The True Cost of the Patient Protection and Affordable Care Act

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Introduction

Chairman Pitts, Vice-Chairman Burgess, Ranking Member Waxman and members of the Committee, I am pleased to have the opportunity to appear today to discuss the costs of the Patient Protection and Affordable Care Act (ACA). In this testimony, I wish to make five major points:

- At a time when sound policy requires low taxes and reductions in present and future transfer spending, the ACA moves dramatically in the wrong direction;
- The mandates and tax provisions in the ACA will have detrimental impacts on employment growth, wages, and economic growth;
- The impact of ACA will be more expensive health insurance, putting employers in the position of either reduced wage rates, fewer employees, or dropping insurance coverage;
- The ACA has strong incentives to drop health insurance coverage, and to the extent that employers pursue these incentives, taxpayers face tremendous upside risk to the cost of the ACA; and
- Even without unexpectedly large numbers of employers dropping coverage, the ACA will exacerbate an already-dangerous fiscal outlook.

Let me pursue each in additional detail.

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* The opinions expressed herein are mine alone and do not represent the position of the American Action Forum. I am grateful to Ike Brannon, Cameron Smith, Michael Ramlet, and Matt Thoman for assistance. All errors are my own.

Policy Response to the Fiscal Threat

The primary policy problem facing the United States is the projected continued explosion of federal debt. If left unchecked, the debt will corrosively erode the Nation's economic foundations, engender future financial crises, hamstring the ability of the United States to project is values around the globe, and diminish its ability to secure its citizens safety.

The source of these threats is commitments to federal spending that rise above any reasonable metric of taxation for the indefinite future. Period. There is a mini-industry devoted to producing alternative numerical estimates of this mismatch, but the diagnosis of the basic problem is not complicated. The diagnosis leads as well to the prescription for action. The budget problem is primarily a spending problem and correcting it requires reductions in discretionary outlays and the growth of large mandatory spending programs.

As an example, using the President's 2012 Budget, the CBO projects that over the next decade the economy will fully recover. Despite this, the deficit in 2021 will be $1.2 trillion and nearly 5 percent of Gross Domestic Product. The problem is not revenues, which are projected in 2021 to be 19.3 percent of GDP, well more than the historic norm of 18 percent. Instead, the deficit derives from spending. Federal outlays in 2021 are expected to be 24.2 percent of GDP, higher than the 20 percent that has been business as usual in the postwar era.

The fiscal future outlined above represents a direct impediment to job creation and growth. The United States is courting downgrade as a sovereign borrower and a commensurate increase in borrowing costs. In a world characterized by financial market volatility stemming from Ireland, Greece, Portugal, and other locations this raises the possibility that the United States could find itself facing a financial crisis. Any sharp rise in interest rates would have dramatically negative economic impacts; even worse an actual liquidity panic would replicate (or worse) the experience of the fall of 2008.

Alternatively, businesses, entrepreneurs and investors perceive the future deficits as an implicit promise of higher taxes, higher interest rates, or both. For any employer contemplating locating in the United States or expansion of existing facilities and payrolls, rudimentary business planning reveals this to be an extremely unpalatable environment.

In short, cutting spending is a pro-growth policy move at this juncture. As summarized by a recent American Action Forum study, the research indicates that the best strategy to both grow and eliminate deficits is to keep taxes low and reduce public employee costs and transfer payments.[1] Unfortunately, the ACA moves in precisely the wrong direction. It contains trillions of dollars of new transfer

[1] See http://americanactionforum.org/news/repairing-fiscal-hole-how-and-why-spending-cuts-trump-tax-increases

spending, combined with hundreds of billions of dollars in new taxes. It is the wrong economic policy at a pivotal moment in U.S. economic history.

Employer Mandate and Tax Impacts on Jobs and Growth

The United States' economy has endured a severe recession and is currently growing slowly. The pace of expansion remains solid and unspectacular. In many ways this is not surprising. As documented in Rogoff and Reinhart (2009), economic expansions in the aftermath of severe financial crises tend to be more modest and drawn out than recovery from a conventional recession.[2] Accordingly, it is imperative that policy be focused on generating the maximum possible pace of economic growth. More rapid growth is essential to the labor market futures of the millions of Americans without work. More rapid growth will be essential to minimizing the difficulty of slowing the explosion of federal debt to a sustainable pace. More rapid growth will generate the resources needed to meet our obligation to provide a standard of living to the next generation that exceeds the one this generation inherited.

Unfortunately, key provisions of the ACA are inconsistent with strong, pro-growth policies. In what follows, I focus on three in particular: mandate costs, administrative burdens, and tax increases.

Employer Mandate Costs

Among the key aspects of the ACA is its mandate to cover employees with health insurance. Focusing first on those employers with more than 50 workers, beginning in 2014, those firms must pay a penalty if any of their full-time workers receive subsidies for coverage through the exchange. The penalty is equal to the lesser of $3,000 for each full-time worker receiving a premium credit, or $2,000 for each full-time worker, excluding the first 30 full-time workers. The fees are paid monthly in the amount of 1/12th of the specified fee amounts. Firms with fewer than 50 employees are exempt from the so-called employer "play or pay" penalties if they do not offer coverage and their workers receive a subsidy in the exchange.

