

Indexing in the Affordable Care Act: The Impact on the Federal Budget

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ABSTRACT

Proponents of the Affordable Care Act have pointed to the Congressional Budget Office's cost estimates to support their argument that the law will result in lower federal budget deficits in the future. Much less is said about the reasons for this forecast. This paper explains that the primary reason for the projected deficit reduction is the law's heavy reliance on indexing important provisions in order to restrain spending and increase revenue. The key provisions are a "productivity adjustment factor" that results in across-the-board cuts to hospitals and other facilities in perpetuity; frozen income thresholds for new taxes that supposedly apply only to higher-income households; thresholds for a new "Cadillac" tax on high-cost insurance that rise more slowly than healthcare costs; and indexing rules for premium credits that will cause lower-income households to pay ever higher percentages of their income in premiums. As more taxpayers and beneficiaries come to understand the full implications of these provisions, pressure will build to make significant adjustments to them. The result could be much higher spending and lower revenue than originally forecast by the Congressional Budget Office.

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One of the most important arguments made in favor of the Affordable Care Act (ACA) during its consideration in Congress was that it would not increase projected annual federal budget deficits, in either the short or the long term. This argument was made forcefully by President Obama at a number of key points in the debate, and it was echoed by many House and Senate members as well.¹ They received critical validation for their argument from the Congressional Budget Office (CBO), which released cost estimates showing small reductions in future deficits at crucial points in the legislative process, including right before the bill's final passage in March 2010.²

All of this is well-known history. What is not well known even today, more than five years after the law's enactment, is why CBO concluded that the legislation would slightly restrain future deficits.

Both during consideration of the legislation and in the years since its enactment, the Obama administration has implied that the favorable CBO cost estimate was due to the cost-saving effects of the law's "delivery system reforms."³ These are the provisions, mainly attached to the Medicare program, that aim to improve the efficiency with which doctors and hospitals care for patients by measuring the performance of providers and "paying for quality." But there is no evidence that these provisions will have any significant financial effects. In fact, CBO has consistently estimated that they will produce very

1. "Remarks by the President to a Joint Session of Congress on Health Care," White House press release, September 9, 2009, <http://www.whitehouse.gov/the-press-office/remarks-president-a-joint-session-congress-health-care>.

2. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to House Speaker Nancy Pelosi, March 20, 2010, <http://www.cbo.gov/sites/default/files/amendreconprop.pdf>.

3. For an example of this, see Centers for Medicare & Medicaid Services, Department of Health and Human Services, "Lower Costs, Better Care: Reforming Our Health Care Delivery System," CMS fact sheet, January 30, 2014, <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-01-30-03.html>.

minor changes relative to the overall cost of the ACA and to trends in national health spending.⁴

Far more significant from a budgetary perspective are the key *indexing* provisions of the ACA that helped produce—at least on paper—more favorable revenue and cost projections. These are the provisions that adjust key tax and benefit parameters from year to year. For example, if federal payments for health services are indexed to grow with the consumer price index (CPI) rather than with faster-growing overall health spending, that would be scored by CBO as reducing spending compared with the spending they assume would otherwise occur. CBO’s finding that the ACA will modestly reduce future deficits depends entirely on the vigorous and uninterrupted implementation of these provisions.⁵

It is certainly possible that congresses and presidents will allow these indexing provisions to be implemented as written in the ACA far into the future. But a careful examination of the provisions and the effects they will have both on the health system and on federal spending and taxation makes it clear that they are likely to be more appealing in theory than in practice. These provisions will only produce the beneficial fiscal effects CBO projected in its ACA cost estimates if they successfully impose large, and growing, financial sacrifices on program beneficiaries and taxpayers. It follows that if these provisions are eased to reduce the burdens they impose on taxpayers and program participants, the fiscal effects of the law will be very different from what CBO has forecast to this point. Indeed, it would not take much of a shift

4. For instance, CBO estimated at the time of enactment that Medicare accountable care organizations would reduce Medicare spending by \$4.9 billion between 2010 and 2019. Similarly, the provision penalizing hospitals for excessive readmission rates was estimated to save \$7.1 billion over the decade. By comparison, CBO projects that Medicare will spend \$632 billion in 2015. CBO, “March 2015 Medicare Baseline Projections,” March 9, 2015, <http://www.cbo.gov/publication/44205>.

5. CBO’s expectation that the ACA will reduce future federal deficits is flawed for a reason that is separate and apart from what happens with the key indexing provisions. As Charles Blahous has pointed out in a recent paper, CBO’s finding depends on an accounting practice that effectively double counts the ACA’s savings in the Medicare program. Charles Blahous, “The Fiscal Consequences of the Affordable Care Act” (Mercatus Center at George Mason University, Arlington, VA, 2012), <http://mercatus.org/publication/fiscal-consequences-affordable-care-act>. The reduced Medicare spending is used to partially finance the ACA’s coverage expansion and to improve the solvency of the Medicare hospital insurance (HI) trust fund, thus allowing the trust fund to pay out full Medicare benefits past its previously projected depletion date. Restricting the savings from the Medicare changes in the ACA to improving the HI trust fund solvency would eliminate all the supposed deficit-reducing effects of the ACA. Although treating the Medicare HI savings in this way would more accurately reflect fiscal reality, the analysis conducted in this paper takes as a starting point current conventions for budgetary scorekeeping, which allowed the double count of Medicare savings to be a part of the official ACA cost estimates.

in these provisions to turn the ACA into a massive fiscal drain for the federal government.

While the key indexing provisions of the ACA are critical to understanding the budgetary effects of the law, they are not widely understood even among those who closely follow developments in health policy. As the debate over the ACA continues, it is important to identify and describe the implications of these provisions carefully so that participants in that debate have a clear and accurate view of what the ACA, as currently written, will really mean in the future.

WHAT IS INDEXING?

Indexing is an adjustment mechanism used to keep tax and benefit program parameters consistent with policy preferences over time. Many times, this means adjusting a tax or benefit provision so that it maintains its real—that is, inflation-adjusted—value from year to year. This is a particularly important aspect of programs and tax provisions that are enacted with the expectation that they will operate for many years into the future without the need for further legislation by Congress. Placing into permanent law the manner by which a program parameter will be adjusted over time eliminates the risk that individuals or organizations participating in a federal program will be unduly harmed or aided by inaction on the part of a future Congress. Indexing also provides a ready mechanism by which Congress can fine-tune a legislative proposal to achieve a desired level of budget savings, as estimated by CBO.⁶

The most famous indexing provision in federal law today is the Social Security cost-of-living adjustment, or COLA. The Social Security Act specifies that beneficiaries receiving a monthly Social Security check should be given a COLA increase at the beginning of every new calendar year, effective with payments due on January 1. The increase is based on the rise in the consumer price

6. There are two primary alternatives to indexing to achieve a given level of budget savings. First, Congress could impose specific dollar reductions in spending (or specific dollar increases in revenue) each year instead of linking the spending or revenue levels to an index. Such an approach ignores changes in the economy or other circumstances that might justify more or less budget savings in a future year than was assumed when the legislation was enacted. Moreover, expressing a change in budget policy in terms of absolute dollars (as opposed to a percentage adjustment in a program parameter) is likely to be less desirable in terms of political perceptions in many instances. For instance, it is likely harder to explicitly call for a \$10 billion tax hike than to fine-tune key tax parameters to achieve such a tax hike automatically. The other option is to replace indexing with additional concrete policy proposals to achieve a given level of budget savings. It is often difficult to identify additional policies that achieve savings and whose nonbudgetary impacts are acceptable to Congress and the president.

“Small changes in indexing can have large financial implications over time due to the power of compounding.”

index, measured over the one-year period ending the previous October 31. Social Security benefits were increased by 1.7 percent in January 2015 due to the COLA provision.⁷ Congress enacted the Social Security COLA provision to ensure that the purchasing power of Social Security payments to senior citizens did not erode over time due to the effects of inflation on the prices of goods and services.

