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RESEARCH SUMMARY

INDEXING IN THE AFFORDABLE CARE ACT
The Impact on the Federal Budget

Proponents of the Affordable Care Act (ACA) have frequently pointed to official cost estimates projecting that the law will reduce federal budget deficits. Much less attention has been paid to the primary reason for this favorable outlook: the law's heavy reliance on indexing important provisions to restrain spending and increase revenue. These components of the ACA will automatically impose perpetual, across-the-board cuts on payments to certain institutional medical providers; increase premiums for lower-income households; and raise taxes on an ever-expanding segment of taxpayers.

As the effects of these provisions become more evident, policymakers will face growing pressure to loosen them. Such policy adjustments, however, would likely transform the ACA into a major deficit-increasing law, according to a new study published by the Mercatus Center at George Mason University. Below is a summary of this analysis. To read the entire paper and learn more about its authors—James C. Capretta and Joseph R. Antos—please see "Indexing in the Affordable Care Act: The Impact on the Federal Budget."

BACKGROUND

Indexing is a commonly used practice that specifies automatic annual adjustments for certain government benefits and tax provisions in order to maintain their value as the economy changes over time. A well-known example of indexing is the annual cost-of-living adjustment for Social Security, which raises benefit payments by a factor based on the consumer price index (CPI).

Much of the deficit reduction projected for the ACA results from four specific indexing provisions. These provisions yield steep spending cuts or significant tax increases that will likely be difficult to sustain. Changing them, however, would reduce or even reverse the ACA's projected deficit reduction.

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PROVIDER PAYMENT CUTS

For the 70 percent of Medicare beneficiaries enrolled in the program's traditional fee-for-service option, the federal government follows a complex system of payment formulas to reimburse all manner of medical professionals and institutions for the services they provide. Typically, these payments are automatically adjusted each year to account for changes in the costs of medical goods and services. From time to time, Congress has reduced these payment increases to achieve budgetary savings.

- One of the major savings provisions of the ACA reduces Medicare payments to institutional providers by means of a "productivity adjustment factor" that bases reimbursements on economy-wide productivity improvements rather than on the rising costs of medical goods and services, which are higher. Unlike most previous payment reductions—which applied to specific, limited time periods—the ACA's deep reductions will continue to occur every year unless they are changed by future legislation.

- In its final assessment of the ACA before the law's passage, the Congressional Budget Office (CBO) estimated that this provision would cut Medicare spending by $196 billion over 10 years, the largest single spending reduction in the law. Actuaries at the Centers for Medicare & Medicaid Services projected the reduction at $205.3 billion over 10 years. As the effects of these annual cuts accumulate, the payment reductions will grow steeper, reducing payments by 21 percent in 2030 compared with the level under the previous payment formula.

- Owing to these reductions, the Centers for Medicare & Medicaid Services actuaries estimate that by 2040 half of all hospitals, 70 percent of skilled nursing facilities, and 90 percent of home health agencies will be losing money each year. At the end of 75 years, Medicare payments will have fallen to just 40 percent of what private insurers pay (Medicare payments are 67 percent now). Many institutions will have to stop serving Medicare enrollees or shift costs to other patients and payers. This will generate increasing pressure to ease these spending cuts, leading to less deficit reduction from the ACA—or to actual deficit increases.

TAXES ON "HIGH-INCOME" HOUSEHOLDS

ACA proponents also claimed the law would protect middle-income households from tax increases. In fact, some of the taxes—such as a new limit on the deductibility of medical expenses—will explicitly hit middle-income households. Other taxes on various sectors of the healthcare industry—insurers, drug manufacturers, and medical device companies—will be passed on to all consumers in the form of higher prices.

In addition, some of the ACA's new taxes supposedly aimed at the wealthy will eventually reach middle-income households directly—in this case because of a lack of indexing.

- The two key taxes—a 0.9-percent add-on to the Medicare hospital insurance payroll tax and a 3.8-percent tax on so-called "unearned" income—were supposed to apply to individuals earning $200,000 or more and families earning $250,000 or more. Because these income thresholds are not indexed for inflation, however, many more households will eventually become subject to the taxes. After 75 years, roughly 80 percent of US households will pay these taxes.

- This amounts to a reintroduction of the "bracket creep" that for years grew with levies such as the alternative minimum tax, a tax which initially affected only a small group of wealthy taxpayers but increasingly ensnared the nonwealthy because it was not indexed. The authors of the ACA clearly chose not to index certain taxes so they could show ever-increasing revenue from the law, and consequently declining deficits. Indexing these provisions would reduce or eliminate much of the ACA's projected deficit reduction.

THE CADILLAC TAX

The Cadillac tax, scheduled to take effect in 2018, will impose a 40 percent excise tax on insurance policies valued at $10,200 or more for individuals and $27,500 or more for families, indexed to rise each year. Although the tax is intended to hit high-end coverage, it is likely to affect middle-income earners anyway:

- Though the tax is to be levied on insurers or employers who self-insure, CBO says the costs will be passed on to workers. Even now, employers are taking steps to raise deductibles, impose other cost-sharing requirements, or move toward narrower provider networks to avoid paying the tax. As a result, employees are bearing a greater share of the cost of health coverage.

- The insurance value thresholds are indexed to the CPI plus one percentage point in 2019, and to just the CPI thereafter. National healthcare spending is expected to rise at a faster rate, driving more and more health plans past the Cadillac thresholds. Thus, the Cadillac tax will reach beyond high-end insurance plans, forcing large cutbacks and adjustments on what are today's average-cost plans.

THE PREMIUM CREDITS

The insurance premium subsidies intended to assist individuals and families in purchasing health coverage are the heart of the ACA. The amount of subsidy for a given recipient is determined by a complex calculation, but the amount is capped at a fixed percentage of income.

- To limit the government's financial burdens, the law increases the income cap each year, reducing the premium credits that would have previously been available to qualifying households. In addition, the ACA limits the total amount spent for premium subsidies to a

fixed percentage of GDP. If the cap is breached, then the amount of premiums paid by each household will increase.

- Medical costs and health insurance premiums have generally grown faster than both the economy and inflation, and that is almost certain to continue. The ACA's complex indexing provisions for premium subsidies, designed to limit the government's financial risk, will impose ever-increasing costs on lower-income households for their health insurance.

THE BUDGETARY EFFECTS OF ALTERNATIVE INDEXING ASSUMPTIONS

The ambitious major indexing provisions of the ACA are intended to limit spending and boost revenue. Largely owing to these provisions, CBO projects that the ACA will reduce budget deficits by about 1 percent of GDP in the decade beyond the current 10-year budget window (roughly 2026 through 2035). Because the cuts are deep and the tax increases significant, policymakers will likely face pressure to ease or eliminate the burden on taxpayers and providers of medical services.

Applying more realistic and historically consistent assumptions regarding the indexing of these key ACA provisions, the deficit reduction forecast by CBO would eventually be wiped out, converting the ACA into a deficit-increasing law. More importantly, because the effect of adjusting these provisions would accumulate over time, the higher spending and lower tax revenue that would result from less aggressive indexing would lead to ever-growing deficits in the future.