

THE FISCAL CONSEQUENCES OF THE
AFFORDABLE CARE ACT

Charles Blahous

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ABSTRACT

THE AFFORDABLE CARE Act (ACA) enacted in 2010 will significantly worsen the federal government's fiscal position relative to previous law. Over the years 2012–21, the ACA is expected to add at least \$340 billion and as much as \$530 billion to federal deficits while increasing federal spending by more than \$1.15 trillion over the same period and by increasing amounts thereafter. These adverse fiscal effects are not everywhere understood because of widely circulated analyses referencing scoring conventions of the Congressional Budget Office (CBO) and the Medicare Trustees, which compare the health care reform legislation to a baseline scenario that differs from actual law. Moreover, there is substantial risk that the ACA's cost-saving provisions will not be enforced as currently specified. To avoid worsening the federal fiscal outlook, legislative corrections are required before the ACA's provisions become fully effective in 2014. Roughly two-thirds of the law's subsidies for health insurance exchanges must be eliminated to avoid worsening federal deficits and the entirety of their costs eliminated to avoid further increasing federal health care financing commitments.

ON MARCH 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act, often referred to simply as the Affordable Care Act or ACA. The enactment of this law represented the culmination of many policy advocates' strenuous efforts. Among other changes, the law would establish a federal mandate that all individuals purchase health insurance, create federally subsidized health insurance exchanges, expand eligibility for Medicaid, reduce the growth of Medicare payments, and impose an array of new taxes.

Among the strongest hopes reposed in comprehensive health care reform was that it would deliver a much-needed correction to the federal government's unsustainable fiscal outlook. This objective was assuredly not the only one; multiple aspirational goals for the effort were articulated. Other stated objectives included humanitarian ones, such as using the authority of the federal government to dramatically expand health insurance coverage. But while the priority given to different objectives varied according to the advocate, the fiscal benefits of reform were consistently presented as a primary motivation for enacting legislation.

During the 2009–10 period that health care legislation was being considered (as well as afterward), supporters frequently quantified the fiscal benefits predicted to arise under specific bills. Earlier, before specific bill text was available (and especially in 2007–09), the fiscal case for reform had been made more generally and abstractly. The essence of this view was that the federal government's long-term fiscal shortfall was almost entirely due to excess health care cost inflation and that comprehensive health care reform was therefore the most urgent requirement for fixing the fiscal problem. Advocates for this view ranged from noted experts at the Brookings Institution¹ to the head of the influential advocacy organization AARP.²

1. Aaron, Henry, "There Is No Entitlement Problem," Brookings Institution, February 23, 2009, accessed March 5, 2012, http://www.brookings.edu/opinions/2009/0223_entitlements_aaron.aspx. "That the United States faces daunting long-term budget challenges is indisputable. But the very projections—those of the Congressional Budget Office—cited to document the long-term budget challenge, show that there is no general entitlement problem. Rather, the nation faces a daunting health care financing problem that bedevils private insurers and public programs alike."

2. See comments of AARP CEO Bill Novelli, "The U.S. Healthcare System: Can This Patient Be Saved?" *The Global Human Capital Journal*, February 24, 2008, accessed March 5, 2012, <http://globalhumancapital.org/the-us-healthcare-system-can-this-patient-be-saved>.

This viewpoint increased in prominence when Peter Orszag, one of its leading advocates, was named to head the Congressional Budget Office (CBO). Soon thereafter, CBO published a frequently cited graph that appeared to substantiate the view that the fiscal problems created by excess health care inflation dwarfed those arising from other known sources of fiscal strains, such as population aging.³

This author and others criticized these portrayals, believing they overstated the (undeniably substantial) prominence of excess health care inflation relative to the more pressing factor of demographic change.⁴ CBO later modified its presentations to clarify that population aging would remain the more significant source of fiscal strain for decades into the future. In 2011, for example, CBO found that through 2035, population aging would account for fully 64 percent of the cost growth in the major federal mandatory health programs and Social Security, with excess health-cost inflation being a relatively smaller factor.⁵

By the time of these later publications, however, the impression had already been created in the minds of many that health care reform was itself the key to fixing the federal government's fiscal outlook. The seductive premise was that health-cost inflation was the appropriate primary target, through reforms that aimed to render the health care sector more efficient, as opposed to the politically unattractive task of constraining the number of health care consumers receiving federal assistance.

Despite disputes over the specific numbers, experts of a variety of policy views generally agreed that rapid health care cost inflation was a substantial problem with potentially severe consequences for federal finances. Policy differences over whether such reforms should involve expanding or contracting the federal role in health care remained, along with differences over how much of the government's overall fiscal repair could be accomplished through health care reform alone. Nevertheless, there was a general concurrence that health care reform, however undertaken, must significantly improve the fiscal outlook.

Throughout 2009, advocates urged that health care reform be given the highest priority among economic policy objectives because it was itself the essence of meaningful fiscal reform. Orszag, by 2009 director of the Office of Management and Budget (OMB), stated at a White House fiscal responsibility summit that "health

3. Congressional Budget Office, "The Long-Term Outlook for Health Care Spending," November 6, 2007, front cover.

4. For example, see Charles Blahous, "CBO Explodes the Health Care Myth," Hudson Institute, June 30, 2009, accessed March 5, 2012, http://www.hudson.org/files/publications/CBO_Health_Care_Myth_Blahous.pdf; and Concord Coalition, "Honey, I Shrunk the Demographics!" *Facing Facts Quarterly*, December 19, 2007.

5. Congressional Budget Office (CBO), "Long-Term Budget Outlook," June 2011, 10.

care reform is entitlement reform. The path to fiscal responsibility must run directly through health care.”⁶ President Obama later echoed this argument, stating in April 2009, “Make no mistake: health care reform is entitlement reform.”⁷

As the legislative process moved from general principles to specific decisions, supporters coalesced around including a substantial expansion of health insurance coverage, subsidized by the federal government, as a major focus of the legislation. These advocates, including the Obama administration, argued that this coverage expansion was consistent with—or at least not destructive of—successful fiscal consolidation. As OMB director Orszag wrote in a May 2009 blog post, “health care reform has two components: cost containment provisions and expanded coverage. In the near term, the impact of expanded coverage will temporarily dominate, and health care reform will therefore temporarily increase government spending. Over time, however, the impact of the cost containment provisions will accumulate, and the net impact will be a reduction—and perhaps a dramatic one—in government spending. Second, while we are waiting for the cost containment provisions to take hold, we are insisting that health care reform be deficit neutral.”⁸

This statement implicitly acknowledged that health care reform, at least as envisioned by the spring of 2009, would not embody an unalloyed, immediate fiscal improvement. Instead, due to an expansion of federally subsidized health insurance coverage, federal health care cost growth would first accelerate before it slowed down. This rendered the hoped-for fiscal improvement both more modest and more distant: confined to not making a bad situation worse over the first 10 years of reform, while anticipating a net fiscal improvement in the decades beyond.

Those familiar with Washington, D.C., budget agreements will recognize a familiar gambit here: specifically, worsening fiscal pressures in the short run to gain agreement on changes in law hoped to improve the long-term outlook. In the past, this gambit has not always produced lasting fiscal improvements. A too-common legislative occurrence is for the long-term austerity measures to be later repealed or moderated before they take full effect, while the added costs take root and mount over time.⁹

6. Peter Orszag, “Opening Remarks at White House Fiscal Responsibility Summit,” transcript in *New York Times: The Caucus*, February 23, 2009, accessed March 5, 2012, http://www.nytimes.com/2009/02/23/us/politics/23text-summit.html?_r=1&pagewanted=all.

7. Barack Obama, “Remarks by the President on the Economy” (speech, Georgetown University, Washington, DC, April 14, 2009).

8. Peter Orszag, “Health Care Reform and Fiscal Discipline,” Office of Management and Budget Blog, May 29, 2009, accessed March 5, 2012, <http://www.whitehouse.gov/omb/blog/09/05/29/HealthCareReformandFiscalDiscipline>.

9. The 2006 Pension Protection Act is but one typical example of this phenomenon. That legislation provided near-term relief from contribution requirements to employer sponsors of worker pension plans, relief provided in part as a political sweetener to allow for the establishment of tighter long-term pension funding targets. The act’s long-term funding targets have since been relaxed repeatedly in subsequent legislation. The near-term funding relief, meanwhile, resulted in some large airline pension plans being significantly more underfunded than they otherwise would have been when their sponsor later entered bankruptcy.

After the ACA was enacted, supporters of the law frequently pointed to a CBO analysis that appeared to show that it would reduce federal deficits by \$124 billion over the first decade (a figure since increased to \$210 billion with the shift of the end of the 10-year budget window from 2019 to 2021), and by over \$1 trillion during the second. President Obama himself has referred to the \$1 trillion figure, stating in an April 2011 speech that the reforms in the health care law would “reduce our deficit by \$1 trillion.”¹⁰ Fiscal benefits have thus remained a central, if not the primary, justification for the enactment of health care reform legislation.

There are, of course, many arguments to be made both on behalf of and in opposition to the health care reforms recently enacted. In particular, the humanitarian arguments for expanded federally subsidized health insurance coverage are important, complex, and beyond the scope of this study. On the one hand, advocates contend that expanding coverage should be a goal in and of itself; on the other, opponents question the humanitarian achievement of making additional long-term promises beyond those the federal government has yet shown the capacity to honor. Though this is an important debate, this study instead focuses solely on evaluating whether the recent legislation will achieve the fiscal benefits believed by supporters and opponents alike to be essential.

Because of the federal government’s untenable long-term fiscal outlook under current law,¹¹ and because of the political difficulty (and thus infrequency) of comprehensive health care reform, it is essential that such reform unambiguously and significantly improve the government’s fiscal outlook. For our unsustainable fiscal trajectory to remain qualitatively unimproved after the expenditure of so much political capital would represent a substantial failure of governance. Furthermore, for comprehensive health care reforms to have rendered an already unsustainable federal fiscal situation still worse would be a disastrous outcome warranting immediate legislative corrections before the law becomes fully operational and before such corrections become too difficult to achieve.

YARDSTICKS FOR MEASURING FISCAL EFFECTS

THERE ARE TWO important yardsticks for measuring the fiscal effects of health care reform:

1. Its effect on projected federal *deficits*.
2. Its effect on projected federal health care *spending*.

For reform to be considered fiscally successful, it must reduce both projected federal deficits and projected federal health care spending. Neither is a sufficient barometer by itself, for reasons detailed below.

10. Obama, “Remarks by the President on Fiscal Policy.”

11. CBO, “Long-Term Budget Outlook.”

Federal finances are on an unsustainable trajectory threatening severe consequences.¹² This projected financial imbalance consists of an imbalance between outgoing spending and incoming revenues. Health care spending is a significant and growing contributor to this fiscal imbalance, with Medicare and Medicaid growth between them accounting for more of projected long-term federal spending growth than all other budget categories. To constitute effective reform, health care policy changes must not make this situation worse; they must make it far better.

A focus on the net deficit impact of legislation is not, however, a sufficient basis for evaluating reforms. In theory, one could address federal deficits while leaving the skyrocketing path of federal health care spending uncorrected and perpetually raising taxes by a still greater amount. But as figure 1 shows, even under current law both taxes and spending would rise to unprecedented levels as a percentage of GDP. All other things being equal, a solution that fails to restrain the growth of federal health care commitments would result in future generations being subjected to tax burdens far higher than previous American generations have ever tolerated and suffering lower after-tax incomes.

It is essential, therefore, that health care reform legislation not only reduce projected federal deficits, but that it qualitatively slow the growth of total federal health care costs. Analysts on different sides of the health care reform debate generally recognize these twin imperatives. For example, many experts have stressed that reform must (and will) “bend the cost curve” in addition to reducing federal deficits.¹³ This study therefore examines the projected effects of the ACA on both projected federal deficits and projected federal health care spending.

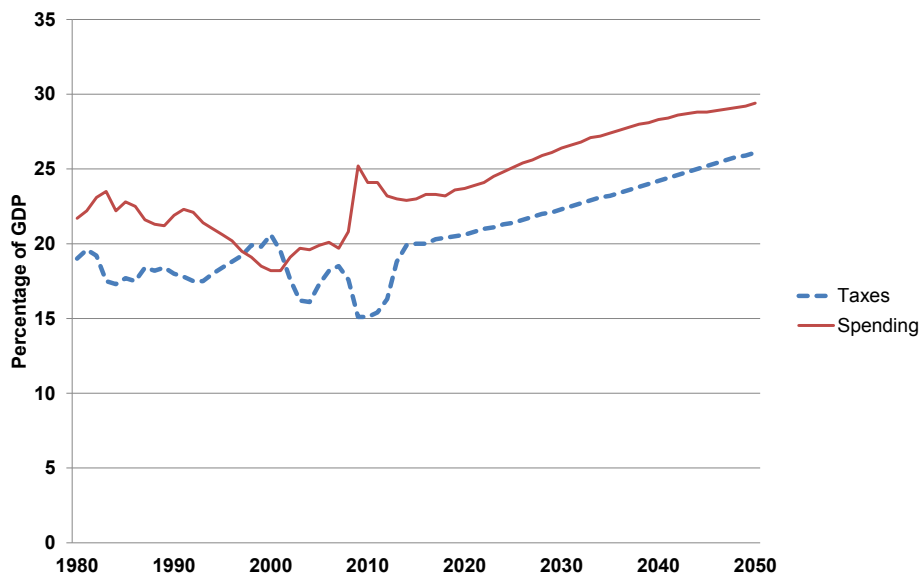
Such an evaluation first requires a proper understanding of the fiscal effects of the ACA’s use of Medicare cost-savings to finance a new federal health entitlement. An explanation of this issue is presented in the next section of this study. A complete analysis of the ACA also requires projections of the future efficacy of its various other provisions designed to slow the rate of cost growth. These provisions are examined separately in subsequent sections (see also appendix B, page 48).

Whether the ACA’s various cost-savings provisions are successfully implemented is central to a determination of the long-term fiscal effects of the legislation. Such outcomes are impossible to know in advance with certainty. Both CBO and the Centers for Medicare and Medicaid Services (CMS) Medicare Actuary have openly questioned whether certain provisions of the ACA will be politically sustainable, pointing to examples of Congress’s relaxing similar austerity measures at the point when they begin to inflict significant costs upon various constituencies.

12. Ibid.

13. For one example, see Engelberg Center for Health Care Reform, “Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth,” Brookings Institution, August 2009, accessed March 6, 2012, http://www.brookings.edu/-/media/Files/rc/reports/2009/0826_btc/0826_btc_fullreport.pdf.