Other provisions of federal tax and entitlement law are tied to different indices for different policy reasons. For instance, the threshold establishing the maximum taxable income for the Social Security payroll tax is increased each year based on a measure of the growth in average national wages. In 2014, wages up to \$117,000 were subject to the Social Security payroll tax. In 2015, the maximum annual wage subject to the tax is \$118,500.⁸ The “tax max” is indexed in this way because Congress wanted the Social Security tax and benefit structure to keep pace, as much as possible, with rising wages in the national economy to ensure that the program did not slowly evolve into something focused mainly on lower-income households.⁹

How key tax and benefit programs are indexed is very important because small changes in indexing can have large financial implications over time due to the power of compounding. As an example, assume a retiree is getting \$1,000 per month from Social Security. If the annual COLA for that retiree were to be set in law at 3 percent per year, the monthly amount paid to the retiree would rise to \$2,427 after 30 years. By contrast, if the

7. See Social Security Administration, “2015 Fact Sheet: Social Security Changes,” <http://www.ssa.gov/news/press/factsheets/colafacts2015.pdf>.

8. Ibid.

9. Social Security’s rules link wages covered by the payroll tax during working years to benefits payable in retirement. Wages earned above the maximum are not subject to the tax and do not factor into benefit calculations. As explained in a report from the Congressional Research Service, proponents of indexing the “tax max” wanted to ensure that “moderate and well-to-do” households were paying taxes into Social Security, and thus were also receiving benefits on their higher-income contributions, so as to preserve “their support for the system.” See Janemarie Mulvey, Congressional Research Service, *Social Security: Raising or Eliminating the Taxable Earnings Base*, report for Congress, pp. 1–2, September 24, 2010.

COLA were set in law at 2 percent annually, the monthly payment to the retiree would be just \$1,811 after 30 years. Multiply that more than \$600 difference in monthly checks across millions of beneficiaries and the power of an indexing adjustment as a budgetary device comes into clearer focus. It also explains why the senior lobby has always been adamantly opposed to arbitrary COLA cuts for Social Security beneficiaries. If inflation really is 3 percent per year, but the law only provides for a 2 percent annual COLA, then a Social Security check of \$1,000 per month will lose roughly one-fourth of its purchasing power during the course of three decades.

The authors of the ACA made choices about indexing that are analogous to COLA cuts in four key places: (1) payment adjustments for medical service providers; (2) the income thresholds for assessing new taxes on individuals; (3) the dollar thresholds for determining what constitutes a “Cadillac” insurance plan; and (4) the rate at which the large subsidies provided through the ACA’s exchanges will rise each year. The budgetary implications of these key ACA provisions run into trillions of dollars over the coming decades.

AN EXPLANATION OF ACA COST ESTIMATES

CBO provided a comprehensive estimate of the budgetary effects of the ACA on a few occasions, both before and after enactment of the law. Most notably, just before its final passage in March 2010, CBO provided a comprehensive look at all the law’s tax and spending provisions.¹⁰ In July 2012, as the House prepared to vote on a full repeal of the law, CBO provided an estimate of the budgetary effects of that effort.¹¹ And in June 2015, CBO provided a new estimate of the budgetary effects of a full repeal, and included in its assessment projections of what would occur both with and without macroeconomic feedback effects from repeal.¹² Moreover, at the regular intervals when CBO routinely updates its overall budget and economic projections, it has also provided new estimates of the insurance coverage and budgetary effects of the ACA’s exchanges and Medicaid expansion.

10. Elmendorf, letter to Nancy Pelosi.

11. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to House Speaker John Boehner, July 24, 2012, https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/cost-estimate/43471-hr6079_0.pdf. CBO noted that estimating the budgetary effects of repeal is not the same thing as simply reversing the signs on the numbers for the estimate of the budgetary effects of enactment. Nonetheless, it is clear that CBO projections for repeal provide a close approximation of what the agency assumes the budgetary effects of the law will be.

12. Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act*, June 2015.

Normally, CBO provides 10-year cost estimates for proposed legislative changes in federal entitlement spending and tax laws. However, in the case of the ACA, there was great interest in Congress for an assessment of what the legislation would do to the federal budget over a longer period of time. To provide some guidance to Congress on this question, CBO included in its March 2010 estimate a description of what it believed would occur in the second decade of the legislation's implementation. As stated in the cost estimate,

Reflecting the changes made by the [two laws that together put in place the ACA], the combined effect . . . would also be to reduce federal budget deficits over the ensuing decade relative to those projected under current law—with a total effect during that decade in a broad range around one-half percent of GDP.

It is noteworthy that in its estimate, CBO specifically cited the effects of key indexing provisions for both the law's new premium credit payments and the "Cadillac" tax as reasons for the potential second decade deficit reduction.

In its July 2012 estimate of repeal of the ACA, CBO noted that reversing the law's provisions would increase the deficit by about 0.5 percent of GDP in the second decade.

In its most recent assessment of the ACA, again looking at the budgetary and other effects of full repeal, CBO again concluded that undoing the provisions of the ACA would increase the deficit both in the short and long term. Over 10 years (2016 to 2025), CBO estimated that full repeal would increase the deficit by \$353 billion, assuming no macroeconomic effects from the repeal. With the macroeconomic effects included in the assessment, CBO estimated the 10-year increase in the deficit at \$137 billion. Beyond 2025, CBO once again reiterated that its projections are highly uncertain, but once again suggested that a full repeal would add to the deficit, in the range of about 1 percent of GDP, and that the macroeconomic effects of repeal would not substantially alter this finding. Importantly, CBO specifically cited the key indexing provisions discussed in this paper in reaching this conclusion.¹³

13. *Ibid.*, 19.

THE PRODUCTIVITY ADJUSTMENT FACTOR AND RATE CUTS IN PROVIDER PAYMENTS

Medicare beneficiaries can elect to take their coverage in one of two ways. They can select a private insurance option—called a Medicare Advantage plan—or they can enroll in the traditional fee-for-service (FFS) insurance program. The traditional FFS option is an insurance plan administered by the federal government through the Centers for Medicare & Medicaid Services (CMS). Although enrollment in Medicare Advantage has been growing in recent years, about 70 percent of Medicare beneficiaries are enrolled in the traditional FFS program.¹⁴

For the beneficiaries enrolled in a FFS plan, the federal government makes payments to all manner of medical professionals and institutions for the services they deliver. Over many years, Congress and the CMS have built a complex series of payment systems for these providers. One common theme is that the payment systems are generally updated every year to reflect the rise in costs of the goods and services the providers must purchase to run their facilities or practices. So, for instance, the cost of running a hospital is measured by examining a hospital-based “market basket” of items and services typically purchased for use in inpatient facilities. The costs of those items and services are measured and then used to create an index that is the basis for updating Medicare’s payments for inpatient stays for the program’s beneficiaries.

Since 1983, when Congress established the prospective payment system for hospital stays, it has frequently made ad hoc adjustments to the annual percentage increase that otherwise would have applied to payment rates for inpatient stays. For instance, in 1990, as part of a large budget-cutting effort, Congress reduced the market basket increase that was scheduled to be paid in fiscal year 1991 by 2.0 percentage points for hospitals located in urban areas and 0.7 percentage points for facilities located in rural communities.¹⁵ Congress has imposed similar ad hoc cuts in the payment updates scheduled for hospitals at various intervals over the past three decades, mainly for budgetary reasons.

In a sense, the ACA’s intervention into what the law otherwise would require for annual increases in provider payments might be described as just one more instance in a long series of budget-cutting efforts by Congress. But the ACA’s cuts are really of a different character from previous reductions because

14. *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (hereafter referred to as the 2015 Medicare Trustees’ Report), table IV.C1, July 2015, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>.

15. See section 1886(b)(3)(B)(i)(VI) of the Social Security Act, Social Security website, http://www.ssa.gov/OP_Home/ssact/title18/1886.htm.

of their permanence. In previous rounds, Congress imposed cuts for defined periods of time based on a view of the financial condition of the facilities. The ACA's cuts, which are deep, will occur every year in perpetuity regardless of the financial state of facilities in question—unless future legislation reduces the severity of these provisions.¹⁶

The ACA imposes cuts in the rate updates of provider payments by introducing a “productivity adjustment factor” into Medicare’s reimbursement rules, beginning with fiscal year 2012.¹⁷ The productivity adjustment factor is a reduction in the regular market basket increase scheduled for various providers of medical services to Medicare patients, based on economy-wide productivity increases and measured over a rolling 10-year period preceding the year in question. Productivity is essentially a measure of output per worker, so growth in productivity means the same workers can produce additional goods and services over time due to any number of factors that improve worker efficiency.

