What does the health reform law (PPACA) mean for older Americans?

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UC Davis Professor of Medicine and Pediatrics
February 2013
International Comparison of Spending on Health, 1980–2010

Average spending on health per capita ($US PPP)

Total health expenditures as percent of GDP

Notes: PPP = purchasing power parity; GDP = gross domestic product.
Source: Commonwealth Fund, based on OECD Health Data 2012.
<table>
<thead>
<tr>
<th>Country Rankings</th>
<th>AUS</th>
<th>CAN</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
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<tr>
<td>1.00–2.33</td>
<td>3</td>
<td>6</td>
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**Overall Ranking of National Health Care System Performance**

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<th>OVERALL RANKING (2010)</th>
<th>AUS</th>
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<td>Quality Care</td>
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<td>Access</td>
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<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>6.5</td>
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<td>3.5</td>
<td>2</td>
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<td>1</td>
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<tr>
<td>Timeliness of Care</td>
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<td>7</td>
<td>2</td>
<td>1</td>
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<td>4</td>
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<td>Efficiency</td>
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<td>5</td>
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<td>4</td>
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<tr>
<td>Equity</td>
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<td>5</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>7</td>
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<tr>
<td>Long, Healthy, Productive Lives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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**Health Expenditures/Per Capita, 2007**

<table>
<thead>
<tr>
<th>Country</th>
<th>Health Expenditures/Per Capita, 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUS</td>
<td>$3,357</td>
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<tr>
<td>CAN</td>
<td>$3,895</td>
</tr>
<tr>
<td>GER</td>
<td>$3,588</td>
</tr>
<tr>
<td>NETH</td>
<td>$3,837*</td>
</tr>
<tr>
<td>NZ</td>
<td>$2,454</td>
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<tr>
<td>UK</td>
<td>$2,992</td>
</tr>
<tr>
<td>US</td>
<td>$7,290</td>
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</tbody>
</table>

**Note:** * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Public share of total US health care spending

NIHCM Foundation analysis of data from the National Health Expenditure Accounts.
Health Insurance Coverage in the U.S., 2010

- Employer-Sponsored Insurance: 49%
- Medicaid: 17%
- Medicare: 12%
- Private Non-Group: 5%
- Uninsured: 16%

Total = 305.2 million

* Medicaid also includes other public programs: CHIP, other state programs, military-related coverage. Numbers may not add to 100 due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2011 ASEC Supplement to the CPS.
Number of Nonelderly Uninsured Americans, 2004 - 2010

Characteristics of the Nonelderly Uninsured, 2010

Family Status
- Adults without Dependent Children: 59%
- Children: 16%
- Parents: 24%

Family Income
- <100% FPL: 41%
- 100-250% FPL: 37%
- 251-399% FPL: 13%
- 400% FPL and Above: 10%

Family Work Status
- No Workers: 24%
- 1 or More Full-Time Workers: 61%
- Part-Time Workers: 16%

Total = 49.1 million uninsured

The federal poverty level was $22,050 for a family of four in 2010.
Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2011 ASEC Supplement to the CPS.
Market failure in health insurance and health care

- Information asymmetry (patients/providers vs. insurers, providers vs. patients/insurers)
  - Adverse selection (death spiral)
  - Supplier-induced demand for low-value services (principal agent problem)
- Moral hazard
  - Increases utilization of medical care
- Insufficient competition
  - Barriers to entry, limited supply
  - Poor antitrust enforcement
Consequences of market failure

• Information asymmetry (patients/providers vs. insurers, providers vs. patients/insurers)
  – “Cream skim” by excluding pre-existing conditions, offering limited networks, selective marketing
  – Policy rescission, lifetime caps

• Moral hazard
  – Underinsurance (high deductibles & copayments)
  – Experience rating, market segmentation

• Insufficient competition
  – “Monopoly rent”
Fixing market failure

• Eliminate or marginalize the insurance market
  – “Single payer,” not “socialized medicine”
  – Many models (e.g., Medicare, Medicaid, SCUSD, SMUD, PG&E)

• Regulate the market (Nixon, Clinton, Obama)

• Unleash the market
  – Eliminate barriers to entry
  – Provide better information about cost & quality
  – Increase consumers’ sensitivity to price
  – Promote robust competition
Market regulation

• Prohibit undesirable underwriting practices (designed to avoid adverse selection) and limit insurer profits ("medical loss ratio")
  - policy rescissions
  - lifetime coverage limits
  - pre-existing exclusions
  - excessive “anticipatory” premium increases