FIGURE 1. CURRENT LAW PROJECTIONS FOR TAXES AND SPENDING AS A PERCENTAGE OF GDP



Sources: OMB (historical data) and CBO (projections)

Published findings that the ACA would result in net fiscal improvements are premised on assigning an equal certainty to both the legislation's cost-increasing provisions and its cost-saving provisions being sustained. However, historical evidence suggests that the upholding of these respective provisions may not be equally certain. Congress's legislative history reflects the political difficulty of constraining the growth of previously enacted commitments, especially once individuals have grown dependent upon federal benefits. There is also little consistency in Congress's historical willingness to uphold previously enacted austerity measures, with examples ranging from Medicare's Sustainable Growth Rate (SGR) formula for physician payments to the nonindexed income thresholds triggering the Alternative Minimum Tax (AMT).¹⁴ A more complete analysis of the likely fiscal effects of the ACA must recognize that the legislation employs comparatively uncertain cost-saving measures as budgetary offsets for comparatively certain cost-increasing provisions.

Evaluating the ACA is not the only instance of such a projection difficulty. For example, similar uncertainty surrounds the path of future income tax law. Under literal current law, income tax rates would rise for all taxpayers by the end of 2012, while more would be swept up by the AMT. As there is bipartisan opposition to these tax increases and they are thus widely expected not to occur, CBO

14. See "Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System," Congressional Research Service, August 6, 2010; and "The Alternative Minimum Tax for Individuals," Congressional Research Service, August 23, 2011.

publishes an “alternative fiscal scenario” in which Congress acts as expected to avoid them, resulting in substantially lower projected revenue collections than under current law.

To display a range of realistic fiscal effects for the ACA, this paper will present a set of alternative scenarios analogous to the methods employed by CBO for income tax law. The first optimistic scenario assumes that all future cost-savings now enshrined in the ACA will be fully realized, including those that it is suspected may become politically implausible (and also including some additional savings not scored by CBO). The optimistic scenario is not a best-case scenario in the sense that it accepts CBO’s economic and behavioral projection assumptions, but it could be thought of as best case with respect to legislative risk.

That this scenario truly represents the best case from a legislative risk perspective has been amply testified to by the nonpartisan scorekeepers of both Congress and the federal Executive Branch. Each has taken pains to warn lawmakers that the provisions of the ACA intended to produce budgetary savings ultimately may be less than fully effective. In its score of health care reform, CBO warned that the law would “put into effect a number of policies that might be difficult to sustain over a long period of time.” Later in the same paragraph, it singled out payment reductions to physicians and other providers, as well as savings to be produced by the legislation’s Independent Payment Advisory Board (IPAB), as examples of such policies that might be difficult to sustain.¹⁵ The CMS Medicare Actuary also opined that projected Medicare savings under the ACA “may be unrealistic.”¹⁶

The second, mixed-outcome scenario assumes that future Congresses will pull back slightly on certain future austerity measures, though by less than has been done with several comparable processes in the past. A third, more pessimistic scenario shows the consequences of Congresses ultimately acting to overturn certain savings provisions under the ACA in a manner relatively consistent with historical precedent.

15. CBO, “H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation),” March 20, 2010. This study does not include an analysis of the financing risk associated with likely legislative overrides of the SGR formula for Medicare physician payments. Under literal current law, payments for physicians under Medicare would drop by over one-quarter upon the next expiration of the most recent temporary legislative override, an outcome that faces strong bipartisan opposition. While there is general bipartisan agreement that the SGR payment formula under current law should be overridden, there is less unanimity on whether the costs of the higher payments should be added to the federal deficit or offset with other cost-savings. When the ACA was developed, the Obama administration’s position was that the cost of higher physician payments would be added to the deficit, giving rise to the critical observation that when the total effects of the administration’s health policies were tabulated, the net budgetary impact would be significantly worse than shown in the CBO analysis of the ACA alone. Since then, the administration has modified its position to favor offsetting at least part of the cost of higher Medicare physician payments. It is impossible to know with certainty how the political economies of the SGR debate might today be quantifiably different in the absence of the ACA, and for this reason the costs of overriding the SGR formula are not analyzed within this study.

16. Memorandum, Richard Foster, “Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended,” Centers for Medicare and Medicaid Services, April 22, 2010.

This is by no means a worst-case scenario, in that it accepts various assumptions made by CBO that could well turn out to have been fiscally optimistic. The intermediate position of the mixed-outcome scenario is not intended to imply a higher level of probability than the other two scenarios, but rather simply one in which roughly half of the policy risk embodied in the pessimistic scenario materializes.

The projected range of possible fiscal outcomes under these scenarios is shown in table 1.

TABLE 1. FISCAL EFFECTS OF THE AFFORDABLE CARE ACT

	Optimistic Scenario	Mixed-Outcome Scenario	Pessimistic Scenario
ACA Effect on Federal Spending, 2012–2021 (Cumulative, \$B)	+1,160	+1,204	+1,242
ACA Effect on Federal Budget Balance, 2012–2021 (Cumulative, \$B)	–346	–439	–527

Note: The figures pertaining to the effects on budget balances are positive if they improve the budget outlook and negative if they worsen deficits.

Under all six scenarios in table 1, reflecting a variety of alternative assumptions, the ACA would both substantially increase federal spending and worsen federal deficits, thereby considerably worsening the fiscal outlook by any applicable measure. The derivation of the figures above is provided in the following sections of this study.

THE USE OF MEDICARE SAVINGS TO FINANCE A NEW HEALTH ENTITLEMENT

THE ACA CONTAINS several provisions that would substantially increase federal health care expenditures. Among others, these include provisions to provide federal subsidies for health insurance coverage under newly established exchanges and to expand eligibility for Medicaid and the Children’s Health Insurance Program (CHIP), two federal health entitlements for the poor.

The legislation also included provisions to offset the costs of these coverage expansions. Prominent among these are provisions to constrain the growth of costs in the (already existing) Medicare program. The relationship between these respective provisions has important implications for whether the ACA will improve or worsen the federal fiscal outlook. To conduct a thorough analysis, certain federal budget concepts must be clearly understood.

First: the Medicare program is financed from special, separate trust funds. Medicare is only permitted to spend money to the extent that there is a positive balance in these trust funds. For example, if legislation creates new cost savings in the Medicare Hospital Insurance (HI) program, the HI Trust Fund’s solvency is thereby extended along with its authority to pay benefits (see appendix A, page 46).

Second: the Medicare savings in the ACA were a principal reason the legislation

was scored as having a positive effect on the federal budget. Near the time of its enactment, CBO scored the ACA's net unified budget effect as a positive \$124 billion over the 2010-19 period.¹⁷ This improvement was more than accounted for by the savings taken from Medicare alone, which the CMS Medicare Actuary's office estimated at a net of \$575 billion over the same period.¹⁸ Were it not for the fact that these Medicare savings were scored as a pure fiscal gain for the federal government, the ACA would have been scored as worsening the federal fiscal outlook.

The Medicare savings provisions in the ACA were also then scored as extending the solvency of the Medicare HI Trust Fund from 2017 to 2029.¹⁹ (An updated 2011 estimate quantified the solvency extension as being from 2016 through 2024.)²⁰ Because the same Medicare savings that were being credited for extending the solvency of Medicare were also being used to finance a new health entitlement, the ACA's supporters were accused of "double-counting." A passage from the CMS Medicare Actuary's April 2010 memorandum encapsulates the concern:

The combination of lower Part A costs and higher tax revenues results in a lower Federal deficit based on budget accounting rules. However, trust fund accounting considers the same lower expenditures and additional revenues as extending the exhaustion date of the HI trust fund. In practice, the improved HI financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions.²¹

CBO explained this phenomenon in a January 22, 2010, letter. The bill under consideration at that time would have reduced publicly held debt by \$132 billion over 10 years, but also resulted in an additional \$358 billion being credited to the Medicare HI Trust Fund. As CBO wrote, "[T]he act's effects on the rest of the budget—other than the cash flows of the HI Trust Fund—would amount to a net *increase* in federal deficits of \$226 billion over the same period."²²

Much of the public discussion of this matter involved both accusations and denials of double counting and debate over the advisability of spending solely

17. CBO, "H.R. 4872, Reconciliation Act of 2010."

18. Foster, "Financial Effects of the Patient Protection and Affordable Care Act."

19. Memorandum, Solomon M. Mussey, "Estimated Effects of the 'Patient Protection and Affordable Care Act,' etc.," Centers for Medicare and Medicaid Services, April 22, 2010.

20. Centers for Medicare and Medicaid Services (CMS) Office of Public Affairs, "Trustees' Report Shows Medicare Remains Viable, but Challenges Remain," news release, May 13, 2011.

21. Foster, "Financial Effects of the Patient Protection and Affordable Care Act."

22. CBO to Senator Jeff Sessions, letter regarding additional information on the effect of the Patient Protection and Affordable Care Act on the Hospital Insurance Trust Fund, January 22, 2010 (emphasis in the original).

needed Medicare cost savings on a new health entitlement. But this issue, properly understood, involves much more: it cuts to the heart of the question of how the legislation will affect the broader federal fiscal outlook.

A full understanding of the ACA's budget effects requires appreciation of the distinction between two important points:

1. CBO found that the ACA would reduce federal deficits when a *specific scoring convention* was applied;
2. The same analysis shows implicitly that the ACA would substantially increase federal deficits *relative to previous law*.

Some additional background may be required to fully understand the distinctions between these two statements. Many budget scorekeeping conventions, including those of CBO as well as the Social Security and Medicare Trustees, assume that scheduled benefit payments for such programs as Social Security and Medicare will be fully honored, even if under actual law lower benefits would be paid as a consequence of the projected depletion of the Social Security and Medicare HI Trust Funds.

The prevailing scoring convention serves a number of important purposes. Among other things, it quantifies the gaps between scheduled benefits and scheduled revenues for policymakers. By contrast, a hypothetical alternative treatment in which these shortfalls were always shown as being resolved by the trimming of benefits upon Trust Fund depletion would show much of the fiscal picture correcting automatically. This would understate the real-world policy problem to be solved while also depicting a scenario policymakers are unlikely to find desirable, plausible, or useful to their decision-making.

Useful though this scorekeeping convention is, it does not represent the law. Under law, neither Social Security nor Medicare can make benefit payments in the absence of a positive balance in their Trust Funds.²³ Under current law, for example, Social Security benefits would be cut sharply in 2036 and Medicare HI payments in 2024 under 2011 projections.²⁴

23. The text of the Social Security Act stipulates that benefit payments "shall be made only" from the program's trust funds. *Social Security Act*, Public Law 74-271, 74th Cong., 1st sess. (August 14, 1935), § 401. The limitations on benefit expenditures upon Medicare HI Trust Fund depletion are described in Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, DC: U.S. Government Printing Office, 2011), 26. "If assets were exhausted, payments to health plans and providers could only be made from ongoing tax revenues, which would be inadequate to cover total costs."

24. The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2011 Annual Report of the Boards of Trustees*; and Board of Trustees, Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, *The 2011 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds* (Washington, DC: U.S. Government Printing Office, 2011).

As an example of this scorekeeping convention in action, consider the Social Security Trustees' report. It shows the cost of scheduled benefits rising permanently above 17 percent of taxable wages by the year 2070, even though under literal current law this level of benefits would not be paid. This presentational convention enables policymakers to see the full gap between benefits and revenues that must be addressed, even though in a literal sense current law would automatically correct this imbalance via sudden, sharp benefit cuts in 2036.

What this all amounts to is that the ACA, as analyzed by both CBO and the CMS Medicare Actuary, would worsen the fiscal outlook relative to previous law. The savings envisioned within Medicare under the ACA would not only be used to finance a new health entitlement, but would also result in an expansion of the spending authority of the Medicare Part A (HI) Trust Fund. The combination of these two effects exceeds the cost-saving measures in the legislation. This results in the worsening of federal deficits relative to previous law.

This use of the ACA's Medicare savings to extend Medicare HI solvency and thus expand its spending authority is acknowledged and often praised by the legislation's supporters. To take but one example, Congressmen Henry Waxman and Frank Pallone wrote in a January 18, 2011, "Dear Colleague" letter that the legislation "strengthens the Medicare trust fund, extending its solvency from 2017 to 2029."²⁵ To the extent that this is true, however, the legislation necessarily also expands the spending authority of Medicare in ways not accounted for under the scoring conventions that show positive budgetary effects of the legislation.

To point out that the oft-cited CBO analysis is based on a scoring convention rather than on a literal reading of law should not be construed as a criticism of the methodology of the CBO or of the Medicare trustees (of whom this author is one).²⁶ There are many reasons the CBO's and trustees' scoring convention is appropriate in many circumstances. Among these reasons is that without it, policymakers would not receive appropriate credit for tough choices made to correct the fiscal imbalances of Social Security and Medicare and would thus be less likely to make them. If Congress were to enact comprehensive Social Security reforms to eliminate the imbalance between the program's scheduled benefits and taxes, they would get far less scorekeeping credit for this important action under a true current law baseline. Without the usual scoring convention, both CBO and the trustees would effectively assume that the program's imbalance vanishes by itself as a result of benefit cuts upon Trust Fund depletion.

Useful or not, however, the fact remains a good portion of the Medicare savings under the ACA are not net new savings but substitutions for other savings required

25. Representatives Henry Waxman and Frank Pallone to congressional colleagues, letter regarding the ramifications of repeal, January 18, 2011, accessed March 6, 2012, <http://democrats.energycommerce.house.gov/index.php?q=news/impact-of-repealing-health-care-reform>.

26. The two public trustee positions were vacant at the time the ACA was scored and enacted. The author's term of service began later in 2010.

under previous law. Perhaps the best and most accurate way to think through the issue is to appreciate that were it not for the Medicare savings in the ACA, other Medicare savings measures would have been necessary under prior law to avert HI Trust Fund insolvency.

Specifically, were it not for these provisions, one of two other things would have happened:

1. The Medicare HI Trust Fund would have been depleted in 2017 (or 2016, under updated estimates), thereby reducing benefit payments and costs, or
2. Other Medicare savings would have had to be found.

In this context, the Medicare savings in the ACA are not “found money” for the federal government, free to be spent on a new health entitlement without worsening the deficit. This is why, when comparing the ACA not to a common scoring convention but to the actual change in law, a worsening of both federal costs and of federal deficits results.

It is important to understand that this is not simply a technical point of reading the letter of the law in a way disconnected from real-world events. Historical patterns of political behavior demonstrate that lawmakers are much less likely to address cost growth in Medicare (or Social Security) when the program is deemed to be solvent. Whenever the solvency of one of these programs is further extended, the political imperative for change is diminished and more spending occurs as a result. Both by statute and as a matter of political economy, the ACA worsens the fiscal outlook.

