



# Congressional Budget Office

## Testimony

**Statement of  
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Director**

### **CBO's Analysis of the Major Health Care Legislation Enacted in March 2010**

**before the  
Subcommittee on Health  
Committee on Energy and Commerce  
U.S. House of Representatives**

**March 30, 2011**

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Chairman Pitts, Congressman Pallone, and Members of the Subcommittee, thank you for inviting me to testify about the Congressional Budget Office's (CBO's) analysis of the Patient Protection and Affordable Care Act (PPACA, Public Law 111-148) and the provisions of the Health Care and Education Reconciliation Act of 2010 (hereafter called "the Reconciliation Act," P.L. 111-152) that are related to health care.

CBO and the staff of the Joint Committee on Taxation (JCT) have provided the Congress with extensive analyses of the legislation both before and after its enactment in March 2010. My statement summarizes the major results of those analyses—in particular, the projected effects of those laws on the federal budget (over the first 10 years and the subsequent decade), health insurance coverage, Medicare, premiums for health insurance, and labor markets.

## Summary

Among other things, PPACA and the Reconciliation Act will do the following: establish a mandate for nearly all legal residents of the United States to obtain health insurance; create insurance exchanges through which certain individuals and families will receive federal subsidies to substantially reduce the cost of purchasing health insurance coverage; significantly expand eligibility for Medicaid; permanently reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected to occur under prior law); impose an excise tax on health insurance plans with relatively high premiums; impose certain taxes on individuals and families with relatively high income; and make various other changes to the federal tax code, Medicare, Medicaid, and other programs.

## Estimated Effects on Health Insurance Coverage

CBO and JCT estimate that PPACA and the Reconciliation Act will increase the number of nonelderly Americans with health insurance by about 32 million in 2016 and about 34 million in 2021.<sup>1</sup> About 95 percent of legal nonelderly residents will have insurance coverage in 2021, compared with a projected share of about 82 percent in the absence of that legislation (and an estimated 83 percent currently). In 2021, approximately 24 million people will purchase their own coverage through insurance exchanges, and Medicaid and the Children's Health Insurance Program (CHIP) will have roughly 17 million additional enrollees, CBO and JCT estimate. Compared with the number projected under prior law, about 6 million fewer people will purchase individual coverage directly from insurers, and about 1 million fewer people will obtain coverage through their employer. About 23 million nonelderly residents will remain uninsured: About one-third of that group will be unauthorized immigrants, who are not eligible to participate in Medicaid or the insurance exchanges; another quarter will be eligible for Medicaid but are not expected to enroll;

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1. See Congressional Budget Office, "Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)" (March 2011).

**Table 1.****Estimated Budgetary Effects of the Enactment of PPACA and the Health Care Provisions of the Reconciliation Act**

(Billions of dollars, by fiscal year)

	March 2010		February 2011		March 2011	
	Estimates		Estimates		Estimates	
	2010- 2019	2012- 2019	2012- 2019	2012- 2021	2012- 2019	2012- 2021
Effects on the Federal Budget Deficit						
Insurance coverage provisions <sup>a</sup>						
Gross cost	938	931	934	1,390	971	1,445
Net cost	788	778	733	1,042	794	1,131
Other provisions affecting direct spending	-492	-498	-477	-732	n.a.	n.a.
Other provisions affecting revenues	-420	-412	-376	-520	n.a.	n.a.
<b>Net Increase or     Decrease (-) in the Deficit</b>	<b>-124</b>	<b>-132</b>	<b>-119</b>	<b>-210</b>	<b>n.a.</b>	<b>n.a.</b>
<b>Memorandum:</b>						
Effects on Outlays	401	393	417	604	n.a.	n.a.
Effects on Revenues	525	524	536	813	n.a.	n.a.

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: The March 2010 estimates come from CBO's cost estimates for PPACA and the Reconciliation Act released in March 2010. The February 2011 estimates were produced using the CBO baseline projections of revenues and outlays available in early 2011, and the March 2011 estimates were taken from CBO's March 2011 baseline projections.

PPACA = Patient Protection and Affordable Care Act; Reconciliation Act = Health Care and Education Reconciliation Act of 2010; n.a. = not available.

- a. The gross cost of insurance coverage provisions reflects additional spending for Medicaid and the Children's Health Insurance Program, exchange subsidies and related spending, and tax credits for small employers. The net cost of insurance coverage provisions reflects that spending partly offset by penalties paid by uninsured individuals and employers, excise taxes on high-premium insurance plans, and other effects of the provisions on tax revenues and outlays.

and the remaining fraction will include individuals who are ineligible for subsidies, are exempt from the individual mandate, choose not to comply with the mandate, or have some combination of those characteristics.

**Estimated Budgetary Effects from 2012 to 2021: Direct Spending and Revenues**

The legislation will have a number of effects on the federal budget—including added spending to subsidize the purchase of health insurance and increased outlays for Medicaid, as well as reductions in outlays for Medicare and added revenues from taxes, fees, and penalties. On net, CBO and JCT's latest comprehensive estimate is that the effects of the two laws on direct spending and revenues related to health care will reduce federal deficits by \$210 billion over the 2012–2021 period (see Table 1).

**The Most Recent Comprehensive Estimate.** CBO and JCT’s most recent comprehensive estimate of the budgetary impact of PPACA and the Reconciliation Act was in relation to an estimate prepared for H.R. 2, the Repealing the Job-Killing Health Care Law Act, as passed by the House of Representatives on January 19, 2011. H.R. 2 would repeal the health care provisions of those laws. CBO and JCT estimated that repealing PPACA and the health-related provisions of the Reconciliation Act would produce a net *increase* in federal deficits of \$210 billion over the 2012–2021 period as a result of changes in direct spending and revenues.<sup>2</sup> Reversing the sign of the estimate released in February provides an approximate estimate of the impact over that period of enacting those provisions. Therefore, CBO and JCT effectively estimated in February that PPACA and the health-related provisions of the Reconciliation Act will produce a net *decrease* in federal deficits of \$210 billion over the 2012–2021 period as a result of changes in direct spending and revenues. The projected net reduction in deficits is the difference between \$813 billion in projected additional revenues and \$604 billion in projected additional outlays.

The provisions related to health insurance coverage—which affect both outlays and revenues—were projected to have a net cost of \$1,042 billion over the 2012–2021 period; that amount represents a gross cost to the federal government of \$1,390 billion, offset in part by \$349 billion in receipts and savings (primarily revenues from penalties and other sources). The other provisions related to health care and revenues will reduce budget deficits by an estimated \$1,252 billion over that 10-year period—including \$520 billion in revenues, mostly from new taxes and fees, and \$732 billion in outlay savings for Medicare and other federal health care programs (see Figure 1). Those outlay savings reflect the net effect of some provisions that will reduce direct spending—such as lower payment rates in Medicare—and others that will increase direct spending, such as the expansion of Part D benefits and mandatory funding for a number of grant, research, and other programs.

**Comparison with the March 2010 Estimate.** That February 2011 estimate differs somewhat from the estimate that CBO prepared when the legislation was being considered. In March 2010, CBO and JCT estimated that PPACA and the provisions of the Reconciliation Act related to health care would produce a net reduction in federal deficits of \$124 billion over the 2010–2019 period as a result of changes in direct spending and revenues.<sup>3</sup> The difference between the two estimates does not reflect any substantial change in the estimation of the overall effects of the two laws. CBO has seen no evidence to date that the steps that will be taken to implement the

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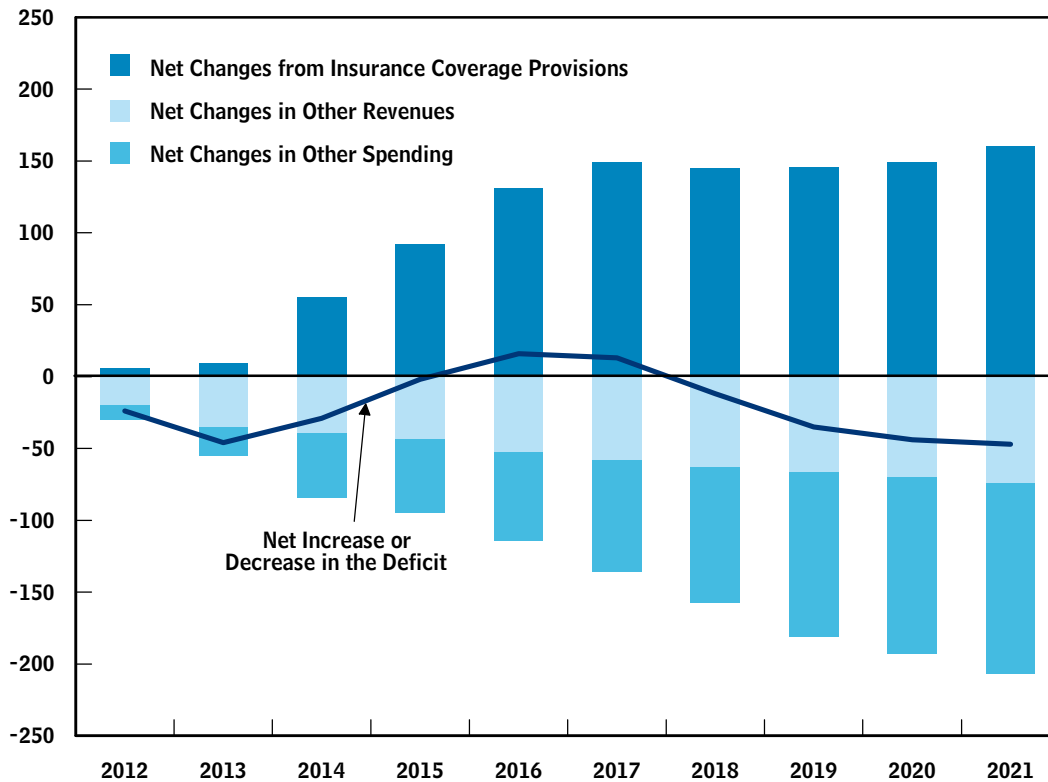
2. See Congressional Budget Office, *cost estimate for H.R. 2, the Repealing the Job-Killing Health Care Law Act* (February 18, 2011). That document and the others by CBO that are cited in this testimony are available on the agency’s Web site ([www.cbo.gov](http://www.cbo.gov)); many of the documents that were published in 2009 and 2010 are contained in Congressional Budget Office, *Selected CBO Publications Related to Health Care Legislation, 2009-2010* (December 2010).