• Quid pro quo: Bring/force healthy people into the insurance market
  - Subsidize low-to-middle income families and small businesses (tax credits)
  - Encourage parental coverage of young adults
  - Penalize (or tax?) “free riders”
Principles of “Obamacare”

• Create a new, regulated market through state-level “health insurance exchanges”
  - Subsidies up to 400% Federal poverty level so premium contribution is limited to 9.5% of income
  - Insurers required to cover anyone, underwriting restrictions

• Expand Medicaid and high-risk pools to cover those who still cannot afford health insurance

• Constrain Medicare costs, modestly expand benefits
  - Phase out “doughnut hole” for Part D drug coverage
  - “First dollar” coverage for preventive services
  - Reduce “overpayments” to hospitals and HMOs

• Promote innovative models of healthcare delivery
  - Accountable Care Organizations, bundled payment
  - Patient-Centered Medical Homes
Why Clinton-care failed

• Opposition of key stakeholders
  – Insurance industry opposition (Harry and Louise)
  – Business opposition to employer mandate

• White House-driven approach
  – “We have the experts”
  – Slow movement during critical year

• Failure to mobilize support
Overview of the Health Reform Legislative Process: Committees and Floor Debate

**HOUSE**
- **Energy & Commerce**
  - Passed July 31
- **Ways & Means**
  - Passed July 16
- **Education & Labor**
  - Passed July 17

Three bills combined into one

- October 29

Limited floor debate - **One Day**

- Two Amendments Considered;
  - One Adopted

November 7

**HOUSE VOTE**
- Passed 220-215

November 7

**SENATE**
- **Finance**
  - Passed October 13
- **HELP**
  - Passed July 16

Two bills combined into one

- November 18

Motion to proceed to debate **adopted**

November 21

Floor debate - **21 days**

Nov. 30-Dec. 24

**NEGOTIATIONS BETWEEN HOUSE, SENATE & PRESIDENT**

- Filibuster
  - Defeated 3 times -- on 2 amendments and on the bill
  - By Invoking Cloture -- 60 votes required

Dec. 21-23

**SENATE VOTE**
- Passed 60-39

December 24

Source: Kaiser Family Foundation, 2010
Changes in Sources of Coverage Under the Act Assuming Full Implementation in 2011 (millions)

- Medicaid: 13.0
- Employer Coverage: -2.8
- Individual Coverage: 19.3
- Uninsured: -29.5
- Employers Who Drop Coverage: -17.2
- Newly Covered Employer Coverage Plan: 14.4
- Net Change in Employer Coverage: -2.8
The Health Reform Law contains many Medicare-related provisions

• $105 billion in new Medicare spending over 10 years
• $43 billion to gradually close the Part D doughnut hole
• $5 billion for prevention benefits including new annual wellness visit
  • No deductibles or coinsurance on prevention plans that receive an A or B grade from US Prevention Services Task Force
• $8 billion for primary care physicians and other providers

Source: Kaiser Family Foundation analysis of Congressional Budget Office (CBO) cost estimates as provided on March 20, 2010.
Standard Medicare Prescription Drug Benefit, 2010

- **Deductible:** $310
- **Initial coverage limit:** $2,830 in total drug costs ($940 out-of-pocket)
- **Coverage gap:** $3,610 Coverage Gap ("Doughnut Hole")
- **Catastrophic coverage limit:** $6,440 in total drug costs ($4,550 out-of-pocket)

**Beneficiaries with spending in the doughnut hole get $250 rebate in 2010**

- Enrollee pays 5%
- 15% paid by plan; 80% paid by Medicare
- 100% paid by enrollee

**SOURCE:** Kaiser Family Foundation illustration of standard Medicare drug benefit in 2020 under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.
Standard Medicare Prescription Drug Benefit, 2020
*Before and After Health Reform*

**Before:**
- **Deductible:** 100% paid by enrollee
- **Initial coverage limit:** 25% paid by enrollee
- **75% paid by plan**
- **100% paid by enrollee**
- **Catastrophic coverage limit:** 15% paid by plan; 80% paid by Medicare
- **5% paid by enrollee**

**After:**
- **Brands:** 50% discount
  - 25% paid by enrollee
- **Generics:** 75% paid by plan
- **Coverage gap:** 25% paid by enrollee
- **100% paid by enrollee**

*SOURCE:* Kaiser Family Foundation illustration of standard Medicare drug benefit in 2020 under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.
Sources of Savings