There is an important distinction to be made here between Medicare parts A, B, and D. Medicare parts B and D are essentially deemed solvent by statutory construction. Each year, they are annually provided with general fund revenues sufficient to maintain a positive Trust Fund balance. As a result, any savings under the ACA in Medicare parts B and D do improve federal finances relative to previous law. It was not otherwise required that they be enacted.

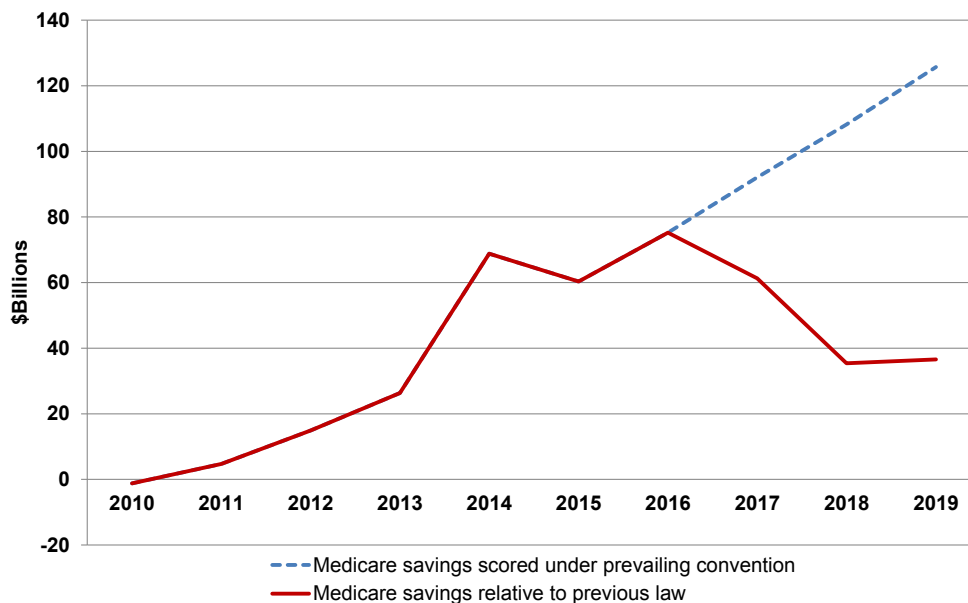
By contrast, much of the ACA’s savings in Medicare Part A (HI) extends the spending authority of that part of Medicare, and in effect displaces savings that must otherwise occur.²⁷ Figure 2 shows the Medicare savings projected by the CMS Medicare Actuary’s office (in 2010) under the ACA.²⁸

An Actuary’s memorandum of 2010 indicates that in the absence of the ACA, the Medicare HI Trust Fund would be insolvent in 2017. Prior to this projected depletion

27. In theory, Congress could choose to bail out the Medicare Part A Trust Fund with commitments of general revenues without improving the unified budget balance, but this is not provided for under current law, unlike the case with Medicare parts B and D.

28. Foster, “Financial Effects of the Patient Protection and Affordable Care Act.” I refer to the Actuary’s analysis for two reasons: one, because these estimates are the basis for the trustees’ projections for Medicare, the statutorily sanctioned mechanism for projecting Medicare finances. Second, because the Actuary’s memorandum provides more detail than the CBO publications with respect to the division of projected savings between Medicare parts A, B and D. I will perform an adjustment at the end of these calculations to more closely align these estimates with the CBO’s as they are folded into the CBO’s unified budget analysis.

FIGURE 2. MEDICARE SAVINGS UNDER THE ACA (2010 PROJECTIONS)



Source: CMS Medicare Actuary and the author's calculations

date, Medicare HI would be solvent under either scenario (with or without the ACA), so the pre-2017 Medicare savings under the ACA contribute positively to the unified budget balance relative to previous law. Starting in 2017 and continuing through the end of the 2019 budget window over which the ACA was originally scored, Medicare HI Trust Fund depletion would have prevented full payment of Medicare obligations in the absence of the ACA's (or alternative) Medicare savings provisions.

This information can be used to construct a rough estimate of the Medicare expenditure reductions that would have occurred by law starting in 2017 had the ACA not been passed—or, put another way, the amount of ACA Medicare savings that were already required to occur under previous law. Subtracting these savings from those credited under the prevailing scoring convention produces an estimate of the net Medicare savings under the ACA relative to the previous-law baseline.²⁹

By this calculation, roughly \$190 billion³⁰ of ACA Medicare savings were already required to occur under previous law, resulting in total net Medicare savings under the ACA through 2019 of approximately \$380 billion, based on the 2010 analysis.

29. To simplify the calculation, it is assumed that under pre-ACA law HI insolvency would have occurred midyear in 2017.

30. The exact calculation finds \$192.7 billion, rounded here to two significant digits to acknowledge imprecision.

CBO's updated 10-year valuation window, however, extends through 2021. With the addition of two further years, ACA's reliance on projected Medicare savings becomes even more significant. Updated data also show a much larger effect of substituting for previously required savings, as opposed to creating net new savings.

Updated estimates indicate that in the absence of the ACA, HI insolvency would have been reached in 2016; this by itself means that a larger proportion of the ACA's Medicare expenditure reductions would otherwise have been required to occur. A close inspection of the updated projections in the 2011 Medicare Trustees' Report also reveals that HI cash flows over the 2016-2021 period are now expected to be significantly less favorable than projected in 2010. This means required expenditure reductions would have been significantly deeper under previous law, i.e., in the absence of the ACA's Medicare savings provisions.

Using updated analysis and trend lines provided by CBO in February, 2011, we can extrapolate forward the growing effects of Medicare savings anticipated under the ACA through 2021.³¹ Based on this, we arrive at an updated estimate of the total amount of Medicare savings anticipated through 2021 under prevailing conventions (\$850 billion),³² of the amount of this that displaces previously-required savings (\$560 billion),³³ and of the net 10-year Medicare savings under the ACA relative to previous law (\$290 billion).³⁴ (See figure 3.)

Calculations thus far have been based upon the Medicare savings projected for the ACA by the CMS Medicare Actuary.³⁵ To incorporate this analysis into the larger unified budget analysis performed by CBO, a downward adjustment to all of these figures is needed to be consistent with CBO's other projections. This produces the conservative estimate that over \$470 billion of the Medicare savings under the ACA scored by CBO through 2021 substitutes for savings required under previous law.³⁶ (The same calculation through 2019, under 2010 assumptions, produces a figure of roughly \$160 billion in duplicated savings).

A similar analysis can be performed specifically with respect to the spending aspects of the legislation (exclusive of revenues), pursuant to the earlier point that fiscally successful health care reform must not only reduce deficits but the size

31. CBO, "H.R. 2, Repealing the Job-Killing Health Care Law Act: Cost Estimate for the Act as Passed by the House of Representatives on January 19, 2011," February 18, 2011.

32. The calculated figure of \$851.7 billion is rounded in the text to reflect imprecision.

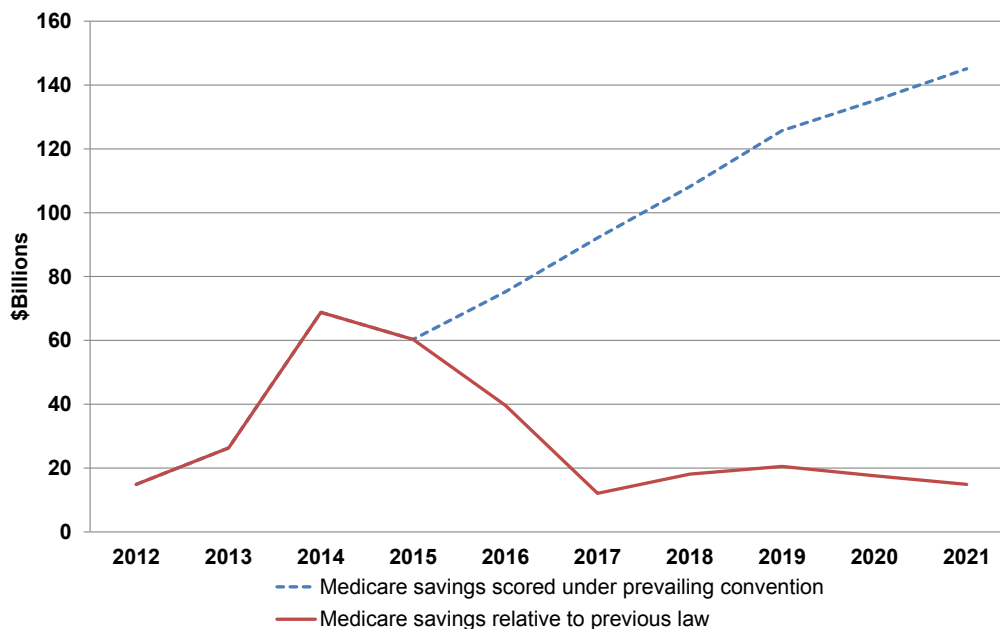
33. The calculated figure of \$558.5 billion is rounded in the text to reflect imprecision. Once again, to simplify, it is assumed that insolvency in the absence of the ACA would occur midyear in 2016.

34. The calculated figure of \$293.2 billion is rounded in the text to reflect imprecision.

35. The calculations were based on the CMS Medicare Actuary through 2019. For 2020-21 the CMS-published figures are extrapolated.

36. The adjustment is performed as follows. First, the April 22, 2010, memorandum of the CMS Medicare Actuary was referenced for its estimates of annual Medicare savings under the ACA. As explained in a previous footnote, this memorandum was used in part because of the necessity of distinguishing

FIGURE 3. MEDICARE SAVINGS UNDER THE ACA (UPDATED FOR 2011 DATA)



Source: Author's calculations based on CBO and CMS Actuary projections

of the federal commitment to health care. CBO's 2010 analysis projected that the health care law would add \$401 billion to total federal outlays through 2019; its updated 2011 analysis found that it would add \$604 billion to total outlays through 2021.³⁷ These figures would have been roughly \$160 billion and \$475 billion higher, respectively, if outlay reductions already required in Medicare under previous law had not been counted as new savings.

... continued. Medicare savings in Part A (which in part displace savings required under previous law) from those in parts B and D (for which no similar savings were required under previous law to maintain solvency). Some of these savings (for example, payments for home health, various market basket updates, and IPAB) are not broken down between Medicare Trust Funds in comparable detail in the publicly available CBO scoring. The total Medicare-wide savings as scored by the CBO and CMS under these various provisions was then compared to produce the finding that the CBO forecast roughly 85 percent as much savings under commonly analyzed provisions through 2019 as did CMS. Because the CBO's net unified budget analysis was performed on the basis of the CBO's estimates of net Medicare savings, the estimate of "displaced savings" in Medicare Part A was thus reduced by 15 percent relative to CMS's estimates to provide consistency.

37. House Subcommittee on Health, Committee on Energy and Commerce, *Douglas W. Elmendorf: CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*, 112th Cong., 1st sess., March 30, 2011. Though published with the March analysis, the figures are taken from the February 2011 CBO analysis and are thus consistent with the estimates provided earlier in this section.

THE CLASS PROGRAM

THIS STUDY NOW turns to a review of various provisions of the ACA that were scored as having positive fiscal effects, analyzing the risks—and, in at least one case, the near certainty—that these provisions will ultimately produce less cost savings than originally scored. Notable among these are provisions contained within the ACA to establish a new federal entitlement program providing insurance for long-term care, the Community Living Assistance Services and Support program (CLASS).

From the start, the financial design of the CLASS program was widely criticized as fundamentally flawed. The CMS Medicare Actuary’s office wrote that “voluntary, unsubsidized, and non-underwritten insurance programs such as CLASS face a significant risk of failure as a result of adverse selection by participants” and that “there is a very serious risk that the problem of adverse selection will make the CLASS program unsustainable.”³⁸ Similarly, the American Academy of Actuaries wrote upon the original bill’s introduction that it “will not only be unsustainable within the foreseeable future, but [is] unlikely to cover more than a very small proportion of the intended population.”³⁹ These are but two examples of a broad, bipartisan analytical consensus that the CLASS program would be financially unworkable.

The CLASS provisions in the ACA also contain language inserted at the initiative of U.S. Senator Judd Gregg (R-NH), requiring that the Secretary of the Department of Health and Human Services (HHS) certify the long-term actuarial soundness of CLASS as a condition of implementation. The HHS analysis released pursuant to this provision on October 14, 2011, concluded that adverse selection “would cause the program to quickly collapse.”⁴⁰ HHS Secretary Kathleen Sebelius thereupon announced that “we have not identified a way to make CLASS work,” and that HHS would therefore “suspend work” on implementing it.⁴¹

It is now assumed for budget scorekeeping purposes that the CLASS program will not be revived. On October 31, 2011, CBO wrote to Senator John Thune (R-SD) to state that “CBO considers the October 14 announcement to be definitive new information, and in its next baseline projections (which will be issued in January), CBO will assume that CLASS will not be implemented unless there are changes in law or other actions by the Administration that would supersede the Secretary’s announcement.”⁴²

38. Foster, “Financial Effects of the Patient Protection and Affordable Care Act.”

39. American Academy of Actuaries and Society of Actuaries to members of Congress, letter: “Re: Actuarial Issues and Policy Implications of a Federal Long-Term Care Insurance Program,” July 22, 2009, accessed March 6, 2012, http://www.actuary.org/pdf/health/class_july09.pdf.

40. Kathy Greenlee to Secretary Kathleen Sebelius, memorandum on the CLASS program, October 14, 2011.

41. Secretary Kathleen Sebelius, “The CLASS Program,” *The Huffington Post*, October 14, 2011, accessed March 6, 2012, http://www.huffingtonpost.com/sec-kathleen-sebelius/the-class-program_b_1011270.html?view=print&comm_ref=false.

42. CBO to Senator John Thune, letter regarding the removal of the CLASS program from the CBO baseline, October 31, 2011.