3. See Congressional Budget Office, *cost estimate for H.R. 4872, the Reconciliation Act of 2010* (March 20, 2010).

**Figure 1.**

## Estimated Effects of PPACA and the Health Care Provisions of the Reconciliation Act on the Federal Budget

(Billions of dollars, by fiscal year)



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: These estimates from February 2011 were produced using the CBO baseline projections of revenues and outlays available in early 2011.

Coverage provisions include the excise tax on high-premium insurance plans.

PPACA = Patient Protection and Affordable Care Act; Reconciliation Act = Health Care and Education Reconciliation Act of 2010.

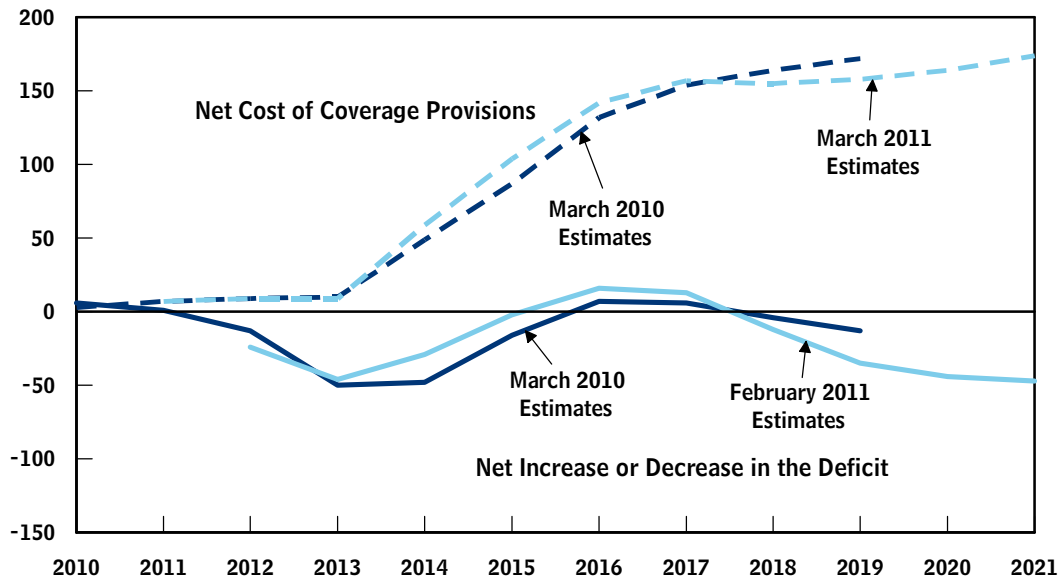
legislation—or the ways in which participants in the health care and health financing systems will respond to that legislation—will yield overall budgetary effects that differ significantly from the ones projected earlier.

Instead, the difference between the two estimates is primarily attributable to the different time periods they cover. In particular, including the years 2020 and 2021 in the analysis results in a substantially larger estimated decrease in budget deficits; in those two years alone, the legislation will decrease federal deficits by a total of about \$90 billion. Over the eight years that are common to the two analyses—2012 to 2019—enactment of PPACA and the health-related provisions of the Reconciliation Act was

**Figure 2.**

## Comparison of CBO's 2010 and 2011 Estimates for PPACA and the Health Care Provisions of the Reconciliation Act

(Billions of dollars, by fiscal year)



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: The March 2010 estimates, which cover 2010 to 2019, come from CBO's cost estimates for PPACA and the Reconciliation Act released in March 2010. The March 2011 estimates were taken from CBO's March 2011 baseline projections for 2011 to 2021; the February 2011 estimates, based on a cost estimate covering 2012 to 2021, were produced using CBO's baseline projections of revenues and outlays available in early 2011.

Coverage provisions include the excise tax on high-premium insurance plans.

PPACA = Patient Protection and Affordable Care Act; Reconciliation Act = Health Care and Education Reconciliation Act of 2010.

projected last March to reduce federal deficits by \$132 billion, whereas the February 2011 estimate implies that the legislation will reduce deficits by \$119 billion (see Figure 2).

**The Most Recent Estimate of the Effects of Coverage Provisions.** CBO's baseline budget projections that were issued earlier in March 2011, like the baseline projections issued in January 2011 and August 2010, reflect the impact of PPACA and the Reconciliation Act on revenues and various spending programs.<sup>4</sup> In some cases, those effects are implicit in broader revenue or spending categories, so the total projected

4. See Congressional Budget Office, *Preliminary Analysis of the President's Budget for 2012* (March 18, 2011).

impact of the laws cannot be readily identified; in other cases, the impact of those laws can be separately identified. The provisions related to expanding health insurance coverage fall in the latter category; compared with the estimate released in February, they are now projected to increase deficits by an additional \$90 billion over the 2012–2021 period, bringing the total net cost of those provisions as result of changes in direct spending and revenues to \$1,131 billion over that period.<sup>5</sup> CBO has not updated its estimate of the effects of the other provisions of the legislation because those effects are not separated out in the agency’s baseline projections.

How does the current estimate of the cost of expanding health insurance coverage compare with the estimate that was prepared when the laws were enacted? Again, the difference between the two estimates is primarily attributable to the different time periods they cover. Over the eight years that are common to the two analyses (2012 to 2019), the provisions related to health insurance coverage were projected last March to result in gross costs of \$931 billion and net costs (after accounting for penalty payments, receipts from the new excise tax on high-premium health insurance plans, and certain other effects) of \$778 billion. CBO and JCT now estimate gross costs of \$971 billion and net costs of \$794 billion over that eight-year period, increases of 4 percent and 2 percent, respectively.<sup>6</sup>

The estimates summarized above focus on direct spending and revenues because those are the figures that are relevant for the pay-as-you-go law and Congressional rules and because those effects will occur without any additional legislative action. The legislation will also affect discretionary spending (that is, spending subject to future appropriation action) in ways that are discussed below. Following standard procedures for the Congressional budget process, the estimates do not include any effects of the legislation on overall economic output. However, last summer, CBO estimated that the effects of the legislation on overall employment would be small.

### **Estimated Budgetary Effects from 2012 to 2021: Discretionary Spending**

Discretionary costs will arise from the effects of the legislation on several federal agencies and on a number of new and existing programs. CBO expects that the Internal Revenue Service (IRS) and the Department of Health and Human Services (HHS) will incur costs of between \$5 billion and \$10 billion each over 10 years to carry out their responsibilities for implementing the legislation.

PPACA includes a number of authorizations for future appropriations, which might or might not result in additional appropriations. CBO estimated that such provisions authorizing specific amounts, if fully funded, would result in appropriations of

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5. See Congressional Budget Office, “Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)” (March 2011), cited earlier.

6. Over that eight-year period (2012 to 2019), the current estimate of the net cost of the coverage provisions (\$794 billion) is about 8 percent *higher* than the February 2011 estimate (\$733 billion)—but the latter was about 6 percent *lower* than the March 2010 estimate (\$788 billion).



\$106 billion over the 2010–2019 period. Updating those estimates for the 2012–2021 period would result in authorizations of just under \$100 billion. However, most of those authorizations—accounting for about \$85 billion—are for activities that were already being carried out under prior law or that were previously authorized and that PPACA authorized for future years; for example, that amount includes an estimated \$39 billion for ongoing activities of the Indian Health Service and \$34 billion for continued grants to federally qualified health centers.<sup>7</sup>

### **Impact on the Federal Budget Beyond the First 10 Years**

CBO does not generally provide cost estimates beyond the 10-year projection period, but certain Congressional rules require some information about the budgetary impact of legislation in subsequent decades, and many Members have requested analyses of the long-term budgetary impact of the broad changes in the health care and health insurance systems that will result from these laws. That impact, however, becomes more and more uncertain the farther into the future one projects. Over a longer time span, a wide range of changes could occur—in people’s health, in the sources and extent of their insurance coverage, and in the delivery of medical care—that are very difficult to predict but that could have a significant effect on federal health care spending, both under current law and under the law prior to passage of PPACA and the Reconciliation Act.

Therefore, CBO developed a rough outlook for the second decade after enactment by grouping the elements of the legislation into broad categories and assessing the rate at which the budgetary impact of each of those broad categories will increase over time. On the basis of its February 2011 analysis, CBO effectively projected that PPACA and the Reconciliation Act would reduce federal budget deficits by an amount in a broad range around one-half percent of gross domestic product (GDP) for the 2022–2031 period, assuming that all provisions of the legislation were fully implemented. That estimate has not been updated since the February analysis.

### **Other Effects of the Legislation**

CBO has also analyzed the legislation’s impact on the “federal budgetary commitment to health care,” a term that the agency uses to describe the sum of net federal outlays for health programs and tax preferences for health care; on premiums for health insurance; and on labor markets.

**Effects on the Federal Budgetary Commitment to Health Care.** In its February 2011 analysis, CBO estimated that PPACA and the Reconciliation Act would increase the federal budgetary commitment to health care by \$464 billion over the 2012–2021 period. The net increase in that commitment is driven primarily by the expansion in coverage, which would be partly offset by other factors such as the decrease in other

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7. PPACA and the Reconciliation Act also include mandatory appropriations for certain grants, research, and other programs. The costs of those provisions are included in the estimates of the legislation’s effects on direct spending.

federal health care spending (primarily for Medicare) and the imposition of the excise tax on high-premium insurance policies in 2018.