From the perspective of economic performance, the most important point is that the *best* possible impact is that the firm is already offering insurance, no individual ends up receiving subsidies and triggering penalties, and thus costs are unaffected. In every other instance, health insurance costs will compete with hiring and growth for the scarce resources of those firms.

One might think that the same situation prevails for the smallest firms – those under 50 employees – who are exempt from the coverage mandate. Unfortunately, for these firms, the greatest impact is the tremendous impediment to expansion.

[2] See *This Time Is Different: Eight Centuries of Financial Folly*, by Carmen M. Reinhart and Kenneth Rogoff, 2009.

Suppose for example that a firm does not provide health benefits. Hiring one more worker to raise employment to 51 will trigger a penalty of $2,000 per worker multiplied by *the entire workforce*, after subtracting the first 30 workers. In this case the fine would be $42,000 (21 (51-30) workers times $2,000). How many firms will choose not to expand?

Proponents of the ACA like to point toward the fact that small businesses will receive aid in the form of a small businesses tax credit, ostensibly offsetting the burdens outlined above. Unfortunately, the credit is available only for employers with fewer than 25 workers and those in which average wages are under $50,000. Thus, the cost and growth impacts for those with 26 to 50 employees remains unchanged. Moreover, the credit is not a permanent part of the small business landscape. An employer may receive the credit only until 2013 and then for two consecutive tax years thereafter. Thus, the credit is available for a maximum of six years.

Turning to the credit itself, to be eligible the employer must pay at least 50 percent of the premium. The credit is equal to 35 percent of employer contributions for qualified coverage beginning in 2010, increasing to 50 percent of the premium in 2014 and thereafter. The amount of the credit is phased-out for firms with average annual earnings per worker between $25,000 and $50,000. The amount of the credit is also phased-out for employers with between 10 and 25 employees.

The combination of requirements for premium contributions, limitations on employees, limitations on earnings, and phase-outs has surprised the small business community. In particular, the reform's strict definition that a firm is only a small business if it has 25 or fewer employees proved convenient to the legislators who crafted the bill. This narrow definition has led to a number of studies that assert that more than 80 percent of small businesses will be eligible for the tax credit.

Even those studies that recognize the limitation imposed by the 25-employee limit tend to overstate the likely penetration of the credit. For example, the Small Business Majority and Families USA recently estimated that 84 percent of the nation's 4.8 million businesses that employ 25 or fewer employees will be eligible for the tax credit.[3] Unfortunately, the net impact of the credit in offsetting the cost burden of the ACA will depend not upon *eligibility* but rather on *receipt* of the tax credits. This distinction was noted early in the debate by the Congressional Budget Office. In November 2009 when the law was being considered before Congress, CBO found that, "A relatively small share (about 12 percent) of people with coverage in the small group market would benefit from that credit in 2016."[4]

A more useful study focuses on the estimated number of small firms who would qualify for the small business health insurance tax credit. A recent analysis

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[3] See, http://www.smallbusinessmajority.org/_pdf/tax_credit/Helping_Small_Businesses.pdf

[4] See, http://cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf

conducted by the National Federation of Independent Business (NFIB) found that the total number of firms that offer health insurance and pay more than half of their employees' premium costs, as mandated under ACA, is more likely 35 percent of all firms with less than 25 employees.[5]

In the same way that the mandate provides an implicit tax on growth, the structure of the small business tax credit will raise the effective marginal tax rate on small business expansion. For this reason, the credit may discourage firms from hiring more workers or higher-paid workers. Consider two examples.

In the first, employers will have an incentive to avoid increases in the average rate of pay in their firm. Suppose that the average wage in a small (3 worker) firm is $25,000 and the owner decides to add a more highly paid supervisor being paid $50,000. This will raise the average wages in the firm to $31,250 there by *reducing* the tax credit per worker from $2,100 to $1,596.[6] In effect, the structure of the credit raises the effective cost of adding valuable supervisory capacity.

In this example, total credits to the firm are essentially unchanged ($6,300 to $6,384) by raising the average wage. If the new supervisor were paid $75,000 however, total credit payments would fall from $6,300 to $4,368. The lesson is clear in that the structure of the credit can impose large effective tax rates on raising the quality of the labor force for those receiving the small business credit.

Similar incentives affect the decision to hire additional workers because the overall tax credit falls by 6.7 percent for each additional employee beyond 10 workers. This is a very strong disincentive to expanding the size of the firm. Using the example above, suppose that the firm has 10 employees and total credits received were $21,000. The firm's total subsidy will peak at $21,840 with the hiring of the 13th worker. Thus, a firm employing 13 workers would get a total tax credit of $21,840 while a firm employing 24 workers would receive a total credit of only $3,360.[7]

The upshot is that the small business tax credit is a mixed economic blessing. Relatively few firms will qualify for the credit and be able to offset the costs of health insurance. For those that do qualify, receipt of the credit imposes a new regime of hidden effective marginal tax increase on improvements in scale and quality.

Tax Increases

The Act raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers,

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[5] See, http://www.nfib.com/nfib-on-the-move/nfib-on-the-move-item?cmsid=52099

[6] This example assumes the employer contributes $6,000 toward insurance for each employer.

[7] See, http://www.ncpa.org/pdfs/ba703.pdf

pharmaceutical companies, and health insurance providers; and other revenue provisions. There is no theory or empirical research on job creation that suggests that large tax increases will spur employment. Taken at face value, one should be skeptical that ACA will not harm the pace of overall economic recovery.