Despite wide understanding that the CLASS program was financially unsound, it had been scored as contributing a positive budgetary effect over the first 10 years of the ACA, both in the original 2010 CBO score and in its updated 2011 estimates. Of the \$124 billion in net positive budgetary impact originally scored for the ACA over 2010–19, \$70 billion was attributed to the CLASS program (see figure 4).⁴³

Of the ACA’s \$210 billion positive impact over 2012–21 in CBO’s updated 2011 estimate, \$86 billion is attributed to CLASS (see figure 5).⁴⁴

The expressed justification for this positive budgetary treatment was that CLASS would initially attract some premium payments before untenable long-term costs began to overwhelm the program. As CBO stated in a November 25, 2009, letter, “the Congressional Budget Office (CBO) estimates that the cash flows under the new program would generate budgetary savings (that is, a reduction in net federal outlays) for the 2010–2019 period and for the 10 years following 2019, followed by budgetary costs (an increase in net federal outlays) in subsequent decades. Because participation in the program would be voluntary, collections of insurance premiums under CLASS would be recorded as offsetting receipts (a credit against direct spending).”⁴⁵ The CMS Medicare Actuary agreed that the program would have a positive (if smaller) budget impact over its first 10 years while anticipating that it would run annual deficits by 2025.⁴⁶

It was well understood at the time of ACA’s passage that the insertion of CLASS was motivated partly by a desire to show a positive fiscal impact over the first 10 years for the ACA as a whole. As columnist Albert R. Hunt reported in October 2009:

In the early private talks, there are two major revenue-raisers mentioned to bring in as much as \$100 billion. One is to reduce the \$81 billion surplus the Congressional Budget Office projects the Senate Finance Committee bill passed last week would raise over the next decade. The other is to adopt a long-term individual health-care plan promulgated by the late Senator Edward M. Kennedy of Massachusetts, the so-called CLASS, or Community Living Assistance Services and Supports, Act. This would enable individuals to voluntarily put a small portion of their paychecks into a

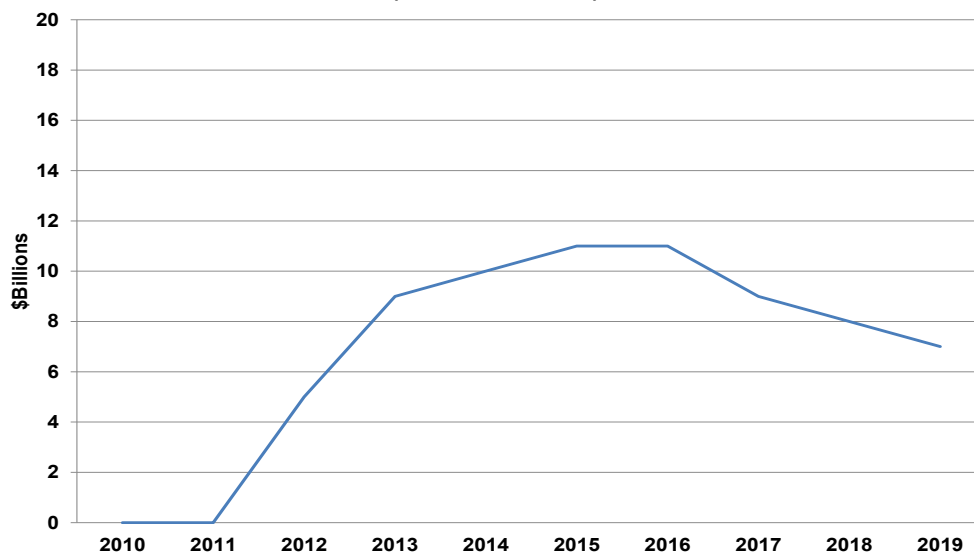
43. CBO, “H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation).”

44. CBO, “Repealing the Job-Killing Health Care Law Act.” This was later lowered slightly to \$83 billion in a March CBO analysis. The \$86 billion figure is used here for consistency with figures cited earlier in this study from the February CBO estimates and also because it was published in annual increments.

45. CBO to Representative George Miller, letter containing additional information on CLASS program proposals, November 25, 2009. CBO stated in the same letter that a Senate version of the bill would reduce federal outlays by about \$72 billion over 10 years, \$88 billion from premium collections and \$2 billion in Medicaid spending reductions versus \$14 billion in new benefit payments and \$3 billion in administrative costs.

46. Foster, “Financial Effects of the Patient Protection and Affordable Care Act.”

FIGURE 4. BUDGET SAVINGS ATTRIBUTED TO CLASS (2010 CBO SCORE)



Source: CBO

government fund that eventually would pick up long-term health care for them. Over the next decade it would raise money both because of the fee and because less would be spent on Medicaid and Medicare.⁴⁷

CLASS is no longer expected to be implemented and thus no longer expected to make a positive contribution to the ACA's fiscal effects. An accurate projection of the law's net fiscal impact must therefore subtract the positive contributions originally attributed to the CLASS program. Figure 6 shows the effects of updating the 2011 CBO score of the ACA based on the suspension of the CLASS Program.⁴⁸ The depiction reflects the CBO scoring convention (as opposed to scoring relative to prior law) and represents an optimistic scenario in which all of the ACA's cost-savings materialize as envisioned. In figure 6, a positive score means the legislation improves the budget balance and reduces the federal deficit.

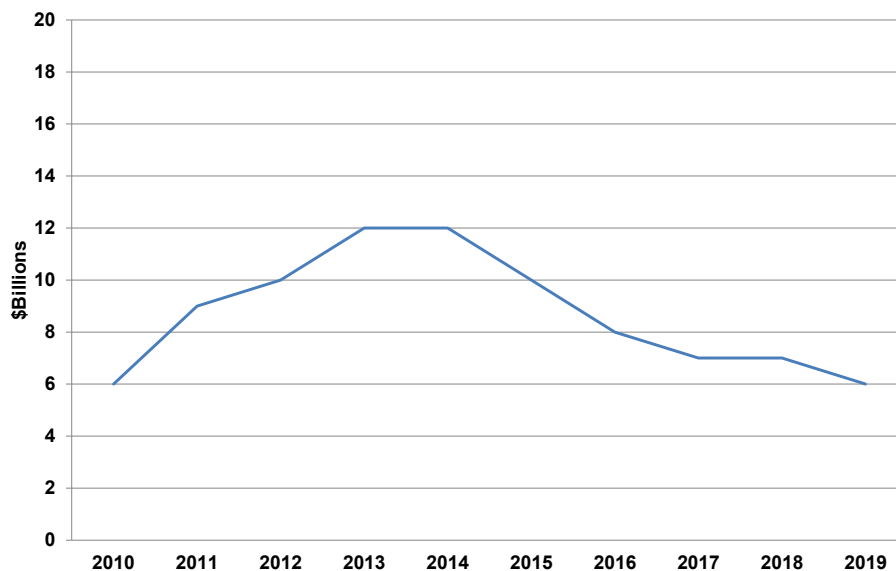
FEDERALLY SUBSIDIZED HEALTH INSURANCE EXCHANGES

PERHAPS THE MOST fiscally significant provision of the ACA establishes federal subsidies for many individuals to buy health insurance in state-established exchanges. According to a 2011 CBO analysis, the total budgetary effect of the exchange subsi-

47. Albert R. Hunt, "A Roadmap to Health-Care Overhaul by Christmas," *Bloomberg*, October 18, 2009.

48. Numbers reflect the February 2011 CBO analysis, consistent with earlier sections of this study.

FIGURE 5. BUDGET SAVINGS ATTRIBUTED TO CLASS (2011 CBO SCORE)



Source: CBO

dies and related spending will total \$777 billion from 2012–21, more than any other aspect of the legislation.⁴⁹ These subsidies include refundable tax credits toward premium payments under exchange plans and cost-sharing subsidies that limit individual out-of-pocket costs.

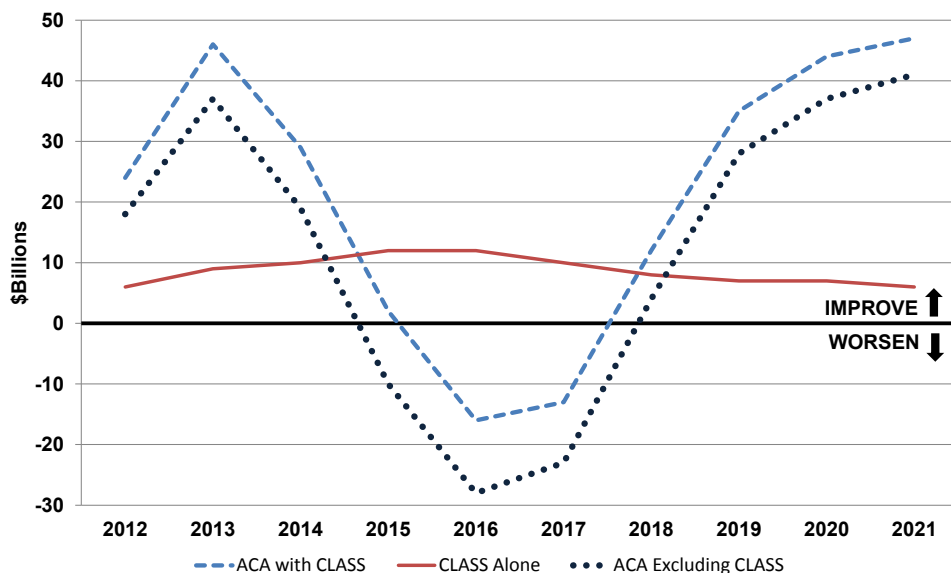
These subsidies are generally available to individuals with incomes between 100 and 400 percent of the Federal Poverty Line (FPL).⁵⁰ Detailing the full schedule of these subsidies is beyond the scope of this study, but in general the premium subsidies limit the percentage of an individual’s income that can be paid in premiums, with the maximum percentage rising as a function of the individual’s income relative to the FPL. An individual at 133 percent of the FPL could not face a premium exceeding 2 percent of his or her household income for a so-called “silver” health plan, whereas an individual at 400 percent of the FPL could not face a premium exceeding 9.5 percent of household income for such a plan.⁵¹ An individual with an

49. House Subcommittee on Health, Committee on Energy and Commerce, *Douglas W. Elmendorf: CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010*. Though it did not do so for several other provisions of the ACA, CBO updated its projections for health exchange subsidy costs from February to March 2011. The updated figures are cited here.

50. That is, provided that the individual is not qualified for Medicaid or CHIP, certain other health benefits, or “affordable” employer-sponsored coverage.

51. The legislation defines bronze, silver, gold, and platinum levels of coverage. These designations are a function of the percentage of medical expenses covered by the insurer. The premium maximums described in the paragraph pertain to the second lowest-cost silver plan available to the individual. The legislation also defines household income in terms of modified gross incomes of the taxpayer and other family members.

FIGURE 6. BUDGET EFFECT OF THE ACA UNDER CBO SCORING CONVENTION (2011 CBO SCORE)



Source: CBO.

Note: The figures above are positive if they improve if they improve the budget outlook and negative if they worsen deficits.

offer of employer-based coverage would be ineligible for such subsidies unless the employment-based offer was deemed “unaffordable”—for example, if it required the worker to pay more than 9.5 percent of income in premiums to receive it or if the plan’s payments covered less than 60 percent of total allowed costs.⁵²

Federal cost-sharing subsidies, which limit the potential out-of-pocket costs of the insured individual, would likewise be a function of income. An individual with income under 150 percent of the FPL, for example, could receive subsidies that reduce out-of-pocket limits by two-thirds, whereas an individual with income of 400 percent of the FPL could receive subsidies reducing the out-of-pocket limit by one-third.⁵³

The provision of federal subsidies to low-income purchasers of health insurance represents a substantial further fiscal commitment of the federal government. Current projections for the size of this fiscal commitment are subject to at least two forms of financing risk:

1. The risk that participation by subsidy-eligible individuals will be higher than currently estimated, and

52. House Subcommittee on Health, Committee on Energy and Commerce, *Douglas W. Elmendorf: CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010*.

53. Congressional Research Service, “Private Health Insurance Provisions in PPACA (P.L. 111-148),” April 15, 2010.

2. The risk that elected officials will choose to expand the growth of these subsidies in the future relative to projections under current law.

Both of these risks are substantial.

The first source of financing risk—participation rates—is subject to considerable projection uncertainty. During and after the passage of the ACA, an ample body of literature developed with widely divergent projections for changes in future levels of employer-sponsored insurance (ESI) under the ACA and for participation in the newly established exchanges.

This difficult projection task bears important implications for estimating the total costs of the ACA. To the extent that employers choose to drop offers of health insurance coverage and to accept a modest penalty of \$2,000 per employee, more low-income individuals will lack offers of affordable ESI coverage and the costs of exchange subsidies will increase.⁵⁴ The fiscal and behavioral effects involved are complex and beyond the capacity of forecasters to model with precision. On the behavioral side, there will be mutual feedback between the decisions of employers and employees, as individual decisions to gravitate to the exchanges will influence employers' decisions with respect to the maintenance of coverage for other employees and vice versa. Some fiscal effects will also be offsetting, as higher federal direct spending as a consequence of higher exchange participation should also be reflected in lower ESI-coverage rates and thus a higher proportion of employee compensation received in the form of taxable wages.

Much of the public debate surrounding the future of ESI pertained to whether individuals would be able to keep their current health plans (as the ACA's supporters asserted) or whether this would be rendered impossible by a decline in future ESI offers. This was an important discussion, connected to fundamental value judgments about whether the employer-based system should retain its central role in how Americans finance their health care. For the purposes of this study, this author takes no position on whether it is preferable that individuals receive health insurance through their employers or as individual purchasers. Instead, I focus solely on the fiscal consequences of movement from the ESI system to the newly established exchanges.

Although the literature concerning participation rates is diverse, it is a fair synopsis of it to note that CBO foresees comparatively little net movement into the exchanges from ESI relative to the expectations of employer associations and right-of-center economists. CBO projects that ESI coverage will decrease by a net of 1 million through 2021 relative to the prior-law baseline. It arrives at this figure by projecting that roughly 6–7 million individuals who would have had an ESI offer under previous law would no longer have it (this loss mostly involves small employers and employers of low-income individuals eligible for exchange subsidies), while

54. Foster, "Financial Effects of the Patient Protection and Affordable Care Act."

another 1–2 million with an ESI offer would nevertheless move to the exchanges. Moving in the other direction, 7–8 million individuals who wouldn't have had an ESI offer are projected to have one after the enactment of ACA (a combined effect of the legislation's mandates, tax credits and employer penalties).⁵⁵

CBO acknowledges that some other forecasters foresee a greater impact of ACA in reducing ESI coverage and stimulating movement into the new federally subsidized exchanges. (“Some commentators have expressed surprise that CBO and JCT do not expect a much larger reduction in employment-based insurance coverage owing to PPACA and the Reconciliation Act, in light of the expansion of the eligibility for Medicaid and the subsidies for individual insurance coverage created by that legislation.”)⁵⁶ An analysis by former CBO Director Douglas Holtz-Eakin, for example, found that the legislation created powerful incentives for employers to drop coverage, especially for employees with incomes below 250 percent of the FPL, with the potential result that the federal cost of the exchanges could be many times larger than projected.⁵⁷ A much-publicized analysis of a survey by the National Federation of Independent Businesses also found that 26 percent of small employers were “very likely to explore” dropping their health insurance plans if their employees begin to leave for the exchanges.⁵⁸ A McKinsey study anticipated even more dramatic consequences in which 30 percent of employers “will definitely or probably stop offering ESI in the years after 2014.”⁵⁹

On the other hand, other studies echo CBO in foreseeing only minor shifts away from ESI and into the exchanges. A June 2011 Avalere study projected that “the overall ESI market will remain relatively stable after 2014.”⁶⁰ The importance of this projection controversy to the overall impact of the ACA is reflected in the sheer number of such studies, which in addition to those cited here include timely

55. House Subcommittee on Health, Committee on Energy and Commerce, *Douglas W. Elmendorf: CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*. CBO's projections of movement away from ESI were slightly higher in its February 2011 analysis.

