Economic Analysis
Published by Applied | Economic | Strategies, LLC

December 9, 2009 *Economic Analysis No. 2009-8*

The Hidden Costs Of Health Care Reform In The Senate Bill

Actual Price Tag for the Reid Health Care Bill is $1.7 Trillion Over The First Ten Years
It Contains $894 Billion In Hidden Costs On Employers, Insurers And Individuals
In Addition To $486 Billion In Higher Taxes plus $210 Billion to Fix Medicare

By D. Mark Wilson

Although the Senate health care reform bill, the Patient Protection and Affordable Care Act, is estimated to cost the federal government $848 billion over 10 years, the bill would also impose hundreds of billions of dollars in costs on the private sector and states that would make its total price tag $1.7 trillion over the first ten years.[1]

These costs include $894 billion in hidden costs over 10 years on the private sector that are not included in the Congressional Budget Office (CBO) analysis, and $486 billion in higher taxes on employers, insurers, and individuals that have been scored by the CBO and the Joint Committee on Taxation.[2] Moreover, the Senate bill cost estimate does not take into account $210 billion in health care costs that the federal government would pay over 10 years should Congress permanently fix Medicare's sustainable growth rate mechanism governing the program's payments to physicians, something it has frequently done in the past.[3]

Specifically, the hidden costs in the Senate bill would:

- Increase employer and private sector costs by at least $20.7 billion per year in addition to the $42.0 billion in higher taxes on insurers and employers and $6.6 billion in higher taxes on individuals;[4]
- Increase health insurance premiums in the individual market by 10 to 13 percent, or $52.5 billion per year, and increase costs for small businesses by $13.6 billion per year;[5]
- Create at least $139 million per year in new administrative and compliance costs for the private sector, *not including the initial implementation costs*;[6] and
- Increase state Medicaid costs by $2.5 billion per year.[7]

As employers analyze the likely impact health care legislation will have on their firms and employees, they are finding that the bills will significantly increase the cost of employer provided health care. These cost increases may discourage employers from hiring American workers as the economy struggles to recover, and force them to pass these cost increases on to employees or drop their health insurance benefits altogether.

Hidden Costs on Employers and Employees

Increased Cost Shifting: Although the CBO's assessment of the Senate bill is that it will have a "minimal effect" on private-sector premiums via cost shifting, it does recognize that some cost shifting will occur.[8] In fact, under the Senate bill $20.7 billion per year in increased cost shifting to the private sector will likely occur from the deep cuts in Medicare and Medicaid programs.[9]

Government programs like Medicare and Medicaid pay artificially low rates for health care services and providers compensate by passing on billions of dollars in under-compensated costs to employer plans. A 2008 Milliman study estimated cost shifting increases the costs for private sector payers by $88.8 billion per year, resulting in a hidden tax that accounts for more than ten percent of the cost of employer-based coverage.[10] The Senate health care reform bill would result in a net increase of $20.7 billion per year in cost-shifting from the cuts in Medicare and Medicaid spending and the expansion of Medicaid, less the reduction from the cost of uncompensated care from the uninsured.[11] Although the Senate bill would lower the government's health care costs, it would raise the cost curve for the private sector.

Premium increases: The CBO estimates that 6.4 million workers will lose their employment-based coverage and have to purchase insurance in the nongroup market.[12] The CBO also estimates that the Senate and House bills will significantly increase insurance premiums by 10 to 13 percent for 32 million people in the nongroup market.[13] This will cost individuals and families $52.5 billion per year.[14]

The CBO and other studies also estimate that the Senate bill could increase insurance premiums by 1 to 3 percent for 25 million people in the small-group market.[15] This would increase the cost of health insurance premiums on small businesses and their employees by up to $13.6 billion per year.[16]

Further, CBO estimates that 19 percent of employees, or 30.2 million workers, would be affected by the excise tax on high-cost insurance plans in 2016.[17] Those employees who kept their high-cost policies would pay significantly higher premiums than under current law. Or, to avoid the cost of the excise tax, employees could enroll in plans that cover fewer services, pay a smaller share of covered health care costs, or manage benefits more tightly.