The theory of the productivity adjustment factor is that providers of medical services to Medicare patients should be able to achieve the same level of productivity improvement as workers in the rest of the US economy. Regardless of whether healthcare providers can actually achieve that level of productivity improvement, Medicare’s payment updates will be reduced as required by this adjustment factor. The ACA applies the productivity adjustment factor to the inflation updates that otherwise would occur for hospitals, skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, home health agencies, psychiatric hospitals, hospices, dialysis centers, outpatient hospital clinics, ambulance services, ambulatory surgical centers, laboratories, and certain providers of durable medical equipment.¹⁸

The actuaries at the CMS who produce the Medicare cost projections for the executive branch estimate that the productivity adjustment factor will reduce the market basket index by, on average, 1.1 percentage points, from 3.5

16. As noted later, Congress has frequently modified formula-based spending reductions when those cuts became untenable.

17. See section 3401 of the ACA in the Compilation of Patient Protection and Affordable Care Act, May 2010, <http://housedocs.house.gov/energycommerce/ppacacon.pdf>.

18. In addition to the productivity adjustments, the ACA includes an overall limitation on the growth of Medicare spending by creating the Independent Payment Advisory Board (IPAB). The IPAB will propose legislation to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Initially, the target was the average of the CPI and the medical CPI (which is a price index based on a subset of the goods and services examined for price changes related just to medical care and services). Beginning in 2018, the target will be GDP per capita plus 1 percent. CBO projects that the IPAB provision will not be triggered for at least the next decade because of the recent slowdown in Medicare spending.

percent annually to 2.4 percent.¹⁹ This adjustment has already been made to hospital and other payments each year since 2012, and it will be taken out of the annual updates every year going forward.

In addition to the productivity adjustment, the ACA also imposed additional ad hoc annual cuts to the statutory market basket formula for hospitals for the years 2010 through 2019, as shown in table 1.

TABLE 1. AD HOC ADJUSTMENTS TO THE HOSPITAL MARKET BASKET UPDATES INCLUDED IN THE AFFORDABLE CARE ACT

Fiscal year	Ad hoc reduction to the market basket update
2010	-0.25%
2011	-0.25%
2012	-0.10%
2013	-0.10%
2014	-0.30%
2015	-0.20%
2016	-0.20%
2017	-0.75%
2018	-0.75%
2019	-0.75%

Source: Section 3401(a), Compilation of the Patient Protection and Affordable Care Act, Joint Committee Print, 111th Congress, 2nd Session, May 2010.

Both CBO and the actuaries at the CMS have estimated that the productivity adjustment factor would result in large spending reductions over the first decade after the ACA’s enactment. In CBO’s cost estimate for the final legislation, issued in March 2010, the agency separately identified the effects of this provision and concluded it would cut Medicare spending by \$196 billion over 10 years—the largest single spending reduction included in the ACA.²⁰ The CMS actuaries estimated in April 2010 that these provisions would reduce Medicare spending by \$205.3 billion over 10 years.²¹

19. Stephen Heffler, Kimberly Andrews, Mary Kate Catlin, and Mollie Knight, Office of the Actuary, Centers for Medicare & Medicaid Services, “Simulations of Affordable Care Act Medicare Payment Update Provisions on Part A Provider Financial Margins,” July 8, 2014.

20. Elmendorf, letter to Nancy Pelosi, table 5.

21. Richard S. Foster, Chief Actuary, Office of the Actuary, Centers for Medicare & Medicaid Services, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act,’ as Amended,” April 22, 2010.

As shown in table 2, the savings from the productivity adjustment factor (as well as the cuts to the Medicare Advantage program) are far higher than the projected savings from the reforms the administration more frequently cites, such as the introduction of a new managed care organization into Medicare—“accountable care organizations”—and the policy by which Medicare reduces payments to hospitals found to have high rates of readmitting previously discharged patients.

TABLE 2. SELECTED ACA MEDICARE SAVINGS PROVISIONS

	2013-2022 (\$ billions)
Productivity adjustment factor	-196
Medicare Advantage payments	-136
Medicare and Medicaid DSHs*	-36
Accountable care organizations	-5
Hospital readmission policy	-7

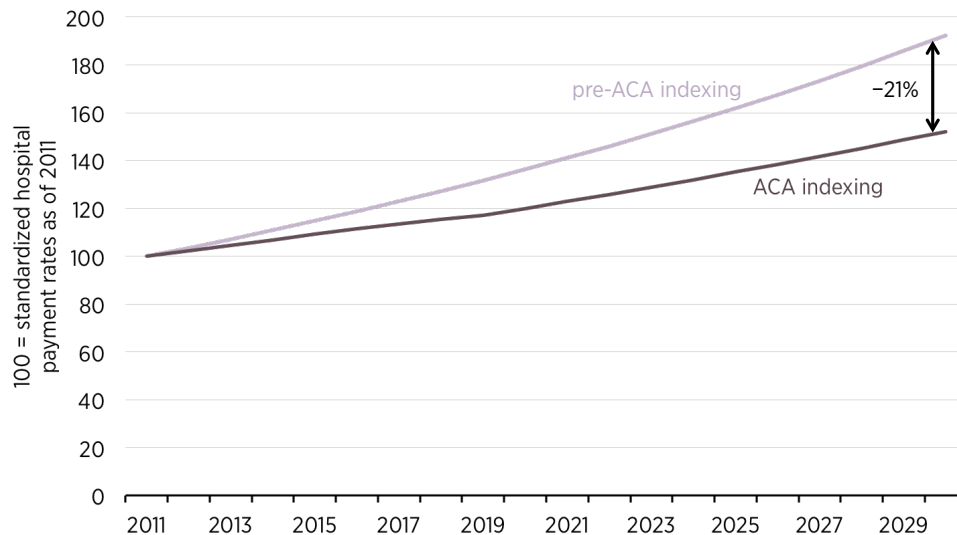
* disproportionate share hospitals.

Source: Congressional Budget Office to House Speaker Nancy Pelosi, March 20, 2010, <https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf>.

These cost estimates make it clear that the market basket cuts in the ACA will have significant budgetary implications even within the first decade of implementation. But it is over the longer term, as the compounding effects of the cuts begin to accumulate, that the budgetary effects of these cuts will become truly massive. As shown in figure 1, the cumulative effect of the reduction in payment rates would grow quickly, and in the case of hospitals, would reduce payments in 2030 by 21 percent compared to a projection that assumes payments would be adjusted fully for market basket price increases.

It is possible to see an approximation of the size of the cuts in budgetary terms over the long run in tables produced by the CMS actuaries. Each year since 2010, the actuaries have produced an alternative projection of Medicare expenses based on the assumption that some of the ACA’s cuts, and in particular the productivity adjustment factor, cannot be sustained indefinitely. A comparison of the present value of expenditures under Part A of the program (which covers hospitalizations and stays in other facilities) shows a \$4.0 trillion gap between what would occur under current law versus what would occur if the market basket cuts in the ACA were relaxed and the previous payment

FIGURE 1. THE PRODUCTIVITY ADJUSTMENT FACTOR AND AD HOC CUTS IN PAYMENTS TO INPATIENT FACILITIES



Source: Authors' calculations.

policy restored.²² The cumulative effect of the market basket cuts would be a 56 percent reduction in what Medicare pays for services at the end of the 75-year projection period.²³

The CMS actuaries have repeatedly highlighted the significance of the market basket cuts in the ACA because they do not believe they can be sustained. In an analysis released in conjunction with the 2015 Medicare Trustees' Report, the actuaries estimated that, by 2040, half of all hospitals, 70 percent of skilled nursing facilities, and 90 percent of home health agencies would be losing money each year because of the deep cuts in their Medicare reimbursement rates.²⁴ The cuts would widen the already large gap between what private insurers pay for services and what Medicare pays, according to the actuaries.

22. Suzanne Codespote, Deputy Director, Medicare and Medicaid Cost Estimates Group, Office of the Actuary, Centers for Medicare & Medicaid Services, memorandum to Senate Budget Committee, July 22, 2015. The \$4.4 trillion gap identified in this memorandum likely understates the total budgetary effects of section 3401 of the ACA for two reasons. First, the actuary's alternative scenario assumes that the productivity adjustment factor would begin to phase down in 2022, rather than immediately. Second, some of the spending reduction would occur in Part B of the program. The full impact would include budget savings resulting from the productivity adjustment factor for the entire 75-year period in both Part A and Part B.

