

EXAMINING OBAMACARE'S HIDDEN MARRIAGE PENALTY AND ITS IMPACT ON THE DEFICIT

HEARING

BEFORE THE
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF
COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES
OF THE

COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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CONTENTS

Hearing held on October 27, 2011	Page 1
Statement of:	
Holtz-Eakin, Douglas, Ph.D., president, American Action Forum, former CBO Director; Diana Furchtgott-Roth, senior fellow, Manhattan Institute for Policy Research; Richard V. Burkhauser, Ph.D., professor of economics, Cornell University; and Sara R. Collins, Ph.D., vice president, Affordable Health Insurance, the Commonwealth Fund	35
Burkhauser, Richard V., Ph.D.	60
Collins, Sara R., Ph.D.	76
Furchtgott-Roth, Diana	54
Holtz-Eakin, Douglas, Ph.D.	35
Letters, statements, etc., submitted for the record by:	
Burkhauser, Richard V., Ph.D., professor of economics, Cornell University, prepared statement of	62
Collins, Sara R., Ph.D., vice president, Affordable Health Insurance, the Commonwealth Fund, prepared statement of	78
Cummings, Hon. Elijah E., a Representative in Congress from the State of Maryland, prepared statement of	5
Furchtgott-Roth, Diana, senior fellow, Manhattan Institute for Policy Research, prepared statement of	56
Gowdy, Hon. Trey, a Representative in Congress from the State of South Carolina, staff report	13
Holtz-Eakin, Douglas, Ph.D., president, American Action Forum, former CBO Director, prepared statement of	38

EXAMINING OBAMACARE'S HIDDEN MARRIAGE PENALTY AND ITS IMPACT ON THE DEFICIT

THURSDAY, OCTOBER 27, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF
COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:34 a.m., in room 2154, Rayburn House Office Building, Hon. Trey Gowdy (chairman of the subcommittee) presiding.

Present: Representatives Gowdy, Gosar, Burton, DesJarlais, Davis, and Cummings.

Staff present: Alexia Ardolina, staff assistant; Brian Blase, professional staff member; Robert Borden, general counsel; Molly Boyd, parliamentarian; Gwen D'Luzansky, assistant clerk; Linda Good, chief clerk; Christopher Hixon, deputy chief counsel, oversight; Sery E. Kim and Christine Martin, counsels; Mark D. Marin, director of oversight; Laura L. Rush, deputy chief clerk; Jaron Bourke, minority director of administration; Yvette Cravins, minority counsel; Ashley Etienne, minority director of communications; Devon Hill, minority staff assistant; Carla Hultberg, minority chief clerk; Paul Kincaid, minority press secretary; and Lucinda Lessley, minority policy director.

Mr. GOWDY. The committee will come to order.

This is a hearing entitled "Examining Obamacare's Hidden Marriage Penalty and Its Impact on the Deficit."

I will recognize myself for an opening statement and then the gentleman from Illinois, Mr. Davis.

Over the past several months, this committee has heard from job creators regarding the negative impact the President's health-care law is having and will continue to have on hiring and job growth.

In addition to the impact on job creators, the new law will also negatively impact individuals. The Affordable Care Act contains refundable tax subsidies to assist certain people in purchasing health insurance. The Congressional Budget Office estimates these tax subsidies are the most expensive component of the law. The tax subsidies begin in 2014, and by 2017 CBO projects the tax subsidies will add \$100 billion to the national debt each year, with an escalating cost into the future. The CBO estimates three-quarters of this cost will be new government spending.

These tax subsidies are available to individuals who do not receive health insurance through their place of work. Instead of only being available for individuals not receiving employer-sponsored health care, any individual within a certain income range—it would be more effective if the Tax Code did not care whether people receive their health insurance at work or purchase it in a private market.

Two households with the same number of children, same number of wage-earners, and same combined levels of income are otherwise the same except for the source of health insurance. These two households should not have tax bills that differ by thousands of dollars because of their choice of health care. With so many families struggling throughout the country, and especially in my home State of South Carolina, we should be working toward ensuring families have the tools to invest in their health.

The Joint Committee on Tax has estimated that less than 20 percent of the beneficiaries of the tax subsidy will be married couples and their families. This is partly due to a recent HHS rule that prevents families from accessing the tax subsidy if either parent has an offer of coverage at work. In other words, if a husband is offered health insurance at work for just himself, and his wife and children must go purchase health insurance in the open market, the cost of covering the wife and children would not be eligible for a subsidy.

This rule was meant to minimize the cost of the subsidy, but the collateral damage will be that the Affordable Care Act will exacerbate the marriage penalty already in the Tax Code. Over time, this act will force couples to choose not to get married because of the sizable tax benefit that will only be available if they stay unmarried.

In addition to the penalty against marriage in the act, several of the witnesses before us today have conducted research that demonstrates the cost of the health-care law will likely be much higher than the Congressional Budget Office originally projected. From underestimating the cost of the long-term-care program, demonstrated by the administration's decision to eliminate the program, to the law's likely unsustainable Medicare cuts, the tax subsidies in the law will be the biggest reason the law will exceed the projected cost. Because this biased tax credit will encourage employers to discontinue health insurance and employees to decline employer-sponsored coverage, the cost of the health-care law will continue to increase.

In contrast to CBO's prediction, several surveys predict the number of employers who cease to offer health insurance to their employees will be much higher than it is now. Just last week, it was reported the Nation's largest private employer, Wal-Mart, will no longer offer health care to new employees working less than 24 hours per week. Additionally, employees working 24 to 34 hours per week will not be offered insurance for their spouses. This is an example of how government mandates and regulations are significantly increasing the price of health insurance, and companies must make adjustments to compete globally.

As more and more companies cut back on health insurance coverage, the cost of the Affordable Care Act will increase. It is essen-

tial we explore the unintended costs associated with the new health-care law. We need laws that are transparent and uniform in their impact on families. As the health-care law is implemented, we must examine how we are using taxpayer dollars and if government is being a good steward of those dollars.

One of the President's fiscal commission guiding values was to reduce inefficiencies, loopholes, and the complexity in the Tax Code in order to lower rates, simplify the Tax Code, and bring down the deficit. As demonstrated with problems with the tax credits, the Affordable Care Act moves in precisely the opposite direction. The act introduces another major inequity into the Tax Code, effectively encouraging employers and workers to drop employer-sponsored insurance and pass these costs to taxpayers. Additionally, the law adds a large marriage tax penalty and discourages job growth.

I look forward to hearing from today's witnesses about what they have learned about the health-care law and whether I am right to be skeptical about how the law will play out.

At this point, I would recognize the ranking member of the subcommittee, the distinguished gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman. And let me thank you for calling this hearing.

I want to thank our witnesses for coming to participate.

For many years, I have been an avid supporter and advocate of a national health plan. And I have been that because I have always believed, since I learned about health, that health care ought to be a right and not a privilege. Nor do I believe that it can be left to chance, because it is obviously too precious. When you think about it, without good health care, students cannot concentrate at school, families cannot pursue work and other activities that are needed to develop and sustain what we call a good life.

So when the opportunity came to vote on the Patient Protection and Affordable Care Act, I was delighted. And I was delighted because it has provided various pathways to accessible health care for the masses.

One such path establishes State-based health-care exchanges that can be utilized by individuals if they cannot find coverage through their large employer. Small businesses are the Medicaid expansion. The subsidies vary with income and are based upon the Federal poverty level, a similar eligibility threshold for numerous government programs. In addition, further tax credits will be available to those eligible for employer coverage and public assistance coverage but only in narrow circumstances.

The ACA will benefit families and reduce the Federal deficit. First of all, the families and individuals impacted by crippling medical debt—that is a significant causation of personal bankruptcies—will become a thing of the past because preventative care and early detection are no longer cost-prohibitive. Second, the nonpartisan Congressional Budget Office found the health-care legislation will reduce deficits by \$143 billion, further benefiting our Nation's finances.

As I have previously said, the ACA is progress. And while each individual will face unique circumstances and challenges under ACA, generally there are significant benefits that result in good health for the American public. Every time I think of the fact that

more than 32 million additional people will have the opportunity to purchase, maintain, and make use of health insurance, I say that is good for me and I believe that that is good for America.

So I thank our witnesses for coming.

Again, Mr. Chairman, I thank you for holding the hearing. I yield back.

Mr. GOWDY. I thank the gentleman from Illinois.

Members may have 7 days to submit opening statements and extraneous materials for the record.

[The prepared statement of Hon. Elijah E. Cummings follows:]

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Opening Statement

Rep. Elijah E. Cummings, Ranking Member

Subcommittee on Health Care, District of Columbia, Census, and the National Archives Hearing on "Examining Obamacare's Hidden Marriage Penalty and Its Impact on the Deficit"

October 27, 2011

Chairman Gowdy and Ranking Member Davis, thank you for holding today's hearing.

In 2010, more than 195 million Americans obtained health care coverage from private insurance companies, either through individually purchased policies or employer-sponsored coverage. Unfortunately, about 50 million Americans were uninsured. Both individuals and employers have seen their costs for health insurance skyrocket. Premium increases have far exceeded wage increases, and individuals are being asked to bear more of the costs for their health care each year.

Clearly, this trajectory is not sustainable for individuals or employers. That is why Congress passed the Affordable Care Act, to incentivize high-quality care, ensure appropriately priced services, and fight waste, fraud, and abuse. Thanks to the Affordable Care Act, starting this year, consumers and companies will receive more value for their money because insurance companies will be required to spend at least 80% of premium dollars on medical care and health care quality improvement, rather than on administrative expenses, marketing costs, and CEO compensation.

Starting in 2014, premium assistance credits will become available for Americans whose household incomes are between 133% and 400% of the federal poverty level to help make quality private health insurance more affordable. Also, in 2014, Medicaid eligibility will be expanded to 133% of the Federal poverty level, ensuring that our most vulnerable Americans have access to needed health care.