There are two taxes of particular interest contained in ACA. Section 9015 increases the Medicare HI tax by 0.9 percentage points on wages in excess of $200,000 ($250,000 for couples filing jointly, $125,000 for married individuals filing separately), and also applies to self-employed earnings.

Sec. 1402 of HCERA imposes a 3.8 percent Medicare contribution tax on individuals, estates, or trusts of the lesser of net investment income or the excess of modified adjusted gross income over the threshold amount. The threshold amount is $250,000 for joint returns, $125,000 for married filing separately, or $200,000 for any other case. Both taxes are effective for taxable years beginning after 2012.

The first point to note is that these taxes have nothing to do with Medicare finance. While gross inflows may be credited to the HI trust fund, these dollars will finance the expansion of the new insurance subsidy entitlement program.

The second point to note is that these taxes apply to the labor and investment earnings of pass-thru entities taxed through the individual income tax. Thus, they are targeted at precisely the same group of individuals most likely to be business owners or entrepreneurs. The Joint Committee on Taxation projects that $1 trillion in business income will be reported on individual income tax returns in 2011. Notably, of that $1 trillion, roughly one-half, $470 billion, will be reported on returns that are likely to be the new surtaxes.[8]

This has the potential to impact employment. According to the Small Business Administration, there are almost 120 million private sector workers in the United States. Slightly more than half those workers, 60 million, work for small businesses. About two-thirds of the nation's small business workers are employed by small businesses with 20 to 500 employees. According to Gallup survey data conducted for the National Federation of Independent Business (NFIB), half of the small business owners in this group fall into the surtax brackets. This means there is a pool of more than 20 million workers in those firms directly targeted by the higher marginal tax rates. This is likely a conservative estimate as it ignores flow-through entities with one to 19 workers.

A final tax impact of the ACA is that the impact of phase-outs of refundable credits may have even more perverse growth consequences. As noted in Brill and Holtz-

[8] The Joint Committee on Taxation analysis does not take into account the impact on small, non-publicly-traded "C" corporations. There are several million of these entities, which will likely be adversely affected by the marginal rate increases on ordinary and capital income.

Eakin (2010) the phase-outs in insurance subsidies contribute to high effective marginal tax rates.[9] The effect is to raise to as high as 41 percent the effective marginal tax rate on some of the lower-income U.S. workers. This has implications for the ability of families to rise from the ranks of the poor, or to ascend toward the upper end of the middle class. This growth and mobility is the heart of the American dream and is the most pressing issue at this time.

ACA and Health Insurance Premiums

Health care reform was presumed to encompass both expansion of affordable insurance options and provision of quality medical care at lower costs. The reality of the ACA could not be more different. Objective analysts have uniformly concluded that the new law raises – not lowers – national health care spending.[10] The rising bill for national health care spending will, in turn produce sustained upward pressures on health insurance premiums.

In addition, the law's array of insurance market reforms will increase premiums. Barring limits on annual and lifetime out-of-pocket spending, coverage of pre-existing conditions for children, and the ability for children to stay on parents' policies, are all initiatives that enhance benefits. These benefits must necessarily be covered by higher premiums.

These features of the law are increasingly well understood, much to the dismay of insurance consumers. However, other aspects of the new law are less appreciated. In particular, the financing of the health care law will have significant implications for purchasers of insurance as well.

As noted above, ACA raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions.

The impact of these fees on medical device manufacturers, insurers, and pharmaceutical companies is important and not well understood. To understand better, consider the fee on health insurers. The fee amounts to a *de facto "health insurance premium* tax" that will raise the cost of health insurance for American families and small employers. Specifically, under the law, an annual fee applies to

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[9] Brill, Alex and Holtz-Eakin, Douglas, "Another Obama Tax Hike." *Wall Street Journal,* February 4, 2010. See also, Douglas Holtz-Eakin and Cameron Smith, "Labor Markets and Health Care Reform, 2010. http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10_0.pdf

[10] See http://www1.cms.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf or http://www.cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf.

U.S. health insurance providers, with the intent of raising nearly $90 billion over the next 10 years. The aggregate annual fee for all U.S. health insurance providers begins at $8 billion in 2014 and then rises thereafter. (See Table 1.)

Table 1
Aggregate Insurance Fees

Year	Fee
2014	$ 8 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018 & Beyond [11]	$14.3 billion
Total through 2020	$87.4 billion

To see the implications for insurance costs, one must examine how it affects individual insurers. Each firm will be liable for a share of the aggregate fee, which is calculated in two steps. First, each company will compute the total premiums affected by the law using the formula outlined in Table 2. For example, an insurer with net premium revenues of $10 million is unaffected. In contrast, an insurer with net premiums of $100 million will have $62.5 million ($12.5 million from the 50 percent component between $25 million and $50 million, and $50 million from the remainder). The aggregate fee is apportioned among the insurers based on their shares of the affected premiums. Importantly, the fees are not deductible for income tax purposes.