Hidden Cost of Fixing Medicare Reimbursement Rates

The Senate bill leaves out a significant health care financing issue that Congress typically addresses on an annual basis, increasing Medicare's payment rates for physicians' services, and in doing so hides $210 billion in higher spending that would completely offset the deficit neutrality of the bill.[18] Moreover, the elderly who are enrolled in Medicare Part B would pay about $49 billion in higher premiums over the 10 year period.[19]

In a bit of budget slight-of-hand, the Senate bill would increase payment rates for physicians' services in 2010, and then reduce the rates by about 23 percent in 2011 and subsequent years.[20] However, as noted by CBO, "the sustainable growth rate (SGR) mechanism governing Medicare's payments to physicians has frequently been modified (either through legislation or administrative action) to avoid reductions in those payments, and legislation to do so again is currently under consideration in the Congress."[21]

Hidden Administrative Costs

The CBO estimates the Senate bill would increase administrative costs for the private sector by $139 million per year, or $1.4 billion over ten years, for the recordkeeping, reporting, and other administrative costs.[22] Although some reform provisions are intended to reduce costs, many more provisions will increase private sector costs. For example, the information that is required for the individual affordability credits and small business credits, the auto-enrollment procedures and opt-out requirements, the employer notice requirement, the reporting of employer health insurance coverage, various grievance and appeal procedures and transparency and disclosure requirements, and providing proof of insurance coverage for the individual mandate will all increase private sector administrative costs on a recurring basis.

The Senate bill is over 2,000 pages and its implementing regulations are likely to rival the complexity of the IRS rules. In fact, the CBO estimates that it will cost the IRS up to $1.0 billion per year to implement and administer their responsibilities in the bill.[23] Although well-intended, these requirements will significantly increase private sector administrative costs.

Hidden Costs on the States

Almost 50 percent of the 31 million people gaining health insurance coverage under the Senate bill will be put into Medicaid, a government run program.[24] Although CBO estimates this would cost the federal government $374 billion over 10 years, it did not include the $25 billion in costs that state governments will incur for their share of Medicaid's expansion.[25]

Moreover, CBO did not estimate what impact a 43 percent expansion of the program would have on Medicaid fraud and improper payments.[26] According to the Government Accountability Office (GAO), Medicaid fraud is a troubling 10.5 percent of total benefit payments every year.[27] However, substantially expanding Medicaid will significantly increase the possibility of fraud. Even if the improper payment rate can be reduced, which it hasn't since GAO put Medicaid on their "High Risk" list in 2003, the level of Medicaid fraud is likely to increase by $4.2 billion per year.[28]

Hidden Cost of Long-Term Care Program

The Senate bill also includes a Community Living Assistance Services and Supports (CLASS) program that would establish a voluntary federal program for long-term care insurance. The program would initially increase tax revenues by $72 billion over 10 years, followed by net outlays in later years.[29] This makes the Senate bill appear less costly than it really is and accounts for over 55 percent of the 10 year budget savings that is calculated by CBO.[30] Specifically, the program would pay out far less in benefits than it takes in over the 10-year period, however, eventually program outlays would exceed premiums. According to CBO, in the decade following 2029, the CLASS program would begin to increase budget deficits.

Conclusion

In 1999, the average cost of family coverage was $5,791; by 2009, average family coverage had soared to $13,375.[31] In addition to imposing billions of dollars in mandates and taxes on jobs, employers are concerned that the health care reform bills contain a number of hidden costs that will significantly increase the cost curve for employer provided health care. True reform should not inhibit the ability of companies to compete globally, drive up labor costs for employers and potentially erode the quality of the benefits that they currently provide their employees.