In contrast, CBO anticipates that those laws will decrease the federal budgetary commitment to health care in the decade following the 10-year projection period, assuming that the provisions of current law remain unchanged. The estimated effect in later years differs from that in the first decade because the budgetary impact of provisions that reduce the commitment is projected to grow faster than the impact of provisions that increase it.

**Effects on Health Insurance Premiums.** Under PPACA and the Reconciliation Act, premiums for health insurance in the individual market will be somewhat higher than they would otherwise be, CBO and JCT estimate, mostly because the average insurance policy in that market will cover a larger share of enrollees' costs for health care and provide a slightly wider range of benefits.<sup>8</sup> The effects of those differences will be offset in part by other factors that will tend to reduce premiums in the individual market; for example, purchasers in that market will tend to be healthier than they would have been under prior law, leading to lower average costs for their health care. Although premiums in the individual market will be higher on average, many people will end up paying less for health insurance—because the majority of enrollees purchasing coverage in that market will receive subsidies via the insurance exchanges.

Premiums for employment-based coverage obtained through large employers will be slightly lower than they would otherwise be; premiums for employment-based coverage obtained through small employers may be slightly higher or slightly lower.

**Effects on Labor Markets.** The legislation will affect some individuals' decisions about whether and how much to work and some employers' decisions about hiring workers. CBO estimates that the legislation, on net, will reduce the amount of labor used in the economy by a small amount—roughly half a percent—primarily by reducing the amount of labor that workers choose to supply. That net effect reflects changes in incentives in the labor market that operate in both directions: Some provisions of the legislation will discourage people from working more hours or entering the workforce, and other provisions will encourage them to work more. Moreover, many people will be unaffected by those provisions and will face the same incentives regarding work as they otherwise would have.

Because the legislation will affect individuals' decisions on both whether to participate in the workforce and the number of hours they work, its effect on employment is difficult to predict. If the legislation did not affect the average number of hours worked per employed person, CBO projects that it would reduce household employment in 2021 by about 800,000. However, because the legislation will probably affect average

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8. See Congressional Budget Office, [letter to the Honorable Evan Bayh providing an analysis of health insurance premiums under the Patient Protection and Affordable Care Act](#) (November 30, 2009).

hours worked among those employed, the effect on employment will be somewhat different.

### **Uncertainty Surrounding the Estimates**

The projections of the budgetary impact and other impacts of health care legislation are quite uncertain because assessing the effects of making broad changes in the nation's health care and health insurance systems—or of reversing scheduled changes—requires assumptions about a broad array of technical, behavioral, and economic factors. CBO and JCT, in consultation with outside experts, have devoted a great deal of care and effort to analyzing health care legislation in the past few years, and the agencies strive to develop estimates that are in the middle of the distribution of possible outcomes. Nevertheless, the actual outcomes will surely differ from those estimates.

As with all of CBO's cost estimates, the estimates described in this testimony reflect an assumption that the provisions of current law otherwise remain unchanged throughout the projection period and that the legislation being analyzed is enacted and implemented throughout that period in its current form. CBO's responsibility to the Congress is to estimate the effects of proposals and of current law as written and not to forecast future legislation. The budgetary impact of PPACA and the Reconciliation Act could be quite different if key provisions of that original legislation are subsequently changed or not fully implemented.

In fact, CBO's cost estimate for the legislation noted that it will put into effect a number of policies that might be difficult to sustain over a long period of time. The combination of those policies, prior law regarding payment rates for physicians' services in Medicare, and other information has led CBO to project that the growth rate of Medicare spending (per beneficiary, adjusted for overall inflation) will drop from about 4 percent per year, which it has averaged for the past two decades, to about 2 percent per year on average for the next two decades. It is unclear whether such a reduction can be achieved through greater efficiencies in the delivery of health care or will instead reduce access to care or the quality of care (relative to the situation under prior law). Also, the legislation includes a provision that makes it likely that exchange subsidies will grow at a slower rate after 2018, so the shares of income that enrollees have to pay will increase more rapidly at that point, and the shares of the premiums that the subsidies cover will decline.<sup>9</sup> Such possibilities could lead to pressure on lawmakers to adjust those policies.

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9. For further discussion of some of these issues, see Congressional Budget Office, "The Effects of Health Reform on the Federal Budget," *Director's Blog* (April 12, 2010) and "Uncertainty in Estimates for Health Care Legislation," *Director's Blog* (March 19, 2010).

## **Overview of the Budgetary Effects in the First Decade**

On March 20, 2010, CBO and JCT published estimates of the budgetary impact of PPACA and the Reconciliation Act. Those estimates covered 2010 through 2019, the period used for Congressional budget enforcement procedures when the legislation was being considered (in calendar years 2009 and early 2010).

CBO subsequently incorporated PPACA and the Reconciliation Act into its baseline budget projections published in August 2010 and January 2011. Revisions to baseline projections reflect the enactment of legislation, changes in CBO's economic forecast, and updates to the agency's projection methods and assumptions. Revisions to baseline projections can result in new estimates of the effects of existing laws that appear separately in the projections. However, such revisions do not result in new estimates of the effects of existing laws that are interwoven with the effects of other laws. For PPACA and the Reconciliation Act, the effects of the provisions related to insurance coverage can be separately identified in CBO's baseline projections, but many of the effects of other provisions cannot be separately identified.

On February 18, 2011, CBO and JCT published an estimate of the budgetary impact of H.R. 2, the Repealing the Job-Killing Health Care Law Act, which would repeal PPACA and the health-related provisions of the Reconciliation Act. That cost estimate covered 2012 through 2021, the period covered by CBO's current baseline projections. Reversing the sign of that estimate provides an approximate estimate of the impact of PPACA and the health-related provisions of the Reconciliation Act over that later time period. The figure is only approximate because the cost estimate for H.R. 2 did not include the effects of funding provided by the health care legislation that has already been obligated or spent and because it incorporated the effects of subsequent legislation that modified certain aspects of the original legislation.

Most recently, CBO released its March 2011 baseline projections. As with the preceding two sets of baseline projections, the latest ones incorporated the budgetary impact of PPACA and the Reconciliation Act. However, as noted above, many of the effects of provisions not related to health insurance coverage cannot be separately identified.

The evolution of estimates does not indicate any substantial change in the overall effects of PPACA and the Reconciliation Act from what CBO and JCT projected in March 2010. In its ongoing monitoring of developments, CBO has seen no evidence to date that the steps that will be taken to implement that legislation—or the ways in which participants in the health care and health financing systems will respond to that legislation—will yield overall budgetary effects that differ significantly from the ones projected earlier.

CBO will continue to update its budget projections as the outlook for various economic and technical factors changes. In cases in which PPACA and the Reconciliation Act created a new flow of spending or revenues that is tracked separately—such as outlays for the subsidies provided through the insurance exchanges or collections of new excise taxes—the direct effects will be observable and can be compared with the

original estimates. But any indirect effects of those provisions on other aspects of the budget will not be identifiable. Moreover, for provisions that affect an existing flow of spending or revenues—such as Medicare outlays or income tax receipts—the effects will not be identifiable. Therefore, comparing all elements of the laws’ ultimate impact with the amounts estimated at the time of their enactment will not be possible.

### **Estimates of the Impact of Enacting PPACA and the Reconciliation Act Made in March 2010**

In March 2010, CBO and JCT estimated that enacting PPACA and the Reconciliation Act would produce a net reduction in federal deficits of \$143 billion over the 2010–2019 period as a result of changes in direct spending and revenues.<sup>10</sup> That figure comprised \$124 billion in net reductions deriving from the health care and revenue provisions of those laws and \$19 billion in net reductions deriving from the education provisions.

The net decrease in deficits from enacting all of those provisions except those affecting education had three major components (see Table 1 on page 2):

- PPACA and the Reconciliation Act contained a set of provisions designed to expand health insurance coverage that was estimated to increase federal deficits. The costs of those coverage expansions—which include the cost of the subsidies to be provided through the exchanges, higher outlays for Medicaid and the Children’s Health Insurance Program, and tax credits for certain small employers—will be partially offset by revenues from the excise tax on high-premium insurance plans and net savings from other coverage-related effects. For the 2010–2019 period, those provisions yielded estimated gross costs of \$938 billion and estimated net costs (after accounting for the offsets just mentioned) of \$788 billion.
- The legislation also included a number of other provisions that were estimated to reduce net federal outlays (primarily for Medicare) by \$492 billion over the 2010–2019 period.
- Apart from the effect of provisions related to insurance coverage, the legislation will increase federal revenues in various ways, mostly by increasing the Hospital Insurance payroll tax and imposing fees on certain manufacturers and insurers. The additional revenues were estimated to equal \$420 billion over the 2010–2019 period.

All told, those provisions of PPACA and the Reconciliation Act were estimated to increase direct spending by \$401 billion and to increase revenues by \$525 billion over

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10. See Congressional Budget Office, *cost estimate for H.R. 4872, the Reconciliation Act of 2010* (March 20, 2010).

the 2010–2019 period, yielding the net estimated savings of \$124 billion over those 10 years (as noted above).

### **Estimates of the Impact of Repealing PPACA and the Health Care-Related Provisions of the Reconciliation Act Made in February 2011**

In February 2011, CBO and JCT estimated that repealing PPACA and the health-related provisions of the Reconciliation Act would produce a net increase in federal deficits of \$210 billion over the 2012–2021 period as result of changes in direct spending and revenues.<sup>11</sup> Reversing the sign of the estimate released in February provides an approximate estimate of the impact of those provisions over that period. Therefore, CBO and JCT effectively estimated in February that PPACA and the health-related provisions of the Reconciliation Act will produce a net decrease in federal deficits of \$210 billion over the 2012–2021 period as result of changes in direct spending and revenues.