Table 2
Fraction of Premiums Counted

Annual Net Premiums	Fraction
Less than $25 million	0
$25 million to $50 million	50 percent
$50 million or more	100 percent

So far, seemingly so good, for families and small employers, as insurers have to pay this new "health insurance premium tax." Unfortunately, this ignores the influence of market forces. For any company, as it sells more insurance policies it will incur a greater market share, and thus a greater share of the $87 billion. That is, with each policy sold, the firm's total tax liability rises; precisely the structure of an excise tax. Firms don't really pay taxes; they attempt to shift them to suppliers, workers, or customers. Thus, it is important to distinguish between the *statutory incidence* of

[11] The statute provides that after 2018 the insurance fee is equal to the amount of the fee in the preceding year increased by the rate of premium growth for the preceding calendar year.

the premium tax – the legal responsibility to remit the tax to the Treasury – and the *economic incidence* – the loss in real income as a result of the tax.

Insurance companies will have to send the premium tax payments to the Treasury, so the statutory incidence is obvious. However, a basic lesson of tax policy is that people pay taxes; firms do not. Accordingly, the economic burden of the $87 billion in premium taxes must be borne by individuals. Which individuals will bear the economic cost?

The imposition of the premium tax will upset the cost structure of insurance companies, raising costs per policy and reducing net income (or exacerbating losses). Some might argue that the firms will simply "eat the tax" – that is simply accept the reduction in net income. For a short time, this may well be the case. Unfortunately, to make no changes whatsoever will directly impact companies' abilities to make investments in health IT programs, wellness initiatives and disease management tools. Ultimately, this hurts individuals and small employers who won't have access to the types of tools and programs that can improve the quality of care and lower costs. Trying to retain the *status quo* also hurts the return on equity invested in the firm. Because insurance companies compete for investor dollars in competitive, global capital markets, they will be unable to both offer a permanently lower return and raise the equity capital necessary to service their policyholders.

Importantly, these impacts will be felt equally by the not-for-profit insurers. Non-profits have comparable resource needs for disease management, wellness efforts, or IT equipment. They also have equity capital demands, as they rely on retained earnings as reserves to augment their capital base. Bearing the burden of the tax means lower access to these reserves and diminished capital, harming their ability to continue serving policyholders effectively.

In short, all insurers – *for profit* and *non-profit* alike – will seek to restructure in an attempt to restore profitability, with the main opportunity lying in the area of labor compensation costs. To the extent possible, firms will either reduce compensation growth, squeeze labor expansion plans (or even lay off workers), or both. However, there are sharp limits on the ability of companies to shift the effective burden of excise taxes onto either shareholders (capital) or employees (labor). Moreover, their ability to do so diminishes over time as capital and labor seek out better market opportunities.

The only other place to shift the tax cost is onto customers – i.e., families and small businesses. This economic reality is reflected in the Congressional Budget Office and Joint Committee on Taxation revenue estimating procedures. Specifically, they apply a 25 percent "offset" to the estimated gross receipts of any excise tax. In terms of the premium tax, this convention has two important implications. First, if the aggregate fee were recognized as a premium excise tax that carried incentives to shift some of the burden via lower dividends, capital gains, and wages, then the aggregate fee will overstate the net budget receipts. To the extent this happens,

receipts of income-based taxes will fall; hence the need for an offset to the gross receipts of the excise tax.

The second implication is that the remainder of the tax is passed on to consumers. That is, the offset is not 100 percent meaning that the non-partisan consensus-based revenue estimators have concluded that the vast majority of the burden of excise taxes will *not* be borne by shareholders or workers.

If market conditions make it impossible for insurers to absorb the economic burden of the premium tax, they will have no choice but to build the new, higher costs into the pricing structure of policies. In this way, the economic burden of the tax is shifted to the purchasers of health insurance. In particular, the more competitive markets are for equity capital and hired labor, greater is the fraction of the burden that will be borne by consumers.

The implications for purchasers of health insurance are obvious and unambiguously negative. In addition, as employers pay more for health insurance, they will have to shave back on cash wage increases, and thus taxable compensation. Thus the health insurance premium tax will have the perverse effect of lowering personal income and payroll taxes.

To top things off, the new law has an especially unpleasant feature for those facing higher premiums: the fees are not tax-deductible, but higher premiums will be taxable.

This non-standard tax treatment matters a lot. If an insurance company passes along $1 of premium taxes in higher premiums and cannot deduct the cost (fee), it will pay another $0.35 in taxes. Accordingly, the impact on the insurer is $0.65 in net revenue *minus* the $1 fee. Bottom line: a loss of $0.35. (The problem gets worse when you consider that the $1 of additional premium is also subject to other state-level premium taxes and in some cases a state income tax.)

To break even, each insurer will have to raise prices by $1/(1-0.35) or $1.54. If it does this, the after-tax revenue is the full $1 needed to offset the fee. This has dramatic implications for the overall impact of the premium taxes. Instead of an upward pressure on premiums of $87.4 billion in fees over the next 10 years, the upward pressure will be $134.6 billion.

This line of reasoning is sometimes met with skepticism, and countered with the notion that consumers will simply be unwilling to accept a higher price. Evidence suggests that this is not true, but suppose the counter-argument is taken at face value. To the extent that firms accept a lower rate of return, they will be less able to attract capital. Similarly, to the extent they reduce employment in response to the tax (or cut wages and lose skilled employees to better opportunities), they will again suffer in their ability to expand their scale of operations. In short, insurers that attempt to adjust entirely on the cost side will be unable to maintain their

operations at a competitive level, and will lose market share or even exit the industry entirely. For health insurance markets as a whole, this reduces competition. The bottom line for consumers is the same: higher prices.