[1] Congressional Budget Office, Letter to Senator Harry Reid, November 18, 2009, page 1; available at: http://www.cbo.gov/ftpdocs/107xx/doc10731/Reid_letter_11_18_09.pdf. The $1.7 trillion is derived as follows: $848 billion in government costs plus $207 billion in increased cost shifting plus $525 billion in higher insurance premiums in the individual market plus up to $136 billion in higher insurance premiums in the small group market plus $25 billion in higher state Medicaid premiums that will be passed along to state taxpayers plus $1.4 billion in higher administrative costs.

[2] Congressional Budget Office, Letter to Senator Harry Reid, November 18, 2009, see Table 2; the Joint Committee on Taxation, JCX-55-09, November 18, 2009, available at: http://www.jct.gov/index.php; and Applied Economic Strategies, LLC estimates. The $894 billion is derived as follows: $207 billion in increased cost shifting plus $525 billion in higher insurance premiums in the individual market plus up to $136 billion in higher insurance premiums in the small group market plus $25 billion in higher state Medicaid premiums that will be passed along to state taxpayers plus $1.4 billion in higher administrative costs.

[3] Congressional Budget Office, Letter to Representative Paul Ryan, November 19, 2009, available at: http://www.cbo.gov/ftpdocs/107xx/doc10732/ HR3961_HonRyan.pdf. Also see, Congressional Budget Office Cost Estimate for H.R. 3961, November 4, 2009, available at: http://www.cbo.gov/ftpdocs/107xx/ doc10704/hr3961.pdf.

[4] Congressional Budget Office, Letter to Senator Harry Reid, November 18, 2009, Table 2. The broad "changes in revenue" categories in Table 2 were roughly assigned employers and individuals by Applied Economic Strategies. Also see footnote 9 for how the $20.7 billion estimate was derived.

[5] Congressional Budget Office, Letter to Senator Evan Bayh, November 30, 2009, available at: http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf; and Applied Economic Strategies estimate. Also see footnotes 13 and 15 for how the $52.5 billion and $13.6 billion estimates were derived.

[6] Congressional Budget Office, Letter to Senator Harry Reid, November 18, 2009, page 18.

[7] *Id* at page 7; $25 billion / 10 yrs = $2.5 billion.

[8] Congressional Budget Office, Letter to Senator Evan Bayh, November 30, 2009. On page 12 and 13, the CBO states that "changes in cost shifting seems likely to be quite small" and "the total amount of cost shifting in the current health care system appears to be modest *relative to the overall cost of health insurance.*" [emphasis added] This language strongly suggests that CBO believes there will be some increase in cost shifting. On page 16, the CBO states that the "Effects Related to Cost Shifting Would Be Minimal" and that the "legislation would have opposing effects on the pressures for cost shifting." The CBO notes that "On the one hand, the legislation would reduce payments to hospitals and certain other providers under Medicare" and "significantly increase enrollment in Medicaid, which pays providers appreciably lower rates than private insurers do. Those changes could cause premiums for private coverage to increase." The CBO further notes that "On the other hand, the legislation would ultimately reduce the uninsured population by more than half, which would sharply reduce the amount of uncompensated or undercompensated care provided to people who lack health insurance" and that "The net effect of those opposing pressures would depend on their relative magnitude and also on the degree to which costs are shifted." Although CBO "expects that the magnitude of those opposing pressures would be *about* the same" [emphasis added], it concludes that "the legislation would have a *minimal effects on private-sector premiums* via cost shifting." [emphasis added] Note that the CBO did not conclude that there would be no impact or effect, only that it would be minimal on private-sector premiums. Moreover, the CBO did not present a net cost-shifting estimate as a dollar amount.