23. 2015 Medicare Trustees' Report, 191.

24. *Ibid.*, 192. See also John D. Shatto and M. Kent Clemens, Office of the Actuary, Centers for Medicare & Medicaid Services, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," July 22, 2015.

Today, Medicare’s payments for services are about 67 percent of what private insurers pay for the same care. With the market basket cuts in the ACA, Medicare’s payments would fall to just 40 percent of what private insurers would pay at the end of 75 years.²⁵ If providers of services to Medicare beneficiaries are losing money because the cost of caring for Medicare patients far exceeds what they are paid for providing the services, then some facilities and practices will stop admitting Medicare enrollees into their facilities.

These analyses from the CMS actuaries are important. The actuaries explain that “in practice, providers could not sustain continuing negative margins and, absent legislative changes, may have to withdraw from providing services to Medicare beneficiaries” or take actions to shift the cost of Medicare patients to other payers.²⁶

Put another way, if Medicare’s long-term solvency could be assured just by lowering what Medicare pays for services, then why not do just that? The answer of course is that Medicare is only valuable to the program’s beneficiaries if hospitals and physicians are willing to take care of them. And there’s nothing to stop providers of medical care from catering to patients covered by private insurance and avoiding those on Medicare and Medicaid. Indeed, today there is ample evidence that Medicaid participants have much more trouble than the privately insured finding physicians who will see and take care of them.²⁷ Medicare beneficiaries could face the same problem if the program’s payment rates fall so low that physicians and hospitals decide they are better off without the business.

Indeed, what’s ironic about the ACA’s cuts to hospitals and other institutional providers of services is their similarity to what has already been tried and failed with Medicare payments to physicians. Beginning in 1989, Congress established upper boundaries (updated in 1997) for total physician fees paid under Medicare that are entirely disconnected from what is necessary to properly care for patients. The so-called “sustainable growth rate,” or SGR, was indexed to GDP to ensure that Medicare’s physician payments would grow no faster than the overall economy. Enforcement of the SGR came in the form of across-the-board payment rate reductions for all physician fees.

25. 2015 Medicare Trustees’ Report, 191.

26. *Ibid.*, 192.

27. See, for instance, Joanna Bisgaier and Karin V. Rhodes, “Auditing Access to Specialty Care for Children with Public Insurance,” *New England Journal of Medicine* 364 (June 16, 2011): 2324–33, <http://www.nejm.org/doi/full/10.1056/NEJMsa1013285#t=article>. The study found that children on Medicaid faced significant barriers to accessing care from specialists.

Nearly from its inception, the policy didn't work. Because the SGR formula was cumulative, fee reductions called for in earlier years that had not been implemented were added to the current year's cut. As a result, the SGR formula called for ever-greater payment reductions to keep total spending within the limit. But the cuts that were required were so impractical as to be impossible to implement. For instance, the SGR formula was supposed to result in a 24 percent cut in physician fees in 2014, but Congress chose to override the cut, just as it has done nearly continuously since 2002.²⁸ When confronted with a choice between sticking with formulaic cuts or protecting access to care for beneficiaries, Congress predictably sided with the beneficiaries of the program.

The authors of the ACA could have devoted some of the budgetary savings associated with the law's new revenue provisions or spending cuts to undoing all or a portion of the scheduled cuts in Medicare physician fees under the SGR. They chose not to do so, presumably to ensure that the resources available under the bill would be used primarily to expand subsidies for insurance coverage.

In April 2015, Congress enacted a permanent change in the method of calculating annual increases in physician fees in the Medicare Access and CHIP Reauthorization Act of 2015.²⁹ CBO estimated that the changes to Medicare's physician payment policy enacted in this law would increase federal spending by about \$175 billion through 2025.³⁰ Ironically, though the legislation eliminates the threat of double-digit reductions in physician payment

“The SGR formula was supposed to result in a 24 percent cut in physician fees in 2014, but Congress chose to override the cut, just as it has done nearly continuously since 2002.”

28. Jim Hahn and Janemarie Mulvey, Congressional Research Service, “Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System,” August 2, 2012; Catherine Hollander, “SGR, ICD-10 Extensions Approved by Senate,” Modern Healthcare, March 31, 2014, <http://www.modernhealthcare.com/article/20140331/NEWS/301019918>.

29. John Boehner, Speaker of the House, “10 Things You Should Know about the Permanent Doc Fix,” March 24, 2015, <http://www.speaker.gov/general/10-things-you-should-know-about-permanent-doc-fix>.

30. Congressional Budget Office, “H.R. 2, Medicare Access and CHIP Reauthorization Act of 2015,” March 25, 2015, <https://www.cbo.gov/publication/50053>.

rates from the despised SGR formula, it substitutes a new formulaic approach to increasing physician fees that will still leave those fees falling behind consumer inflation and the growth of healthcare costs more generally.

Under the new law, physician payments are now set to increase 0.5 percent annually for several years, transitioning by 2026 to an annual increase of 0.25 percent for services provided under the merit-based incentive payment system (which is essentially fee-for-service payment adjusted according to how well physicians meet performance standards) or 0.75 percent for services provided under alternative payment models (such as accountable care organizations or the inclusion of physician payments within larger “bundles” covering a full episode of care and shared with all the various service providers associated with taking care of the patient).³¹ These increases will not keep pace with medical price inflation, which has increased 2.5 percent to 4.4 percent annually over the past decade.³² Consequently, this new approach to indexing fees for physician services will lead to problems that closely resemble those that will occur for facilities under the productivity adjustment factor. Indeed, that is exactly what the CMS actuaries warned about in their official cost estimate of the new legislation.³³

The fact that there is a real bottom below which Medicare payments cannot go without harming access to care for seniors is an important consideration when looking at the ACA and its fiscal effects. If the ACA’s market basket cuts push payments below that floor, Congress will be forced to scale them back, at which point the ACA could become a major financial drain on the US Treasury.

TAXES ON “HIGH-INCOME” HOUSEHOLDS

Proponents of the ACA have argued that the law protects the middle class from paying new taxes by limiting the revenue provisions to the healthcare industry and to higher-income individuals and households. But this contention is misleading for two reasons. First, as shown in assessments of the law by the Joint Committee on Taxation (Congress’s independent scorekeeper for revenue provisions), some of the taxes imposed, such as a new limit on the deductibility of

31. House Committees on Energy & Commerce and Ways & Means, “SGR Repeal and Medicare Provider Payment Modernization Act: Section by Section,” March 19, 2015.

32. Bureau of Labor Statistics, Consumer Price Index: Medical Care, September 18, 2015, http://data.bls.gov/timeseries/CUUR0000SAM?output_view=pct_12mths.

33. Paul Spitalnic, Chief Actuary, Centers for Medicare & Medicaid Services, “Estimated Financial Effects of the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2),” April 9, 2015.

medical expenses, will explicitly hit middle-income households.³⁴ Moreover, the taxes on sectors of the healthcare industry (insurers, drug manufacturers, and medical device companies) will get passed on to all consumers in the form of higher prices. That means middle-class patients will pay more for services because of these taxes.

But, just as importantly, although the authors of the ACA said the law would only raise taxes for higher-income individuals and households, it is clear that households with incomes far below those of “upper-income” Americans will ultimately pay much higher taxes. The reason is indexing—or, in this instance, the lack of it.