According to the non-partisan Kaiser Family Foundation, nine out of ten uninsured families have incomes below 400% of poverty and could benefit from the expansion of Medicaid eligibility or the subsidized private insurance coverage provided under the Affordable Care Act.

The Affordable Care Act is this country's best opportunity to provide health care for millions of uninsured, low- and middle-income American families and reduce overall health care costs.

I am disappointed that, in the nine months Republicans have been in charge of the House of Representatives, they have not yet revealed the "replace" portion of their "repeal and replace" plan for the Affordable Care Act. Instead, it appears that they prefer to return to having no health insurance and higher health care costs for millions of Americans.

Clearly, I think this is the wrong direction to go, but I look forward to hearing the perspectives of our witnesses at today's hearing.

Contact: Ashley Etienne, Communications Director, (202) 226-5181.

**Questions for Sara R. Collins
Vice President, Affordable Health Insurance
The Commonwealth Fund**

**Representative Gosar
Committee on Oversight and Government Reform
Subcommittee on Health Care, District of Columbia, Census and the National Archives**

Hearing on “Examining Obamacare’s Hidden Marriage Penalty and Its Impact on the Deficit”

1. As a result of the health care law, will many of the currently uninsured end up in Medicaid, a program with low payment rates and poor access?

The Affordable Care Act expands Medicaid to individuals earning up to 133 percent of poverty or \$29,726 for a family of four.¹ People earning up to 400 percent of poverty (\$89,400 for a family of four) will be eligible for new premium tax credits to offset the cost of private plans sold through the new state insurance exchanges that will cap contributions for premiums as a share of income from 2 to 9.5 percent. The Congressional Budget Office (CBO) estimates that 34 million adults and children will become newly covered by 2020 under the law. An estimated 16 million uninsured people will gain coverage through Medicaid, 18 million uninsured people will gain coverage through the new state insurance exchanges or employer plans.

2. What will be the financial burden on federal and state budgets because of this new population coming onto Medicaid?

Under the Affordable Care Act, the federal government will pay a very large share of new Medicaid costs in all states. Of the total change in Medicaid spending projected as a result of ACA over 2014–19, the federal government will cover 95% of it, according to analysis by the Urban Institute.² The federal government will provide federal Medicaid matching payments for newly eligible enrollees in all states except “expansion states” that have already expanded Medicaid to both parents and non-pregnant childless adults to 100 percent of poverty before December 1, 2009. The matching rates are the following:

- 100 percent in 2014, 2015, and 2016;
- 95 percent in 2017;
- 94 percent in 2018;
- 93 percent in 2019;
- 90 percent thereafter.

Expansion states will receive additional federal financial assistance that will phase-in over 2014–2019 according to a formula such that in 2019 and later, expansion states will receive the same level of federal matching for this population as other states.

Across states, the Urban Institute estimates that state Medicaid spending will increase by 1.4 percent over 2014–19. This is a small increase relative to the increase in coverage (27.4% in Medicaid

coverage) and federal expenditures (22.1%), and to what states would have spent on uncompensated care if ACA had not been enacted.

3. With respect to the Massachusetts exchange: isn't it true that Massachusetts already had the lowest rate of uninsured residents before embarking on this reform effort in 2006?

Massachusetts' uninsured rate in 1999-2000 for 19-64 year olds was 9.6 percent, it fell to 6.5% in 2009-2010, following the implementation of the state's reform law in 2006.³ By contrast, Minnesota had an uninsured rate of 8.6% in 1999-2000, it rose to 12.5% in 2009-2010. All states are expected to see substantial reductions in the share of people who are uninsured as reforms are implemented over the next decade. Texas currently has the highest uninsured rate in the country at 32.4 percent of its 19-64 population, but that is estimated to fall to 13.8 percent by 2019. South Carolina has an uninsured rate of 25.1% among 19-64 year olds; that is estimated to fall to 10.1 percent in 2019. Arizona has an uninsured rate of 24.1%; that is estimated to fall to 11.8% by 2019.

4. And isn't it also true that the state underestimated the costs by about \$1.5 billion annually?

Unlike the Affordable Care Act, Massachusetts implemented its coverage reforms prior to delivery system reforms. Massachusetts is now engaged in a public-private effort to reform its delivery system with a particular focus on provider payment reform. In contrast, the hallmark of the Affordable Care Act is that it provides for near universal coverage as well as an extensive set of delivery system reforms. It is the combination of these reforms that has led CBO to estimate that the delivery system reforms and as well as new revenues will more than offset the cost of the coverage expansion. Over 2012-2021, CBO estimates the net effect of the ACA is to lower the federal deficit by \$124 billion, excluding the CLASS Act. Indeed other analyses like that of David Cutler and colleagues estimate even greater savings from delivery system reforms of \$409 billion by 2019, and consequently a much larger decrease in the deficit: \$400 billion by 2019.⁴

5. Is Massachusetts currently working with HHS to secure \$4.6 billion via a 3 year waiver to determine the federal support for Massachusetts' Medicaid program?

I do not know.

6. Did the Massachusetts Congressional delegation on November 1st try to secure continuing federal funding to be able to pay the state's safety-net hospitals and other aspects of care for the poor?

I do not know.

7. You stated in your testimony that the state exchanges will provide "affordable coverage". How do you define "affordable"? What evidence can you provide that will substantiate that statement? Who will be paying for the "affordable" coverage?

The combination of the Medicaid expansion to families earning up to \$29,726 for a family of four and premium tax credits for families earning up to \$89,400 for a family of four will substantially improve the affordability of coverage for people who are without access to an employer-based health plan and must buy coverage on their own. The tax credits are federally financed, the Medicaid expansion is mostly federally financed (see question 2). Families who are not currently eligible for Medicaid and do not have health insurance through a job, currently face the full premium in the individual insurance market, and are also underwritten on the basis of health status in most states. A recent Commonwealth Fund report found that more than half (57%) of working-age adults who lost a job with health benefits became uninsured over the period 2008 to 2010.⁵ Families with low and moderate incomes have been particularly hard hit. Adults with incomes under 200 percent of the federal poverty level, about \$44,700 for a family of four, were less likely to have benefits through a job that was lost, but those who did have benefits through their former job were much more likely to become uninsured than adults with higher incomes.

While employees of companies with more than 20 workers who lose a job can stay on their employer's policy for up to 18 months under COBRA (Consolidated Omnibus Budget Reconciliation Act), they must pay the full premium. Average family premiums in employer plans climbed to \$5,429 per year for single coverage and \$15,073 for a family plan in 2011, placing coverage out of reach for workers who have also lost a significant amount of their income.⁶ Just 14 percent of people who lost a job with benefits in the last two years enrolled in the COBRA program. Those with low incomes were least likely to enroll in COBRA: only 8 percent continued their coverage through COBRA, compared to 21 percent of those with higher incomes.

Other than COBRA, there are few options for workers who lose their jobs and their health benefits. In most states, insurance coverage through public insurance programs like Medicaid and the Children's Health Insurance Program is available only to pregnant women, children, and parents with very low incomes; less than half of states cover childless adults. People who buy insurance in the individual insurance market must pay the full premium, and, in most states, policies are underwritten on the basis of health—meaning that a health plan can charge people a higher premium, exclude a health condition from coverage, or turn down someone for coverage altogether because of a preexisting condition. The Commonwealth Fund found that in 2010, 60 percent of adults under age 65 who shopped for coverage in the individual market found it very difficult or impossible to find a plan they could afford, and 35 percent were turned down by an insurance carrier or had a specific health problem excluded from coverage.⁷

Under the Affordable Care Act, people with incomes under 133 percent of poverty will be eligible for Medicaid, but legal immigrants in the five-year waiting period for Medicaid are eligible for tax credits. Under the law, taxpayers eligible for tax credits are required to make contributions to their premiums, as a share of their income, of from 2 percent to 9.5 percent. Those eligible for tax credits will have a choice of private QHPs sold through the exchanges that will offer a comprehensive set of benefits known as the essential benefit package. Insurers will offer these plans at four levels of cost-sharing: bronze plans (covering on average 60% of someone's annual medical costs), silver (70% of costs), gold (80% of costs), and platinum (90% of costs). However, for people with low incomes, the average costs

covered by the silver plan will be increased to 94 percent (for those with incomes up to 149% of poverty), 87 percent (150%–199% of poverty), and 73 percent (200%–249% of poverty). In addition, QHPs will have limits on out-of-pocket spending related to income that range from \$1,983 for a single policy and \$3,967 for a family policy for those earning up to 199 percent of poverty (\$44,700 for a family of four) to \$3,967 for a single policy and \$5,950 for a family policy for those earning up to 400 percent of poverty (\$89,400 for a family of four). For those earning 400 percent of poverty or more, out-of-pocket limits are set at the level for health saving accounts or \$5,950 for a single policy and \$11,900 for a family policy.

Jonathan Gruber, professor of economics at MIT, conducted an analysis of the Affordable Care Act's insurance expansions and found that 90 percent of households with median out of pocket spending would have sufficient room in their budgets to afford both premiums and out of pocket costs.⁸ Using data from the Consumer Expenditure Survey, Dr. Gruber set a standard for necessities and then assessed whether there was sufficient additional income in family budgets to pay for health insurance and health care. Dr. Gruber used the Family Economic Self-Sufficiency Standard which considers necessities as: child care, food, housing, taxes, transportation, and miscellaneous expenses. But Dr. Gruber did find risks: among people with high spending in a given, year about 25% of those with incomes between 201-250% FPL would not have room in their budgets for premiums and out-of-pocket costs. This suggests that higher cost-sharing protections may be necessary for families in this income range to protect them from unexpectedly high costs.

8. The new revenues you cite in your testimony include health insurance premium taxes as well as taxes on medical devices and drugs. Will these taxes result in higher prices for consumers?