[9] Applied Economic Strategies estimate based on CBO data, Lewin research, and Milliman research. Although on page 17 of the Congressional Budget Office, Letter to Senator Evan Bayh, November 30, 2009, CBO's assessment of "the evidence is that a small amount of cost shifting occurs but that it is not as widespread or extensive as is commonly assumed", other research has found that a substantial amount of cost shifting occurs. See: Will Fox and John Pickering, Hospital & Physician Cost Shift, *Payment Level Comparison of Medicare, Medicaid, and Commercial Payers,* Milliman, December 2008; Michael Davis, 2009 Vermont Health Care Cost Shift Analysis, State of Vermont, Department of Banking, Insurance, Securities, and Health Care Administration, February 20, 2009; Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller, *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs,* Health Affairs, Web Exclusive, August 25, 2008; Allen Dobson, Joan DaVanzo, Namrata Sen, *The Cost-Shift Payment 'Hydraulic': Foundation, History, And Implications,* Health Affairs, January/February 2006; Michael A. Morrisey, Cost Shifting: New Myths, Old Confusion, And Enduring Reality, Health Affairs, October 8, 2003; Jack A. Meyer and William R. Johnson, *Cost Shifting In Health Care: An Economic Analysis,* Health Affairs, 1983; and John Sheils, *The Cost and Coverage Impacts of a Public Plan, Testimony before the Ways and Means Committee,* The Lewin Group, April 29, 2009. In fact, Sheils stated in his testimony that "the literature indicates that only about 40 percent of uncompensated care and payment shortfalls are passed-on as higher prices for the privately insured. The remainder (60 percent) appears to be absorbed through reductions in costs and net income. Similar effects also have been observed for physician care." The reason CBO believes that $20.7 billion in cost-shifting will have a minimal

effect on insurance premiums is because it represents just 1.7 percent of the projected total private insurance expenditures in 2016. The AES estimate was derived as follows: $491 billion in Medicare and Medicaid cuts (CBO) times .40 (the Lewin cost shift estimate) equals $196.4 billion over ten years, or $19.6 billion per year; plus the average annual increase in the number Medicaid participants, or 6.8 million people (CBO) times the current cost shift estimate per Medicaid participant of $481 per year (per capita cost estimate developed from data in Will Fox and John Pickering, *Hospital & Physician Cost Shift, Payment Level Comparison of Medicare, Medicaid, and Commercial Payers,* Milliman, December 2008, adjusted for medical cost inflation, $19.0 billion / 39.5 million beneficiaries = $481) equals $3.3 billion per year in additional cost shifting; minus the average annual decrease in the number uninsured, or 16.1 million people (CBO) times the current cost shift estimate per uninsured person of $138 per year (per capita cost estimate developed from data in Will Fox and John Pickering, *Hospital & Physician Cost Shift, Payment Level Comparison of Medicare, Medicaid, and Commercial Payers,* Milliman, December 2008, adjusted for medical cost inflation, $6.3 billion / 45.6 million people = $138) equals $2.2 billion per year in reduced cost shifting; for a net increase of $20.7 billion per year. Note that the cost shift increase associated with the expansion of Medicaid ($3.3 billion) is largely offset by the reduction in cost shifting associated with fewer uninsured ($2.2 billion). However, the significant cuts in Medicare and Medicaid provider reimbursements increase the net cost shifting estimate. It should also be noted that the House has passed H.R. 3961 that would significantly offset the Medicare cuts to providers.

[10] Will Fox and John Pickering, *Hospital & Physician Cost Shift, Payment Level Comparison of Medicare, Medicaid, and Commercial Payers,* Milliman, December 2008, available at: http://www.milliman.com/expertise/ healthcare/ publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf. During the past 20 years, documentation has accumulated in the health service research literature of hospital cost shifting to private payers due to uncompensated care for the uninsured and Medicare and Medicaid reimbursement levels that do not cover the cost of providing those services. See footnote 9.

[11] Applied Economic Strategies estimate based on CBO data, Lewin data, and Milliman data. See footnote 9.

[12] Congressional Budget Office, Letter to Senator Evan Bayh, November 30, 2009, see Table 1 and page 21, (32 million times 1/5 = 6.4 million).

[13] *Id,* see Table 1.