That net decrease in deficits has the same three major components as the net decrease in deficits estimated last March:

- The provisions designed to expand health insurance coverage were estimated to yield gross costs of \$1,390 billion and net costs (after accounting for the offsets mentioned above) of \$1,042 billion over the 2012–2021 period.
- The other provisions affecting direct spending were estimated to reduce net federal outlays (primarily for Medicare) by \$732 billion over the 2012–2021 period.
- The provisions affecting federal revenues (apart from those related to insurance coverage) were estimated to increase revenues by \$520 billion over the 2012–2021 period.

Altogether, those provisions of PPACA and the Reconciliation Act were estimated to increase direct spending by \$604 billion and to increase revenues by \$813 billion over the 2012–2021 period.

The estimated 10-year reduction in deficits for enacting PPACA and the Reconciliation Act that is implied by the February estimate differs from the 10-year reduction in deficits that CBO and JCT estimated in March 2010 for enactment of that legislation. The difference between the two estimates is primarily attributable to the different time periods they cover. In particular, including the years 2020 and 2021 in the analysis results in a substantially larger estimated decrease in budget deficits; in those two years alone, the legislation will decrease federal deficits by a total of about \$90 billion, CBO estimates. That larger decrease in deficits in later years reflects the fact that the net costs of the coverage provisions are projected to rise more slowly than the combined effect of the factors that will reduce deficits (the decrease in other direct

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11. See Congressional Budget Office, [cost estimate for H.R. 2, the Repealing the Job-Killing Health Care Law Act](#) (February 18, 2011).

spending and the increase in other revenues). Over the eight years that are common to the two analyses—2012 to 2019—enactment of PPACA and the health-related provisions of the Reconciliation Act was projected last March to reduce federal deficits by \$132 billion, whereas the February 2011 estimate shows that those provisions will reduce deficits by an estimated \$119 billion (see the second and third columns of Table 1 on page 2).

The remaining (relatively modest) differences between the two estimates arise from several factors. First, some of the funding provided by the legislation has been obligated or spent and thus is not included in the estimate of the effects of repealing the legislation. Second, subsequent legislation has already modified the laws enacted last March, so the estimate of H.R. 2 did not include a reversal of all of the provisions of the original legislation. Specifically, the Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309) increased the amount that could be recovered from enrollees in insurance exchanges whose actual income in a year differed from the figure used to determine their tax credit for health insurance premiums. That legislation was estimated to reduce net federal payments for subsidies through the health insurance exchanges. Third, the estimates prepared last March were based on the projections of economic conditions, health care costs, federal spending and revenues, and other factors that CBO published in March 2009. In particular, the economic outlook is now somewhat different, and CBO and JCT made a number of technical changes to their spending and revenue projections related to the provisions of PPACA and the Reconciliation Act.

### **Updated Estimates of the Impact of the Coverage Provisions of PPACA and the Reconciliation Act Made in March 2011**

CBO's March 2011 baseline projections include somewhat different estimates for the coverage provisions of PPACA and the Reconciliation Act. Specifically, over the 2012–2021 period, those provisions are now estimated to yield gross costs of \$1,445 billion and net costs (after accounting for the offsets mentioned above) of \$1,131 billion (see Table 2).

The March 2011 estimate of the net cost of the insurance provisions represents a \$90 billion increase (over 10 years) since the previous estimate. CBO made a number of technical modifications to its models for health insurance coverage; as a result of those modifications, slightly fewer low-income people are projected to be eligible for Medicaid, and slightly more are expected to be eligible for subsidies through the health insurance exchanges. Altogether, the upward revision of \$90 billion reflects the following changes: a \$47 billion reduction in the impact on Medicaid and CHIP outlays; a \$100 billion increase in exchange subsidies and related spending; a \$41 billion reduction in revenues from other effects of the coverage provisions (including the excise tax on high-premium insurance plans); and smaller changes in other payments related to coverage provisions.

CBO's current estimate of the net cost of the coverage provisions differs from the original estimate issued in March 2010 primarily because of the different time periods

**Table 2.**

## Estimated Budgetary Effects of the Insurance Coverage Provisions of PPACA and the Reconciliation Act

(Billions of dollars, by fiscal year)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total, 2012- 2021
Effects on the Federal Budget Deficit												
Medicaid and CHIP outlays <sup>a</sup>	0	0	0	30	55	77	84	87	93	97	105	627
Exchange subsidies and related spending <sup>b,c</sup>	0	2	2	23	55	87	104	115	123	130	137	777
Small-employer tax credits <sup>d</sup>	4	5	5	7	8	5	2	2	2	2	2	41
<b>Gross Cost of Insurance Coverage Provisions</b>	<b>4</b>	<b>6</b>	<b>7</b>	<b>60</b>	<b>118</b>	<b>169</b>	<b>189</b>	<b>204</b>	<b>218</b>	<b>229</b>	<b>245</b>	<b>1,445</b>
Penalty payments by uninsured individuals	0	0	0	0	-2	-5	-5	-5	-5	-6	-6	-34
Penalty payments by employers <sup>d</sup>	0	0	0	-4	-8	-9	-10	-11	-12	-13	-14	-81
Excise tax on high-premium insurance plans	0	0	0	0	0	0	0	-12	-20	-24	-29	-87
Other effects on tax revenues and outlays <sup>e</sup>	2	3	2	3	-4	-13	-17	-20	-22	-22	-22	-113
<b>Net Cost of Insurance Coverage Provisions</b>	<b>7</b>	<b>9</b>	<b>9</b>	<b>59</b>	<b>104</b>	<b>142</b>	<b>157</b>	<b>155</b>	<b>158</b>	<b>164</b>	<b>174</b>	<b>1,131</b>

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: These estimates were produced using CBO's March 2011 baseline projections of federal revenues and outlays. They do not include federal administrative costs that would be subject to appropriation.

Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit. Numbers may not add up to totals because of rounding.

PPACA = Patient Protection and Affordable Care Act; Reconciliation Act = Health Care and Education Reconciliation Act of 2010; CHIP = Children's Health Insurance Program.

- a. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2012–2021 period would increase by about \$60 billion as a result of the coverage provisions.
- b. Includes spending for high-risk pools and the net budgetary effects of proposed collections and payments for reinsurance and risk adjustment.
- c. Numbers may not match those shown in the table "CBO's March 2011 Baseline: Health Insurance Exchanges" located on CBO's Web site because different related items were included in the two tables.
- d. The effects of this provision on the deficit include the associated effects of changes in taxable compensation on tax revenues.
- e. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about \$4 billion over the 2012–2021 period and that the coverage provisions would have negligible effects on outlays for other federal programs.



covered in the analysis. Over the eight-year period that is common to both analyses (2012 to 2019), the net cost of the coverage provisions estimated in March 2011 (\$794 billion) is 2 percent higher than the March 2010 estimate (\$778 billion) (see Figure 2 on page 5). For those years, the current estimate is 8 percent *higher* than the February 2011 estimate (\$733 billion), but that projection was 6 percent *lower* than the March 2010 estimate.

### **Effects on Discretionary Spending**

Implementing PPACA and the Reconciliation Act will affect not only direct spending and revenues but also annual spending subject to future appropriation actions. Those effects on discretionary spending arise from provisions of the legislation that affect a variety of federal programs and agencies. The legislation establishes a number of new programs and activities, and it authorizes new funding for existing programs. By its nature, however, discretionary spending is subject to future acts of the Congress through the annual appropriation process; that process could lead to greater or smaller costs than the sums authorized by PPACA.<sup>12</sup>

The discretionary costs associated with last March's legislation fall into two broad categories:

- The costs that will be incurred by federal agencies to implement the new policies established by the legislation, such as administrative expenses for the Internal Revenue Service and the Department of Health and Human Services in carrying out key requirements of the legislation, and
- Explicit authorizations for spending by a variety of grant and other programs; in many cases, specified funding levels for one or more years are provided in the legislation, although in other cases, the legislative language authorizes the appropriation of "such sums as necessary."

CBO estimated that costs to the IRS of implementing the eligibility determination, documentation, and verification processes for premium and cost-sharing credits would probably total between \$5 billion and \$10 billion over 10 years. In addition, CBO estimated that HHS would require similar amounts over 10 years to implement the changes in Medicare, Medicaid, and CHIP.

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12. In addition to such spending that is subject to appropriations, PPACA and the Reconciliation Act created a number of new programs or requirements for which the legislation provided direct appropriations. Those amounts that were appropriated by the legislation are included in CBO's estimate of direct spending (as discussed previously).

CBO estimated that the provisions authorizing the appropriation of specific amounts, if fully funded by future laws, would result in appropriations of \$106 billion over the 2010–2019 period.<sup>13</sup> Updating those estimates for the 2012–2021 period would result in authorizations of just under \$100 billion.<sup>14</sup> Most of those authorizations—amounting to about \$85 billion—were for activities that were already being carried out under prior law or that were previously authorized and that PPACA authorized for future years; for example, that amount includes an estimated \$39 billion for ongoing activities of the Indian Health Service and \$34 billion for continued grants to federally qualified health centers.<sup>15</sup>

The estimates discussed above are not included in CBO’s estimate of direct spending under PPACA and the Reconciliation Act or in the effects of that legislation on deficits (as discussed earlier in this testimony) because the newly authorized funding is subject to future appropriation actions. The budgetary costs for carrying out those authorizations will be counted at the time and to the extent that the authorized amounts are appropriated, as is the case for all discretionary funding authorized and then ultimately appropriated by the Congress.

## **Effects on Insurance Coverage**

PPACA and the Reconciliation Act included numerous provisions that will affect insurance coverage, including the following:

- The requirement that nearly all legal U.S. residents obtain health insurance;
- The establishment of health insurance exchanges and the provision of subsidies for certain individuals and families who purchase coverage through the exchanges;
- The requirements that insurers accept all applicants, not limit coverage for preexisting medical conditions, and not vary premiums to reflect differences in enrollees’ health;
- The requirement that insurers extend coverage for dependent children up to age 26;

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13. CBO has not estimated the amount of appropriations required to implement activities for which PPACA authorized the appropriation of “such sums as necessary.”