• Provider payments, including DSH and home health - $219 billion
• Medicare Advantage – $136 billion
• Income-related Part B and D premiums – $36 billion
• New Independent Payment Advisory Panel – $16 billion
• Delivery system reforms and hospital readmissions – $12 billion

Ten-Year Medicare Savings = $533.1 Billion

Source: Kaiser Family Foundation analysis of Congressional Budget Office (CBO) cost estimates as provided on March 20, 2010.
Notes: *Savings include interactions with Medicare Advantage and TRICARE; spending includes implementation of Medicare changes, Part D interactions with Medicare Advantage provisions, Part B interactions with Part D provisions, and Medicaid interactions with Medicare Part D provisions.
Beneficiaries have choice of fee-for-service “original” Medicare or can enroll in a Medicare Advantage (MA) plan (such as HMOs and PPOs).

Medicare Advantage plans are paid a fixed amount per enrollee, but more than usual under FFS.

Relatively high payment to plans has resulted in an increase in plan availability and enrollment.

“Overpayments” to plans shorten the life of the Part A Trust Fund and increase Part B premiums.

Medicare Advantage Enrollment
(in millions)

- 2000: 6.9
- 2002: 5.6
- 2004: 5.3
- 2006: 6.8
- 2008: 9.7
- 2010: 11.1

25% of beneficiaries are enrolled in Medicare Advantage plans in 2010.

Medicare Advantage Savings: Implications for Beneficiaries

Key Provisions
- Freezes benchmarks for 2011; phases in reductions, based on FFS costs in county
- Reduces plan’s share of rebate from 75% to 50% for most plans (2012)
- Provides new bonus and higher rebates to plans receiving high quality ratings (2012)

Impact on Beneficiaries
- Fewer enrollees (CBO)
- Fewer extra benefits (CBO)
- Possibly fewer plans
Numerous delivery system, quality and payment reforms

- New Center for Medicare and Medicaid Innovations (2011)
- Shared Savings/Accountable Health Organizations (2012)
- Reduces payments for preventable hospitalizations (2012)
- Independents at Home demonstration project with shared savings (2012)
- Value-based purchasing for hospitals (2012)
- National pilot to bundle payments for hospital and post-acute care (2013)
- Reduces payments for hospital-acquired conditions (2015)
- Establishes mandatory physician quality reporting program (2015)
- The CBO estimates that these initiatives will reduce Medicare spending by $12 billion over ten years
Independent Payment Advisory Board with unprecedented authority to recommend reductions in Medicare spending

- Creates new board with 15 full-time members, appointed by President, confirmed by U.S. Senate
- Requires the board to recommend specific Medicare savings proposals if Medicare spending exceeds target growth rates
- Requires the HHS Secretary to implement board’s recommended proposals, unless Congress enacted an alternative with equivalent savings
- Prohibits board from recommending proposals that would ration care, reduce benefits, increase cost-sharing, or modify benefits, eligibility, premiums, or taxes, or reduce payments for certain providers (before 2018)
- Requires board to make recommendations to slow the growth in health care spending outside of Medicare – though these recommendations are not binding
- CBO projects the Board will achieve Medicare savings of $15.5 b (2015-2019)
New Medicare-related revenue sources in the health reform law

- Medicare savings attained through increases in premiums paid by higher income Medicare beneficiaries under Parts B and D.
- Freezes income threshold for Part B premium at $85,000/individuals and $170,000/couples; income thresholds will no longer be indexed for inflation (2011)
- Establishes new income-related Part D premium, with same, fixed income thresholds as Part B (2011)
- Increases the Medicare Part A tax from 1.45% to 2.35% on earnings over $200,000/individuals and $250,000/couples (2013)
Projection: Health reform legislation will extend the life of the Medicare Part A Trust Fund from 2017 to 2029.
Rate of Medicare Spending Projected to Slow

Congressional Budget Office Projections

Medicare Baseline Spending (in $ billions)

Baseline Medicare Spending (6.8% annual growth)

Medicare Spending AFTER Health Reform (5.5% annual growth)

Projected Savings

$1,000
$900
$800
$700
$600
$500
$400

$523 $570 $580 $617 $635 $652 $696 $725 $732 $748 $771 $819 $854 $845 $943


NOTE: Estimates do not take into account future changes to the Sustainable Growth Rate formula to prevent reduction in fees.