To gain a rough empirical feel of an average $87 billion health insurance premium tax, I employ publicly-available data on Yahoo! Finance.[12] Those data indicate that the earnings for the industry called "Health Care Plans" were roughly $16 billion. The average annual aggregate fee of $8.7 billion is a substantial impact on the cost structure and profitability of the companies; roughly one-half of the net earnings.

Could insurers absorb the fee and remain competitive in the market for equity capital? As a whole, the overall profit margin is shown as 4.2 percent. Assuming no change in behavior, a 50 percent decline on a sustained basis would make it impossible to obtain the financing needed to compete. Accordingly, it will be a matter of competitive reality for the insurers to pass the fee to consumers in the form of higher health insurance premiums.

The health insurance fee will likely quickly and almost completely be incorporated, resulting in higher insurance premiums. The premium tax alone means that American families will pay as much as $135 billion more in insurance premiums over the next 10 years. Incorporating the impact of medical devices and pharmaceuticals raises the total impact.

The final channel by which ACA affects insurance costs are through the mandates regarding insurance benefit designs. Mandating greater benefits will unambiguously raise the costs of insurance. However, one widely-touted promise of the ACA was that if you "like your health plan, you can keep it."

In this regard, it is important to note that the interim final rules governing insurance copayments, deductibles, premium increases, and employer contributions are so strict that that even conservative estimates by the Department of Health and Human Services (HHS) indicate a majority of Americans will be unable to keep their existing health care coverage by 2013.[13] A more realistic estimate, accounting for the response from American businesses since the rules were released, places the likely percentage of plans without grandfathered status well above the HHS' high-end estimate of 69 percent of plans by 2013.[14] Thus it appears that the interim final rules ensure that grandfathered status will be lost in the near-future and that a substantial majority of Americans will face higher costs.

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[12] See http://biz.yahoo.com/p/522qpmd.html.

[13] "Group Health Plans and Health Insurance Coverage Rules Pertaining to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act. Federal Register. Volume 75. Page 34571

[14] "2010 UBA Health Plan Survey." United Befit Advisors. October 2010.

ACA and Employer-Sponsored Insurance

Today about 163 million workers and their families receive health insurance coverage from their employers. Proponents of the ACA insisted that a key tenet of was to build on this system of employer-sponsored coverage.

Roughly one-half of the $900 billion of spending in the ACA is devoted to subsidies for individuals who do not receive health insurance from their employers. These subsidies are remarkably generous, even for those with relatively high incomes. For example, a family earning about $59,000 a year in 2014 would receive a premium subsidy of about $7,200. A family making $71,000 would receive about $5,200; and even a family earning about $95,000 would receive a subsidy of almost $3,000.

By 2018, subsidy amounts and the income levels to qualify for those subsidies would grow substantially: a family earning about $64,000 would receive a subsidy of over $10,000, a family earning $77,000 would receive a subsidy of $7,800 and families earning $102,000 would receive a subsidy of almost $5,000.

An obvious question is how employers will react to the presence of an alternative, subsidized source of insurance for their workers, which can be accessed if they drop coverage for their employees. The simplest calculation focuses on the tradeoff between employer savings and the $2,000 penalty (per employee) imposed by the ACA on employers whose employees move to subsidized exchange coverage. Consider a $12,000 policy in 2014, of which the employer would bear roughly three-quarters or $9,000. A simple comparison of $9,000 in savings versus a $2,000 penalty would seemingly suggest large-scale incentives to drop insurance.

Unfortunately, the economics of the compensation decision are a bit more subtle than this simple calculation. Health insurance is only one portion of the overall compensation package that employees receive as a result of competitive pressures. Evidence suggests that if one portion of that package is reduced or eliminated – health insurance – and another aspect – wages – will ultimately be increased as a competitive necessity to retain and attract valuable labor. Thus, the key question is whether the employer can keep the employee "happy" – appropriately compensated and insured – *and* save money.

As Table 3 outlines, the answer is frequently "yes" – thanks to the generosity of federal subsidies. To see the logic, consider the first row of the table, which shows the implications for a worker at 133 percent of the Federal Poverty Level (FPL) or $31,521 in 2014. We project that this worker will be in the 15 percent federal tax bracket, which means that $100 of wages (which yields $85) is needed to offset the loss of $85 dollars of employer-provided health insurance (which is untaxed). Consider now a health insurance policy worth $15,921, of which the employer picks up 75 percent of the cost. The employer's contribution to health insurance of $11,941 is the equivalent of a wage increase of $14,048 to the worker.

Do the economics of ACA ever suggest that employer's could drop? Yes. The employer would receive $14, 176 in subsidies – *more than the value of the lost health insurance*. On paper, they could take a pay cut and be better off. Clearly, the employer comes out way ahead – $11,941 less the penalty. Obviously, there is room for the employer to actually improve the worker's life by having a small pay raise and the same insurance and still save money. This is a powerful, mutual incentive to eliminated employer-sponsored insurance.