14. The estimate of authorizations of specific amounts is lower for the 2012–2021 period than for the 2010–2019 period because it excludes the amounts authorized for 2010 or 2011 and because, in most cases, the authorization period expires before 2020.

15. For more information, see Congressional Budget Office, [letter to the Honorable Jerry Lewis about potential effects of the Patient Protection and Affordable Care Act on discretionary spending](#) (May 11, 2010); and “Additional Information about the Potential Discretionary Costs of Implementing PPACA” (May 12, 2010).

- The expansion of Medicaid coverage to include most nonelderly people with income below 138 percent of the federal poverty level;<sup>16</sup>
- The penalties on certain employers if any of their workers obtain subsidized coverage through the exchanges;
- The tax credits for small employers that offer health insurance; and
- The excise tax on insurance policies with relatively high premiums.

### **Changes in Insurance Coverage and Federal Budgetary Flows**

According to CBO and JCT's most recent estimates, PPACA and the Reconciliation Act will increase the number of nonelderly Americans with health insurance by about 32 million in 2016 and about 34 million in 2021 (see Table 3). The share of legal nonelderly residents with insurance coverage in 2021 will be about 95 percent, compared with a projected share of about 82 percent in the absence of that legislation (and an estimated 83 percent currently). About 23 million nonelderly residents will remain uninsured; about one-third of that group will be unauthorized immigrants, who are not eligible to participate in Medicaid or the insurance exchanges; another quarter will be eligible for Medicaid but are not expected to enroll; and the remaining fraction will include individuals who are ineligible for subsidies, are exempt from the mandate to obtain insurance, choose to not comply with the mandate (and take the risk of paying a penalty), or have some combination of those characteristics.

That projected increase of 34 million in the number of insured people in 2021 reflects a number of differences relative to circumstances in the absence of PPACA and the Reconciliation Act. Approximately 24 million people will purchase their own coverage through insurance exchanges, and Medicaid and CHIP will have roughly 17 million additional enrollees. Partly offsetting those increases will be net reductions, relative to the number projected under prior law, of about 6 million people purchasing individual coverage directly from insurers and about 1 million people obtaining coverage through their employer.<sup>17</sup>

CBO and JCT estimate that PPACA and the provisions of the Reconciliation Act affecting health insurance coverage will result in a net increase in federal deficits of \$1,131 billion over fiscal years 2012 through 2021. That estimate includes a

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16. The legislation established the eligibility threshold for Medicaid at 133 percent of the federal poverty level, but 5 percent of applicants' income is disregarded, raising the effective threshold to 138 percent of the federal poverty level.

17. Under the legislation, certain employers can allow all of their workers to choose among the plans available in the exchanges, but those enrollees will not be eligible to receive subsidies via the exchanges (and thus are shown in Table 3 as enrollees in employment-based coverage rather than as enrollees in plans purchased via the exchanges). Nearly 4 million people are projected to obtain coverage in that way in 2021, bringing the total number of people enrolled in exchange plans to about 28 million in that year.

**Table 3.****Estimated Effects of PPACA and the Reconciliation Act on Insurance Coverage**

(Millions of nonelderly people, by calendar year)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<b>Effects on Insurance Coverage, by Source</b>											
Coverage Under Prior Law <sup>a</sup>											
Medicaid and CHIP	37	37	37	36	35	35	35	35	35	36	35
Employer	152	154	157	159	161	163	163	163	163	163	162
Nongroup and other <sup>b</sup>	25	25	25	26	26	27	28	28	28	29	30
Uninsured <sup>c</sup>	55	55	54	54	53	53	54	54	55	56	57
Total	269	271	272	274	276	277	279	281	282	284	285
Increase or Decrease (-) in Coverage											
Medicaid and CHIP	*	*	*	9	12	16	16	16	16	16	17
Employer	3	3	3	6	3	-1	*	-1	-1	-1	-1
Nongroup and other <sup>b</sup>	*	*	*	-3	-4	-5	-5	-6	-6	-6	-6
Exchanges	0	0	0	9	14	22	23	23	24	24	24
Uninsured <sup>c</sup>	-3	-3	-3	-21	-26	-32	-33	-33	-33	-34	-34
<b>Uninsured and Insured Populations Under Current Law</b>											
Nonelderly Uninsured People <sup>c</sup>	52	51	51	32	27	21	20	21	22	23	23
Insured People as a Percentage of the Nonelderly Population											
All U.S. residents	81	81	81	88	90	93	93	92	92	92	92
U.S. residents except unauthorized immigrants	83	83	83	90	93	95	95	95	95	95	95

Continued

\$627 billion increase in net federal outlays for Medicaid and CHIP and \$777 billion in exchange subsidies and related spending. In addition, the tax credit for certain small employers who offer health insurance is estimated to cost \$41 billion over 10 years. Those costs will be partly offset by higher revenues or lower costs, totaling about \$314 billion over the 10-year budget window, from four sources: an increase in net revenues from the excise tax on high-premium insurance plans, totaling \$87 billion; penalty payments by uninsured individuals, increasing revenues by \$34 billion; penalty payments by employers, increasing revenues by \$81 billion; and other budgetary effects, mostly on tax revenues, associated with shifts in the mix of taxable and nontaxable compensation resulting from changes in employment-based health insurance coverage, which will decrease deficits by \$113 billion.<sup>18</sup>

18. Changes in the extent of employment-based health insurance affect federal revenues because most payments for that coverage are tax-preferred. If employers increase or decrease the amount of compensation they provide in the form of health insurance (relative to prior-law projections), CBO and JCT assume that offsetting changes will occur in wages and other forms of compensation—which are generally taxable—to hold total compensation roughly the same. Such effects also arise for specific elements of the legislation (such as the tax credits for small employers); those effects are included within the estimates for those elements.

**Table 3.**

**Continued**

**Estimated Effects of PPACA and the Reconciliation Act on Insurance Coverage**

(Millions of nonelderly people, by calendar year)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<b>Memorandum:</b>											
Exchange Enrollees and Subsidies											
Number with unaffordable offer from employer <sup>d</sup>				*	1	1	1	1	1	1	1
Number of unsubsidized exchange enrollees				1	2	4	4	4	4	4	4
Average exchange subsidy per subsidized enrollee (Dollars)				4,610	5,320	5,450	5,630	6,120	6,460	6,740	7,080

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: These estimates were produced using CBO’s March 2011 baseline projections of federal revenues and outlays.

Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.

PPACA = Patient Protection and Affordable Care Act; Reconciliation Act = Health Care and Education Reconciliation Act of 2010; CHIP = Children’s Health Insurance Program;

\* = between -500,000 and 500,000 people.

- a. Numbers reflect average annual enrollment; people reporting multiple sources of coverage were assigned a primary source. To illustrate the effects of the 2010 health care legislation, which is now current law, changes in coverage are shown relative to coverage projections in the absence of that legislation, or under “prior law.”
- b. Other coverage includes Medicare. The effects of the proposal are almost entirely on nongroup coverage.
- c. The count of uninsured people includes unauthorized immigrants and people who are eligible for, but not enrolled in, Medicaid.
- d. Workers who would have to pay more than a specified share of their income (9.5 percent in 2014) for employment-based coverage could receive subsidies through an exchange.

**Effects on Employment-Based Insurance**

On balance, the number of people obtaining coverage through their employer will be about 1 million lower in 2019 through 2021 under PPACA and the Reconciliation Act than under prior law, CBO and JCT estimate. The net change in employment-based coverage under that legislation will be the result of several flows, which can be illustrated using the estimates for 2019:

- About 6 million to 7 million people who would have had an offer of employment-based coverage under prior law will not have an offer under current law. That estimate represents about 4 percent of the roughly 160 million people projected to have employment-based coverage. The businesses that choose to not offer coverage as a result of last year’s legislation will tend to be smaller employers and employers with predominantly lower-wage workers—people who will be eligible for Medicaid or subsidies through the exchanges—although some workers who will not have

employment-based coverage because of the legislation will not be eligible for such subsidies. Whether those changes in coverage will derive from existing coverage that is dropped or a lack of new offers of coverage is difficult to determine.

- Another 1 million to 2 million people will have an offer of employment-based coverage but will be covered via the exchanges instead. Under the legislation, workers with an offer of employment-based coverage will generally be ineligible for exchange subsidies, but that “firewall” will presumably be enforced imperfectly, and an explicit exception to it will be made for workers whose offer of employment-based coverage is deemed unaffordable.
- About 7 million to 8 million people not covered by an employment-based plan under prior law will have that coverage under PPACA. That estimate reflects the combined impact of the insurance mandate, the penalties for employers, and the tax credits for small employers—which will lead some employers who would not have offered coverage before to the passage of PPACA to offer it and will lead some people to take up existing offers.

Some commentators have expressed surprise that CBO and JCT do not expect a much larger reduction in employment-based insurance coverage owing to PPACA and the Reconciliation Act, in light of the expansion of eligibility for Medicaid and the subsidies for individual insurance coverage created by that legislation. However, the legislation leaves in place substantial financial advantages for many people to receive insurance coverage through their employers, and it provides some new incentives for employers to offer insurance coverage to their employees. The key considerations include these:

- Although workers with low family income whose employers do not offer health insurance will be eligible for coverage through Medicaid or for significant subsidies through the insurance exchanges, middle-income workers will not be eligible for Medicaid and will be eligible for more moderate subsidies through the exchanges, and high-income workers will not be eligible for any subsidies. Most large firms—which are the predominant source of health insurance now—have a mix of higher-income and lower-income workers, so not all of their employees would be eligible for exchange subsidies if those employers decided not to offer coverage. Furthermore, nondiscrimination provisions in the Internal Revenue Code discourage firms from offering health insurance benefits to more highly paid employees while not offering them to lower-paid employees.
- Employment-based insurance receives a significant subsidy through the tax exclusion for employer-paid premiums, which will provide a continuing incentive for employers to offer coverage (even after high-premium plans face an excise tax beginning in 2018). The value of the tax exclusion for workers who obtain health insurance through their employer is usually proportional to their combined tax rates for payroll taxes and for federal and state income taxes—which usually do not

apply to the employer's contribution to the insurance premiums or to the employee's contribution. For higher-income workers, that tax subsidy typically amounts to 25 percent or more of the premiums. The subsidy will not be available to workers whose employers drop coverage and who end up purchasing insurance through an exchange.