By 2020, 34 million more people at least will have comprehensive health insurance coverage. Research shows that people who are uninsured spend half of what insured people do on health care. This influx of new people into the health system translates into substantial new revenues for both insurance carriers and medical device and pharmaceutical manufacturers. This new market will likely offset the marginal costs of these fees to a significant degree.

9. You cite numbers for coverage gains for young adults, but a number of states have lost coverage options for child-only policies. How many states do not have insurers who offer new child-only policies?

Beginning on September 23, 2010, those applying for insurance in the individual market no longer face exclusions or denials of coverage based on a preexisting condition exclusion if they are under the age of 19.⁹ In addition, children covered by non-grandfathered individual coverage with a rider or an exclusion period that excludes coverage for a preexisting condition will gain coverage for that condition. In the group market, participants and dependents who are under age 19 and have experienced a lapse in coverage will no longer face up to a 12 month exclusion for preexisting conditions. Clearly for families with children who have health problems, this will provide relief. Beginning in 2014, this will apply to everyone seeking coverage in the exchanges, individual and small group markets.

I do not know the number of states that do not have insurers who offer new child-only policies. However, beginning in 2014, all qualified health plans sold through the exchanges, must offer a child-only policy for each non-catastrophic plan offered.

¹ S. Collins, Premium Tax Credits Under The Affordable Care Act: How Will They Help Millions of Uninsured Americans Gain Affordable, Comprehensive Health Insurance," U.S. House of Representatives Committee on Oversight and Government Reform Subcommittee on Health Care, October 27, 2011.

² J Holahan, I Headen. Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. May 2010. Kaiser Family Foundation. *Projections based a 57% participation rate among newly eligible uninsured and lower rates across other coverage groups. Scenario assumes moderate levels of participation similar to current experience among those newly eligible and little additional participation among currently eligible individuals.

³ Current Population Survey, Census Bureau; estimates of the effect of the Affordable Care Act on coverage by Jonathan Gruber of MIT for the Commonwealth Fund, using the Gruber Microsimulation Model.

⁴ D. M. Cutler, K. Davis, and K. Stremikis, *The Impact of Health Reform on Health System Spending* (Center for American Progress and The Commonwealth Fund, May 2010).

⁵ M. M. Doty, S. R. Collins, R. Robertson, and T. Garber, *Realizing Health Reform's Potential—When Unemployed Means Uninsured: The Toll of Job Loss on Health Coverage, and How the Affordable Care Act Will Help* (New York: The Commonwealth Fund, Aug. 2011).

⁶ Kaiser Family Foundation/Health Research and Educational Trust, 2011 Employer Health Benefits Survey, September 2011, <http://ehbs.kff.org>.

⁷ S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010, The Commonwealth Fund, March 2011.

⁸ J. Gruber and I. Perry, Realizing Health Reform's Potential: Will the Affordable Care Act Make Health Insurance Affordable? The Commonwealth Fund, April 2011.

⁹ Department of the Treasury, Department of Labor, Department of Health and Human Services, Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, Interim final rules with request for comments.

Mr. GOWDY. I would now ask unanimous consent that the staff report entitled, "Uncovering the True Impact of the Obamacare Tax Credits" be included in the record.

Mr. DAVIS. Mr. Chairman, I have no objection, but I also would like to make sure that the report is reflected as a partisan staff report and has not been marked up. So, as long as we make sure that that depiction is shown, I would have no objection.

Mr. GOWDY. The distinguished gentleman from Illinois' comments are obviously part of the record and can be read in conjunction with the report. And, with that——

Mr. CUMMINGS. Chairman.

Mr. GOWDY. Yes, sir.

Mr. CUMMINGS. I just want to be clear. The staff, we got the report about 10 minutes ago. And I wondered, is that a report of the committee, or is that a report of the Republican side of the committee, since we had no input? And I think that is what Ranking Member Davis was trying to get to. I mean, we haven't even read it.

Mr. GOWDY. The gentleman from Maryland is correct. It is a report of the Republican staff. It is not the committee as a whole. The gentleman is correct.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. GOWDY. Without objection, so ordered, with the comments of the gentleman from Illinois and the gentleman from Maryland.

[The information referred to follows:]

U.S. House of Representatives
Committee on Oversight and Government Reform
Darrell Issa (CA-49), Chairman



**Uncovering the True Impact of the Obamacare Tax Credits: Increases the Deficit,
Expands Welfare through the Tax Code, and Implements a New Marriage Tax Penalty**

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Table of Contents

Executive Summary 3

I. Health Law Harms Marriage, Reduces Tax Fairness, and Results in Fewer Taxpayers 5

II. The PPACA Takes Millions Off Tax Rolls 7

III. The PPACA Contains Incentives to Drop ESI and Pass Costs to Taxpayers 10

IV. The PPACA Penalizes Marriage and Two-Parent Families 16

V. The PPACA Was the Wrong Policy Prescription 18

VI. Technical Appendix 20

Executive Summary

- The Congressional Budget Office (CBO) projects that Obamacare's refundable health insurance tax credits and Medicaid expansion will increase the nation's debt burden by \$1.36 trillion in the first seven years that these provisions are fully implemented.
- The CBO estimates that about three-quarters of the cost of the Obamacare tax credits will be new spending since many of the filers who claim the health insurance tax credit will lack positive income tax to offset.
- The CBO has estimated that Obamacare's health insurance tax credits will grow significantly more expensive over time. According to the CBO, the tax credits are projected to increase the deficit by \$55 billion in 2015, \$87 billion in 2016, \$104 billion in 2017, \$115 billion in 2018, \$123 billion in 2019, \$130 billion in 2020, and \$137 billion in 2021 – the last year of the ten-year budget window.
- The Joint Committee on Taxation (JCT) estimates that in 2020 about 14 million tax filers will claim Obamacare's health insurance credit but only about two million of these households will have positive income tax liability after benefitting from the credit.
- 85 percent of filers who claim the credit will end the year with zero or negative income tax liability. Since the tax credit is refundable, nearly all 11.3 million of these filers will have negative income tax liability and will no longer pay the cost of government by contributing federal income taxes.
- By 2020, the health insurance tax credits will directly move between 7.4 million and 8.1 million tax filers off the tax rolls.
- The Obamacare tax credit will result in many additional filers in the middle class and, some in the upper-middle class receiving net payments through the tax code.
- Nearly half of the beneficiaries of the Obamacare tax credit will be single individuals without any dependent children and most of the other beneficiaries will be single parents.
- According to the JCT estimates, married couples will receive only 14 percent of the PPACA's tax credits. At most, only two million married couples (out of nearly 60 million married couples) are projected to benefit from the health insurance tax credit in any year through 2021. The evidence suggests, therefore, that Obamacare introduces a

substantial new marriage penalty into the tax code. Over time, PPACA's marriage penalty will directly cause fewer individuals to marry.

- The result of linking the tax credit to the FPL is that two individuals who make between \$61,600 and \$91,200 in 2014 will not benefit from the tax credit if they decide to marry but both individuals can qualify for the tax credit if they remain unmarried or if they decide to divorce.
- Under Obamacare, the tax code will continue to treat otherwise identical individuals very differently, depending on the source of their health insurance. Many workers and employers will have a significant incentive to drop employer-sponsored health insurance because of the sizeable health insurance tax credits created by the law. For example, a family of four headed by a 50-year old making around \$50,000 per year will benefit by approximately \$7,500 from not receiving health insurance. Employers dropping ESI en masse would lead to a staggering increase in the budget deficit.

Health Law Harms Marriage, Reduces Tax Fairness, and Results in Fewer Taxpayers

President Obama's health care law, the Patient Protection and Affordable Care Act (PPACA),¹ creates refundable tax credits to assist certain individuals in purchasing health insurance. Individuals in households below 400 percent of the federal poverty level (FPL) qualify for a tax credit unless they are eligible for Medicare or Medicaid or someone in the household has an offer of "affordable" coverage at work.² The PPACA also expands Medicaid by requiring that states enroll all applicants who live in households below 133 percent of the FPL. The Congressional Budget Office (CBO) projects that the tax credits and the Medicaid expansion will increase the nation's debt burden, excluding interest costs, by \$1.36 trillion from 2015-2021,³ the first seven years that these PPACA provisions are fully implemented.

A tax credit offsets the amount of income tax that a household would otherwise owe to the Internal Revenue Service (IRS). A tax credit is therefore more generous than a tax deduction since a deduction reduces the amount of income that is subject to the tax. Similar to the earned income tax credit (EITC), the PPACA's health insurance tax credit is refundable. This means that if the amount of the credit is greater than the amount of the income tax that the household would otherwise owe to the IRS, the IRS rebates the difference to the taxpayer. If this occurs, a taxpayer has negative federal income tax liability.

The PPACA tax credit is configured to limit the percentage of out-of-pocket income that qualifying households would pay for insurance purchased through a state health insurance exchange.⁴ The value of the tax credit is based on household income with the credit decreasing in value as household income increases. Households at 133 percent of the FPL receive a credit so that their out-of-pocket premium is three percent of household income while households between 300 percent and 400 percent of the FPL receive a credit so their out-of-pocket premium

¹ PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010, PUB. LAW 111-148; HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010, PUB. LAW 111-152.

² The PPACA requires that employer-sponsored insurance (ESI) cover at least 60 percent of the cost of benefits. The PPACA defines ESI as "unaffordable" if the out-of-pocket premiums exceed 9.5 percent of income for self-only coverage.

³ Douglas W. Elmendorf, Testimony before the U.S. House of Representatives Committee on Energy and Commerce Health Subcommittee "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," March 30, 2011 available at

<http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/033011/Elmendorf.pdf>.