The remaining rows of Table 3 repeat this calculation for workers at ascending levels of affluence. For example, at 200 percent of the FPL, the "surplus" between the pay raise required to hold a worker harmless ($4,936) and the firm's cash-flow benefit from dropping coverage ($9,941) has narrowed, but the bottom line decision in the final column is the same. Indeed, the incentives are quite powerful up to 250 percent of FPL, or $59,250. Only for higher-income workers do the advantages of untaxed health insurance make it infeasible to drop insurance and re-work the compensation package.[15]

How big could this impact be? In round numbers, at present there are 123 million Americans under 250 percent of the FPL. Roughly 60 percent of Americans work and about 60 percent of those receive employer-sponsored insurance. This suggests that there are about 43 million workers for whom it makes sense to drop insurance.[16]

CBO estimated that only 19 million residents would receive subsidies, at a cost of about $450 billion over the first 10 years. This analysis suggests that the number could easily be triple that (19 plus an additional, say, 38 million in 2014) – meaning the price tag would be $1.4 trillion.

In contrast, the CBO predicted that only 3 million individuals who previously received coverage through their employers will get subsidized coverage through the new exchanges. One mechanism that would reduce employer drop is if high-wage workers continue to receive insurance and non-discrimination rules force employers to offer insurance to all workers – even those for whom it makes sense to drop coverage. For those firms dominated by lower-wage workers this is unlikely to succeed as it will be possible to use the accumulated savings to retain the few high-wage workers. Or, there may be incentives for firms to "out-source" their low-wage workers to specialist firms (that do not offer coverage) and contract for their skills. In any event, the massive federal subsidies are money on the table inviting a vast reworking of compensation packages, insurance coverage, and labor market relations.

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[15] Notice that what this really means is that an *existing* federal subsidy (via the tax code) trumps the new federal subsidy!

[16] This is likely an upper bound estimate as there is a positive correlation between wage levels and the probability of having insurance.

Table 3

Health Care Reform and Employer-Sponsored Insurance in 2014

(Employer Health Plan = $11,941)

Percent of Federal Poverty Level	Income[1]	Tax Bracket[2]	Wage Equivalent of Employer Health	Federal Subsidies[4]	Required Pay Raise[5]	Employer Free Cash Flow[6]	Employer Drop Decision[7]
133%	$31,521	15%	$14,048	$14,176	($128)	$9,941	Drop
150%	$35,550	15%	$14,048	$13,385	$663	$9,941	Drop
200%	$47,400	25%	$15,921	$10,985	$4,936	$9,941	Drop
250%	$59,250	25%	$15,921	$7,530	$8,391	$9,941	Drop
300%	$71,100	25%	$15,921	$5,187	$10,734	$9,941	Keep
400%	$94,800	28%	$16,585	$2,935	$13,650	$9,941	Keep

1. Income calculated based on 2009 FPL for a family of four of $22,050 (HHS), indexed to CPI projections (CBO)
2. Tax bracket calculated based on 2010 tax brackets, indexed to CPI projections (CBO)
3. Computed as CBO estimate of Silver Plan in 2016, indexed to 2014 ($11,941), and divided by (1-Tax Rate)
4. Estimated federal insurance subsidy
5. Wage equivalent minus subsidies
6. Value of insurance plan minus $2,000 penalty
7. Drop if required pay raise is greater than free cash flow

ACA and the Budget Outlook[17]

The United States faces a daunting budgetary outlook, with the Administration's budget displaying an unsustainable debt spiral emerging over the next decade. In this context, the fiscal consequences of the newly-enacted Patient Protection and Affordable Care Act are of extreme importance.

The Context: An Approaching Fiscal Train Wreck

The federal government's unsustainable long-run fiscal posture has been outlined in successive versions of the CBO's *Long-Term Budget Outlook*. In broad terms, over the next 30 years, the inexorable dynamics of current law will raise outlays, or committed federal expenditures, from about 20 percent of Gross Domestic Product (GDP) to anywhere from 30 to 40 percent of GDP.[18] Any attempt to keep tax revenues at their post-war norm of 18 percent of GDP will generate an

[17] This sections draws heavily on Holtz-Eakin and Ramlet "Health Care Reform Is Likely To Widen Federal Budget Deficits, Not Reduce Them," *Health Affairs*, 2010.
[18]Congressional Budget Office. The Long-Term Budget Outlook. Washington (DC): Congress of the United States; June 2009.

unmanageable federal debt spiral. In contrast, a strategy of ratcheting up taxes to the 30 to 40 percent of GDP needed to match the federal spending appetite would likely be self-defeating as it would undercut badly-needed economic growth. *

The policy problem is that spending rises above any reasonable level of taxation for the indefinite future. This diagnosis leads as well to the prescription for action. Over the long-term, the budget problem is primarily a spending problem and correcting it requires reductions in the growth of large mandatory spending programs and the appetite for federal outlays.

This depiction of the federal budgetary future has been unchanged for a decade or more. However, the most recent Administration budget shows that in part due to the financial crisis, recession, and policy responses, the problem has become dramatically worse and will arrive more quickly than forecast. The federal government ran a fiscal 2010 deficit of $1.3 trillion. Going forward, there is no relief in sight. Over the next ten years, according to the CBO's preliminary analysis of the President's Budgetary Proposals for Fiscal Year 2012, the deficit will never fall below $748 billion dollars.[19] In 2021, the deficit will be nearly 5 percent of GDP, or roughly $1.2 trillion, of which over $900 billion will be devoted to servicing debt on previous borrowing.