- The administrative costs involved in operating and managing health insurance plans will be higher in the exchanges than they will be for large employers, principally because administering plans (including handling enrollment and the payment of premiums) for many individual policyholders is more expensive than administering them for a single employer. That advantage for employers will encourage employees to continue seeking employment-based coverage and thus will encourage employers to keep offering it.
- The mandate and penalties for individuals will lead more workers to want health insurance coverage. Because employers design benefit packages to appeal to their current and potential workers, that increased demand for health insurance will tend to boost the number of employers that offer insurance and the number of workers who obtain it.
- PPACA and the Reconciliation Act applied both sticks and carrots to employers to encourage them to offer insurance to their employees. Firms with more than 50 employees that do not offer insurance and have at least one employee who receives an exchange subsidy are subject to a penalty of up to \$2,000 per full-time worker (beyond the first 30 such workers). Firms with fewer than 25 employees and with average annual wages of less than \$50,000 may be eligible for a tax subsidy that covers a percentage of the premiums. Before 2014, for the smallest and lowest-wage firms, the credit covers up to 35 percent of the employer's payments for premiums; for 2014 and later, the credit will cover up to 50 percent of the employer's payments but only for two years.
- Employers who drop coverage and leave their employees to purchase insurance on their own will generally have to raise their cash compensation to compete with employers who continue to offer health insurance. Some evidence of such substitution has been found in studies that examine the wages of workers with differing job-related insurance benefits. Further evidence of such substitution can be seen at the aggregate level, where the share of national income devoted to compensation has been fairly steady during the past few decades, as rising costs of health benefits have been offset by slower growth of wages and salaries.

Other analysts who have carefully modeled the nation's existing health insurance system and the changes in incentives for employers to offer insurance coverage created by last year's legislation have reached conclusions similar to those of CBO and JCT. The Office of the Actuary at the Centers for Medicare and Medicaid Services concluded that, on net, about 1 million fewer people would have employment-based coverage

under PPACA in 2019.<sup>19</sup> Analysts at the Urban Institute estimated that such coverage would have diminished by about half a million people, on net, if the legislation had been fully implemented in 2010.<sup>20</sup> Analysts at the Lewin Group predicted a net reduction in employment-based coverage of about 3 million people, assuming full implementation in 2011.<sup>21</sup> Other analysts have concluded that employment-based coverage might increase: Analysts at RAND estimated that the number of workers offered, although not necessarily enrolled in, employment-based coverage would increase, on net, by about 14 million when the health care legislation was fully phased in.<sup>22</sup>

There is clearly a tremendous amount of uncertainty about how employers and employees will respond to PPACA and the Reconciliation Act, and there is little direct evidence on the issue up to now. Models of the insurance system are based on observed differences in behavior in response to more modest changes in incentives, but last year's legislation is much more sweeping in its nature.

Recent surveys of employers regarding their plans for offering health insurance coverage after Medicaid has been expanded and insurance exchanges are in place are broadly consistent with CBO and JCT's analysis. However, those surveys probably do not convey much real information at this point, because firms do not know very much yet about how last year's legislation will affect the market for health insurance. For example, firms have not experienced the added demand for coverage from their workers who will be subject to the insurance mandate, and very little evidence exists about how the insurance exchanges will operate.

### **Effects on Medicaid and CHIP Coverage**

CBO and JCT estimate that the coverage provisions of PPACA and the Reconciliation Act will increase the number of Medicaid and CHIP beneficiaries by about

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19. Richard S. Foster, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended* (Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary, April 22, 2010), [www.cms.gov/ActuarialStudies/Downloads/PPACA\\_2010-04-22.pdf](http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf).
  20. Matthew Buettgens, Bowen Garrett, and John Holahan, *America Under the Affordable Care Act* (Washington, D.C.: Urban Institute, December 2010), [www.urban.org/uploadedpdf/412267-america-under-aca.pdf](http://www.urban.org/uploadedpdf/412267-america-under-aca.pdf).
  21. The Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers*, Staff Working Paper No. 11 (Falls Church, Va.: The Lewin Group, June 2010), [www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf](http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf).
  22. Christine Eibner, Peter S. Hussey, and Federico Girosi, "The Effects of the Affordable Care Act on Workers' Health Insurance Coverage," *New England Journal of Medicine*, vol. 363, no. 15 (2010), p. 1394. RAND analysts also estimated that the Senate-passed bill (H.R. 3590) would increase employment-based coverage, on net, by about 6 million people in 2019. See Jeanne S. Ringel and others, *Analysis of the Patient Protection and Affordable Care Act (H.R. 3590)* (Washington, D.C.: RAND Corporation, February 2010), [www.rand.org/content/dam/rand/pubs/research\\_briefs/2010/RAND\\_RB9514.pdf](http://www.rand.org/content/dam/rand/pubs/research_briefs/2010/RAND_RB9514.pdf).



17 million in 2021 and will increase federal spending for those programs by \$627 billion over the 2012–2021 period (see Table 2 on page 14). Those estimates reflect the following provisions of the legislation:

- PPACA and the Reconciliation Act expand eligibility for Medicaid to nearly all legal residents of the country with income below 138 percent of the federal poverty level.
- The legislation provides that the federal government pay a substantially higher share of Medicaid costs for newly eligible enrollees than it will pay for previously eligible enrollees. The matching rates for newly eligible enrollees will be 100 percent from 2014 through 2016 and will then decline to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent thereafter.<sup>23</sup>
- The legislation requires nearly all individuals to have health insurance coverage, and if they do not comply, it generally imposes penalties.<sup>24</sup> CBO and JCT expect that the mandate and its associated penalties will increase Medicaid enrollment among both those who will become newly eligible for the program under the legislation and those who were eligible before the legislation.
- PPACA and the Reconciliation Act establish maintenance-of-effort requirements for states as a condition of receiving federal Medicaid funding. Those requirements prohibit states from establishing, for certain periods of time, eligibility standards, methodologies, or procedures that are more restrictive than those in effect when the legislation was passed. Specifically, states are required to maintain such effort for adults through 2013 and for children through 2019. CBO expects that, after 2013, nearly all states will eliminate Medicaid coverage for adults with income above 138 percent of poverty. Similarly, CBO expects that, after 2019, about half of the states will cease participating in CHIP, while the remaining states will reduce eligibility levels for CHIP. Adults and children no longer eligible for Medicaid and CHIP will become eligible for subsidies in the insurance exchanges to the extent that they meet other applicable eligibility requirements.
- The legislation establishes streamlined eligibility determinations for Medicaid and subsidies through the insurance exchanges. Under that policy, people who apply for coverage through a health insurance exchange but are found to be eligible for Medicaid are to be enrolled in that program. Similarly, people who apply for Medicaid but whose income would qualify them for subsidies through the exchanges are to be enrolled for those subsidies.

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23. The average federal share for current enrollees is about 57 percent. Starting in 2014, the average federal share, taking into account the rate for people newly eligible under PPACA's provisions, will range between 60 percent and 62 percent, depending on the year.

24. The penalties apply to all people with income above the threshold at which filing a federal tax return is required, which, depending on the filing status of the household, is about 80 percent to 90 percent of the federal poverty level.

Relative to the situation under prior law, the coverage provisions of PPACA and the Reconciliation Act are estimated to increase state governments' outlays for Medicaid by about \$60 billion over the 2012–2021 period. That estimate reflects the flexibility states have to defray some of the additional costs associated with that legislation by making programmatic changes to Medicaid and CHIP. The costs accruing to the states from the legislation are greatest in the later years of the 10-year projection period because the federal share of Medicaid costs for newly eligible enrollees will decline from 100 percent between 2014 and 2016 to 90 percent after 2019.

By comparison, last March CBO estimated that the coverage provisions of PPACA and the Reconciliation Act would increase state spending for Medicaid by \$20 billion over the 2010–2019 period. The difference between those two estimates mostly reflects the different time periods they cover.

In addition to the coverage provisions discussed here, other provisions of PPACA and the Reconciliation Act will also affect states' costs for Medicaid. The legislation reduced federal allotments for hospitals that treat a disproportionate share of low-income individuals, altered Medicaid prescription drug policies, changed community-based long-term care benefits, and made other changes that might affect states' Medicaid spending as well. CBO has not estimated the effects of those provisions on states' outlays for Medicaid.

## **Additional Effects on Spending for Medicare, Medicaid, and Other Programs**

Many of the provisions of PPACA and the Reconciliation Act apart from those related to insurance coverage will affect spending under Medicare, Medicaid, and other federal programs. That legislation made numerous changes to payment rates and payment rules in those programs, established a voluntary federal program for long-term care insurance through the Community Living Assistance Services and Supports (CLASS) provisions, and made other changes to federal health programs.

In February 2011, CBO and JCT estimated that repealing the provisions of PPACA and the health-related provisions of the Reconciliation Act that were not related to insurance coverage would produce a net increase in direct spending of \$732 billion over the 2012–2021 period. Reversing the sign of that estimate provides an approximation of the impact of enacting those provisions over that period. Therefore, CBO and JCT effectively estimated in February that enacting the provisions of PPACA and the Reconciliation Act unrelated to insurance coverage will produce a net decrease in direct spending of \$732 billion over the 2012–2021 period.

A few provisions of the legislation account for most of those projected savings: changes to Medicare's payment rates in the fee-for-service sector and to Medicare Advantage plans; reductions in Medicaid and Medicare payments to "disproportionate share hospitals" (hospitals that treat a disproportionate number of low-income people); and establishment of a long-term care insurance program (the CLASS Act).