⁴ State health insurance exchanges will be set either by the state or by the federal government if a states refuses to set up its own exchange. The exchanges are basically portals where individuals can purchase health insurance. Many individuals who purchase insurance through an exchange will qualify for a tax credit. The reference plan for calculating the size of the tax credit will have actuarial value of 70 percent, which means that for all enrollees in a typical population, the plan will pay 70 percent of the total expenses for covered benefits. Individuals can purchase plans with actuarial values greater or less than 70 percent, but the value of the credit is determined by the second-lowest cost plan in an exchange that has an actuarial value of 70 percent.

is 9.5 percent of household income.⁵ For example, a family of four at 200 percent of the FPL (about \$48,677 in 2016)⁶ cannot pay more than 6.3 percent of their income for health insurance. The CBO estimates that the average cost of the reference insurance plan (the plan used to calculate the tax credit) will be \$14,100 for family coverage in 2016.⁷ Therefore, a family of four that qualifies for a credit in 2016 and that makes \$48,677 would be required to pay about \$3,067 for health insurance (6.3 percent of household income). The difference, \$11,033, is the value of this family's refundable tax credit.

According to the CBO, 20 million Americans will receive health insurance tax credits in 2020 at a cost of \$130 billion.⁸ This means the average tax credit per person receiving it will be about \$6,500. The Oversight and Government Reform Committee requested that the Joint Committee on Taxation (JCT) produce estimates of the distributional impact of the PPACA's tax credit on Americans' tax status. On September 6, 2011, the JCT provided the Committee with these estimates.⁹

The JCT estimates that in 2020 about 14 million tax filers will claim the health insurance credit and only about two million of these households will have positive income tax liability after benefitting from the credit. The vast majority of the remaining 12 million households, about 85 percent of the households claiming the credit, will have negative tax liability, meaning they will receive more from the U.S. Treasury than they pay in.¹⁰ By 2020, the health insurance tax credits will directly move between 7.4 million and 8.1 million tax filers off the tax rolls.¹¹ As a result, these households will have a disincentive to care about the growth of government.

⁵ Individuals in household below 133 percent of the FPL cannot pay more than 2 percent of their income in personal premium contributions. The applicable percentage for individuals in households between 300 percent and 400 percent of FPL is 9.5 percent. Those percentages for individuals between 133 percent and 300 percent of the FPL are based on a sliding scale with a linear interpolation for individuals in the middle of 5 FPL levels. The applicable percentages are: 3 percent for individuals at 133 percent of the FPL, 4 percent for individuals at 150 percent of the FPL, 6.3 percent for individuals at 200 percent of the FPL, 8.05 percent for individuals at 250 percent of the FPL, and 9.5 percent for individuals at 300 percent of FPL.

⁶ In 2011, 200 percent of the FPL is \$44,700. The CBO projects the growth in the CPI will be 1.3 percent in 2011 and 2012, and 2.0 percent in 2013-2016. Using these projections yields an estimated 200 percent of the FPL of \$48,677 in 2016.

⁷ Douglas W. Elmendorf, Letter to Evan Bayh, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act," November 30, 2009 available at <http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf>.

⁸ Douglas W. Elmendorf, Testimony before the U.S. House of Representatives Committee on Energy and Commerce Health Subcommittee "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," March 30, 2011 available at <http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/033011/Elmendorf.pdf>.

⁹ See the Attached letter sent from Thomas A. Barthold to Congressman Darrell Issa, September 6, 2011.

¹⁰ Most of these households owe payroll taxes, but the value of the PPACA tax credit is so large that many more filers will get more back through the income tax code than they owe through payroll taxes.

¹¹ In Table 1 of the JCT estimates, 8.1 million filers move from positive income tax liability before the credit to zero or negative liability after the credit. In Table 2 of the JCT estimates, the corresponding number is 7.4 million filers.

Nearly half of the beneficiaries of the tax credit will be single individuals without any dependent children and most of the other beneficiaries will be single parents. Most of the dependent children in this group will not benefit from the tax credit, however, since they will qualify for the Children's Health Insurance Program (CHIP); and children who qualify for CHIP are not eligible for the PPACA's tax credits.¹² The JCT estimates that only 14 percent of the filers who claim the health insurance credit will be married couples. The evidence suggests, therefore, that the PPACA introduces a substantial new marriage penalty into the tax code. Moreover, since the credit is not available to people who get insurance through their employer, the PPACA introduces a major new inequity in the tax code. These outcomes may not have been intended, but they are significant collateral damage from the law's unaffordable addition to the welfare state.

The PPACA Takes Millions Off Tax Rolls

Because of massive new government spending and declining revenues, over 40 percent of federal spending over the past three years has been financed by borrowing.¹³ This combination has added more than \$4 trillion to the national credit card since President Obama took office.¹⁴ In 2008, the year before federal revenue cratered and budget deficits exploded, the federal government collected about \$2.52 trillion in tax revenue.¹⁵ Tax revenue flows from mainly three sources: the income tax (45.4 percent of total federal tax revenue in 2008), the payroll tax (35.7 percent of total federal tax revenue in 2008), and the corporate tax (12.1 percent of total federal tax revenue in 2008). The payroll tax is the primary funding source for Social Security and Medicare Part A (Hospital Insurance), although in 2010 the Medicare Part A payroll tax only financed about three-quarters of Part A expenditures and the Social Security payroll tax failed to cover program expenditures for the first time in the program's history.¹⁶ Federal spending on other items, such as national defense, grants to the states, welfare, national parks, and federal employees' salaries has traditionally been largely financed out of income tax and corporate tax revenue.

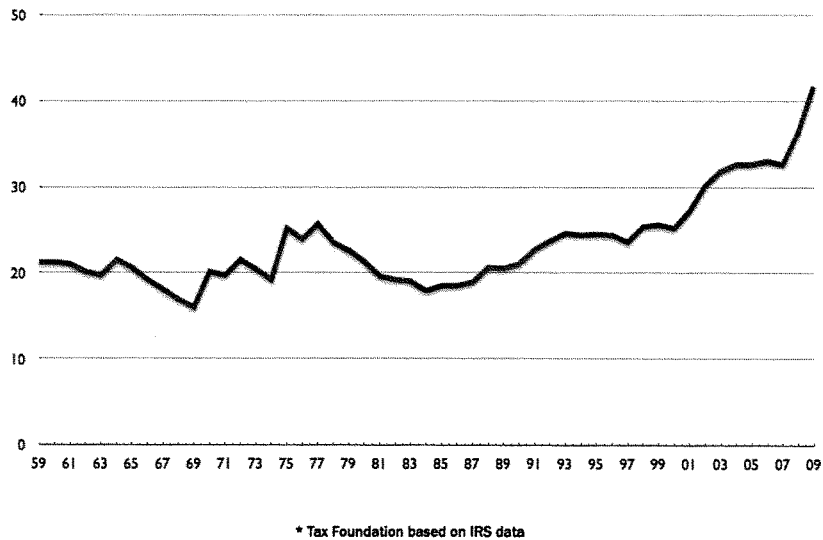
¹² U.S. Department of the Treasury Notice of Proposed Rulemaking, Health Insurance Premium Tax Credit, 26 CFR Part 1 Federal Register Vol. 76, No. 159, August 17, 2011, available at <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf>.

¹³ Office of Management and Budget, "Historical Tables – Budget of the U.S. Government Fiscal Year 2011," available at <http://www.gpoaccess.gov/usbudget/fy11/pdf/hist.pdf>.

¹⁴ *Id.*

¹⁵ Tax Policy Center, "Historical Federal Receipt and Outlay Summary," March 25, 2011 available at <http://www.taxpolicycenter.org/taxfacts/displayafact.cfm?DocID=200&Topic2id=20&Topic3id=23>.

¹⁶ The Boards of Trustees Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, THE 2011 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS, May 13, 2011 (hereinafter THE 2011 ANNUAL REPORT OF THE BOARDS OF TRUSTEES), available at <http://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf>.

Figure 1: Percentage of Tax Filers Who Don't Pay Income Taxes

According to the Tax Foundation, 41.7 percent of filers (58.6 million returns out of the 140.5 million total returns filed) had zero or negative income tax liability in 2009.¹⁷ Since many of the tax credits that these 58.6 million households claim are refundable, most of these households actually receive net payments through the income tax code. The health insurance tax credits in the PPACA will directly remove millions of additional households from the tax rolls. If the PPACA was in effect in 2009, the percentage of filers without federal income tax liability would be nearly 47 percent.¹⁸ In April 2011, the JCT produced estimates for the Senate Finance

¹⁷ Tax Foundation, "Federal Individual Income Tax Returns with Zero or Negative Tax Liability, 1950-2009," October 18, 2011 available at <http://taxfoundation.org/research/show/25587.html>.

¹⁸ According to the Tax Foundation calculations based on IRS data, 140.5 million tax returns were filed in 2008 and 58.6 million of these returns had zero or negative income tax liability. Under the assumptions of current policy, the 6.9 million households in 2016 will go from positive income tax liability to zero or negative income tax liability. Adding 6.9 million households to the 58.6 million households without income liability would result in over 41 percent of households with zero or negative federal income tax liability.

Committee that included non-filers and showed 51 percent of tax filers and non-filers in the aggregate paid no federal income tax in 2009.¹⁹

According to the JCT estimates, 13.3 million tax filers will claim the health insurance tax credit in 2016, the third year the tax credits will be in place and 14.0 million tax filers will claim the credit in 2020.²⁰ Both the refundable and non-refundable pieces of the credit will increase the federal budget deficit. The federal government will bring in less tax revenue from the tax offset (the non-refundable piece of the credit) and the tax credit will cause the federal government to increase spending (the refundable piece of the credit) since many of these filers lack positive income tax to offset. According to the CBO, about three-quarters of the cost of the tax credit is from the refundable component.²¹ By definition, this amounts to new spending for the benefit of Americans who do not contribute to the cost of government through federal income taxes.