Bundled Payment

- Healthy person
- Continued health
- Chronic illness
- Successful management
- Acute episode
- Post-acute care

Primary care physicians
Specialist physicians
Pharmacy
Labs

Hospitals
Specialist physicians
Pharmacy
Labs

Post-acute providers
Primary care physicians
Specialist physicians
Pharmacy
Labs
Medicare Enrollment, 1966-2010

- **Nonelderly Disabled (Under Age 65)**
- **Elderly (Age 65 and Older)**

**Number in millions:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Nonelderly Disabled</th>
<th>Elderly</th>
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<tbody>
<tr>
<td>1966</td>
<td>19.1</td>
<td>20.5</td>
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<tr>
<td>1970</td>
<td>25.0</td>
<td>22.8</td>
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<td>2008</td>
<td>46.1</td>
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<td>2009</td>
<td>47.0</td>
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</table>

**NOTES:** Numbers may not sum to total due to rounding. People with disabilities under age 65 were not eligible for Medicare prior to 1972.

**SOURCE:** Centers for Medicare & Medicaid Services, Medicare Enrollment: Hospital Insurance and/or Supplemental Medical Insurance Programs for Total, Fee-for-Service and Managed Care Enrollees as of July 1, 2008: Selected Calendar Years 1966-2008; 2009-2010, HHS Budget in Brief, FY2011.
Elderly Medicare Beneficiaries More Satisfied with Insurance, Less Likely to Experience Cost- or Access-Related Problems

Adjusted percentage

<table>
<thead>
<tr>
<th></th>
<th>Individual insurance (ages 19–64)</th>
<th>Employer-sponsored coverage (ages 19–64)</th>
<th>Medicare beneficiary (age 65+)</th>
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<td>33**</td>
<td>20</td>
<td>8***</td>
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<td>Any medical bill</td>
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<td>or debt problem</td>
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<tr>
<td>Any access problem</td>
<td>39</td>
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<td>because of cost</td>
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</table>

Notes: Medical bill problems include: not able to pay bills, contacted by a collection agency for unpaid medical bills only, had to change way of life because of medical bills, or have medical bills or debt being paid off over time. Access problems include: did not fill prescription, did not get needed specialist care, skipped recommended test or follow-up, had medical problems but did not visit doctor. Indicates significant difference from employer insurance: ** p<0.01, *** p<0.001.

Historical and Projected Number of Medicare Beneficiaries and Number of Workers Per Beneficiary

Number of Beneficiaries (in millions)

- 1966: 19
- 1970: 20
- 1990: 34
- 2000: 40
- 2010: 47
- 2020: 64
- 2030: 80

Number of Workers Per Beneficiary

- 2000: 4.0
- 2007: 3.8
- 2010: 3.4
- 2020: 2.8
- 2030: 2.3

Estimated Sources of Medicare Revenue, 2012

- **General revenue:** 40%
- **Payroll taxes:** 38%
- **Beneficiary premiums:** 13%
- **State payments:** 2%
- **Taxation of Social Security benefits:** 3%
- **Interest and other:** 4%

**TOTAL** $532.7 billion

- **Part A** $238.6 billion
- **Part B** $230.9 billion
- **Part D** $63.2 billion

**SOURCE:** 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.
Sources of Growth in Projected Federal Spending on Medicare and Medicaid, 2007 to 2082

Reforming health care

This is going to hurt
"I think of this as synchronized swimming. There's a lot of focus on bathing caps, but there are a lot of things happening under the surface.”
Secretary Sebelius at AcademyHealth National Policy Conference, Feb 2013

"Think of synchronized swimmers going over Niagara Falls…”
Rep. Michael Burgess (R-TX), founder of Congressional Health Care Caucus
Extra slides
Overview of Center for Medicare and Medicaid Innovation–Sponsored Initiatives

**Bundled Payments for Care Improvement.** Tests four different payment models to encourage improved care coordination and efficiency related to hospital admissions. Currently selecting participants.

**Pioneer ACO Model.** Tests advanced ACO models. 32 organizations are participating.

**ACO Advance Payment Model.** Tests whether advance payments will assist participation in the Medicare ACO programs for physician-led and rural organizations with limited access to start-up capital. 20 organizations are currently participating.

**Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration.** Supports 500 FQHCs’ transformation to medical homes through $6 per member per month payment for each eligible Medicare beneficiary.

**Comprehensive Primary Care Initiative.** Public and private payer collaborative to strengthen primary care, involving risk-adjusted, monthly care management fees, as well shared savings payments. 7 states and 500 primary care practices are currently participating.

**Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents.** Seeks to improve quality of care for people in nursing facilities by reducing preventable inpatient hospitalizations. Currently selecting participants.

**Partnership for Patients.** Nationwide public–private partnership to support safer care and more effective transitions of patients from hospitals to other settings. $218 million was awarded to 26 organizations to be Hospital Engagement Networks, which help identify and spread solutions already working to reduce health care–acquired conditions. An additional $500 million is available for models improving care transitions and reducing readmissions for high-risk Medicare beneficiaries. Already, 47 participants have been selected for that program.

**Independence at Home Demonstration.** Tests effectiveness of delivering comprehensive primary care at home, focusing on patients with multiple chronic conditions. 15 independent practices and 3 consortia participating.

**Medicaid Emergency Psychiatric Demonstration.** Tests whether Medicaid can support higher-quality care at a lower total cost by reimbursing private psychiatric hospitals for certain psychiatric services for which Medicaid reimbursement has historically been unavailable. 11 states and D.C. are participating.

**Medicaid Incentives for the Prevention of Chronic Diseases.** Provides incentives to Medicaid beneficiaries participating in prevention programs and demonstrate changes in health risk. 10 states are participating.

**Financial Alignment Initiative.** Aligns financial incentives of Medicare and Medicaid to provide Medicare–Medicaid enrollees with a better care experience. This opportunity is open to all states. Currently, one state is participating.

**State Innovation Models Initiative.** A competitive funding opportunity for states to design and test multipayer payment and delivery models that deliver high-quality health care and improve health system performance. Up to $275 million will be made available for up to 30 grants.

**Health Care Innovation Awards.** Provides grants up to $30 million to participants who are implementing innovative ideas to deliver better health, improved care, and lower costs. 107 grants totaling $894 were awarded. Nearly $2 billion in savings is expected over three years from these initiatives.

**Strong Start for Mothers and Newborns.** Supports reducing the risk of significant complications and long-term health problems for both expectant mothers and newborns.

**Graduate Nurse Education Demonstration.** Provides hospitals with funds for clinical training of advanced practice registered nursing (APRN) students. 5 hospitals are participating.

**Innovation Advisors Program.** Creates a network of delivery system reform experts. 73 advisors have been selected.
## Major Sources of Savings and Revenues Compared with Projected Spending, Net Cumulative Effect on Federal Deficit, 2010–19

### Dollars in billions

<table>
<thead>
<tr>
<th>Description</th>
<th>CBO estimate of Affordable Care Act of 2010</th>
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<tbody>
<tr>
<td>Total Net Impact on Federal Deficit, 2010–19</td>
<td>−$143</td>
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<tr>
<td>Total Federal Cost of Coverage Expansion and Improvement</td>
<td>$820</td>
</tr>
<tr>
<td><strong>Gross Cost of Coverage Provisions</strong></td>
<td>$938</td>
</tr>
<tr>
<td>• Medicaid/CHIP outlays</td>
<td>434</td>
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<tr>
<td>• Exchange subsidies</td>
<td>464</td>
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<tr>
<td>• Small employer subsidies</td>
<td>40</td>
</tr>
<tr>
<td><strong>Offsetting Revenues and Wage Effects</strong></td>
<td>−$117</td>
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<td>• Payments by uninsured individuals</td>
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<tr>
<td>• Play-or-pay payments by employers</td>
<td>−52</td>
</tr>
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<td>• Associated effects on taxes and outlays</td>
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<td><strong>Total Savings from Payment and System Reforms</strong></td>
<td>−$511</td>
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<tr>
<td>• Productivity updates/provider payment changes</td>
<td>−160</td>
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<tr>
<td>• Medicare Advantage reform</td>
<td>−204</td>
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<tr>
<td>• Other improvements and savings</td>
<td>−147</td>
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<td><strong>Education System Savings</strong></td>
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<td><strong>Total Revenues</strong></td>
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</tr>
<tr>
<td>• Excise tax on high premium insurance plans</td>
<td>−32</td>
</tr>
<tr>
<td>• Surtax on investment income for high income earners</td>
<td>−123</td>
</tr>
<tr>
<td>• Other revenues</td>
<td>−277</td>
</tr>
</tbody>
</table>

**Note:** Totals do not reflect net impact on deficit due to rounding.

Medicare Spending per Enrollee Projected to Increase More Slowly Than Private Insurance Spending per Enrollee and GDP per Capita

Annual rate of growth (percent)

Note: GDP = gross domestic product.