The estimated savings also reflect numerous other provisions of the legislation that CBO estimates will have more modest budgetary effects within the 10-year projection period. Some of those provisions, however, could have significant effects on the health care delivery system and on Medicare spending in the long run. Finally, the net savings of \$732 billion includes the additional spending generated by other provisions of the legislation, such as an expansion of Part D benefits and the appropriation of funds for a number of new or expanded activities.

### **Changes to Payment Rates in Medicare**

In February 2011, CBO estimated that the permanent reductions in the annual updates to Medicare's payment rates for most services in the fee-for-service sector (other than physicians' services) and the new mechanism for setting payment rates in the Medicare Advantage program will reduce Medicare outlays by \$507 billion during the 2012–2021 period. That figure excludes interactions between those provisions and others—namely, the effects of the changes in the fee-for-service portion of Medicare on payments to Medicare Advantage plans and the effects of changes in both the fee-for-service portion of the program and in the Medicare Advantage program on collections of premiums for Part B (Supplementary Medical Insurance).

The estimated savings from those changes in payment rates are quite close to the savings that CBO estimated originally, for the overlapping period of 2012 through 2019. For that period, the estimated gross savings for the fee-for-service updates and the Medicare Advantage provisions—taking into account interactions between spending in the fee-for-service sector and payments to Medicare Advantage plans but not the effects on collections of Part B premiums—was \$399 billion in the original estimate in March 2010 and \$400 billion on the basis of CBO's updated estimate in February 2011.

By CBO's estimates, enrollment in the Medicare Advantage program in 2017 and later years will be about 60 percent of the enrollment that would have occurred in the absence of PPACA and the Reconciliation Act.

### **Disproportionate Share Hospitals**

Both Medicare and Medicaid provide additional payments to hospitals that serve a disproportionate number of low-income patients. PPACA and the Reconciliation Act modified the formulas used to calculate such payments under Medicare and the state-specific allotments that determine such payments under Medicaid. On the basis of CBO's February 2011 estimate, last year's legislation is projected to reduce direct spending for Medicare's and Medicaid's payments to disproportionate share hospitals by \$57 billion over the 2012–2021 period.

### **The CLASS Act**

CBO's February 2011 analysis indicates that implementation of the long-term care insurance program established by the CLASS Act will reduce federal deficits by \$86 billion over the 2012–2021 period. Under those provisions, active workers will

be able to purchase long-term care insurance, usually through their employer. Premiums will be set to cover the full cost of the program as measured on an actuarial basis. CBO projects that the program's cash flows excluding interest earned on income from premiums will show net receipts for a number of years, followed by net outlays in subsequent decades. In particular, the program will pay out far less in benefits than it will receive in premiums over the 2012–2021 period. In CBO's March 2011 baseline, the estimated 10-year reduction in federal deficits owing to the Class Act is reduced to \$83 billion.

### **Other Provisions with Significant Programmatic or Budgetary Effects**

The provisions described above account for about \$650 billion of the \$732 billion in net savings over the 2012–2021 period stemming from the provisions of PPACA and the Reconciliation Act unrelated to insurance coverage. Numerous other provisions and interactions among provisions account for the remaining \$82 billion in net savings. Many of those provisions will reduce spending, whereas others will increase it. The provisions that will reduce spending make a variety of changes to prior law, including establishing a mechanism to reduce the growth rate of Medicare spending if projected growth exceeds a given target, initiating a number of programs intended to modify the health care delivery system, and adjusting payments for prescription drugs in Medicaid. Most of the provisions that will increase spending establish new benefits or expand existing ones in Medicare and Medicaid; increase payment rates for some providers; or provide funding for grant, research, and other programs.

PPACA created the Independent Payment Advisory Board (IPAB), which has the obligation to reduce Medicare spending relative to what would otherwise occur if the rate of growth in spending per beneficiary is projected to exceed a target rate that is based on inflation (for 2015 through 2019) or growth in the economy (for 2020 and subsequent years). In its February 2011 estimate, CBO concluded that the rate of increase in spending would probably exceed the target rate in some years, and that the IPAB, therefore, would have to intervene to reduce the growth of Medicare spending. CBO estimated that those actions would result in \$14 billion in savings over the 2012–2021 period. In CBO's March 2011 baseline, by contrast, the rate of growth in Medicare spending per beneficiary is projected to remain below the levels at which the IPAB will be required to intervene to reduce Medicare spending. As a result of that reduction in projected Medicare spending, CBO's March baseline does not include any savings from actions by the IPAB.

PPACA and the Reconciliation Act include numerous provisions intended to identify opportunities and create incentives for providers to make changes to the health care delivery system that will reduce costs and improve the quality of care. Those provisions involve a wide variety of approaches, some making relatively specific changes and others establishing a process to develop information that could guide decisions on future changes. The more specific provisions include establishing payment incentives to report measures of the quality of care, creating payment incentives to lower costs and improve quality by establishing a shared-savings (or accountable care

organization) program, bundling payments for different aspects of care for a single medical event or condition, and imposing payment penalties for readmissions or medical conditions acquired in the process of receiving health care. By contrast, provisions that seek to develop information that could inform future decisions about the delivery of health care include activities designed to improve how the quality of health care is measured, the expansion of research on outcomes of medical care, and the development of a mechanism to test innovations and to implement those that reduce costs and improve quality. In CBO's estimation, many of those initiatives will reduce spending to some extent—generally either by changing providers' behavior directly or by identifying interventions that will result in changes in providers' behavior.

PPACA and the Reconciliation Act will reduce Medicaid spending for prescription drugs, compared with the level under prior law, as a result of provisions that increase rebates paid by manufacturers of prescription drugs and make other changes to drug reimbursement policy.

PPACA and the Reconciliation Act will also increase spending, relative to the level under prior law, for several programs. In Medicare, the legislation will increase spending for the Part D drug benefit by gradually reducing the coverage gap (sometimes known as the doughnut hole) for people whose spending exceeds the initial coverage level. In Medicaid, spending for benefits will increase as a result of provisions that created new options for states to provide community-based long-term care services and temporarily raised payments for certain primary care providers. In addition, the legislation provided mandatory funding for a number of grant, research, and other programs, including funding for a Prevention and Public Health Fund and grants for programs providing home visits for mothers and young children.

## **Impact on the Federal Budget Beyond the First Decade**

CBO does not generally provide cost estimates beyond the 10-year projection period. Over a longer time span, a wide range of changes could occur—in people's health, in the sources and extent of their insurance coverage, and in the delivery of medical care—that are very difficult to predict but that could have a significant effect on federal health care spending, both under current law and under the law before the passage of PPACA and the Reconciliation Act. Nonetheless, certain Congressional rules require some information about the budgetary impact of legislation in subsequent decades, and many Members have requested analyses of the long-term budgetary impact of proposed broad changes in the health care and health insurance systems.

### **Estimates of Long-Term Budgetary Effects**

CBO and JCT assessed the budgetary effects of PPACA and the Reconciliation Act in the decade following the 10-year projection period by grouping the elements of that legislation into broad categories and assessing the rate at which the budgetary impact of each of those broad categories would increase over time. On the basis of its February 2011 analysis, CBO projected that PPACA and the Reconciliation Act would

reduce federal budget deficits during the 2022–2031 period by an amount that is in a broad range around one-half percent of GDP, assuming that all provisions of the legislation were fully implemented. The imprecision of that estimate reflects the greater degree of uncertainty that attends to it, compared with CBO’s year-by-year dollar estimates for the regular 10-year projection period. That estimate has not been updated since the February analysis.

CBO has not extrapolated those estimates farther into the future. Federal spending and revenues under the legislation depend crucially on the evolution of the health care and health insurance systems—systems that were already undergoing rapid change before the passage of PPACA and the Reconciliation Act and that the legislation would alter in myriad ways. Moreover, the legislation has significant conflicting implications for deficits: On the one hand, it will substantially expand eligibility for Medicaid and provide subsidies through insurance exchanges; on the other hand, the legislation will raise additional revenues and significantly decrease Medicare outlays, largely by reducing payment rates for many types of health care providers relative to the rates that would have been paid under prior law but also by making other specific changes in the program and establishing a mechanism designed to control the growth of the program’s costs. As a result of those conflicting forces, fairly small errors in projecting the effects of some provisions that will increase or decrease deficits could produce notable errors in projecting the net impact of the legislation.

Consequently, CBO does not believe that it has a sufficient analytic basis for evaluating the effects of the legislation on the growth rate of spending over the very long run. However, in view of the projected budgetary effects between 2022 and 2031, CBO anticipates that in subsequent decades PPACA and the Reconciliation Act will probably continue to decrease budget deficits relative to those that would have occurred under prior law.

### **Key Considerations in Evaluating Long-Term Budgetary Effects**

The calculations of longer-term effects are based on the assumption that the provisions of PPACA and the Reconciliation Act will remain unchanged throughout the next two decades. However, those laws put into effect a number of policies that may be difficult to sustain over a long period of time.

Specifically, last year’s legislation restrains the rate of increase in payment rates for many providers of Medicare services to less than the expected rate of increase in the cost of the providers’ inputs, in expectation of ongoing productivity improvements in the delivery of health care. If providers do not improve their productivity sufficiently rapidly to offset the reductions in payment rates, those rates will fall over time relative to the cost of providing services. By holding the rate of increase in payment rates below what would have prevailed under prior law, PPACA will generate savings that are projected to increase considerably during the next 10 years and in the decade beyond that. However, it is unclear the extent to which providers will achieve greater efficiencies in the delivery of health care and the extent to which cost pressures will

instead reduce access to care or diminish the quality of care (relative to the situation under prior law) outcomes that might increase pressure on the Congress to increase payments to providers. It is also unclear whether and how the Congress would respond to such pressure if it arose and what effects the response would have on total federal health care spending, revenues, and deficits.