The CBO has estimated that the health insurance tax credits will grow significantly more expensive over time. According to the CBO, the tax credits are projected to increase the deficit by \$55 billion in 2015, \$87 billion in 2016, \$104 billion in 2017, \$115 billion in 2018, \$123 billion in 2019, \$130 billion in 2020, and \$137 billion in 2021 – the last year of the ten-year budget window.²²

In 2016, the health insurance tax credit will directly move around seven million tax filers (4.2 million single filers, 1.3 million joint filers, and 1.4 million head of household filers) from positive income tax liability before the credit to zero or negative liability after the credit.²³ The number of filers removed from the federal income tax rolls will increase over time as more filers claim the credit.²⁴ Of the 13.3 million filers projected to claim the credit in 2016, only two million of them (15 percent of filers claiming the credit) will have positive tax liability as a result

¹⁹ Joint Committee on Taxation, “Information on Income Tax Liability for Tax Year 2009,” April 29, 2011, at <http://finance.senate.gov/newsroom/recordings/release/?id=e7723a9e-ed4a-4e10-af90-a56dfb0ccec5> (click the PDF labeled “JCT Analysis Income Tax Liability for Tax Year 2009”).

²⁰ Thomas A. Barthold letter to Darrell Issa, September 6, 2011. In this letter, the Joint Committee on Tax presented the Oversight and Government Reform Committee with two tables of the estimated number of returns receiving the health insurance tax credit and the change in tax status from the size of the tax credit. Table 1 provides estimates based on current law, which means the tax rates would return to the rates in place before 2001, the alternative minimum tax (AMT) would be in effect. Table 2 provides estimates on the assumption that the current tax rates are kept in place, the AMT is fixed, and the exemption amounts in 2011 are adjusted annually for inflation. Since the leaders of both political parties believe that the tax rates should not be increased for all households making below \$250,000, the estimates in Table 2 are likely more realistic and are therefore the estimates cited in this paper. For all practical purposes, there are not significant differences between the two sets of estimates.

²¹ Douglas W. Elmendorf, Letter to the Honorable Nancy Pelosi, March 20, 2010. The estimate reflects the combined effects of H.R. 3590 (Public Law 111-148), the Patient Protection and Affordable Care Act, and H.R. 4590, the Health Care and Education Reconciliation Act of 2010. Available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf>.

²² Thomas A. Barthold letter to Darrell Issa, September 6, 2011.

²³ *Id.*

²⁴ *Id.*

of claiming the credit.²⁵ This means that about 85 percent of filers who claim the credit will end the year with zero or negative income tax liability. Since the tax credit is refundable, nearly all 11.3 million of these filers will actually have negative income tax liability and will receive more money from the government than they pay in income tax. In addition to the seven million filers whose status changes from a taxpayer to a tax receiver, four million of the credit beneficiaries (30 percent of filers claiming the credit) are households that had negative income tax liability *before* claiming the credit and around 300,000 additional filers had zero income tax liability *before* claiming the credit.²⁶

The Committee calculated the impact of the PPACA health insurance tax credit combined with the EITC, the child tax credit, and the average tax deduction taken by households in a particular income bracket to show the overall tax impact of the credit for certain households.²⁷ For example, a single parent with two children earning \$40,000 in 2014 would qualify for a tax credit of \$7,540, would not owe income taxes, and would get \$7,953 back from the IRS at the end of the year. This family would have to earn \$68,942 before it paid any net federal income tax. A 40-year old married couple with two children that makes \$80,000 qualifies for a tax credit of \$4,530, would not owe income taxes, and would get \$729 back from the IRS at the end of the year. A 50-year old couple with 3 kids that earns \$90,000 would qualify for a tax credit of \$8,035, would not owe income taxes, and would get \$4,319 back from the IRS at the end of the year. These examples illustrate that the PPACA tax credit will result in many additional filers in the middle class and, depending on the state,²⁸ some in the upper-middle class receiving net payments through the tax code. With record budget deficits and the onslaught of baby boomers beginning to collect Social Security and Medicare, the PPACA's extension of welfare payments this high up the income spectrum is imprudent and unaffordable.

The PPACA Contains Incentives to Drop ESI and Pass Costs to Taxpayers

The federal government currently provides a generous subsidy of health insurance through the employer-sponsored health insurance (ESI) tax exclusion. When a worker gets health insurance through his or her employer, the premium is exempt from both federal income

²⁵ *Id.*

²⁶ *Id.*

²⁷ The methodology used by the Committee in calculating these estimates was based upon the methodology used by Paul Winfree in his paper, "Obamacare Tax Subsidies: Bigger Deficit, Fewer Taxpayers, Damaged Economy," Heritage Foundation, May 24, 2011 available at <http://www.heritage.org/Research/Reports/2011/05/Obamacare-Tax-Subsidies-Bigger-Deficit-Fewer-Taxpayers-Damaged-Economy>. The value of the tax credit was derived from the Kaiser Family Foundation Health Reform Subsidy Calculator, available at <http://healthreform.kff.org/SubsidyCalculator.aspx>.

²⁸ Census Bureau American Community Survey, "Estimated State Median Income, by Family Size and by State for FY 2009," available at http://www.cec.sped.org/Content/NavigationMenu/SpecialEdCareers/ESTIMATED_STATE_MEDIAN_INCOME.pdf.

and payroll taxes. Individuals who purchase health insurance on their own do not get this favorable tax treatment. This means the tax code discriminates against people who do not have access to health insurance through their employer. The PPACA left the ESI tax exclusion in place, but also contained a provision that will prevent individuals with an offer of ESI from claiming the PPACA's health insurance tax credit.²⁹ The result is that the tax code will continue to treat otherwise identical individuals very differently, depending on the source of their health insurance.³⁰

Although employers that offer ESI generally pay the vast majority of the premium,³¹ workers actually bear most of the cost. This is because employees can be compensated with some combination of wages and benefits. Workers who receive a greater share of their compensation in the form of health insurance benefits will therefore see less of their compensation in wages. Individuals who claim the health insurance tax credits, on the contrary, will end up passing most of the cost of their health insurance to the shrinking set of individuals that are paying income taxes and to future generations of Americans through additional deficit spending.

The tax credits in the PPACA are the law's primary fiscal time bomb because they present businesses with an incentive to drop health insurance coverage. A recent McKinsey and Company survey showed 30 percent of employers are seriously considering dropping ESI, and employers who are more familiar with the PPACA are more likely to indicate they will drop ESI.³²

More than 30 percent of employers overall, and 28 percent of large ones, say they will definitely or probably drop coverage after 2014 Interest in these alternatives rises with increasing awareness of reform, and our survey educates respondents about its implications for their companies and employees before they were asked about post-2014 strategies. The propensity of employers to make big changes to ESI increases with awareness largely because shifting away will be

²⁹ U.S. Department of the Treasury Notice of Proposed Rulemaking, Health Insurance Premium Tax Credit, 26 CFR Part 1 Federal Register Vol. 76, No. 159, August 17, 2011, available at <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf>.

³⁰ For a discussion of the substantial inequities created by the PPACA, see Gene Stuerle, "When Health Reform Violates Standards of Equal Justice," November 10, 2009 available at <http://www.tax.com/taxcom/features.nsf/Articles/E91F35F1FF72076F8525766A00671B94?OpenDocument>.

³¹ The average national employee contribution share for single coverage is 20.1 percent and the employee share for family coverage is 27.5 percent.

³² Shubham Singhai, Jeris Stueland, and Drew Ungerman, "How US health care reform will affect employee benefits," McKinsey Quarterly, June 2011, available at https://www.mckinseyquarterly.com/Health_Care/Strategy_Analysis/How_US_health_care_reform_will_affect_employee_benefits_2813.

economically rational not only for many of them but also for their lower-income employees, given the law's incentives.³³

Douglas Elmendorf, the director of the CBO, testified before Congress earlier this year that "[t]here 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."³⁴ Although there is "a tremendous amount of uncertainty in how employers and employees will respond to PPACA," CBO only projected one million fewer individuals, on net, would be receiving ESI as a result of the law.³⁵

Former CBO Director Douglas Holtz-Eakin, however, has argued that "the massive federal subsidies are money on the table inviting a vast reworking of compensation packages, insurance coverage, and labor market relations."³⁶ Holtz-Eakin and Cameron Smith calculated that lower-income workers (those in households with income below about \$50,000 for a family of four) can substantially benefit from replacing workplace insurance with subsidized coverage in an exchange.³⁷ And the employer will have more than enough left from the savings of dropping coverage that the company will be better off as well. According to Holtz-Eakin and Smith, "CBO estimated that only 19 million residents would receive subsidies, at a cost of about \$450 billion over the first 10 years. [Our] analysis suggests that the number could easily be triple that (19 million plus an additional 38 million in 2014) – the gross price tag would be roughly \$1.4 trillion."³⁸

In August 2011, economists Richard Burkhauser, Sean Lyons, and Kosali Simon suggested another way employers and employees can take advantage of the health insurance tax credits.³⁹ Many workers will have a strong incentive to request their employer reduce the employer's contribution to health insurance. This is because if the coverage is "unaffordable," the employee will be able to qualify for subsidized coverage in a state exchange. Firms will set the employee's premium contribution at a level that is affordable for high wage workers and unaffordable for low wage workers. This will result in high wage earners continuing to benefit

³³ *Id.*

³⁴ Douglas W. Elmendorf, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," Testimony before the Subcommittee on Health Committee on Energy and Commerce, March 30, 2011, page 22, available at <http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/033011/Elmendorf.pdf>.

³⁵ *Id.*

³⁶ Douglas Holtz-Eakin and Cameron Smith, "Labor Markets and Health Care Reform: New Results," American Action Forum, May 2010, available at <http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10.pdf>.