[14] Applied Economic Strategies estimate based on CBO and Census Bureau data. Congressional Budget Office, Letter to Senator Evan Bayh, November 30, 2009, see Table 1 (32 million times .745 (Census data: % of persons in families with direct purchase coverage) times ($15,200 - $13,100: CBO Letter to Bayh pg 6) = $50.1 billion; plus (32 million times .255 (Census data: % of individuals with direct purchase coverage) times ($5,800 - $5,500: CBO Letter to Bayh pg 6) = $2.4 billion; for a total of $52.5 billion. Although this increase in premium costs is offset by federal premium subsidies, many of the taxpayers who bear most of the cost of the federal income tax burden are not likely to be the ones who benefit from the subsidies.

[15] Congressional Budget Office, Letter to Senator Evan Bayh, November 30, 2009; and Oliver Wyman, *Insurance Reforms Must Include a Strong Individual Mandate and Other Key Provisions to Ensure Affordability,* October 14, 2009, available at: http://online.wsj.com/public/resources/documents/OliverWymanFinalReport101409.pdf. Although the Wyman study analyzed the Senate Finance Committee bill, similar benefit mandates are in the Patient Protection and Affordable Care Act.

[16] Applied Economic Strategies estimate based on Wyman data, CBO data, Census data, and Kaiser Family Foundation data. According to Census data for the Small Business Administration there are 42.7 million employees in firms with less than 100 employees, and according to the Kaiser Family Foundation 2009 Annual Survey, Exhibit 3.2, 64%, or 27.3 million employees, in small firms are covered by employer-provided health insurance. Further, Census data shows that 76.4%, or 20.9 million employees, in small firms with employer coverage are in families, and 24.6%, or 6.4 million, are single individuals. Therefore, 20.9 million times ($19,000 times .03) = $12.1 billion, and 6.4 million times ($7800 times .03) = $1.5 billion, for a total of $13.6 billion. Although this increase in premium costs may be partially offset by federal subsidies to small businesses, the subsidies are available for only two years for each firm.

[17] Congressional Budget Office, Letter to Senator Evan Bayh, November 30, 2009, see Table 1, ((25 million plus 134 million) times .19 = 30.2 million).

[18] Congressional Budget Office Cost Estimate for H.R. 3961, November 4, 2009. See table on page 1.

[19] *Id*.

[20] Congressional Budget Office, Letter to Senator Harry Reid, November 18, 2009, page 17.

[21] *Id.*

[22] This estimate seems implausibly low given all of the requirements in the bill on employers, insurers and health care providers, and the CBO does not provide an explanation on how it developed it estimate. See: Congressional Budget Office, Letter to Senator Harry Reid, November 18, 2009, page 18, ($139 million times 10 years = $1.4 billion).

[23] Congressional Budget Office, Letter to Senator Harry Reid, November 18, 2009, page 12, ($10 billion / 10 years = $1.0 billion).
[24] Congressional Budget Office, Letter to Senator Harry Reid, November 18, 2009, Table 3, (31 million / 15 million = 48.4%).
[25] *Id.* See Table 3 and page 7.
[26] *Id.* See Table 3, (15 million / 35 million = 42.8%)
[27] Government Accountability Office, *Progress Made but Challenges Remain in Estimating and Reducing Improper Payments,* GAO-09-628T, April 22, 2009, page 1, available at: http://www.gao.gov/new.items/d09628t.pdf.
[28] Applied Economic Strategies estimate based on GAO and CBO data, ($374 billion plus $25 billion) times .105 = $4.2 billion.
[29] Congressional Budget Office, Letter to Senator Harry Reid, November 18, 2009, pages 11 and 12.
[30] Applied Economic Strategies estimate based on CBO data; Congressional Budget Office, Letter to Senator Harry Reid, November 18, 2009, Table 1 and page 15, ($72 billion / $130 billion = 55.4%).
[31] Kaiser Family Foundation, *Employer Health Benefits 2009 Annual Survey*, Exhibit 1.12.