56. *Ibid.*

57. Douglas Holtz-Eakin and Cameron Smith, “Labor Markets and Health Care Reform: New Results,” *American Action Forum*, May 2010.

58. National Federation of Independent Business Research Foundation, “Small Business and Health Insurance: One Year after Enactment of PPACA,” July 2011.

59. Shubham Singhal, Jeris Stueland, and Drew Ungerman, “How US Health Care Reform Will Affect Employee Benefits,” *McKinsey Quarterly*, June 2011.

60. Avalere Health LLC, “The Affordable Care Act's Impact on Employer Sponsored Insurance,” June 2011.

publications of the Urban Institute, Rand Corporation, the Lewin Group, Booz & Company, Mercer, Towers Watson, and Aon Hewitt.⁶¹

CBO currently projects that by 2019, 24 million people will be receiving subsidized coverage under the exchanges (with another 4 million receiving unsubsidized coverage).⁶² In light of the diverse projections of other forecasters, it is clear that this projection is subject to substantial uncertainty. It is but a modest accounting for such uncertainty to place the participation assumptions of the CMS Medicare Actuary alongside CBO's assumptions. The CMS Medicare Actuary projects that 31.6 million individuals will receive coverage under the exchanges by 2019, 25 million of whom will receive federal subsidies.⁶³

For modeling purposes, I use CBO's participation assumptions for the optimistic fiscal scenario and the CMS Medicare Actuary's for the pessimistic scenario, with assumptions for the mixed-outcome scenario located halfway between. This range of uncertainty does not come close to reflecting the full range of opinions of other forecasters, but purposely models a very narrow range so as to reflect only the possibilities seen as realistic by nonpartisan government scorekeepers and also to implicitly adjust for the aforementioned offsetting fiscal effects of wider divergences in participation.⁶⁴ This modest range also does not account for potential variation in the age and income profiles of the population covered under the exchanges, both of which would affect total federal outlays for subsidies. The results here will nevertheless capture but a fraction of the potential fiscal uncertainty arising from the ACA's health exchange subsidy provisions.

Beyond participation rates and profiles, the other major financing risk is political: the risk that future elected officials will be unwilling to uphold the constraints upon the exchanges' cost growth that are the basis of current projections for the ACA.

61. See Bowen Garrett and Matthew Buettgens, "Employer-Sponsored Insurance under Health Reform: Reports of Its Demise Are Premature," Urban Institute, January 2011; John Holahan and Bowen Garrett, "How Will the Affordable Care Act Affect Jobs?" Urban Institute, March 2011; Christine Eibner et al., "Establishing State Health Insurance Exchanges," *Rand Health Quarterly* 1, no. 3 (2011):12; The Lewin Group, "Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers," (Staff Working Paper No. 11, June, 2010); Gary D. Ahlquist et al., "The Future of Health Insurance," Booz & Company, January 25, 2011; Mercer, "Few Employers Planning to Drop Health Plans," November 2010; and Towers Watson, "Employers Committed to Offering Health Care Benefits Today," August, 2011.

62. House Subcommittee on Health, Committee on Energy and Commerce, *Douglas W. Elmendorf: CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*.

63. Foster, "Financial Effects of the Patient Protection and Affordable Care Act."

64. Another potential source of fiscal variation lies in changes in economic assumptions, even those such as the modifications in the CBO baseline made from February to March 2011. March estimates for participation and costs of subsidies are employed here because they are the most current available. The uncertainty analysis is conducted relative to the current CBO participation assumptions, so that when this analysis is combined with the February 2011 unified budget analysis, it subtracts out the effects of absolute changes in projected participation that would arise as a result of modifications to the economic baseline made between February and March.

American political history is replete with examples of federal entitlement programs that expand drastically in cost as individuals become dependent upon them. The original design of Social Security, for example, did not include cost-of-living adjustments, wage-indexed initial benefit growth (added in the 1970s), disability benefits, or early retirement options. All of these were added later as individuals grew reliant upon Social Security income and political pressure mounted to increase benefits, dramatically increasing program costs relative to earlier projections.

There is substantial reason to believe the health exchange subsidies under the ACA are similarly susceptible to future expansion. The subsidies are set as a percentage of total income and linked to premium levels. The text of the law states that at least through 2018, they will “be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year.”⁶⁵ In other words, if premium cost growth exceeds income growth in the near term, subsidies will be adjusted upward accordingly. But after 2018, the legislation contains a “fail-safe” provision designed to hold the total cost of the subsidies to no more than 0.504 percent of GDP.⁶⁶

As currently written, this limitation would likely cause the federal subsidies to grow less rapidly over the long term than the cost of health care and thus require low-income individuals in the exchanges to shoulder a steadily increasing percentage of their health costs. Historically, health care cost inflation has considerably exceeded per-capita GDP growth, implying that even if participation in the exchanges remained a constant share of the economy, their total costs would still rise relative to GDP. Moreover, the CMS Medicare Actuary anticipates that even in 2018 total subsidy costs would exceed the 0.504 percent threshold (0.518 percent),⁶⁷ meaning the “fail-safe” provision would be needed to constrain the growth of federal subsidy support starting immediately in 2019.

It is an open question as to how much successful political pressure would be mounted to spare low-income participants in the exchanges from paying for a rising share of their health expenses. CBO notes that “such possibilities could lead to pressure on lawmakers to adjust those policies.”⁶⁸ The assumption that the fail-safe provision will be perfectly enforced going forward, regardless of its adverse impact upon low-income beneficiaries, represents an optimistic if not unrealistic fiscal scenario.

65. *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152, 111th Cong., 2nd sess. (March 30, 2010).

66. *Ibid.*

67. Foster, “Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended.”

68. House Subcommittee on Health, Committee on Energy and Commerce, *Douglas W. Elmendorf: CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010*.

A more prudent assumption, used here in the pessimistic scenario, is that the cost of the exchanges will be permitted to rise proportionally with overall health care costs. To approximate this, the pessimistic scenario assumes that total participation in the exchange subsidies rises by 1 percent per year over 2019–21, with per-capita costs rising an additional 1.3 percent in excess of per-capita GDP. This cost rate reflects the Medicare Trustees’ assumption for national health care cost growth in the nearer portion of their long-range valuation period.⁶⁹ The mixed-outcome scenario is constructed with an assumption halfway between the optimistic and pessimistic scenarios. Putting these assumptions together results in the projection scenarios shown in table 2.

TABLE 2. PROJECTED EXCHANGE SUBSIDIES AND RELATED SPENDING (\$B)

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2012–21
Optimistic Scenario	2	2	23	55	87	104	115	123	130	137	777*
Mixed-Outcome Scenario	2	2	28	57	83	106	120	128	135	143	803*
Pessimistic Scenario	2	2	33	59	79	108	125	132	140	148	828

* Annual totals do not add due to rounding.

As previously noted, this methodology captures but a small portion of the potential projection uncertainty surrounding the ACA’s exchange subsidies. Perhaps the biggest factor the methodology fails to account for is the synergy between the two forms of financing risk present here. The first risk is that participation in the exchanges will be higher than forecast, and the second is that the subsidies will be expanded. The ACA creates a horizontal inequity between two hypothetical low-income individuals; one who purchases insurance via an exchange receives a substantial direct federal subsidy, whereas one who receives employer-provided insurance does not. This differential treatment could well lead either to the second individual’s moving into the health exchanges (thus increasing participation rates) or to the federal government expanding low-income subsidies to those with ESI (increasing costs).

Some experts have noted that the law may create an incentive for some workers to request reduced employer contributions to health insurance to render them eligible to receive the more generous federal subsidies in the exchanges.⁷⁰ The influence of such inequities upon the substantial financing risks under the ACA is barely

69. Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2011 Annual Report of the Boards of Trustees*, 204.

70. See Richard V. Burkhauser, Sean Lyons, and Kosali I. Simon, “The Importance of the Meaning and Measurement of ‘Affordable’ Under the Affordable Care Act” (National Bureau of Economic Research Working Paper No. 17279, Cambridge, MA, 2011).

taken into account in the figures presented in table 2. Perhaps more importantly, the financing risk surrounding the exchange subsidies is only dimly visible within the projection period ending in 2021. It is over the longer term that the potential for more rapid cost growth in the exchange subsidies threatens its most damaging fiscal effects.

THE INDEPENDENT PAYMENT ADVISORY BOARD

ANOTHER IMPORTANT PROVISION of ACA is the establishment of the Independent Payment Advisory Board (IPAB) within the Medicare program. The board would be charged with recommending reductions in Medicare payments sufficient to prevent overall program cost growth from exceeding a long-term rate of per-capita GDP plus 1 percent (with additional annual growth specifications in the near term).⁷¹ These recommendations would be implemented unless overridden by legislation. The legislative process for overriding IPAB recommendations would be constrained by various procedural restrictions.

Intense controversy surrounded the creation of IPAB. Its expressed purpose is to distance specific cost-saving decisions somewhat from the legislative process and thus from political pressures. This intent engendered divided reactions: support from those who believe that prudent cost-saving decisions can best be made only once they are further removed from political pressures and opposition from those who dislike the idea of critical resource allocation decisions being made comparatively unfettered by unelected officials.

This study will not wade into the larger controversy over the merits and demerits of the IPAB concept, other than to observe that it is not strictly possible to remove Medicare cost-reduction decisions from the political process as long as Medicare remains a federal program. Where government goes, politics must necessarily follow. The effect of IPAB is instead to *shift* the effects of politics from legislators making specific decisions about the growth of Medicare costs to the appointment process determining those who sit on the board. This appointment process would involve the congressional leadership of both parties putting forward names for the president's consideration and would also require confirmation of any presidential nominees by the full U.S. Senate. Once confirmed, there is nothing to prevent the members of IPAB from consulting their own ideological preferences and subjective value judgments when making critical resource-allocation decisions. Indeed, the historical examples of many previous executive branch boards and commissions indicate that they should be fully expected to do so.

The statutory language establishing IPAB is fairly straightforward evidence that politics will suffuse any IPAB process just as it would any traditional legislative process. The language stipulates that the board shall not include any recommendation

71. Foster, "Financial Effects of the Patient Protection and Affordable Care Act."

that would “ration health care, raise revenues or Medicare beneficiary premiums . . . increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.”⁷² The language further states that various payment reductions to providers and suppliers cannot be implemented prior to December 31, 2019. Other language invites IPAB to further target the Medicare Advantage program for spending reductions. All of these stipulations reflect the value judgments and political leanings of the ACA’s authors.

Whether IPAB will be called upon to make additional cost-saving recommendations beyond those elsewhere provided for by the ACA has proved a very difficult matter to project. When the CMS Medicare Actuary’s office originally projected the effects of the ACA, it found that savings would be required from IPAB from years 2015–19 inclusive but not afterwards.⁷³ When Medicare finances were reestimated for the 2011 Trustees’ report, however, the Actuary’s office found that additional savings from IPAB would be required.⁷⁴ CBO has seen similar fluctuations in its projections for the savings required of IPAB. In February 2011, CBO projected that IPAB would be called upon to deliver \$14 billion in savings over 2012–21. Just one month later in March, CBO projected that no cost savings would be needed from IPAB over that period.⁷⁵ These projection difficulties do not arise because of inadequacies on the part of the forecasters, but because the provisions of the ACA interact in such a way that relatively subtle changes in the forecasting baseline can change the savings requirements projected for IPAB.

The principal sources of financing risk with respect to IPAB, therefore, are that (a) once projection uncertainties are past, substantial savings will be required of IPAB to meet statutory Medicare growth targets, and (b) these savings are legislatively overridden. This financing risk is addressed by presenting estimates of the savings IPAB might be required to recommend with respect to Medicare Part B and Part D.⁷⁶ These estimates are produced by consulting the Medicare Actuary’s subdivision of IPAB savings into those affecting Medicare parts A, B, and D over 2015–19, adjusting the parts B and D savings downward to conform to CBO’s aggregate estimates, and extrapolating the rate of growth in such savings requirements through 2021. Under the optimistic scenario, it is assumed that any such savings

72. *Patient Protection and Affordable Care Act*, Public Law 111-148, 111th Cong., 2nd sess. (March 23, 2010), 372.

73. Foster, “Estimated Financial Effects of the Patient Protection and Affordable Care Act.”

74. The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2011 Annual Report of the Boards of Trustees*.

75. House Subcommittee on Health, Committee on Energy and Commerce, *Douglas W. Elmendorf: CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010*.

76. The Part A savings, which might be duplicative of those already required under previous law, are discussed earlier in this study.

that are statutorily required will accrue relative to previous law. Under the worst-case scenario, Congress is assumed to override them. Under the mixed-outcome scenario, roughly 50 percent of the projected savings take place.

In effect, the optimistic scenario replicates the CBO score for the ACA, in that IPAB effectively delivers whatever savings are required (or not) as a consequence of the future evolution of Medicare cost growth. In the pessimistic scenario, events cause Medicare growth rates to exceed targets, triggering savings recommendations from IPAB that are overridden thereafter (see table 3).

TABLE 3. PROJECTED IPAB SAVINGS WITHIN MEDICARE PARTS B AND D OVERRIDDEN IN SUBSEQUENT LEGISLATION (\$B)

	2015	2016	2017	2018	2019	2020	2021	2012–21
Optimistic Scenario	0	0	0	0	0	0	0	0
Mixed-Outcome Scenario	0	0	1	1	2	3	4	13*
Pessimistic Scenario	1	1	2	3	5	7	9	26*

* Annual totals do not add due to rounding.

THE EXPANSION OF MEDICAID AND CHIP

OTHER PROVISIONS OF the ACA would significantly expand insurance coverage under Medicaid and the Children’s Health Insurance Program (CHIP). The legislation would expand Medicaid eligibility to up to 133 percent of FPL, but with a 5 percent income exclusion that brings the effective eligibility level up to 138 percent of FPL.⁷⁷ Other than the new health insurance exchanges, the cost of expanding Medicaid and CHIP is the single biggest line item in the ACA, with CBO’s March 2011 estimate finding that the expansion would add \$627 billion in new direct spending from 2012–21.⁷⁸

Projections for the overall cost of the ACA are sensitive to estimates of the numbers of new beneficiaries in Medicaid and CHIP under the law. CBO projects that by 2021, an additional 17 million people will receive health coverage through these programs.⁷⁹ The greater the expanded participation in Medicaid and CHIP, the greater the outlays under those provisions of the ACA will be.