³⁷ *Id.*

³⁸ *Id.*

³⁹ Richard Burkhauser, Sean Lyons, Kosali Simon, "The Importance of the Meaning and Measurement of 'Affordable' in the Affordable Care Act," NBER Working Paper 17279, August 2011, available at <http://www.nber.org/papers/w17279>.

from the tax exclusion for ESI while low wage workers qualify for tax credits because their premium contribution is “unaffordable.”⁴⁰ The firms will be in compliance with non-discrimination rules that require employers to offer the same coverage to all of their workers because the offer to each employee will be the same. The difference is the required employee contribution will be “affordable” for some workers in the firm and “unaffordable” for other workers in the firm. Burkhauser, Lyons, and Simon show that the net benefit for many workers and employers will exceed the penalty that many employers likely face for failing to offer health insurance, and their research also suggests that the CBO may have significantly under-estimated the costs of the PPACA.

Table 1 shows the magnitude of the incentive for one-person and four-person households to prefer the PPACA’s health insurance tax credit to receiving health insurance through the workplace. The assumption underlying these estimates is that health insurance benefits reduce worker wages and that a company that failed to offer health insurance would have to increase wages in order to attract the same caliber of workers. The estimates in Table 1 represent household income after federal income and payroll taxes and out-of-pocket health insurance payments. The advantage to workers of being offered employer-sponsored insurance (ESI) is that the dollars the employer spends on premiums are not subject to federal income and payroll taxes, while the advantage to qualified workers of not being offered ESI is the PPACA tax credits for premium assistance. For ease of calculations, six specific federal poverty levels (FPLs) were used to represent the amount of employee compensation split between wages and health insurance benefits. For example, the row ‘200% FPL’ represents a household with total compensation (wages plus health insurance benefits) that equals 200 percent of the FPL in 2014 - \$22,797 for a one-person household and \$46,787 for a four-person household.

The column titled ‘Income With ESI’ represents household income after federal income and payroll taxes for a household that obtains health insurance through work. The health insurance plan through work is assumed to have a 70 percent actuarial value, which makes it equivalent to the reference plan in the exchanges used to calculate the PPACA tax credit. The column titled ‘Income Without ESI’ represents household income after federal taxes and the out-of-pocket health insurance premium payment for a household that does not receive health insurance through the workplace but who benefits from a PPACA tax credit. The column titled ‘DIFF’ is the difference between the ‘Income Without ESI’ column and ‘Income With ESI’ column and is an estimate of how much better off the worker is from not being offered health insurance through the employer. It is important to note that this difference is solely driven by the tax treatment of ESI and the PPACA tax credits. And this difference accounts for the fact that the worker in both scenarios has health insurance of identical actuarial value.

⁴⁰ Coverage is unaffordable if it covers less than 60 percent of the cost of benefits or premiums exceed 9.5 percent of income.

Table 1: Magnitude of the Incentive for Workers to Prefer the Tax Credit Instead of ESI in 2014 Once the PPACA Takes Effect (Difference in Household Income After Federal Taxes and Health Insurance Payments)

	Four-person household with family coverage			Individual with self-only coverage		
	Income With ESI	Income Without ESI	DIFF	Income With ESI	Income Without ESI	DIFF
Household head is 30 Years Old						
150% FPL	\$23,785	\$30,253	\$6,468	\$12,454	\$14,386	\$1,932
200% FPL	\$33,602	\$38,270	\$4,668	\$17,105	\$18,126	\$1,021
250% FPL	\$43,044	\$45,557	\$2,512	\$21,513	\$21,677	\$163
300% FPL	\$52,092	\$52,645	\$553	\$25,922	\$25,130	-\$791
350% FPL	\$61,139	\$60,581	-\$558	\$30,330	\$29,347	-\$983
400% FPL	\$70,187	\$68,518	-\$1,669	\$34,738	\$33,756	-\$983
Household head is 40 Years Old						
150% FPL	\$22,061	\$30,253	\$8,192	\$11,648	\$14,386	\$2,738
200% FPL	\$32,064	\$38,270	\$6,205	\$16,341	\$18,126	\$1,785
250% FPL	\$41,600	\$45,557	\$3,957	\$20,756	\$21,677	\$921
300% FPL	\$50,648	\$52,645	\$1,998	\$25,164	\$25,130	-\$34
350% FPL	\$59,695	\$60,581	\$886	\$29,573	\$28,997	-\$576
400% FPL	\$68,742	\$68,518	-\$225	\$33,981	\$32,864	-\$1,117
Household head is 50 Years Old						
150% FPL	\$18,029	\$30,253	\$12,225	\$9,763	\$14,386	\$4,623
200% FPL	\$28,469	\$38,270	\$9,801	\$14,457	\$18,126	\$3,669
250% FPL	\$38,101	\$45,557	\$7,456	\$18,986	\$21,677	\$2,691
300% FPL	\$47,270	\$52,645	\$5,375	\$23,394	\$25,130	\$1,736
350% FPL	\$56,318	\$60,581	\$4,264	\$27,803	\$28,997	\$1,195
400% FPL	\$65,365	\$68,518	\$3,153	\$32,211	\$32,864	\$653
Household head is 60 Years Old						
150% FPL	\$11,902	\$30,253	\$18,352	\$7,115	\$14,386	\$7,272
200% FPL	\$22,704	\$38,270	\$15,566	\$12,027	\$18,126	\$6,099
250% FPL	\$32,638	\$45,557	\$12,919	\$16,704	\$21,677	\$4,972
300% FPL	\$42,138	\$52,645	\$10,507	\$21,113	\$25,130	\$4,018
350% FPL	\$51,186	\$60,581	\$9,395	\$25,521	\$28,997	\$3,476
400% FPL	\$60,233	\$68,518	\$8,284	\$29,930	\$32,864	\$2,935

This table compares household income net federal taxes and the cost of health insurance for households who have identical worth to a business based on whether the household is offered ESI or not. Total household compensation (wages plus the value of health insurance benefits) is represented by the FPL in Column 1. 100 percent of the FPL in 2014 is estimated to be \$11,398 for a one-person household and \$23,394 for a four-person household. Staff calculations are derived from the Kaiser Family Foundation Health Reform Subsidy Calculator and IRS tax information. For a full explanation of the methodology, please see the technical appendix.

Table 1 also breaks down the estimates by age and income. Age is relevant for these calculations because the PPACA allows insurers to charge the oldest individuals in the market three times as much as the youngest individuals.⁴¹ Since health insurance premiums rise as people age, the value of the tax credit is higher for older individuals. This is because the tax credit is based on a restriction of the amount a family is required to pay out-of-pocket for health insurance. Table 1 illustrates how dramatically the benefit of not receiving ESI increases as people age. For example, a four-person household headed by a 30-year old earning total compensation equal to 250 percent of the FPL benefits by \$2,512 if not offered ESI. A four-person household headed by a 60-year old earning that same amount of compensation benefits by \$15,566 if not offered ESI.

Income is relevant for these calculations because the size of the tax credit falls as household income rises for a given family size. The value of having ESI (and taking advantage of the tax exclusion) increases relative to the advantage of not having ESI (and taking advantage of the PPACA tax credit) as household income rises. However, Table 1 shows that in most cases, there is a greater benefit for households in this income range to not receive insurance through their employer so they can claim the credit.⁴² Table 1 also illustrates that the magnitude of this effect is much greater for families than for individuals, since premiums for family health plans are more expensive.

For instance, a four-person household headed by a 50-year old whose total compensation (wages plus health insurance benefits) equals 250 percent of the FPL (\$58,484 in 2014) would receive income after federal taxes of \$38,101 if offered ESI and \$45,557 if not offered ESI.⁴³ The \$45,557 is the result of this person paying \$4,474 in payroll taxes, \$3,745 in income taxes, and \$4,708 in out-of-pocket health insurance premiums.⁴⁴ All else equal, this employee is going to choose a job where he is not offered ESI since he is able to pocket an additional \$7,456 while obtaining health insurance of an equal value.

Table 1 also illustrates the rough magnitude of the incentive that employers and employees will face to drop ESI, or at a minimum to reconfigure ESI as Burkhauser, Lyons, and Simon suggest is possible. In many cases, the gain to workers from not having ESI dwarfs the \$2,000 penalty that companies would face for failing to offer ESI (and this penalty only applies to firms with more than 50 full-time workers). On October 20, 2011, the *New York Times* reported that Wal-Mart, the largest employer in the United States, “is substantially rolling back

⁴¹ The PPACA compresses the age rating band since individuals in their 60s spend about six times as much on health care as individuals in their 20s.

⁴² The calculation of whether employers will offer ESI after 2014 is much more complicated than the numbers in this table suggest. For example, if an employer has more than 50 full-time workers, he would be subject to a \$2,000 penalty on all full-time workers (beyond the first 30).

⁴³ These calculations are explained in depth in the Technical Appendix.

⁴⁴ The out-of-pocket premium payment was the difference between the cost of family coverage for a 50-year old in 2014 (\$16,858) and the value of this household’s tax credit (\$12,150).

(health) coverage for part-time workers and significantly raising premiums for many full-time staff.”⁴⁵ As the estimates in Table 1 show, this decision by Wal-Mart will benefit both the firm as well as many Wal-Mart workers since a greater share of the firm’s and workers’ health insurance costs will be passed to taxpayers starting in 2014.

The PPACA Penalizes Marriage and Two-Parent Families

According to the JCT estimates, married couples will receive less than 15 percent of the PPACA’s tax credits. At most, only two million married couples (out of nearly 60 million married couples in the country)⁴⁶ are projected to benefit from the health insurance tax credit in any year through 2021.⁴⁷ Almost half of the beneficiaries of the tax credit will be unmarried individuals without dependent children.⁴⁸ About forty percent of the individuals who are projected to claim the credit will file as the head of a household.⁴⁹ These households mostly consist of a single parent with at least one dependent child. These numbers suggest that an impact of the PPACA’s health insurance tax credit will be to introduce a significant new marriage penalty into the tax code. It is also important to note that most children of tax filers who claim the credit are not themselves beneficiaries of the credit. This is because a child cannot benefit from a tax credit if they are eligible for a state’s Children Health Insurance Program (CHIP) and most of the children in households that claim the credit will qualify for CHIP.⁵⁰

Although it may seem unfair that the tax credits fail to benefit married couples, this result is a product of the way the law was written and the regulations the Obama Administration has proposed. One reason that the PPACA discriminates against married individuals is that the tax credit amount is linked to the federal poverty level (FPL) and the FPL does not increase proportionally as household size increases. In 2014, 400 percent of the FPL will be about \$45,600 for a one-person household, increasing roughly \$16,000 for each additional household member (\$61,600 for a two-person household).⁵¹ Thus, the result of linking the tax credit to the FPL is that two individuals who make between \$61,600 and \$91,200 (twice the FPL of a one-

⁴⁵ Steve Greenhouse and Reed Abelson, “Wal-Mart Cuts Some Health Care Benefits,” New York Times, October 20, 2011 available at <http://www.nytimes.com/2011/10/21/business/wal-mart-cuts-some-health-care-benefits.html>.