As noted above, the budget outlook is not the result of a shortfall of revenues. The CBO projects that over the next decade the economy will fully recover and revenues in 2021 will be 19.3 percent of GDP – over the historic norm of 18 percent. Instead, the problem is spending. Federal outlays in 2021 are expected to be 24.2 percent of GDP – about $1.6 trillion higher than the 20 percent that has been business as usual in the postwar era.

As a result of the spending binge, in 2021 public debt will have more than doubled from its 2008 level to 90 percent of GDP and will continue its upward trajectory.

The Budgetary Impact of the Patient Protection and Affordable Care Act
In light of the fiscal threat from growing spending, the budgetary impacts of the Act are central to any discussion of its merits. We begin by reviewing the CBO cost estimate that concludes the Act will serve to lower projected deficits over the next ten years and beyond. After our summary review, we proceed by analyzing the budgetary implications of altering certain assumptions.

The final score of ACA with reconciliation amendments was released publicly on March 20, 2010.[20] The CBO and the Joint Committee on Taxation estimated the Act would lead to a net reduction in federal deficits of $143 billion over ten years with

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[19] http://www.cbo.gov/ftpdocs/121xx/doc12103/2011-03-18-APB-PreliminaryReport.pdf

[20] Congressional Budget Office. H.R. 4872, Reconciliation Act of 2010. Washington (DC): Congress of the United States; 2010 March.

$124 billion in net reductions from health care reform and $19 billion derived from education provisions.[21]

Total subsidies in the Act exceed $1 trillion dollars over ten years and include insurance exchange tax credits for individuals, small employers tax credits, the creation of reinsurance and high risk pools, as well as expansions to Medicaid and the Children's Health Insurance Program. To finance the subsidies and reduce the deficit, total cost savings are projected to be nearly $500 billion based on reductions in annual updates to Medicare fee-for-service payment rates, Medicare Advantage rates, and Medicare and Medicaid disproportionate share hospital (DSH) payments. In addition to the cost saving measures, the Act raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions.

To gain a rough feel of the longer-run impacts, consider extrapolating to the years 2020 to 2029 using CBO's estimated compounded annual growth rates. Under this crude approach, the ACA is expected to yield an additional $681 billion in deficit reduction.

The prospect of these savings is important given the daunting fiscal outlook. But they raise an important question: is it really likely that a large expansion of public spending will reduce the long-run deficit? The answer, unfortunately, hinges on provisions of the legislation that the budget office is required to take at face value and not second-guess.

A more realistic assessment emerges if one strips out gimmicks and budgetary games and reworks the calculus. As shown in Table 4 a wholly different picture emerges: the ACA would raise, not lower, federal deficits, by $554 billion in the first ten years and $1.4 trillion over the succeeding ten years.

The list of budgetary features embedded in the CBO score begins with the fact that the Act front-loads revenues and backloads spending. That is to say the taxes and fees it calls for began immediately in 2010, but its new subsides are largely deferred until 2014. This contributes to the illusion that the ACA reduces the deficit. Note that if revenues were delayed to start in 2014, the Act's 2010-2019 net deficit impact would be $66 billion lower.

Additional budgetary provisions of interest fall into four scenarios: unachievable savings, unscored budget effects, uncollectible revenue, and already reserved

[21] To analyze the fiscal impact of health care reform, we have removed the education revenues from the government takeover of all federally financed student loans.

premiums. Table 4 summarizes the annual impact of each scenario and extrapolates the fiscal impact to 2029.

The first adjustment, labeled "Unachievable Savings", removes spending cuts that the Centers for Medicare and Medicaid Services (CMS) will ultimately be unable to implement. These are composed of cost reductions through Medicare market basket updates, the Independent Payment Advisory Board, Medicare Advantage interactions, and the Part D premium subsidy for high-income beneficiaries. While the specifics of each differ, these provisions share two features. First, the ACA does not fundamentally reform Medicare in such a manner that will permit it to operate at lower budgetary cost. Accordingly, when the time comes to implement these savings (or those developed by the Independent Payment Advisory Board) CMS will be faced with the possibility of strongly limited benefits, the inability to serve beneficiaries, or both. As a result, the cuts will be politically infeasible, as Congress is likely to continue to regularly override scheduled reductions. A vivid example is the Medicare Physician Payment Updates. Each year since 2002 the "sustainable growth rate" formula in current law has imposed cuts in payments to physicians under Medicare. And each year Congress has overridden these same cuts.

Table 4
(billions of dollars unless otherwise noted)

Adjustments	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
CBO Projected Subsidies	4	11	13	9	70	125	181	204	219	236	1072
CBO Projected Cost Savings	2	-2	-11	-18	-43	-51	-59	-75	-91	-109	-455
Unachievable Savings	0.1	1.4	4.9	10	20.1	25.7	32.3	41.7	52.1	64.8	253.5
Unscored Budget Effect	8	14.7	16.5	18	18.3	20.4	23.4	26.2	29.3	34.7	274.6
Subtotal	10.1	14.1	10.4	10	-4.6	-4.9	-3.3	-7.1	-9.6	-9.5	73.1
CBO Projected Tax Revenues	0	-8	-15	-43	-77	-90	-114	-123	-131	-141	-739
Uncollectable Revenue	0	-1	-2	-5	1	6	14	18	22.2	26.8	78
Premiums Reserved	0	0	5.4	8.8	10	11.3	11.1	9.1	7.6	7	70.2
Subtotal	0	-9	-11.6	-39.2	-66	-72.7	-88.9	-95.9	-101.2	-107.2	-590.8
Net Change in Projected Deficit	14.1	16.1	11.8	-20.2	-0.6	47.4	88.8	101	108.2	119.3	554.3
Percentage of GDP	*0.10*	*0.11*	*0.08*	*0.12*	*0.00*	*0.27*	*0.50*	*0.55*	*0.58*	*0.62*	*2.90*