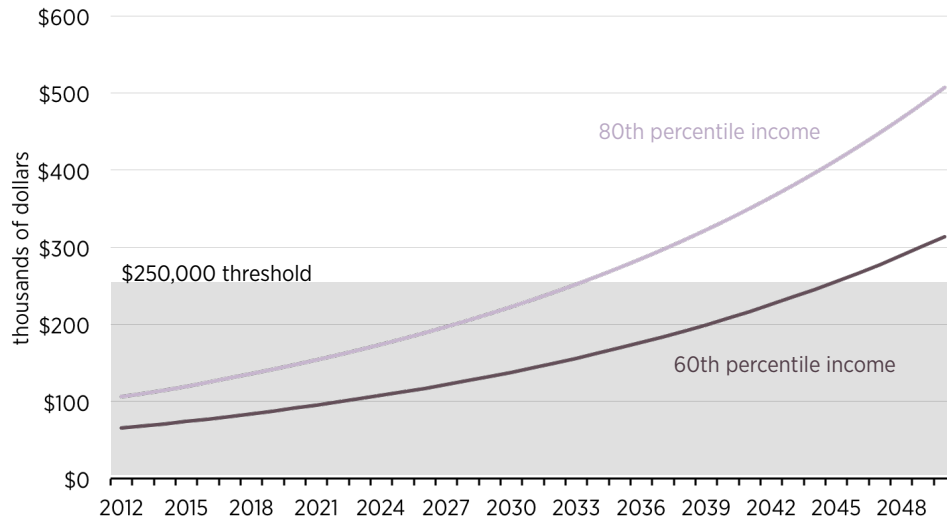
The key taxes in question—a new Medicare Hospital Insurance (HI) tax add-on of 0.9 percent of payroll and a new 3.8 percent tax on so-called “unearned” income—were billed as applying only to individuals and couples filing joint returns with yearly incomes exceeding \$200,000 and \$250,000, respectively. The new Medicare HI payroll tax of 0.9 percent comes on top of the regular 2.9 percent Medicare tax (half of which is paid by employers and half by employees). The new 3.8 percent tax on unearned income is aimed at imposing this new, higher HI payroll tax rate (2.9 percent plus 0.9 percent) on the nonwage income of the same taxpayers.³⁵ Included in unearned income are dividends, interest, rent, royalties, and business income from financial trading or passive business activity.

The authors of the ACA chose not to index these income thresholds to inflation or wage growth, as is the norm for most other thresholds in federal tax law. The reason for this choice is obvious: they wanted these provisions to raise increasing amounts of revenue each year as part of their campaign to claim that the ACA will modestly reduce future deficits. But this additional revenue comes at the expense of another commitment made by the authors of the law: that only the “rich” will pay higher taxes. By not indexing the thresholds, the ACA’s authors guaranteed that, in time, many households that are decidedly not rich will pay these new taxes. In fact, the Medicare actuaries estimate that, by the end of the traditional 75-year projection period used to assess the financial status of the program’s trust funds, 80 percent of US

34. Jay Heflin, “JCT: Healthcare Law to Sock Middle Class with a \$3.9 Billion Tax Increase in 2010,” *The Hill*, April 12, 2010, <http://thehill.com/policy/finance/91669-healthcare-law-socks-middle-class-with-a-39-billion-tax-increase>.

35. Section 9015 of the ACA, as amended, and section 1401 of the Health Care and Education Reconciliation Act of 2010 in the Compilation of Patient Protection and Affordable Care Act, <http://housedocs.house.gov/energycommerce/ppacacon.pdf>.

FIGURE 2. “HIGH-INCOME” THRESHOLD AND HOUSEHOLD INCOMES



Source: Census Bureau data and authors' calculations.

households will have incomes exceeding the income thresholds used to trigger these taxes.³⁶

Figure 2 illustrates this point. The threshold for assessing the two new taxes on joint filing households is fixed at \$250,000. Incomes, on the other hand, tend to rise with growth in the national economy. According to the Census Bureau, in 2013, households with incomes of \$105,910 were at the 80th percentile of the US income distribution, meaning that about 20 percent of all households had a higher annual income. The 60th percentile household—squarely in the middle class—had an annual income of \$65,501. If household incomes grow with GDP, as has generally been the case historically, then households at these points in the income distribution will begin to pay the ACA's “high-income” taxes within a few decades. For the 80th percentile household, the crossover year is 2033. For the 60th percentile household, it is 2045.³⁷

In the 1970s, the income thresholds used to set the individual income tax rate schedule were not indexed to inflation either. With inflation rates as high

36. 2015 Medicare Trustees' Report, 28.

37. These calculations are based on Census Bureau data indicating income levels delineating the quintiles of the income distribution. See US Census Bureau, “Historical Income Tables: Households,” <http://www.census.gov/hhes/www/income/data/historical/household/index.html>. These break points were then indexed using nominal GDP growth rates found in CBO's most recent economic forecast. CBO's assumed GDP growth rate for the years 2018 through 2025 (4.2 percent) was presumed to continue indefinitely into the future.

as 11 percent pushing up wages and salaries, households automatically were pushed into ever-higher tax brackets.³⁸ The resulting resentment at “bracket creep” was one of many factors that laid the groundwork for the Reagan tax cuts in 1981, which permanently indexed the tax brackets to inflation.

A similar phenomenon occurred with the alternative minimum tax (AMT). Originally enacted in 1969 to ensure that a couple of hundred wealthy taxpayers could not avoid federal income taxes altogether through aggressive use of deductions and loopholes, the AMT grew steadily to apply to more and more Americans because its key income thresholds were not indexed. As more upper-income and even middle-income households were required to pay taxes under this complex addendum to the regular income tax law, frustration grew, and Congress was forced to begin enacting ad hoc adjustments to prevent it from becoming a backdoor way to impose a major middle-class tax hike. Congress finally enacted a permanent indexing fix for the AMT in the American Taxpayer Relief Act, signed into law by President Obama in early 2013.³⁹

The taxes on “higher-income” households in the ACA are, in effect, bringing back the bracket creep that caused so much resentment in the 1970s and with the AMT in more recent times. In both of these prior instances, Congress was ultimately forced to enact laws that prevented automatic tax hikes resulting from a lack of indexing key income thresholds in the tax law. This history raises serious questions about the reliability of the revenue projections associated with the ACA taxes, which explicitly assume large tax revenue increases associated with more households crossing over income thresholds that are not indexed for inflation.

The effects of bracket creep are visible even in the short budget window provided in the most recent CBO cost estimate of the ACA’s provisions. In that projection, from July 2012, the taxes on “higher-income” households were estimated to raise \$25 billion in 2015 and then \$46 billion in 2022—for an average annual growth rate of over 9 percent.⁴⁰

If the income thresholds for these two taxes were indexed to either inflation or wage growth, the application of the tax even 15 years from now would be very different. The \$200,000 threshold for individual filers would rise to about \$293,000 in 2030, assuming continuation of CBO’s forecast of 2.4 percent annual growth in the CPI. The \$250,000 threshold for joint filers would rise to \$367,000

38. Bureau of Labor Statistics, *CPI Detailed Report: Data for April 2015*, table 24.

39. For more background on the AMT, see Tax Policy Center, “Quick Facts: The Alternative Minimum Tax (AMT),” http://www.taxpolicycenter.org/taxtopics/quick_amt.cfm.

40. Elmendorf, letter to John Boehner.

if tied to the CPI. If the thresholds were tied to wage growth (as is the current maximum wage threshold for Social Security payroll taxes), then the \$200,000 threshold would rise to \$420,000 in 2030 while the \$250,000 threshold would rise to \$526,000.⁴¹ Such indexing would sharply reduce the revenue that would be collected by the higher payroll tax and the new tax on unearned income.

THE CADILLAC TAX

For many years, economists falling on all points of the political spectrum have urged reform of the tax treatment of health insurance.⁴² Their argument has been that exclusion of employer-paid premiums from the taxable incomes of workers for purposes of both the income and the payroll taxes has encouraged overly generous job-based insurance. Employees are taxed on their cash compensation but not their health benefits, so there has been a natural tendency to shift compensation toward expansive health insurance coverage. And, of course, generous employer-paid health insurance reduces the sensitivity of workers to healthcare costs and puts upward pressure on prices and health consumption.

The typical remedy proposed by economists has been to eliminate, or at least limit, the preferential tax treatment of employer-paid premiums. At various points over the past several decades, these ideas have been introduced into the political debates over healthcare reform. For instance, in 2008 Senator John McCain proposed to provide US households with a fixed, refundable tax credit to be used for purchasing health insurance.⁴³ The credit would have been available in lieu of the tax preference for employer-paid premiums, which would have been eliminated altogether. Other proposals have suggested placing an upper limit on the tax preference for employer-paid premiums instead of eliminating it entirely.⁴⁴

41. Authors' calculations.

42. John Holahan and Linda J. Blumberg, "An Analysis of the Obama Health Care Proposal," Urban Institute, September 22, 2008; Henry J. Aaron and Leonard E. Burman, eds., *Using Taxes to Reform Health Insurance: Pitfalls and Promises* (Washington DC: Brookings Institution, 2008); Greg D'Angelo and Robert E. Moffit, "Health Care Reform: Changing the Tax Treatment of Health Insurance," Heritage Foundation, March 16, 2009, <http://www.heritage.org/research/reports/2009/03/health-care-reform-changing-the-tax-treatment-of-health-insurance>.