⁴⁶ See Table 4 in “Marital Events of Americans: 2009”, American Community Survey Reports, August 2011 available at <http://www.census.gov/prod/2011pubs/acs-13.pdf>.

⁴⁷ Thomas A. Barthold letter to Darrell Issa, September 6, 2011.

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ U.S. Department of the Treasury Notice of Proposed Rulemaking, Health Insurance Premium Tax Credit, 26 CFR Part 1 Federal Register Vol. 76, No. 159, August 17, 2011, available at <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf>.

⁵¹ In 2011, 400 percent of the FPL is \$44,700. The CBO projects the growth in the CPI will be 1.3 percent in 2011 and 2012, and 2.0 percent in 2013-2016. Using these projections yields an estimated 400 percent of the FPL of \$45,594 in 2014.

person household) will not benefit from the tax credit if they decide to marry since they will be over 400 percent of the FPL for a two-person household. These two individuals can benefit from the tax credit, however, if they remain unmarried or if currently married, they decide to divorce.

The second reason for the marriage penalty is because of the Administration's interpretation of the PPACA. The Administration has proposed a rule that if one spouse is offered health insurance at work, then no one in the family is eligible for the tax credits.⁵² The proposed rule issued by the Administration, therefore, disqualifies a family from claiming the credit if either spouse is offered an insurance plan at work with an out-of-pocket premium less than 9.5 percent of household income for *self-only coverage*.⁵³ For example, if a 40-year old married couple with two children makes \$70,000 per year and neither spouse has an offer of ESI, the family would qualify for a tax credit of \$5,579.⁵⁴ If either spouse has an offer of ESI, however, the couple would not qualify for the tax credit. Under the status quo, nearly all employees who are offered coverage at their workplace will likely have an offer of affordable coverage because most employees pay less than 9.5 percent of household income for their portion of the total premium.⁵⁵ Thus, married couples and their families will generally be ineligible for the credits if either spouse has access to coverage through his or her employer. It is important to note, however, that if employers and workers respond by reworking compensation packages to pass more health insurance costs to taxpayers, more married couples will have access to the tax credits and their ultimate cost may be significantly higher than what CBO has projected.

The following example illustrates how the tax credit discriminates against married couples and penalizes marriage. For illustration purposes assume a 40-year old couple with two children: the husband makes \$40,000 per year and the wife makes \$30,000 per year. The wife's employer does not offer coverage through work but the husband's does. The husband's company provides only self-only coverage and the employee only pays a small percentage of the total premium. This company would satisfy the criteria of the PPACA's employer mandate provision even though they don't offer family coverage. Since the husband has access to ESI, the rest of the family is not eligible for the PPACA tax credits. The family would be faced with the decision of buying private coverage at an annual cost exceeding \$10,000 for the mom and

⁵² U.S. Department of the Treasury Notice of Proposed Rulemaking, Health Insurance Premium Tax Credit, 26 CFR Part 1 Federal Register Vol. 76, No. 159, August 17, 2011, available at <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf>.

⁵³ *Id.*

⁵⁴ The value of the tax credit was derived from the Kaiser Family Foundation Health Reform Subsidy Calculator, available at <http://healthreform.kff.org/SubsidyCalculator.aspx>. There is a slight difference from the amount given by the calculator for this household (\$5,504) because of a small difference in assumptions about the estimated FPL in 2014.

⁵⁵ Richard Burkhauser, Sean Lyons, Kosali Simon, "The Importance of the Meaning and Measurement of "Affordable" in the Affordable Care Act," NBER Working Paper 17279, August 2011, available at <http://www.nber.org/papers/w17279>.

kids (unless the kids are covered by the state's CHIP) or foregoing insurance and being forced to pay the tax penalty instituted by the health care law for individuals who lack health insurance.⁵⁶

If the father and mother are unmarried, however, the woman and the two children would qualify for a tax credit of \$10,895 to use to purchase a policy that would cost about \$12,130.⁵⁷ Because of the PPACA, marriage costs this family \$10,895. As this example illustrates, the PPACA health insurance tax credit will create an enormous marriage penalty for many families. Over time, PPACA's marriage penalty is bound to influence behavior and will directly cause fewer individuals to decide to marry and more couples to decide to divorce. Since social scientists have found profound social benefits to marriage,⁵⁸ policy that punishes marriage is a significant concern.

The PPACA Was the Wrong Policy Prescription

President Obama's deficit commission issued its final report in December 2010.⁵⁹ According to the Commission, one of their guiding principles and values was to reform and simplify the tax code:

The tax code is rife with inefficiencies, loopholes, incentives, tax earmarks, and baffling complexity. We need to lower tax rates, broaden the base, simplify the tax code, and bring down the deficit.⁶⁰

Reform of the tax code is needed because it has become littered with deductions, credits, and carve-outs since the Tax Reform Act of 1986.⁶¹ There are currently more than 72,000 pages of

⁵⁶ The PPACA contains a tax penalty for individuals who fail to obtain health insurance that meets the law's requirements. The tax penalty for an individual is \$695, indexed to inflation. A family of three (two parents and one child under 18) would face a tax penalty of \$1,737 in 2016 and a family of four (two parents and two children under 18) would face a tax penalty of \$2,085 in 2016. Blue Cross/Blue Shield of Rhode Island, Federal Healthcare Reform: Patient Protection and Affordable Care Act Individual Mandate and Subsidy, available at https://www.bcbsri.com/BCBSRIWeb/pdf/Individual_Mandate_Fact_Sheet.pdf.

⁵⁷ The value of the tax credit was derived from the Kaiser Family Foundation Health Reform Subsidy Calculator, available at <http://healthreform.kff.org/SubsidyCalculator.aspx>. There is a slight difference from the amount given by the calculator for this household (\$5,504) because of a small difference in assumptions about the estimated FPL in 2014.

⁵⁸ For example, see A. Scott Loveless and Thomas B. Holman "The Positive Impact of Marriage on Society: The Case for Public Policy" 2007. *The Family in the New Millennium: World Voices Supporting the 'Natural' Clan* (Eds). Westport, CN: Praeger.

⁵⁹ The National Commission on Fiscal Responsibility and Reform, "The Moment of Truth," December 2010 available at http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf.

⁶⁰ *Id.*, page 12

⁶¹ Joint Committee on Taxation, "General Explanation of the Tax Reform Act of 1986," October 1987, available at <http://www.jct.gov/jcs-10-87.pdf>.

federal tax rules.⁶² Earlier this year, President Obama endorsed the Commission's approach on tax reform in a major policy address at George Washington University:

I'm calling on Congress to reform our individual tax code so that it is fair and simple – so that the amount of taxes you pay isn't determined by what kind of accountant you can afford. I believe reform should protect the middle class, promote economic growth, and build on the Fiscal Commission's model of reducing tax expenditures so that there is enough savings to both lower rates and lower the deficit.⁶³

Once again, the President's rhetoric contradicts the reality of his policies. Despite the President's rhetoric, his health care law complicates the tax code by introducing a new, expensive tax expenditure. While the intent of the PPACA was probably not to penalize marriage and take millions of people off the tax rolls, it will be the result. Rather than broadening the tax base, the PPACA's tax credits narrow the base by removing 8 million households from the tax rolls by the end of the decade.⁶⁴ The number of households coming off the tax rolls will be much higher, however, if experts such as former CBO director Douglas Holtz-Eakin are correct and there is a much more robust response by employers and workers to the changed law. Moreover, instead of simplifying and equalizing the tax treatment of health insurance, the PPACA introduces another inequity into the tax code, effectively harming many middle-class and working-class Americans who get health insurance through their employer while introducing a powerful incentive for employers to drop workplace health insurance coverage.

The health care law's tax credits serve as a backdoor welfare program and directly contradict the principles of the fiscal commission that the President endorsed. At a time of record budget deficits, the United States simply cannot afford PPACA's tax credits and for our country's fiscal future, Congress should repeal them. The fact that the tax credits produce so many perverse effects only adds to the necessity of repealing and replacing the PPACA as soon as possible.

⁶² CCH Standard Federal Tax Reporter, "Federal Tax Law Keeps Piling Up," available at [http://www.cch.com/wbot2011/WBOT_TaxLawPileUp_\(28\).f.pdf](http://www.cch.com/wbot2011/WBOT_TaxLawPileUp_(28).f.pdf).

⁶³ The Wall Street Journal, "Text of Obama Speech on the Deficit," April 13, 2011 available at <http://blogs.wsj.com/washwire/2011/04/13/text-of-obama-speech-on-the-deficit/>.

⁶⁴ Thomas A. Barthold letter to Darrell Issa, September 6, 2011.

Technical Appendix

According to the provisions of the Patient Protection and Affordable Care Act, variation in premiums for insurance plans will almost entirely be based upon the age of the head of household. This is because premiums are allowed to reflect age, but little else, as long as they do not vary outside the 3-to-1 age banding. Premiums by age for individual and family coverage for 2014 were calculated based off the Health Subsidy Calculator found on the Kaiser Family Foundation website.