That said, higher participation in Medicaid and CHIP does not necessarily translate into higher costs for the ACA as a whole. There is a substantial spillover effect between the ACA’s expanded eligibility for Medicaid and participation expectations for the new health exchanges. One hypothetical projection might find

77. CBO, “H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation).”

78. House Subcommittee on Health, Committee on Energy and Commerce, *Douglas W. Elmendorf: CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010*.

79. *Ibid.*

that as a result of income trends, a certain number of individuals will be below 138 percent of FPL and thus eligible for Medicaid. An alternative projection might find some of those persons to be over 138 percent and expected to buy insurance through an exchange with a substantial federal subsidy. The evolution of estimates has generally been such that whenever there have been higher projected costs for the Medicaid expansion, there have been lower expected costs for the new health exchanges, and vice versa.

From February to March 2011, for example, CBO updated its projections of the sources of insurance coverage under the ACA. In February, CBO anticipated that by 2021, 23 million individuals would receive coverage under the new exchanges, and a further 18 million under Medicaid and CHIP.⁸⁰ In the March update, CBO estimated that a somewhat-larger 24 million would receive insurance under the exchanges, with 17 million added to Medicaid and CHIP. This relative shift from Medicaid to the new exchanges from the February to the March estimates was correlated with an increase of \$100 billion in projected outlays for the exchanges, as well as with a reduction of \$47 billion in the projected cost of Medicaid and CHIP.⁸¹ In other words, the total projected cost of the ACAs' coverage provisions increased as projected Medicaid participation fell. This is partially reflective of the relatively modest insurance coverage provided under Medicaid.

Thus, while the increase in Medicaid coverage is a substantial additional fiscal commitment under the ACA, this study does not include a separate consideration of financing risk associated with the Medicaid provisions. It is reasonably likely that if Medicaid participation exceeded expectations, this would be correlated with a reduction in the cost of the ACA's health exchanges relative to current CBO projections.

THE "CADILLAC-PLAN" TAX

THE ACA CONTAINS a provision to impose an excise tax on high-premium insurance plans, the so-called "Cadillac-plan" tax. The policy purposes of this provision are multifaceted: first, to generate tax revenue to offset the cost of other ACA provisions, but also to lessen the current-law tax preference for compensating employees with health benefits, a factor that many experts believe to have exacerbated health care cost inflation by fostering inefficient and sometimes excessive consumption of health services. Starting in 2018, the provision would impose a 40 percent excise tax on plans that have an annual value of greater than \$10,200 for an individual and

80. CBO, "H.R. 2, Repealing the Job-Killing Health Care Law Act."

81. House Subcommittee on Health, Committee on Energy and Commerce, *Douglas W. Elmendorf: CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*.

\$27,500 for a family. For 2019, these thresholds would be indexed to general price (CPI-U) inflation plus 1 percent, but from 2020 onward they would be indexed to inflation only.⁸²

Because historically health insurance costs have tended to rise substantially faster than general inflation, under current projections a progressively greater proportion of employer-provided health plans would be subject to the excise tax over time. This would produce a number of corollary effects. Generally, many employers would be expected to constrain the generosity of health insurance packages offered to their employees. More directly for our purposes, the Joint Committee on Taxation (JCT) assumes that this tax will produce rapidly escalating revenues for the federal government, both directly and also because it would increase the proportion of worker compensation provided as taxable wages.

Thus, although the tax does not apply until 2018 under current law, under current projections a substantial and rising proportion of the beneficial budgetary effects of the ACA are attributable to it. In CBO's latest projections, the tax is projected to generate \$87 billion in revenues through 2021, with \$29 billion of this arriving in the final year (2021) of the projection period.⁸³ The rapid growth of federal revenues from the excise tax is also a key factor underlying extrapolations that the ACA would have a positive budgetary impact beyond its initial 10 years.

Of all of the provisions of the ACA, the Cadillac-plan tax in its current-law form perhaps warrants the greatest skepticism. It is expressly designed to expose an increasing share of health insurance benefits to taxation over time. Moreover, it did not survive its initial clash with political pressures; the form of the tax enacted with the ACA was almost simultaneously amended in accompanying reconciliation legislation, changes that both postponed the effective date and increased the thresholds below which the tax would not apply.⁸⁴ It is already somewhat widely anticipated that the tax ultimately will not be applied according to the letter of current law. One consultant newsletter, for example, advises its readers that "the expectation is that the amounts (of the thresholds) will increase, annually, by the medical inflation rate."⁸⁵

82. *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152, 111th Cong., 2nd sess. (March 30, 2010) and *Patient Protection and Affordable Care Act*, Public Law 111-148, 111th Cong., 2nd sess. (March 23, 2010).

83. House Subcommittee on Health, Committee on Energy and Commerce, *Douglas W. Elmendorf: CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*.

84. See the texts of the 2010 ACA and Reconciliation laws, the latter of which amended the excise tax established in the former. *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152, 111th Cong., 2nd sess. (March 30, 2010); and *Patient Protection and Affordable Care Act*, Public Law 111-148, 111th Cong., 2nd sess. (March 23, 2010).

85. "Health Care Reform Cadillac Tax," *Banyan Consulting News*, n.d., accessed March 6, 2012, <http://www.banyan-llc.com/bc/bc.nsf/hcr/Health-Care-Reform-Cadillac-Tax>.

Sponsors of the ACA had a compelling motivation to apply the Cadillac-plan tax several years earlier than 2018 to help ensure the ACA would meet the test of improving the federal fiscal outlook over its first 10 years, a criterion that could well have determined the bill’s legislative fate. Despite this, the Cadillac-plan tax did not fully survive its first clash with the realities of political negotiations. To assume that the tax will always be applied to the letter of current law is to assume that political actors in the future will be far more committed to this tax than even the original authors of ACA were.

The current projections for the revenues arising under the Cadillac-plan tax provision are thus appropriately assigned to the optimistic scenario. A more pessimistic, but also reasonably likely, outcome is that after 2018—if applied at all—the tax thresholds will be adjusted so that revenues from the tax grow only as fast as national GDP. Table 4 also includes a mixed outcome projection in which revenues under the tax are permitted to grow at a rate intermediate between the optimistic and pessimistic scenarios.⁸⁶

TABLE 4. PROJECTED REVENUES FROM THE CADILLAC-PLAN TAX (\$B)

	2018	2019	2020	2021	2012–21
Optimistic Scenario	12	20	24	29	87*
Mixed-Outcome Scenario	12	16	19	21	68
Pessimistic Scenario	12	13	13	14	52

* Annual total does not add due to rounding.

THE 3.8 PERCENT “UNEARNED INCOME MEDICARE CONTRIBUTION”

OTHER PROVISIONS OF the ACA would impose additional taxes beginning in 2013 on individuals with annual income exceeding \$200,000 and couples earning more than \$250,000. For such taxpayers, an additional 0.9 percent Medicare HI tax would be imposed on earned income as historically defined, bringing their total Medicare HI tax rate from 2.9 percent to 3.8 percent. As with the previous-law Medicare payroll tax, this revenue would be allocated to the Medicare HI Trust Fund. This policy was implicitly analyzed in this study’s previous section on the use of Medicare savings to finance a new health entitlement.

Under the ACA, an additional 3.8 percent tax would be applied to investment income of individuals above these income levels. Though termed an “Unearned

86. Revenue projections are taken from the March 2011 CBO/JCT estimate, the latest available. House Subcommittee on Health, Committee on Energy and Commerce, *Douglas W. Elmendorf: CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010*. However, the uncertainty analysis is performed relative to the optimistic scenario baseline and thus subtracts the effects upon the unified budget analysis that would arise from varying the economic baseline from the February to the March CBO projections.

Income Medicare Contribution” (UIMC) under the law, this revenue would not come from Medicare’s traditional contribution base and it would not be allocated to a Medicare Trust Fund. The \$200,000 and \$250,000 income thresholds for triggering this tax would not be indexed and would thus capture (if the law remains unchanged) an increasing number of taxpayers over time.

There is a risk that the revenues eventually arising under the UIMC will be considerably lower than projected at the time the ACA was scored. Political pressure may mount in the future for Congress to raise the income thresholds subject to this new tax. This becomes especially likely if the UIMC is for whatever reason “patched” (ameliorated) early in its existence, such that reversion to the current-law path thereafter would cause the sudden exposure of large numbers of taxpayers to the tax. This has been the historical dynamic, for example, with respect to the income thresholds for the AMT. Like the UIMC, the AMT’s income thresholds are not currently indexed to grow over time. This situation has precipitated repeated actions by Congress to raise the AMT thresholds, to spare millions of additional Americans from being obliged to pay the tax.⁸⁷

This is one reason CBO’s “current law” projections of the government’s fiscal imbalance are commonly understood to understate the actual imbalance. Legislators on both sides of the aisle agree that the AMT thresholds should and will be raised, despite the literal text of current law. It is widely understood that the current-law AMT thresholds are now politically unsustainable. This could ultimately be the fate of the UIMC provision under the ACA.

During consideration of the ACA, the JCT estimated that this 3.8 percent surcharge on investment income would produce \$123.4 billion in revenues over the 2012–19 period, as reflected in table 5.⁸⁸ Extrapolations for 2020 and 2021 are presented in the table based on the trend of revenue growth seen by the JCT during the 2019–21 period, and by cross-referencing with 2011 CBO publications citing updated revenue projections.

A more sober assessment of the prospects for this tax is that Congress will act to modify the UIMC’s income thresholds at the point in time when a failure to do so would mean a sudden upward spike in the number of taxpayers subjected to it. Such a spike occurs between years 2014 and 2015 of the JCT estimates. The pessimistic scenario in table 5 therefore projects that the UIMC thresholds will be relaxed, starting in 2015, to hold revenues from the UIMC constant as a percentage

87. See, for example, Katherine Lim and Jeffrey Rohaly, “The Individual Alternative Minimum Tax: Historical Data and Projections, Updated October 2009,” Urban-Brookings Tax Policy Center, October 2009, accessed March 6, 2012, http://taxpolicycenter.org/UploadedPDF/411968_AMT_update.pdf.

88. Joint Committee on Taxation, “General Explanation of Tax Legislation Enacted in the 111th Congress,” JCS-2-11, March 2011.

of GDP.⁸⁹ As with other projections in this study, a mixed-outcome scenario allows for revenue growth relative to GDP at a rate midway between the optimistic and pessimistic scenarios.

TABLE 5. PROJECTED REVENUES FROM THE "UNEARNED INCOME MEDICARE CONTRIBUTION" (\$B)

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2012–21
Optimistic Scenario	1	7	11	19	20	21	22	23	25	26	174*
Mixed-Outcome Scenario	1	7	11	15	16	17	17	18	19	20	142*
Pessimistic Scenario	1	7	11	11	12	12	13	13	14	15	109

* Annual totals do not add due to rounding.

OTHER PROVISIONS OF POTENTIAL FISCAL IMPORTANCE

THE QUESTION OF whether the ACA will produce other fiscal benefits beyond those already analyzed in this study should be explored. Advocates of the ACA's passage frequently argued that it would. In a November 2009 Ronald Brownstein article published in *The Atlantic*, Obama administration consultant Jonathan Gruber said of the legislation that "everything is in here (the pending legislation) . . . I can't think of anything I'd do that they are not doing in the bill. You couldn't have done better than they are doing."⁹⁰ The Brownstein article evaluated the ACA with respect to a letter cosigned by several health economists opining that "four elements of the legislation are critical" to "help keep health care costs under control."⁹¹ OMB Director Peter Orszag, interviewed for the same *Atlantic* article, referenced the letter saying, "If you go down the checklist of what they said was necessary for a fiscally responsible bill that will move us towards the health care system of the future, this passes the bar."

The four elements described in the letter were: "(1) deficit neutrality, (2) an excise tax on high-cost insurance plans, (3) an independent Medicare commission, and (4) delivery-system reforms." Three of these four have already been discussed in this study. With respect to the first point, as mentioned previously and further

89. Consistent with other calculations in this study, GDP projections are taken from CBO's January 2011 budget and economic outlook, the last projections available for CBO's March 2011 rescoring of the health law. See CBO, "Long-Term Budget Outlook," June 2011.

90. Ronald Brownstein, "A Milestone in the Health Care Journey," *The Atlantic*, November 21, 2009, accessed March 6, 2012, <http://www.theatlantic.com/politics/archive/2009/11/a-milestone-in-the-health-care-journey/30619>.

91. "Economists' Letter to Obama on Health Care Reform," reprinted in the *New York Times: Economix Blog*, November 17, 2009, accessed March 6, 2012, <http://economix.blogs.nytimes.com/2009/11/17/economists-letter-to-obama-on-health-care-reform>.

substantiated later in this study, the ACA—as analyzed by CBO—would pass the test of deficit-neutrality only with respect to a specific scoring convention and would fail it relative to actual prior law. The ACA also falls far short of the letter’s stated criterion of being deficit reducing after the 10-year budget window.

The ACA’s excise tax on high-cost insurance plans was also greatly watered down in response to subsequent political pressure, and the question remains as to whether it will produce its projected savings going forward. The endorsement of an “independent Medicare commission” was a somewhat curious inclusion in a list drawing upon the expertise of health care economists as it reflects a subjective judgment as to what political mechanism is most likely to produce savings, as distinct from analysis of a particular health care policy. The economists’ letter was vague with respect to how such a commission should be constituted. As this study has discussed, it remains highly uncertain whether the most notable independent commission established by the ACA, the IPAB, will produce the projected savings attributed to it.