43. Robert E. Moffit and Nina Owcharenko, "The McCain Health Care Plan: More Power to Families," Heritage Foundation, October 15, 2008, <http://www.heritage.org/research/reports/2008/10/the-mccain-health-care-plan-more-power-to-families>.

44. Robert Pear, "Reagan Aides Urge Taxing Employees on Health Benefit," *New York Times*, December 5, 1982, <http://www.nytimes.com/1982/12/05/us/reagan-aides-urge-taxing-employees-on-health-benefit.html>.

The Obama administration, working with Congress in 2009 and 2010, was sympathetic to the concern that an open-ended tax break was pushing health spending higher, and wanted to impose some discipline on the cost of employer plans. But it also wanted to find an approach to the problem that minimized political opposition from labor unions and other groups that strongly oppose the direct taxation of workplace health benefits. The result of these competing interests is the ACA's Cadillac tax provision.

Found in section 9001 of the law, the Cadillac tax imposes a 40 percent excise tax on employer-sponsored insurance coverage with premiums exceeding specified thresholds.⁴⁵ To appease union opposition to this idea, the law delayed the tax until 2018 and applies it only to the value of health insurance coverage exceeding relatively high levels: \$10,200 for individuals and \$27,500 for family coverage.⁴⁶ The Cadillac moniker is intended to suggest that only the richest employer-sponsored plans will be affected by the tax thresholds.

The new excise tax imposed by this provision is either charged to the insurer (in cases where the plan is purchased from an insurer) or charged to the employer (where the plan is self-insured). However, in general, insurers and employers will not bear the additional cost of the tax. As CBO put it in a recent report, "The forthcoming [Cadillac tax] will be levied on insurers and on self-insured employers, but economic theory and empirical evidence suggest that it will be passed on to employers who purchase or provide insurance that is subject to the tax—and then ultimately passed on to workers."⁴⁷

Although the tax will not be collected for several years, employers are already taking steps to raise deductibles, impose other cost-sharing requirements, and move toward narrower provider networks to avoid having to pay the excise tax at all. Workers will pay more for their health benefits based on these adjustments, and very few employers will bear the burden of the tax. This result is intentional: the Cadillac tax was imposed to reduce the value of employer health plans rather than directly raise revenue from high-cost plans.

There is, however, an indirect revenue effect as labor markets adjust to these policy-induced changes in worker compensation. CBO assumes that, in a competitive labor market, employers will compensate workers with higher cash wages to make up for the lost value of their health coverage. The higher

45. Section 9001 of the ACA, as amended, in the Compilation of Patient Protection and Affordable Care Act, <http://housedocs.house.gov/energycommerce/ppacacon.pdf>.

46. Julie Piotrowski, "Excise Tax on 'Cadillac' Plans," Health Policy Brief, *Health Affairs*, September 12, 2013, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=99.

47. Congressional Budget Office, *Options for Reducing the Deficit: 2014 to 2023*, November 2013, 245–46.

salaries and wages paid to workers are of course taxable under both the federal income and payroll tax laws. Thus, CBO expects the main effect of the Cadillac tax provision to be an increase in taxes collected on the higher cash wages that workers get in exchange for reduced health benefits. CBO estimated that the tax would raise \$111 billion between 2018 and 2022, accounting for both the revenue directly collected by the Cadillac tax and the indirect revenue increase from income and payroll taxes.⁴⁸

A key feature of the Cadillac tax design is the indexing of the thresholds over time. The thresholds of \$10,200 for individuals and \$27,500 for families in 2018 are to be increased by the CPI plus one percentage point in 2019. In 2020 and beyond, the thresholds will grow just with the CPI. In CBO's latest baseline projections, the CPI is expected to rise 2.4 percent annually from 2019 to 2025.

What is notable about this choice of indexing is that, absent the tax, premiums for health insurance are expected to rise much more rapidly than the CPI. From 1990 to 2013, the average annual growth rate of national health spending was 6.2 percent. During that same period, the CPI rose at an average annual rate of 2.6 percent. More recently, health spending has risen less rapidly than it has historically—at a rate of 3.9 percent annually from 2008 to 2013—but that still exceeds the 2.1 percent rate of inflation, as measured by the CPI, for the same period.⁴⁹

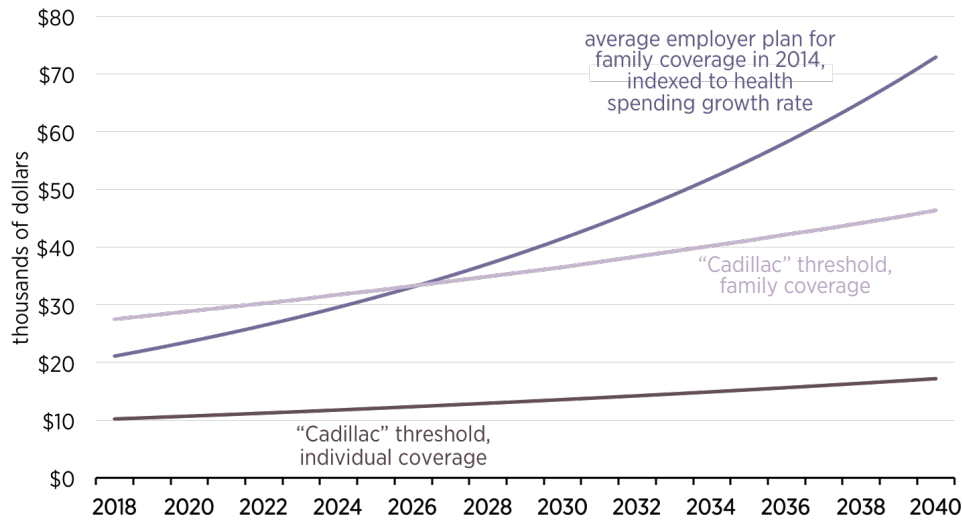
The large difference between consumer inflation and the growth in healthcare costs will drive more and more of the health plans offered by employers and insurers toward the Cadillac thresholds. As shown in figure 3, by 2030, the Cadillac tax thresholds will have risen to only about \$13,500 and \$36,500 for individual and family coverage, respectively. Meanwhile, assuming healthcare costs rise in the future at the rate currently projected by the Medicare actuaries (5.8 percent annually), the average cost of employer coverage for a family plan will rise from \$16,834 in 2014 to about \$41,500 in 2030.⁵⁰ Thus, the Cadillac tax will no longer be pinching only rich benefit plans; it will be forcing large cutbacks and adjustments in what are today's average-cost

48. Elmendorf, letter to John Boehner.

49. For historical health spending growth, see Centers for Medicare & Medicaid Services, National Health Expenditure Data, Historical Tables, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>. For measures of the rate of inflation, see Bureau of Labor Statistics, *CPI Detailed Report: Data for January 2015*, table 24, <http://www.bls.gov/cpi/cpid1501.pdf>.

50. The projected rate of growth of national health expenditures can be found at Sean P. Keehan et al., "National Health Expenditure Projections, 2014–24: Spending Growth Faster Than Recent Trends," *Health Affairs* 34, no. 8 (August 2015).

FIGURE 3. THE CADILLAC THRESHOLDS AND EMPLOYER COVERAGE



Source: Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits, Annual Survey 2014*, and authors' calculations.

plans. In fact, as shown in figure 3, the average-cost plan, indexed to historical spending trends, would exceed the Cadillac tax threshold in 2025.

As Congress was considering the ACA, the authors pushed back the implementation date of the Cadillac tax provision in an attempt to minimize opposition from key constituencies, especially large labor unions. Nonetheless, a political movement has already sprung up to either delay the tax further or scuttle it altogether. Given the level of political opposition that is already evident, it is likely that pressure will build further to adjust it as it begins to pinch just about every employer-based health plan offered in the country.