Last year's legislation will restrain the increases in Medicare payment rates for many providers other than physicians. At the same time, the so-called sustainable growth rate mechanism—which has been in effect since 1997—is projected to cause Medicare's payment rates for physicians' services to be reduced sharply during the next few years. That mechanism has frequently been modified (either through legislation or administrative action) to avoid an abrupt and large reduction in those payment rates that might have reduced Medicare beneficiaries' access to physicians' services.

On the basis of the cuts in payment rates under PPACA and the Reconciliation Act, along with the effects of the sustainable growth rate mechanism, CBO projects that Medicare spending per beneficiary (adjusted for inflation) will increase at an average annual rate of less than 2 percent during the next two decades—compared with the rate of roughly 4 percent that has occurred over the past two decades (a figure that excludes the effect of establishing the Medicare prescription drug benefit).

Another provision that may be difficult to sustain will slow the growth of federal subsidies for health insurance purchased through the insurance exchanges. For enrollees who receive subsidies, the amount they will have to pay depends primarily on a formula that determines what share of their income they have to contribute to enroll in a relatively low cost plan (with the subsidy covering the difference between that contribution and the total premiums for that plan). Initially, the percentages of income that enrollees must pay are indexed so that the subsidies will cover roughly the same share of the total premiums over time. After 2018, however, an additional indexing factor will probably apply; if so, the shares of income that enrollees have to pay will increase more rapidly, and the shares of the premiums that the subsidies cover will decline.<sup>25</sup> Whether a widening gap between subsidies and premiums will increase pressure on the Congress to adjust the subsidy schedule and how the Congress might respond are uncertain.

If those provisions and others will subsequently be modified or implemented incompletely without offsetting changes in federal policies, then the effects that PPACA and the Reconciliation Act have on federal spending, revenues, and deficits could be quite different from the ones that CBO estimated. However, CBO does not forecast future changes in law or assume such changes in its estimates of the budgetary effects of legislation.

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25. Beginning in 2019, enrollees will pay a higher percentage of income to enroll in a given plan if the total cost of exchange subsidies in the prior year exceeded 0.504 percent of GDP. Although it is uncertain when that threshold will be reached, CBO projects that it will become increasingly likely to be reached over time because the exchange subsidies are projected to grow faster than GDP.

## Other Effects of the Legislation

CBO has also analyzed the legislation's impact on the "federal budgetary commitment to health care," a term that CBO uses to describe the sum of net federal outlays for health programs and tax preferences for health care; on health insurance premiums; and on labor markets.<sup>26</sup>

### Effect on the Federal Budgetary Commitment to Health Care

In its February 2011 estimate for repealing PPACA and the Reconciliation Act, CBO in effect projected that the legislation would increase the federal budgetary commitment to health care by \$464 billion over the 2012–2021 period.<sup>27</sup> That increase is driven primarily by the federal cost of expanding insurance coverage, which will be partly offset by other factors such as the decrease in other federal health care spending (primarily for Medicare) and the imposition of the excise tax on insurance policies with relatively high premiums.

However, CBO estimated that PPACA and the Reconciliation Act would decrease the federal budgetary commitment to health care in the decade following the 10-year projection period. The estimated effect in later years differs from the effect in the first decade because the effects of those provisions that will tend to reduce the federal budgetary commitment to health care (such as the reduction in Medicare spending and the imposition of the high-premium excise tax) were estimated to grow faster than the effects of provisions that will tend to increase it (primarily the coverage expansions). As with the longer-term estimate of overall budgetary effects, that projection incorporated an assumption that the provisions of the legislation will be fully implemented.

### Effect on Health Insurance Premiums

Members have also requested information about the effects of the legislation on health insurance premiums. On November 30, 2009, CBO released an analysis, prepared with JCT, of the impact of PPACA as it was originally proposed on average premiums for health insurance in different markets.<sup>28</sup> Although CBO and JCT have not updated the estimates provided in that letter, the estimated effects of PPACA and the Reconciliation Act as enacted would probably be quite similar.

In particular, premiums for health insurance in the individual market will be somewhat higher on average under PPACA and the Reconciliation Act than under prior law, mostly because the average insurance policy in that market will cover a larger

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26. For additional discussion of the term federal budgetary commitment to health care, see Congressional Budget Office, [letter to the Honorable Max Baucus regarding different measures for analyzing proposals to reform health care](#) (October 30, 2009).

27. In March 2010, CBO estimated that PPACA and the Reconciliation Act would increase the federal budgetary commitment to health care by \$390 billion over the 2010–2019 period.

28. See Congressional Budget Office, [letter to the Honorable Evan Bayh providing an analysis of health insurance premiums under the Patient Protection and Affordable Care Act](#) (November 30, 2009).



share of enrollees' costs for health care and provide a slightly wider range of benefits. The effects of those differences will be offset in part by other factors that will tend to reduce premiums in the individual market; for example, insurers will incur lower administrative costs per policy, and enrollees will tend to be healthier (because the subsidies provided through the exchanges and the individual mandate to obtain insurance are expected to result in an influx of enrollees with below-average spending for health care). Although premiums in the individual market are expected to be higher on average under PPACA and the Reconciliation Act than under prior law, many people will end up paying less for health insurance because the majority of enrollees purchasing coverage in that market will receive subsidies via the exchanges.

Premiums for employment-based coverage obtained through large employers will be slightly lower on average under PPACA and the Reconciliation Act than under prior law, reflecting the net impact of many relatively small changes. Average premiums for employment-based coverage obtained through small employers may be slightly higher or slightly lower (reflecting uncertainty about the impact of the legislation on premiums in that market).

### **Effect on Labor Markets**

The legislation will affect some individuals' decisions about whether and how much to work and employers' decisions about hiring workers.<sup>29</sup> According to CBO's August 2010 analysis, the legislation, on net, will reduce the amount of labor used in the economy by a small amount—roughly half a percent—primarily by reducing the amount of labor that workers choose to supply.<sup>30</sup> That net effect reflects changes in incentives in the labor market that operate in both directions: Some provisions of the legislation will discourage people from working more hours or entering the workforce, and other provisions will encourage them to work more. Moreover, many people will be unaffected by those provisions and will face the same incentives regarding work as they otherwise would have.

Since the legislation will affect individuals' decisions on both whether to participate in the workforce and the number of hours they work, its effect on household employment is difficult to predict. According to CBO's projections, if the legislation only affects the number of individuals who participate in the workforce (and not the average number of hours worked per employed person), it will reduce employment in 2021 by about 800,000 relative to what would otherwise have occurred; however, because the legislation will probably affect the average number of hours worked as well, the effect on employment will be somewhat different.

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29. For a general discussion about the potential effects of health care legislation on labor markets, see Congressional Budget Office, *Effects of Changes to the Health Insurance System on Labor Markets*, Issue Brief (July 13, 2009).

30. See Congressional Budget Office, *The Budget and Economic Outlook: An Update* (August 2010).

The net reduction in the supply of labor is largely attributable to the substantial expansion of Medicaid and the provision of subsidies that will reduce the cost of insurance obtained through the insurance exchanges. Those changes in law will effectively increase individuals' financial resources, which will encourage some people to work fewer hours or to withdraw from the labor market. In addition, the phaseout of the subsidies as income rises will effectively increase marginal tax rates, which will also discourage work. But because most workers who are offered insurance through their job will be ineligible for the subsidies and because most people will have income that is too high to be eligible for Medicaid, those effects on financial resources and marginal tax rates will apply to only a small segment of the population.

Other provisions in the legislation are also likely to diminish people's incentives to work. Changes to the insurance market, including provisions that prohibit insurers from denying coverage to people because of preexisting conditions and that restrict how much premiums can vary with an individual's age or health status will increase the appeal that health insurance plans offered outside the workplace have for older workers. As a result, some older workers will choose to retire earlier than they otherwise would.

In contrast, another feature of the Medicaid expansion removes an existing disincentive to work for many low-income individuals. People currently become ineligible for Medicaid if their income rises above a certain level; for working parents, the median income threshold for eligibility among states was 64 percent of the federal poverty level in 2009. The health care legislation will allow parents to work and still qualify for Medicaid until their income exceeds 138 percent of the poverty level. Moreover, parents whose income exceeds the new threshold may be able to work and receive the subsidies for insurance purchased through the exchanges.<sup>31</sup>

Employers' decisions to hire workers will also be affected in some cases by the health care legislation. Employers with 50 or more employees will be required to pay a penalty if they do not offer insurance or if the insurance they offer does not meet certain criteria and at least one of their workers receives a subsidy from an exchange. Those penalties, whose amounts are based on the number of full-time workers in the firm, will, over time, generally be passed on to workers through reductions in wages or other forms of compensation. However, firms generally can not reduce workers' wages below the minimum wage, which will probably cause some employers to respond by hiring fewer low-wage workers. Alternatively, because firms are penalized only if their full-time employees receive subsidies from exchanges, some firms may instead hire more part-time or seasonal employees.

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31. The wider availability of subsidies could also affect the employment decisions of people with disabilities. Disabled people whose income is below 400 percent of the federal poverty level will be able to receive subsidized health care without leaving the work force and enrolling in such programs as Disability Insurance (DI) or Supplemental Security Income (SSI). As a result, some disabled workers who would otherwise be out of the work force might stay employed or seek employment; however, other disabled workers might leave the work force earlier than they otherwise would because, unlike DI, neither Medicaid nor subsidies offered through the exchanges will require people to wait before they can receive benefits.

More generally, the health care legislation may shape the labor market or the operations of other segments of the economy in ways that are difficult to anticipate or quantify. For example, the legislation could influence labor markets indirectly by making it easier for some employees to obtain health insurance outside the workplace and thereby enabling workers to take jobs that better match their skills. Some firms, however, might invest less in their workers—by reducing training, for example—if the probability of retaining those workers declines. To the extent that changes in the health insurance system lead to better health among workers, the nation’s economic productivity could be enhanced. It is not clear, however, whether such changes would have a substantial impact on overall economic productivity or output. Moreover, many of the effects of the legislation may not be felt for several years because it will take time for workers and employers to recognize and to adapt to the new incentives.