This leaves delivery-system reforms as the remaining item suggested as producing substantial additional fiscal benefits. The economists’ letter stressed that “the legislation should include additional funding for research into what tests and treatments work and which ones do not. It must also provide incentives for physicians and hospitals to focus on quality, such as bundled payments and accountable care organizations, as well as penalties for unnecessary re-admissions and health-facility acquired infections. Aggressive pilot projects should be rapidly introduced and evaluated, with the best strategies adopted quickly throughout the health care system.”⁹²

The CMS Medicare Actuary anticipated approximately \$2 billion in budgetary savings arising from such provisions through 2019, all of which were associated with comparative-effectiveness research. With respect to the other delivery-system reforms, CMS opined that there would be a “negligible financial impact over the next 10 years.”⁹³ CBO scored no appreciable savings from the ACA’s comparative-effectiveness provisions, from its national pilot program on payment bundling, or from several of the other provisions of the ACA under Title III, dedicated to improving the “quality and efficiency” of health care.⁹⁴

The analysis in this study credits the ACA for all cost-savings anticipated by CBO under the various reforms in this category. To add further savings to the optimistic scenario, the \$2.3 billion arising from comparative-effectiveness research scored by

92. Ibid.

93. Foster, “Estimated Financial Effects of the Patient Protection and Affordable Care Act.”

94. CBO, “H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation).”

CMS/Office of the Actuary but not by CBO through 2021 is added, and extrapolated fairly aggressively by adding a further \$3.5 billion savings for the years 2020–21. This produces a total savings through 2021 of \$5.8 billion from such “cost-curve-bending” reforms for the optimistic scenario. Doing so places this scenario at a slightly more optimistic position than the projections of the federal government’s nonpartisan scorekeepers.

It is certainly to be hoped that delivery-system reforms will ultimately prove effective in slowing the growth of health care costs. Whether appreciable long-term savings will arise from such provisions is at best a speculative proposition, especially given that the ACA leaves in place a heavy government hand separating individual health care consumers from the financial consequences of their purchasing decisions.

Whatever the merits of these reforms, it is implausible that the cost savings they might produce would approach the size of the new costs associated with other provisions of the ACA. The federal government’s nonpartisan scorekeepers agree that such reforms could at best only produce savings that are fully of a lower order of magnitude than the new federal cost commitments the ACA would create. For decades at least, the fiscal effects of the ACA will be dominated by the cost of its subsidized coverage expansion, not by the success of its reforms to “bend the cost curve.”⁹⁵

SUMMARY OF BUDGETARY EFFECTS OF THE ACA

TAKEN AS A whole, the enactment of the ACA has substantially worsened a dire federal fiscal outlook. The ACA both increases a federal commitment to health care spending that was already unsustainable under prior law and would exacerbate projected federal deficits relative to prior law. This is an unambiguous conclusion, as it would result regardless of the degree of future success attained in upholding various cost-saving provisions now embedded in the law.

That the ACA has substantially worsened the federal fiscal outlook is not universally understood. The biggest source of confusion may reside in the widespread

95. Amicus briefs filed both in support of and in opposition to the ACA provide another window onto the debate over the economic effects of the law, in particular onto the anticipated effect of its individual purchase mandate on the growth of health costs. See, for example, American Action Forum, “Brief for *Amici Curiae* Economists in Support of Respondents Regarding Individual Mandate,” No. 11-398, n.d., accessed March 6, 2012, <http://americanactionforum.org/sites/default/files/Final%20Individual%20Mandate%20Brief.pdf>; and David Cutler et al., “Kinder v. Geithner—Economic Scholars Amicus Brief,” August 19, 2011, accessed March 6, 2012, <http://digitalcommons.law.scu.edu/aca/92/>. As explained in this study, the effects of the mandate and other provisions of the law on federal finances are dwarfed by the effects of the subsidized-coverage expansion the ACA would implement.

consultation of the scoring conventions employed by both CBO and the Medicare Trustees, in which it is assumed in the baseline that various entitlement-benefit promises will be honored without regard to statutory restrictions. Though this is an appropriate scoring convention for many purposes, it is nevertheless true that whenever budgetary savings already required under law to maintain the solvency of either Social Security or Medicare HI are enacted only to be spent on a new entitlement program, the federal government's fiscal position is unequivocally worsened.

This worsened fiscal situation is exacerbated by the substantial financing risks associated with several of the ACA's specific provisions. There are substantial risks that the costs of newly established health exchanges will ultimately be larger than now projected, and that the rising projected revenues of provisions such as the Cadillac-plan tax and the new 3.8 percent surcharge on incomes over \$200,000/\$250,000 will not fully materialize, among other risks. There is comparatively little likelihood, by contrast, that these tax provisions will ultimately produce more revenue than now projected.

Table 6 shows projected net budgetary effects of the ACA under optimistic, mixed-outcome, and more pessimistic scenarios. Positive signs indicate improvement in the budget outlook; negative signs indicate worsened deficits. All the numbers in this table should be taken as rough numbers, especially given the various approximations made with respect to political uncertainties and to the precise date of Medicare HI insolvency in the absence of the ACA. Although the figures are presented in billions so as to parallel similar presentations by CBO, it would be more prudent to read them only to two significant figures (see appendix C, page 51).

The net worsening of the federal fiscal outlook under the ACA is substantial. Under the pessimistic scenario (which is, as previously noted, by no means a worst-case scenario), it exceeds \$100 billion annually by 2021. This is especially sobering in view of the high hopes placed in the ACA, as it indicates a significant risk that in the ACA's second decade alone it would worsen the federal fiscal outlook by over \$1 trillion.

The budgetary information above is also presented in figure 7. As in other figures in this study, positive impacts on the budget are depicted above the zero line and worsening deficits below it. The figure displays the substantially damaging fiscal impact of the ACA, which grows worse near the end of the 10-year valuation period under all projection scenarios.

An equally important fiscal standard is the effect of legislation upon the total federal commitment to financing health care. As discussed earlier in this study, this standard is critical because future federal commitments were already untenable under previous law and increased commitments cannot be financed without sentencing future generations to unprecedented tax burdens.

CBO's updated 2011 estimates found that the ACA would increase federal outlays by roughly \$604 billion over 2012–21. CBO had defined the net effect of CLASS as reducing federal outlays over that period, so the suspension of CLASS increases the ACA's outlay effect to \$691 billion under the prevailing scoring convention.

TABLE 6. NET BUDGETARY EFFECTS OF THE ACA (\$B)

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2012–21
CBO Score Relative to Scoring Convention (Feb 2011)	24	46	29	2	-16	-13	12	35	44	47	210*
CBO Score Relative to Scoring Convention, Excluding the Suspended CLASS Program (Feb 2011)	18	37	19	-10	-28	-23	4	28	37	41	123*
Optimistic Scenario Relative to Prior Law	18	37	19	-10	-58	-91	-72	-61	-61	-68	-346*
Mixed-Outcome Scenario Relative to Prior Law	18	37	14	-16	-59	-98	-84	-77	-82	-93	-439*
Pessimistic Scenario Relative to Prior Law	18	37	9	-23	-59	-106	-95	-92	-101	-116	-527*

* Annual totals do not add due to rounding.

As previously discussed, had the ACA not been enacted, roughly an additional \$475 billion in Medicare outlay reductions would have occurred through 2021 under prior law, relative to the CBO baseline. Also, in the optimistic scenario presented here, it is assumed that nearly \$6 billion in outlay savings will accrue via the ACA's delivery-system reforms. Adding in these two effects produces an optimistic scenario in which the ACA increases total federal health spending by roughly \$1.160 trillion over the 2012–21 period.

Under the mixed-outcome and pessimistic scenarios, outlays would be somewhat higher as a result of increased spending under the new health exchanges and reduced savings via IPAB. This produces the net effects of the ACA on federal spending as given in table 7. As with table 6, the numbers in table 7 should be read only to two significant figures.

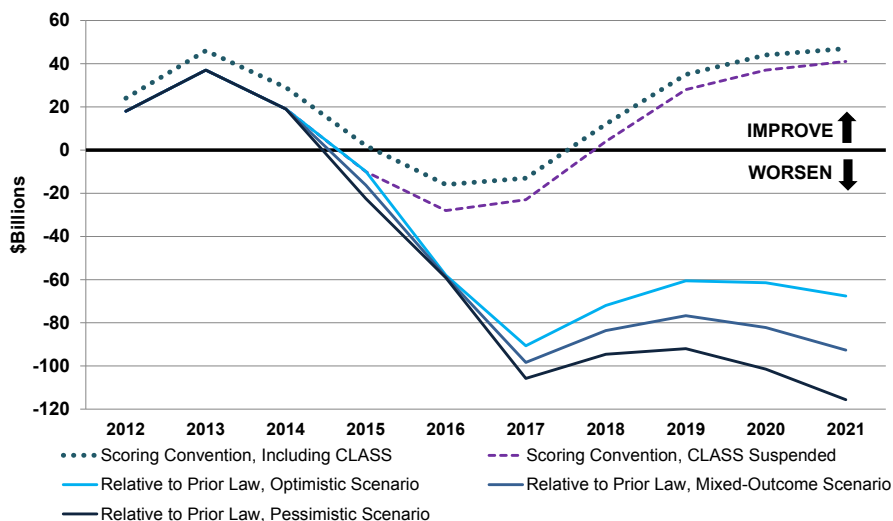
TABLE 7. NET EFFECT OF THE ACA ON FEDERAL SPENDING, 2012–21 (CUMULATIVE, \$B)

Optimistic Scenario	+\$1.160 trillion
Mixed-Outcome Scenario	+\$1.204 trillion
Pessimistic Scenario	+\$1.242 trillion

POSSIBLE FISCAL CORRECTIONS

THE ENACTMENT OF the ACA has seriously worsened a federal fiscal outlook that was already untenable over the long term. The widespread perception that the ACA might instead improve the outlook is based largely on a misunderstanding of how prevailing agency scoring conventions contrast with literal law. Many of the cost-savings measures under the ACA were already required in some form under previous law, and thus their combination with a substantial expansion of federal health entitlements unambiguously worsens the nation's fiscal predicament. Given that

FIGURE 7. NET ANNUAL BUDGETARY EFFECT OF THE ACA



Source: Author's calculations based on CBO and CMS data and projections.
 Note: The figures above are positive if they improve the budget outlook and negative if they worsen deficits.

many of the ACA's other cost-saving provisions are highly susceptible to weakening by future lawmakers, the total fiscal damage wrought by the ACA is likely to be severe indeed in the absence of near-term legislative corrections.

In noting these realities, care should be taken not to deny credit for legislative actions taken with the intent of improving the long-term fiscal picture. It is appropriate to give credit for such actions in certain respects, even if the actions of today's legislators are later undone. An important reality remains, however, that the proceeds of such cost-savings cannot safely be spent until they have verifiably accrued.

Prudent legislating requires that no policies be implemented that further increase the government's commitment to health care financing, at least until it is certain that existing commitments can be honored without either subjecting future generations to onerous levels of taxation or uncontrolled growth of the public debt. The ACA fails this standard by a wide margin, likely increasing federal health care outlays by well over \$1 trillion over the next decade alone. It thus does not constitute effective health care reform.

A total fiscal correction to the ACA, therefore, requires curtailing its projected outlay increases by somewhere between \$1.1 and \$1.3 trillion over the upcoming decade. This would gut the vast majority of the substantial coverage expansion envisioned under the law, possibly requiring both the elimination of federal subsidies for the new health exchanges and canceling roughly two-thirds of the ACA's planned expansion of Medicaid and CHIP. To effect the intended coverage expansion without increasing net federal health commitments would thus require implementation of other constraints on other federal health spending, most likely in both Medicaid and Medicare Part B and Part D.

Meeting this standard of fiscal prudence today would present what many would deem to be a very unpalatable set of choices; these choices, however, reflect the harsh reality that federal health commitments were unaffordable over the long term even before the ACA expanded them further. Given the wide agreement on the unaffordability of prior-law commitments, a substantial expansion of federal health care coverage could not responsibly be undertaken without reducing preexisting commitments by more than the new coverage's cost. Priorities must be set: if expanding subsidized coverage for low-income Americans is indeed the higher policy priority, other commitments must be scaled back sufficiently to allow that to be financed.

A more modest set of fiscal corrections to the ACA would ensure that the legislation not worsen the net federal budget balance while still allowing total federal health commitments to further expand. This would truly be a modest standard in comparison with the high hopes originally placed in health care reform—that it make a meaningful contribution to repairing the federal fiscal outlook.

Application of this lesser standard would include protection against downside risk that the fiscal situation grows still worse, meaning that the net budget effect of the legislation could be no worse than neutral under the pessimistic scenario described in this paper. This would further mean that the optimistic scenario would allow for a modest positive (approximately \$180 billion over 10 years) improvement in the long-term outlook, while still falling well short of ambitions that health care reform embodies a primary corrective to it.

To achieve this standard, over \$525 billion of the new costs in the ACA must be eliminated over 2012–21. The least disruptive way to do so is to scale back the costs of subsidies for the legislation's new health exchanges, while still allowing the full Medicaid/CHIP expansion envisioned under the law. This would also permit the government to focus on expanding coverage where there is a program infrastructure already in place.

To the extent that plans proceed to develop the new exchanges, subsidy costs would need to be reduced by roughly two-thirds relative to current CBO estimates.⁹⁶ One direct means of accomplishing this would be to lower the 400 percent of FPL level at which one becomes eligible for subsidies, as well as the amounts of the subsidies themselves. The fail-safe would also need to be modified so that total subsidy costs cannot exceed roughly 0.16 percent (rather than 0.504 percent) of GDP.

These subsidies may fall well short of the degree of assistance many wish to provide to low-income Americans in attaining health insurance coverage. The realization of these ambitions, however, requires that realistic fiscal choices be made. This in turn requires that other federal spending be reduced, or taxes increased, well beyond requirements already in place under previous law. It also requires that the

96. CBO estimates that total subsidy costs for the exchanges will total roughly \$777 billion over 2012–21, while the pessimistic scenario indicates that the ACA would worsen the fiscal outlook by \$527 billion over the same period.

proceeds of previously enacted savings be reliably secured before they are spent.

Only by considerably reducing the spending commitments made under the ACA—or by finding new financing sources for these commitments—will the legislation make the positive contribution to the federal fiscal outlook that experts across the ideological spectrum agree is required.

CONCLUSION

AMONG THE VARIOUS objectives articulated for comprehensive health care reform, perhaps none was raised with greater persistence than the argument that such reform would help to correct a dire federal fiscal outlook. Unfortunately, despite the fondest hopes of its supporters, the passage of the ACA unambiguously darkens a dim fiscal picture.

Because the ACA relies upon many cost-savings already required in some form under previous law, and because it tapped those savings to finance an ambitious expansion of federal spending commitments, the government's fiscal predicament is now significantly worse than before the law was enacted. Moreover, many of the law's cost-saving measures are subject to considerable financing risk in that they depend upon future enforcement at some variance with historical precedent, including even the precedent of the ACA itself. As currently written, the ACA should be expected to increase federal spending obligations by more than \$1.15 trillion over the upcoming decade and to worsen cumulative federal deficits by somewhere between \$340 and \$530 billion over the same period, depending on the degree of success with which future cost-savings provisions are enforced.

