney JR. Health reform will reduce the deficit: charges of budgetary gimmickry are unfounded. Washington, DC: Center on Budget and Policy Priorities, March 25, 2010. (Accessed May 6, 2010, at <http://www.cbpp.org/cms/index.cfm?fa=view&id=3134>.)

3. Employer health benefits: 2009 annual survey. Washington, DC: Henry J. Kaiser Family Foundation, 2009.

Copyright © 2010 Massachusetts Medical Society.