Massachusetts and Tennessee provide recent examples where insurance coverage expansion has led to substantial cost increases, instead of savings. In 1994, Tennessee implemented a massive Medicaid expansion (eventually covering 500,000 additional residents). A decade later, the state abandoned the experiment after costs more than tripled from $2.5 billion in 1995 to $8 billion in 2004, consuming one-third of the state budget. When the experiment unraveled in 2005, 170,000 enrollees were dropped. More recently in April 2010, Tennessee

announced that, due to cost overruns, the program would need to cut an additional 100,000 people from Medicaid rolls.[22]

In Massachusetts, the state's Special Commission on the Health Care Payment System has produced payment recommendations in the wake of passing an individual insurance mandate, but the commission has so far failed to bend the cost curve on medical inflation (growing 8 percent annually in Massachusetts).[23] The federally impaneled Independent Payment Advisory Board would likely follow a similar trajectory.

The second adjustment, "Unscored Budget Effects", highlights acknowledged costs that are not included in the CBO score. To operate the new health care programs over the first ten years, future Congresses will need to vote for $274.6 billion in additional spending. This spending includes the discretionary costs for the Internal Revenue Service (IRS) to enforce and the CMS to administer insurance coverage, explicitly authorized health care grant programs, and the Medicare Physician Payment Reform Act, which revises the sustainable growth rate for physician reimbursement.

Adjustment three, "Uncollectable Revenue", questions the political will of Congress and directly refers to the excise tax on high-premium, "Cadillac" health plans. This tax was supposed to start immediately in the Senate's version of ACA. After intense lobbying by organized labor, Congress relented and pushed the tax back to 2018. This raises the possibility that it will prove politically infeasible to ever implement the tax. Thus, the scenario shows the impact of not collecting the associated tax revenue of $78 billion over the next ten years.

The final adjustment, "Reserved Premiums", focuses on the CLASS Act premiums for long-term care insurance and the potential increase in Social Security receipts. In principle, these receipts should be reserved to cover future payments and not be devoted to short-term deficit reduction. Specifically, the scenario shows the implications of reserving the $70 billion in premiums expected to be raised in the first ten years for the legislation's new long-term care insurance.

In addition to this accounting sleight of hand, the legislation uses $53 billion for deficit reduction from an anticipated increase in Social Security tax revenue. The CBO estimates that outlays for Social Security benefits would increase by only about $2 billion over the 2010-2019 period, and that the coverage provisions would have

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[22] Wadhwani A. Tennessee removes about 100,000 people from Medicaid rolls. Kaiser Health News. 2010 Apr 8. Available from: http://www.kaiserhealthnews.org/Stories/2010/April/08/TennCare.aspx

[23] Kowalczyk L. Pay for care a new way, state is urged. The Boston Globe. 2009 July 19. Available from: http://www.boston.com/news/local/massachusetts/articles/2009/07/17/pay_for_care_a_new_way_state_is_urged/?page=2

a negligible effect on the outlays for other federal programs. If Social Security revenues do rise as employers shift from paying for health insurance to paying higher wages, the extra money raised from payroll taxes should be preserved for the Social Security trust fund.

What is the bottom line? Removing the potentially unrealistic annual savings, reflecting the full costs of implementing the programs, acknowledging the unlikelihood of raising all of the promised revenues, and preserving premiums for the programs they are intended to finance, produces a radically different bottom line. The Act generates additional deficits of $562 billion in the first ten years. And, as the nation would be on the hook for two more entitlement programs rapidly expanding as far as the eye can see, the deficit in the second ten years would approach $1.5 trillion.

Of course, this is not the only source of budgetary uncertainty. Proponents point toward the possibility that the Act will "bend the curve" more than anticipated, thereby reducing health care spending in federal programs and beyond. In this light, it is important to note that if federal subsidies do not grow at all between 2020 and 2029 – a herculean reduction in annual spending growth of 3.4 percentage points – it will reduce outlays by under $500 billion. That is, extraordinary success in bending the cost curve amounts to less than one-third of the downside budgetary risks embedded in the Act.

The future of the Patient Protection and Affordable Care Act is likely to be even more important than its passage. In light of the extraordinarily precarious state of federal fiscal affairs and the enormous downside risks presented by the Act, one can only hope that every future effort is devoted to reducing its budgetary footprint.

Conclusion

The ACA will have a dramatic impact on the evolution of labor market incentives, economic growth, and the budget outlook over the near term. Unfortunately, at a time when job growth and controlling spending to restore fiscal balance are top policy priorities, its true cost will be become apparent in the form of diminished growth, slower labor market recovery, and greater fiscal distress. Thank you and I look forward to answering your questions.