

Beyond the \$1.6 Trillion Sticker Shock

Timely Analysis of Immediate Health Policy Issues

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\$1.6 trillion is an estimate recently put forth by the Congressional Budget Office (CBO) on the cost of the Senate Finance Committee's health plan. In the current economy and with the budget problems that the nation now faces, it is clearly a considerable sum. The estimate caused the committee to stop its deliberations and develop a new plan that would cost closer to \$1.0 trillion. The cost of the Senate Health, Education, Labor, and Pensions (HELP) Committee plan was estimated at \$1.0 trillion but without including the cost of the Medicaid expansion to all those with incomes up to 150 percent of the federal poverty level that the committee presumed would be a component of the full reform. Thus, it too would result in costs that are probably closer to \$1.6 trillion.

While these numbers are indeed somewhat alarming initially, they need to be put in context. One source of confusion is that the \$1.6 trillion is a 10-year number. Between 2010 and 2019, the total amount of gross domestic product (GDP) is projected to be \$187 trillion, according to CBO.¹ Thus, the estimated gross costs of health reform are less than 1 percent of the GDP over that period. And, importantly, the \$1.6 trillion is a total or gross estimate. Other government costs would be reduced as a result of expanding coverage so significantly. For example, multiple threads of federal and state spending currently devoted to financing uncompensated care could be reduced

substantially, if not eliminated. Such offsets will likely reduce the net new spending attributable to comprehensive reform to about \$1.2 trillion, making the net costs of reform an even smaller fraction of 1 percent of total national income over 10 years.²

The government costs also ignore the private savings to employers and individuals resulting from reform. For example, private savings would be generated for some individuals currently buying coverage through the nongroup market and some small firms whose workers would join purchasing exchanges under reform and obtain coverage at lower administrative costs. Individuals, particularly those in bad health, who are now paying large amounts out of pocket for medical care would pay less in the reformed system, resulting from public subsidies and guaranteed access to comprehensive insurance with broad-based risk pooling. Effective cost containment resulting from reform would produce even greater private and public savings.

Absent reform, total health care expenditures, public and private, will total \$33.0 trillion, over the ten years 2010–2019.³ The \$1.2 trillion that we estimate in net new spending will therefore increase expected health costs by only 3.5 percent. The problem that the nation faces is not the small increment necessary to expand coverage to the uninsured, but the high and growing baseline costs of

the system. The high system costs must be addressed through payment and delivery system reforms. The wide range of savings options include modifying Medicare provider payment rates, the use of medical homes, better coordination of chronic illness care, prevention of such illnesses as diabetes and heart disease, value-based purchasing, and expansion of integrated health systems.

And, as we have shown elsewhere, failing to enact comprehensive reform carries substantial costs as well.⁴ We recently analyzed changes in coverage and expenditures for a 10-year period, if reform was not enacted, using different assumptions about economic growth and health care cost increases. We showed that, absent reform, there would be considerable loss of employer coverage, particularly among the middle class, and a substantial increase in the number of uninsured, from an estimated 49 million in 2009 to over 60 million in 2019. The number of nonelderly people enrolled in Medicaid would increase substantially, from 44 million in 2009 to well over 50 million by 2019, increasing state and federal government costs appreciably. Because of the greater number of uninsured, the amount of uncompensated care that hospitals and clinics would provide would also increase dramatically, putting further pressure on government budgets. We estimate that Medicaid spending would increase over the 10 years by



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about \$800 billion without reform and that the costs of uncompensated care by about \$250 billion.⁵

Without health reform, employer costs would also increase substantially, as would costs to individuals and families from higher premiums and out-of-pocket costs. Higher employer contributions to premiums would also affect individuals and families because increased spending on benefits would eventually mean lower wages. The fact that employer spending on premiums, which is tax exempt, would make up a higher share

of total compensation would mean lower federal tax revenue. Thus, individuals would be faced with lower wages, higher out-of-pocket costs for premiums and cost sharing, new taxes to support higher Medicaid enrollment and uncompensated care, and a need to replace tax revenue lost due to growing employer contributions to health insurance. In addition, many other individuals and families would be faced with the challenges posed by being uninsured.

\$1.6 trillion is a large number, but one that needs to be placed in context.

First, the often-cited gross costs of health care reform do not take into account the public and private savings that would result. Second, the costs of comprehensive reform are not large compared with the gross domestic product and health care spending that will occur over the 10-year period. And third, enormous costs will be borne in the absence of reform, but without the advantages that comprehensive reform would bring.

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About the Authors and Acknowledgements

Linda Blumberg is a Senior Fellow and John Holahan is Director of the Urban Institute's Health Policy Center.

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Notes

¹ Congressional Budget Office, "A Preliminary Analysis of the President's Budget and an Update of CBO's Budget and Economic Outlook. March 2009" (Washington, DC: Congressional Budget Office, 2009), <http://www.cbo.gov/ftpdocs/100xx/doc10014/03-20-PresidentBudget.pdf>.

² Estimated based on extrapolations from data in J. Hadley, J. Holahan, T. Coughlin and D. Miller, "Covering the Uninsured in 2008: Current Costs, Sources of Payment and Incremental Costs" *Health Affairs*, 27, no. 5 (2008): w399-w415.

³ Center for Medicare and Medicaid Services, "Table 1: National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar Years 2003–2018." *National Health Expenditure Projections 2008–2018* (2009), <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf>.

⁴ J. Holahan, B. Garrett, I. Headen and A. Lucas, "Health Reform: The Cost of Failure" (Washington, DC: The Urban Institute, 2009).

⁵ Estimated based on data presented in Holahan et al., "Health Reform."