THE PREMIUM CREDITS

The foundation of the ACA is the premium credits provided to families with incomes above Medicaid eligibility in the states in which they reside—or 100 percent of the federal poverty line (FPL) in states that opted not to implement the ACA's Medicaid expansion—and below four times the FPL.⁵¹ These credits

51. The premium credits are paid to the insurance plans selected by exchange enrollees, but, as a technical matter, they are considered refundable tax credits for federal accounting purposes. For some taxpayers, the credit is shown as a reduction in income tax liability and counted as reduced federal revenue. For others who pay little or no income tax, the premium credit exceeds what is owed in income taxes. The excess of the credit over the tax liability is considered a payment on behalf of the household and is scored as a federal outlay.

are instrumental to expanding insurance enrollment and to making the new regulatory structure for health insurance work. Only families getting their health insurance through the ACA's exchanges are eligible for the credits.⁵²

The premium credit depends on household income and the cost of health insurance available in the applicant's local market. The law provides for a maximum premium deemed affordable for households with incomes between 100 and 400 percent of the FPL. In 2014 (the first year credits were payable to households), a family with an income between 100 and 133 percent of the FPL would pay no more than 2 percent of its income in the form of premium payments if the family chose the second-lowest-cost "silver" plan.⁵³ Households with incomes between 300 and 400 percent of the FPL were expected to pay up to 9.5 percent of their incomes toward premiums.

The maximum amount of the federal premium credit that a household can receive is the difference between the total premium charged by the second-lowest-cost silver plan (which we will refer to as the reference plan) and the maximum premium payment deemed affordable. If the reference plan charges a lower premium than the amount deemed affordable for a particular household, the household would pay the premium in full.

Families are allowed to use premium credits to purchase any qualified plan offered on the exchange (other than a catastrophic plan or a stand-alone dental plan). The amount of the credit does not increase if the household selects a plan that is more expensive than the second-lowest-cost silver plan. If the household selects a lower-cost plan, the premium credit can be no larger than the total premium charged by that plan.

For example, an individual whose income is equal to 300 percent of the FPL, or \$35,010 in 2014, is required to pay as much as \$277 a month (or 9.5 percent of income) for coverage through an exchange. If the plan selected by that person charges a monthly premium of \$300, the required payment will be \$277 and the premium credit will be \$23. If the monthly premium is \$250, the required payment will be the full \$250 and the premium credit will be zero.

52. The Supreme Court decided in June 2015 in *King v. Burwell* that Congress authorized the payment of the ACA's premium credits in all 50 states, regardless of whether or not the state had built its own exchange or had deferred to the federal government to build it instead.

53. The ACA establishes four tiers of health coverage: platinum, gold, silver, and bronze. The four plans cover the same medical services but have different levels of cost-sharing requirements. The silver plan is based on an actuarial value of 70 percent of covered services, meaning that, on average, the insurance plan covers 70 percent of the costs of covered medical services, and the enrollees cover the other 30 percent through deductibles and copayments.

The calculation of the credits is substantially more complicated after 2014 due to the ACA's complex indexing provisions.⁵⁴ In general, premiums for health insurance have risen more rapidly than incomes, and both CBO and the actuaries at the CMS expect that trend to continue. Consequently, absent an explicit adjustment, the ACA's premium credit calculations would push the government's share of the total premium for coverage up rather rapidly because the enrollees would have their premium capped at a fixed percentage of their income, and their income would grow less rapidly than the premiums.

To take this into account, and to hold down federal costs, the ACA increases the percentages of income that households must pay to keep the enrollees' share of the total premium roughly constant over time.⁵⁵ For instance, households with incomes between 300 and 400 percent of the FPL purchasing the second-lowest-cost silver plan are expected to pay as much as 9.56 percent of their incomes toward the premium for the reference plan in 2015, up from 9.5 percent in 2014. CBO and the CMS actuaries expect these percentages to continue growing indefinitely into the future. Increasing the maximum percentages of income that households are required to pay for the reference plan decreases the premium credits that would otherwise have been available to those households.

In addition to this basic adjustment for healthcare cost inflation, the ACA also put a fixed, aggregate cap on the total amount of exchange subsidies (including premium credits and cost-sharing subsidies) that the federal government would pay out each year, beginning in 2019. The cap is set at 0.504 percent of GDP, or about \$108 billion in 2019. If the cap is breached, then the ACA says the premium payments required from households will be adjusted upward further to reflect the "excess (if any) of the rate of premium growth . . . over the rate of growth of the consumer price index."⁵⁶ In effect, this provision limits the growth rate of the federal premium subsidies to something below healthcare cost inflation in an attempt to keep total federal costs at or below the overall cap on federal premium credit spending.⁵⁷

54. For a description of these provisions, see Congressional Budget Office, "Additional Information about CBO's Baseline Projections of Federal Subsidies for Health Insurance Provided through Exchanges," May 12, 2011.

55. Through 2018, the adjustment is equal to the difference between the percentage change in average premiums for private health insurance for the nonelderly nationwide between the two prior years and the percentage change in average US household income between those same two years. See *ibid.* As discussed below, the ACA also caps the total amount of exchange subsidies beginning in 2019.

56. Section 3401 of the ACA in the *Compilation of the Patient Protection and Affordable Care Act*.
57. Congressional Budget Office, "Additional Information about CBO's Baseline Projections."

Healthcare costs and health insurance premiums have generally grown faster than both the economy and inflation, and that is almost certain to continue. The unusual and complex indexing provisions for exchange subsidies are designed to limit the federal government’s financial risk. Consequently, lower-income households will face ever-increasing costs for their health insurance.

THE BUDGETARY EFFECT OF ALTERNATIVE INDEXING ASSUMPTIONS

CBO generally does not provide cost estimates for legislation beyond 10 years, but it provided a general assessment of the fiscal effects for the second decade of the ACA’s implementation on several occasions, both before and after enactment. Undoubtedly, CBO took the unusual step of providing this broad assessment in its cost estimates for the ACA because of intense congressional interest. But CBO also understood that this legislation contains permanent entitlement and tax provisions that could substantially alter the federal government’s long-term fiscal outlook and thus felt an obligation to describe, at least in general terms, what might happen beyond the initial 10-year projection.

The agency has stated that the tax increases and spending cuts, mainly in Medicare, would slightly outpace the rise in spending associated with the law’s Medicaid expansion and new income-tested premium credits, and thus reduce the federal budget deficit that would otherwise be expected in the second decade of the most recent projection—that is, from about 2026 to 2035—by about 1.0 percent of GDP.⁵⁸

Deficit reduction of 0.5 percent of GDP is a rather narrow margin for the ACA. In today’s terms, that’s about \$90 billion per year. Small changes to any one of the key indexing provisions described in this paper could eliminate that level of deficit reduction in just a few years’ time. Large revisions to each of these provisions would quickly transform the ACA into a major fiscal drain on the US Treasury.

We examined the likely long-term budgetary effects of each of the key indexing provisions in order to provide a rough total estimate of the contribution of these aggressive indexing assumptions to CBO’s conclusion that the ACA would reduce future deficits.

- *Productivity adjustment factor.* The CMS actuaries have issued an alternative projection of Medicare spending each year since the ACA was enacted

58. Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act*.

because they are skeptical that the productivity adjustment provision will be maintained as specified in the law. The projection issued in 2015, in conjunction with the release of the 2015 Medicare Trustees' Report, provided estimates for hospital insurance spending as a percentage of GDP, assuming the productivity adjustment to the market basket updates for facilities is modified so that the annual reduction in the update declines from 1.1 percent in 2020 to 0.4 percent over a 15-year period.⁵⁹ We adopted the resulting differential in the actuaries' projection in building our alternative scenario as well. In 2040, the actuaries believe a more realistic indexing of hospital and other facility payments would increase HI spending by 0.25 percent of GDP—about one-quarter of the deficit reduction that CBO identified with the ACA over the longer run.