If the ACA is not to result in severe damage to future federal finances, various of its cost-increasing provisions must be scaled back considerably before they take full effect. Foremost among these is the cost of subsidies for newly established health exchanges. Roughly two-thirds of their projected cost must be eliminated for the legislation not to have an adverse effect on federal deficits, and the entirety of their costs must be eliminated if the legislation is not to have the adverse consequence of further increasing federal health care commitments.

Although ACA supporters frequently asserted companion goals of expanding federal support for health insurance coverage, and of bending the health "cost curve" downward, these two ambitions necessarily conflict to a certain extent. Largely because of the ACA's focus on coverage expansion, the law will greatly worsen federal fiscal strains unless significant legislative corrections are effected prior to 2014.

APPENDIX A: A PRIMER ON THE MEDICARE TRUST FUNDS

Q: What are the Trust Funds?

A: As with the Social Security program, spending in Medicare is conducted from special Trust Funds. Instead of receiving funding through annual appropriations in the manner of a discretionary spending program, Medicare is permitted to spend in accordance with statutory benefit schedules as long as there is a positive balance in the pertinent Trust Fund. Medicare's Trust Funds receive income from dedicated taxation and premium payments and (in the case of Medicare's Supplementary Medical Insurance Trust Fund) from general government revenues. The assets held in the Trust Funds consist of special-issue U.S. Treasury securities that earn interest, which provides another source of revenues.

Q: How many Trust Funds does Medicare have?

A: Medicare has two Trust Funds. The Hospital Insurance (HI) Trust Fund pays primarily for hospital-related services. Medicare also has a Supplementary Medical Insurance (SMI) Trust Fund, which finances spending for two voluntary-enrollment programs: Part B (which provides physician, outpatient, and home-health services) and Part D (which provides prescription drug benefits).

Q: How do the two Medicare Trust Funds operate differently from one another?

A: Medicare's HI Trust Fund operates somewhat analogously to Social Security's. HI is financed primarily with payroll taxes paid by workers and also receives lesser amounts of income from premiums, interest earnings, and taxes on Social Security benefits. As with Social Security, it is theoretically possible for Medicare HI to become insolvent if its obligations exceed its total income. By contrast, Medicare's SMI Trust Fund remains solvent essentially by statutory construction. Each year under law, general budget revenues are transferred to the SMI Trust Fund in amounts sufficient to ensure that, when combined with premium income and interest earnings, it has enough funds to pay scheduled benefits.

Q: What happens if the Medicare HI Trust Fund becomes depleted?

A: Medicare is only authorized to make benefit payments from its Trust Funds. As the Medicare Trustees' report explains, "If assets were exhausted, payments to health plans and providers could be made only from ongoing tax revenues, which would be inadequate to cover total costs. Beneficiary access to health care services would rapidly be curtailed."^{*} It is generally assumed that upon Trust Fund depletion, the Medicare HI program would have to delay benefit payments until sufficient tax and premium revenue had arrived to finance them—in effect cutting the total amount of benefit payments.

^{*} Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2011 Annual Report of the Boards of Trustees*, 26.

Q: Do CBO scoring conventions reflect the statutory requirement to reduce Medicare HI expenditures upon Trust Fund depletion?

A: No. Instead, it is assumed that Medicare will pay full benefits without regard to limitations on its spending authority as a result of Trust Fund depletion. As CBO routinely explains, for example in its latest Budget and Economic Outlook, “In keeping with the rules in section 257 of the Deficit Control Act of 1985, CBO’s baseline incorporates the assumption that payments will continue to be made after the trust fund has been exhausted, although there is no legal authority to make such payments.”*

Q: The ACA contains provisions to reduce the growth of Medicare payments. What would have happened if such provisions had not been enacted?

A: The CMS Medicare Actuary has projected that without these provisions the Medicare HI Trust Fund would be depleted in 2016. If that had remained the case, Medicare HI benefit payments would have been suddenly reduced in that year. The ACA’s Medicare provisions thus reduce HI program payments only until 2016 relative to previous law, while they increase total Medicare HI payments from 2016–24 relative to those that would have occurred if Medicare HI insolvency had transpired under previous law.

Q: What does all this mean for the overall fiscal effects of the ACA?

A: It means the ACA increases spending and worsens deficits relative to previous law. For example, imagine a law that cuts Medicare HI payments by \$1 while also spending \$1 on a new health program. The \$1 Medicare HI spending cut extends the solvency of the Medicare HI Trust Fund, thereby allowing Medicare HI to spend an additional \$1 at a later date. The \$1 of near-term Medicare savings thus results in an additional \$1 of later Medicare spending. Thus, if the law also spends \$1 on a new health program, then altogether the law would permit \$2 in total new spending while enacting only \$1 in savings. On the whole, such a law would increase spending and worsen federal deficits. The case is similar with the ACA.

* CBO, “The Budget and Economic Outlook: Fiscal Years 2012 to 2022,” January 2012, 122n.

APPENDIX B: FISCALLY SIGNIFICANT ACA PROVISIONS

Federally Subsidized Health Exchanges

THE ACA ESTABLISHES federal subsidies for many individuals to buy health insurance in state-established exchanges. These subsidies include refundable tax credits toward premium payments under exchange plans and cost-sharing subsidies that limit individual out-of-pocket costs. They are generally available to individuals with incomes between 100 and 400 percent of the Federal Poverty Line (FPL), provided that they are not qualified for Medicaid or the Children’s Health Insurance Program (CHIP), certain other health benefits, or “affordable” employer-sponsored coverage. In general, the premium subsidies limit the percentage of an individual’s income that can be paid in premiums, with the maximum percentage rising as a function of the individual’s income relative to the FPL. An individual at 133 percent of the FPL could not face a premium exceeding 2 percent of household income for a so-called silver health plan (defined in terms of the percentage of medical expenses covered by the insurer), whereas an individual at 400 percent of the FPL could not face a premium exceeding 9.5 percent of household income for such a plan. An individual with an offer of employer-based coverage would be ineligible for such subsidies unless the employment-based offer was deemed “unaffordable”—for example, if it required the worker to pay more than 9.5 percent of income in premiums to receive it, or if the plan’s payments covered less than 60 percent of total allowed costs. Federal cost-sharing subsidies, which limit the potential out-of-pocket costs of the insured individual, would likewise be a function of income. An individual with income less than 150 percent of the FPL could receive subsidies that reduce the out-of-pocket limit by two-thirds, whereas an individual with income of 400 percent of the FPL could receive subsidies reducing the out-of-pocket limit by one-third. The exchanges are scheduled to be operational by January 2014.

Medicaid/CHIP Expansion

THE ACA WOULD significantly expand insurance coverage under Medicaid and CHIP. The legislation would expand Medicaid eligibility to up to 133 percent of the FPL, but with a 5 percent income exclusion that brings the effective eligibility level up to 138 percent of the FPL. As CBO describes in further detail, “The legislation provides that the federal government pay a substantially higher share of Medicaid costs for newly eligible enrollees than it will pay for previously eligible enrollees. The matching rates for newly eligible enrollees will be 100 percent from 2014 through 2016 and will then decline to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent thereafter.”* The expansion of Medicaid and CHIP coverage is scheduled to take effect in 2014.

* House Subcommittee on Health, Committee on Energy and Commerce, *Douglas W. Elmendorf: CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010*, 23.

Medicare Cost-Containment Provisions

THE ACA INCLUDED various provisions to offset the costs of its subsidized coverage expansions. Prominent among these were provisions to constrain Medicare cost growth. The most fiscally significant of these reduce annual Medicare price increases by the estimated growth in economy-wide multifactor productivity for most health services. Other provisions would reduce the growth of payments under the Medicare Advantage program and of “disproportionate share” hospital (DSH) payments. The ACA contains several provisions that would reduce cost growth in other areas of Medicare.

The 3.8 Percent “Unearned Income Medicare Contribution”

OTHER PROVISIONS OF the ACA would impose additional taxes beginning in 2013 on individuals with annual income exceeding \$200,000 and couples earning more than \$250,000. For such taxpayers, an additional 0.9 percent Medicare HI tax would be imposed on earned income as historically defined, bringing their total Medicare HI tax rate from 2.9 percent to 3.8 percent. As with the previous-law Medicare payroll tax, this revenue would be allocated to the Medicare HI Trust Fund. An additional 3.8 percent tax would be applied to investment income of individuals above these income levels. Though termed an “Unearned Income Medicare Contribution” (UIMC) under the law, this revenue would not come from Medicare’s traditional contribution base and it would not be allocated to a Medicare Trust Fund. The \$200,000 and \$250,000 income thresholds for triggering this tax would not be indexed and would thus capture (if the law remains unchanged) an increasing number of taxpayers over time.

The “Cadillac-Plan” Tax

THE ACA CONTAINS a provision to impose an excise tax on high-premium insurance plans, the so-called Cadillac-plan tax. Starting in 2018, the provision would impose a 40 percent excise tax on plans that have an annual value of greater than \$10,200 for an individual and \$27,500 for a family. For 2019, these thresholds would be indexed to general price (CPI-U) inflation plus 1 percent, but from 2020 onward they would be indexed to inflation only. Because historically health insurance costs have tended to rise substantially faster than general inflation, under current projections a progressively greater proportion of employer-provided health plans would be subject to the excise tax over time.

The CLASS Program

CERTAIN PROVISIONS OF the ACA would have established a new federal entitlement program providing insurance for long-term care, the Community Living Assistance Services and Support (CLASS) program. CLASS had been scored as contributing a positive budgetary effect over the first ten years. The reason for this positive treatment was that CLASS would initially attract some premium payments before untenable long-term costs began to overwhelm the program. HHS Secretary Kathleen Sebelius has announced that CLASS will be suspended due to the inability to operate the program in an actuarially sound manner as required by the language of the ACA. CBO currently assumes that CLASS will not be implemented.

The Independent Payment Advisory Board

THE ACA ESTABLISHES an Independent Payment Advisory Board (IPAB) within Medicare. The board would be charged with recommending reductions in Medicare payments sufficient to prevent overall program cost growth from exceeding a long-term rate of per-capita GDP plus 1 percent (with additional annual growth specifications in the near term). These recommendations would be implemented unless overridden by legislation. The legislative process for overriding IPAB recommendations would be constrained by various procedural restrictions. The language of the ACA stipulates that the board shall not include any recommendation that would “ration health care, raise revenues or Medicare beneficiary premiums . . . increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.* The language further states that various payment reductions to providers and suppliers cannot be implemented prior to December 31, 2019. Other language invites IPAB to further target the Medicare Advantage program for spending reductions. The IPAB is scheduled to be operational by 2015.

* *Patient Protection and Affordable Care Act*, Public Law 111-148, 111th Cong., 2nd sess. (March 23, 2010), 372.

APPENDIX C: HOW ARE THE STUDY'S CONCLUSIONS AFFECTED BY UPDATED CBO PROJECTIONS?

THE FINDINGS IN “The Fiscal Consequences of the Affordable Care Act” are based on analyses of the Congressional Budget Office (CBO) and the CMS Medicare Actuary published before late 2011 when the study entered its final review, editing, and publication process. Subsequent to performing the study, CBO has published updated projections for some (but not all) of the fiscal effects of the ACA, raising the question of how the findings of this study might change in view of CBO’s updated estimates.

A complete update of the analysis in this study is not possible based on information publicly available to date. While CBO has updated its projections for the gross and net costs of the ACA’s coverage provisions, it has not yet done so for the budgetary effects of the ACA as a whole. CBO’s updated projections anticipate increased costs for the ACA’s Medicaid/CHIP expansion and decreased costs for its health exchange subsidies. CBO has not yet published updates for several other parts of the ACA.

Another piece of updated data critical to this study’s analysis is also not yet publicly available: namely, the CMS Medicare Actuary’s analysis of when the Medicare HI Trust Fund would be insolvent in the absence of the ACA. This information is important to an assessment of the amount of the savings in the ACA that substitute for those required under previous law.

It can nevertheless be stated with some certainty that the qualitative findings in “The Fiscal Consequences of the Affordable Care Act” will not change if and when this other information is updated. Estimates of the ACA’s net effects on federal deficits, one of the two yardsticks employed in the study, will remain qualitatively similar over the next ten years. This is because the effects of extending the updated budget window through 2022 should roughly offset the fact that CBO now assigns somewhat lower annual net costs to the subsidized coverage expansion. On the one hand, slightly smaller annual net expenses (costs minus revenues) for the coverage expansion are likely to be reflected in a slightly improved estimate of net annual federal deficit effects through 2021 based on CBO scoring conventions. On the other hand, the extension of the budget window through 2022 increases the ACA’s reliance on Medicare cost constraints and thus increases the extent to which the ACA’s cost-saving provisions substitute for those required under previous law. These two effects are likely to roughly offset.

One potentially complicating factor pertains to the updated status of the Medicare HI Trust Fund as a result of the passage of the Budget Control Act (BCA). If after incorporating updates for recent legislation it is still projected that the Medicare HI Trust Fund would have been depleted in 2016 in the absence of the ACA, the law’s net deficit-worsening effects through 2022 would be roughly comparable to those calculated in the study. The net worsening would be somewhat smaller, however, if it is found that the sequestration required under the Budget Control Act (in combination with updated program financial data) would have delayed Medicare HI insolvency until 2017 in the absence of the ACA.

With respect to the other of the study's two yardsticks—that is, the ACA's net effects on federal health care spending—again the findings should remain qualitatively similar to those in the study, though in this case the adjustments are likely to show a net worsening. CBO has recently projected that the gross costs of the ACA will be higher than projected last year, even before accounting for the extra year of new costs now visible within the budget window. This increase is primarily a result of higher projected costs for the ACA's Medicaid/CHIP expansion.

In sum, the qualitative findings of the study regarding federal finances are likely to be essentially unchanged in view of updated information, with the ACA's effects on federal deficits potentially slightly better and its effects on federal spending obligations potentially slightly worse.

Though CBO's updated numbers do not change the study's qualitative findings with respect to budgetary effects, they do show further movement away from employer-sponsored insurance (ESI) relative to projections at the time the study was written. Previously, CBO had projected that in 2019 through 2021, ESI coverage would decline by roughly 1 million on balance relative to previous law: this estimated 6–7 million people would no longer have an ESI offer as a result of the ACA, plus another 1–2 million would move to the exchanges despite having such an offer, minus 7–8 million who would have a new ESI offer as a result of the law. CBO's updated 2012 estimates indicate that by 2019, fully 11 million individuals will lose their ESI coverage offer due to the ACA, with a further 3 million moving to the health exchanges despite having an ESI offer. Subtracting 9 million who would have a new offer of ESI coverage, CBO now anticipates that net ESI coverage will decline by 5 million in 2019. This is much greater movement away from ESI coverage than CBO had previously been projecting, even though the law's effect on federal finances does not qualitatively change.