- *“High-income” tax provisions.* CBO’s (and the congressional Joint Committee on Taxation’s) last look at the full array of ACA provisions showed the new taxes on households with incomes exceeding \$200,000 for singles and \$250,000 for couples generating \$22 billion in 2016 and rising to \$47 billion in 2025.⁶⁰ The average annual growth rate in revenues from these provisions over that nine-year period is 8.8 percent. Assuming that trend continues because the income thresholds are not indexed produces substantial tax hikes as the years pass, so much so that the expected revenue would rise from about 0.15 percent of GDP in 2018 to 0.33 percent in 2040. If this provision were altered so that the revenue it generated were held constant at 0.15 percent of GDP, then about one-fifth of the projected deficit reduction from the ACA would ultimately be lost.
- *Cadillac tax.* Similar to the tax on higher-income households, CBO and the Joint Committee on Taxation have estimated that the revenue associated with implementation of the Cadillac tax would rise dramatically, from \$3 billion in the first year of implementation in 2018 to \$21 billion in 2025, for an average annual growth rate in revenue of about 32 percent.⁶¹ If the revenue associated with this provision continued to grow at a rate of just 25 percent beyond the first 10 years (well below the rate of growth through 2025), it would generate substantial revenue, rising to nearly 1.2 percent of GDP in new revenue by 2040. If the revenue associated with this provision were limited to 0.15 percent of GDP, the deficit reduction of the ACA would be cut by more than 1.0 percent of GDP in 2040.

59. Shatto and Clemens, CMS, “Projected Medicare Expenditures under an Illustrative Scenario.”
60. Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act*, June 2015.

61. *Ibid.*

- *Premium credits.* The federal cost of the ACA's premium credits is highly uncertain. Unlike the Medicaid expansion, the premium credit program is brand new and without any real precedent in federal law. The ultimate number of participants in the program is hard to predict, as are the per capita subsidy payments, which depend on the incomes of those enrolling in exchange plans, the health plans they choose, and the premiums charged by those plans.

CBO's most recent projections seem to indicate that the total cost of the premium credits will fall below the 0.504 percent of GDP cap established in the ACA. In 2025, CBO projects exchange subsidies (including premium credits, revenue losses from premium credits, and outlays for cost-sharing subsidies) will total \$103 billion, which is about 0.375 percent of CBO's projected GDP for that year.⁶²

Relatively modest changes in the assumptions underlying CBO's estimates could reverse the optimistic conclusion that premium credits will not be reduced to keep federal outlays below the GDP cap. In 2011, for example, CBO projected that total federal subsidies through the insurance exchanges would exceed 0.504 percent of GDP in 2018 and subsequent years, at least through 2021.⁶³

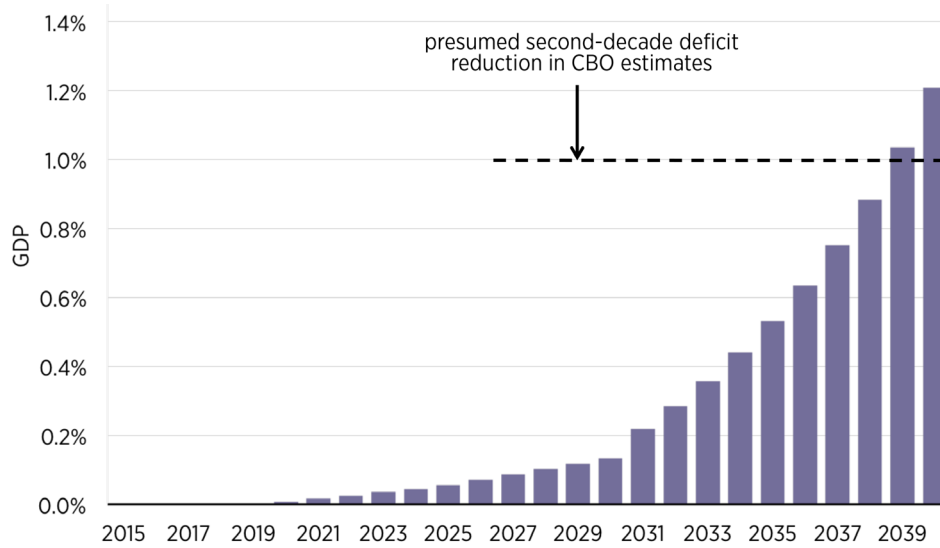
CBO reversed its conclusion about the GDP cap primarily because it is now projecting a much lower rate of growth in health spending over the next decade. In the 2011 estimates, CBO projected total exchange subsidies would be \$107 billion in 2017 and grow to \$140 billion by 2021. That represents an annual growth rate of 6.9 percent. In the current estimates, CBO projects lower initial subsidy levels, starting at \$78 billion in 2017 and reaching \$89 billion in 2021. Over that period, the average rate of growth is 3.3 percent. If health spending returns to the rapid growth rates of earlier years, the GDP cap could force premium subsidies to be reduced and increase the burden on low-income beneficiaries.

Although the GDP cap does not factor into CBO's current 10-year forecast for premium credit spending, the ACA's method for increasing beneficiary premium payments year by year is likely playing some role in keeping

62. Authors' calculation using Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline," March 2015, <https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf>; and Congressional Budget Office, "Updated Budget Projections: 2015 to 2025," March 9, 2015, <https://www.cbo.gov/sites/default/files/cbofiles/attachments/49973-UpdatedBudgetProjections.pdf>. CBO may use slightly different estimates of exchange spending and GDP for its calculations of the GDP cap.

63. Congressional Budget Office, "Additional Information about CBO's Baseline Projections," note 7.

FIGURE 4. DEFICIT-INCREASING EFFECTS OF ALTERNATIVE INDEXING ASSUMPTIONS



Source: Authors' calculations.

overall credit spending below what it might otherwise be. To keep the government’s costs down, the law pushes up the percentage of household income that exchange enrollees must pay to get coverage each year, although CBO’s projection does not indicate how high those percentages are expected to rise over the coming decade.

Because current projections for the premium credits are not bumping up against the GDP limit, we did not provide an alternative projection of premium credit payments to go along with the alternative indexing scenarios described above. Nonetheless, it remains a distinct possibility that costs for the credits could rise more rapidly than CBO now expects, for any number of reasons (such as higher bids from the insurers or a worse health profile among exchange enrollees). If that were to occur, then the ACA’s premium credit indexing provisions will almost certainly begin shifting very large costs onto the insurance enrollees, thus creating the very real budgetary risk that some of these added costs will get pushed back, for political reasons, onto taxpayers.

As shown in figure 4, CBO’s presumed deficit reduction from the ACA is about 1.0 percent of GDP in the decade beyond the current 10-year budget window (roughly 2026 to 2035). Absent the aggressive indexing of the key parameters discussed here, and using projections for the fiscal effects of these provisions that presumes they will generate revenues and spending restraint at levels more consistent with their initial effects, all of that deficit

reduction would eventually be wiped out, thus converting the ACA into a deficit-increasing law. More importantly, the lost taxes and the higher spending that would result from the less aggressive indexing of these provisions would result in ever growing deficit increases.

CONCLUSION

The United States is facing significant fiscal challenges in the coming years due to the costs associated with providing an expansive array of benefits to an aging population. During the long debate over the ACA, both before and since its enactment, there has been much discussion about whether the law would improve or worsen the long-term fiscal outlook. Proponents of the law have pointed to CBO's cost estimates that indicate a small amount of deficit reduction as the best evidence available that the law would, on net, be beneficial from a fiscal standpoint.

Very little has been said, however, about how CBO came to that conclusion. It is clear from a close examination of the provisions discussed in this paper that the deficit reduction CBO assigned to the law in its second decade depends heavily on the uninterrupted implementation of provisions that are sure to generate significant opposition. Deep across-the-board cuts to hospitals and other facilities from the productivity adjustment factor are assumed to occur every year in perpetuity. Many millions of taxpayers will again be subject to bracket creep and pay significantly higher wage and nonwage taxes as inflation naturally pushes up their incomes. Employer health plans that today are not considered out of the norm would soon approach the Cadillac limits and thus necessitate major adjustments, including large cost shifts onto workers. And participants in the ACA's exchanges could face large premium hikes as the subsidies are capped at a fixed percentage of GDP.

None of these provisions received much attention during debate on the ACA. The media focused much more on who would benefit from the entitlement expansions, which themselves are projected to grow rapidly as enrollment expands and healthcare costs escalate in coming years. Indeed, it seems likely, absent some significant change, that these entitlement expansions will soon be viewed like other entitlements, which is to say they will generally be off-limits for spending restraint because of the political sensitivity of taking something away from a citizen once it has been extended by the government. The same cannot be said for the provisions that were instrumental to the claim that these entitlement expansions were "paid for." Indeed, as more taxpayers and beneficiaries come to understand the full implications of

the indexing provisions described in this paper, pressure will build to make significant adjustments to them. The result could easily be that the ACA's massive new spending commitments remain fully intact while its financing provisions slowly vanish.

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