The following are the premiums estimated by the Calculator by the age of the head of household and coverage type in 2014:

Age	Individual	Family
30	\$3,440	\$10,108
40	\$4,500	\$12,130
50	\$6,978	\$16,858
60	\$10,172	\$24,042

The 2011 federal poverty levels were adjusted using the Congressional Budget Office's estimates of the growth in the Consumer Price Index for 2011, 2012, and 2013.⁶⁵ Incomes in 2014 by poverty level for individuals and four families of four are estimated to be:

FPL	Individual	Family
150%	\$17,098	\$35,090
200%	\$22,797	\$46,787
250%	\$28,496	\$58,484
300%	\$34,195	\$70,181
350%	\$39,895	\$81,878
400%	\$45,594	\$93,574

The primary assumption for the calculations is that employers compensate individuals with wages and health insurance benefits and if health insurance benefits are provided, then wages will necessarily be reduced. For example, let's say a worker with a spouse and two children is worth \$46,787 to an employer and he gets paid entirely in wages. The payroll (Social Security and Medicare Part A) tax is assessed on the full value of his wages, and the income tax is assessed on his wages minus applicable exemptions and deductions. This aggregate amount of taxes is subtracted from the value of his wages. This worker qualifies for a PPACA health insurance tax credit if neither he nor his spouse has an offer of "affordable" ESI. Since there

⁶⁵ The CBO's projected increase in the consumer price index is 1.3 percent in 2011 and 2012 and 2.0 percent in 2013.

household income is below 400 percent of the FPL, he is eligible for a refundable tax credit.⁶⁶ But, this individual only receives the tax credit for purchasing health insurance, and the individual will be responsible for a portion of the cost of the premium. The estimates in the table for households with the tax credit equal the worker wages plus the amount of the health insurance tax credit minus federal income and payroll taxes minus the total cost of the premium, which is referenced in the above table.⁶⁷ These calculations ultimately yield the amount of income this household has after paying his federal taxes and after purchasing health insurance.

The calculations for a worker with ESI are different. First, it is necessary to calculate the wages that an employer would offer to an individual who is worth \$46,787 to the firm. The calculations assume that the employer pays the full cost of the health insurance, but this assumption makes little difference because if the employer reduces what it pays in health insurance premium it will have to increase wages to attract the same caliber workers. But, this worker will have to pay more of his wages in his health insurance premium.

The employer does not pay his share of the payroll tax (7.65 percent of income) on compensation in the form of health insurance premium payments. So, 7.65 percent the cost of the premium is added back into the worker's wages. A benefit of ESI to the worker is that taxes are not applied on the value of the health insurance. So, the payroll and income taxes are only assessed on the value of the wages. Since the employer pays the full insurance premium, this reduces the amount of payroll taxes paid by the worker (and probably biases the compensation figures slightly in the favor of a worker with ESI). The estimates in the table for households with ESI equals the dollar amount associated with the FPL level minus the cost of health insurance plus the 7.65 percent of the cost of health insurance (amount of the payroll tax revenue saved by the employer and thus added to worker wages) minus federal income and payroll taxes.

Example of calculations for a 50-year old family of 4 at 250 percent of the FPL

In 2014, 250% of the FPL is estimated to be \$58,484.⁶⁸ If the worker does not receive any of his compensation as health insurance, he will receive this entire amount in wages. The employee portion of the Social Security and Medicare payroll tax is 7.65 percent and would amount to \$4,474 for this family. The CBO estimates that in 2014 the standard deduction for a married couple is estimated to be \$12,200 and the personal exemption is estimated to be \$3,850.⁶⁹ This adds up to a net reduction in taxable income for this family of \$27,600. Therefore, the family has \$30,884 of taxable income (ignoring all other possible deductions as

⁶⁶ The PPACA requires that employer-sponsored insurance (ESI) cover at least 60 percent of the cost of benefits. The PPACA defines that ESI is "unaffordable" if the out-of-pocket premiums exceeds 9.5 percent of income for self-only coverage.

⁶⁷ The premium minus the amount of the tax credit is equal to the subsidized cost of insurance for this household.

⁶⁸ In 2011, 250% of the FPL was \$55,875. Projections of the growth rate in the CPI were made to adjust the FPL into an estimate for 2014.

⁶⁹ The standard deduction for an individual is estimated to be \$6,100 and if Congress fixes this marriage penalty (as is current policy) the standard deduction for a married couple would be \$12,200 in 2014.

well as any interest income). The marginal rate for married couples filing jointly is 10 percent for taxable income below \$17,750 and 15 percent for taxable income between \$17,750 and \$72,000.⁷⁰ The family's federal income tax bill would amount to \$3,745.

Subtracting the net cost of the federal payroll and income taxes leaves this family with \$50,265 of net income. However, the family would be eligible for a premium assistance tax credit through Obamacare. A family at 250 percent of the FPL can only pay 8.05 percent of their income in out-of-pocket health insurance premiums. This amounts to \$4,708 for this family while the net value of insurance with a 70 percent actuarial value to this family (as obtained using the Kaiser Foundation Health Reform Subsidy Calculator) is \$16,858. Therefore the family would qualify for a premium assistance subsidy of \$12,150, the difference between the premium and the out-of-pocket expenses. In order to finish the calculation of the wages after federal income and payroll taxes and health insurance payments, the \$4,708 is subtracted from the \$50,160. The final result is \$45,557, which is the amount of income this family has after paying federal income and payroll taxes and its health insurance premiums for the year.

The calculations for a worker with ESI are somewhat different. A business offering this worker ESI will have to subtract the value of the insurance coverage from their wages and add back in the employer portion of the Social Security tax. Thus the net wages would be \$42,916 which includes the gross wages with a reduction of 92.35 percent of the value of the premium (the employer does not pay its share of the payroll tax and thus that component can be passed to the worker), which is \$16,858 for this family. The worker pays Social Security and income taxes on the wages, excluding the value of the employer's contribution to worker health insurance. The Social Security taxes amount to \$3,283 and the income taxes amount to \$1,532. Subtracting his net wages by his total federal tax liability yields a net after tax income of \$38,101 for this individual.

The difference between these two amounts is \$7,456 and this represents the advantage to this household of not being offered affordable health insurance at work.

⁷⁰ These tax brackets are projected brackets for 2014 assuming the tax relief of 2001 and 2003 is extended for individuals in these lower tax brackets.

Mr. GOWDY. We will now welcome our first panel of witnesses. On behalf of all of us, thank you for coming, and welcome.

I will introduce you from my left to right, your right to left. And that will be the order in which we would like you to give your opening remarks.

Douglas Holtz-Eakin is president of the American Action Forum and former director of the Congressional Budget Office. Diana Furchtgott-Roth is a senior fellow at the Manhattan Institute for Policy Research. Richard Burkhauser is a professor of economics at Cornell University. Sara Collins is vice president for affordable health insurance at The Commonwealth Fund.

Pursuant to committee rules, all witnesses will be sworn before they testify. So I would ask if you would please rise and lift your right hands.

[Witnesses sworn.]

Mr. GOWDY. May the record reflect all witnesses answered in the affirmative.

You may be seated.

The lights—and I know many of you have testified before and you are more familiar with the process than I am. So the lights mean what they traditionally mean in life: green, go; yellow, speed up, try to get under the red light before it changes; and red, kind of see if you can start bringing it to a conclusion.

And, with that, we will recognize Mr. Holtz-Eakin.

STATEMENTS OF DOUGLAS HOLTZ-EAKIN, PH.D., PRESIDENT, AMERICAN ACTION FORUM, FORMER CBO DIRECTOR; DIANA FURCHTGOTT-ROTH, SENIOR FELLOW, MANHATTAN INSTITUTE FOR POLICY RESEARCH; RICHARD V. BURKHAUSER, PH.D., PROFESSOR OF ECONOMICS, CORNELL UNIVERSITY; AND SARA R. COLLINS, PH.D., VICE PRESIDENT, AFFORDABLE HEALTH INSURANCE, THE COMMONWEALTH FUND

STATEMENT OF DOUGLAS HOLTZ-EAKIN, PH.D.

Mr. HOLTZ-EAKIN. Thank you, Mr. Chairman, Ranking Member Davis, and members of the committee. It is a privilege to be able to be here today to discuss this important topic.

There are many perspectives on the Affordable Care Act. In mine, I want to focus on some of the economic consequences of this legislation.

Viewed from the perspective of economic policy, I believe this is an unwise legislation at this point in our Nation's history. And let me spell out a couple of reasons why.

First and foremost, as the committee is well aware, the United States faces a daunting fiscal future in which projected debt relative to the economy is, under current law, to spiral ever upward and invite a sovereign debt crisis of the type that we are watching unfold in Europe at this very moment. In such circumstances, the laws, budgetary consequences are of extreme importance, and it is my belief that it will exacerbate, not improve, the fiscal outlook and, for that reason, is a dramatic step in the wrong direction.

We knew at the time of its passage that the law contained many budget gimmicks which disguise its true impact on future deficits. We have already seen the unwinding of one of those, the so-called

CLASS Act, which was used in the first 10 years to provide \$80 billion worth of revenue and hid all the spending past the budget window.

But there are others, as well. As the chairman mentioned in his opening remarks, there are billions of dollars of cuts to Medicare which will not be sustainable in the future. The business model for Medicare has not changed in a way that will allow those cuts to be implemented. A future Congress will be faced with the choice between denying seniors access to care or restoring those cuts. My expectation is those cuts will be restored. The cost of the program will become larger and larger.

And, as one of my fellow witnesses, Dr. Burkhauser, has done extensive research on, the serious upside risk of the insurance subsidies off of the exchanges being far more expensive than the Congressional Budget Office originally estimated, there is simply too much subsidy money on the table for employers and employees not to take advantage of it. And we will see a reworking of many employment contracts so that employers no longer offer coverage and the workers go get their insurance subsidies.

So I think, budgetarily, this is very dangerous.

The second perspective is, from what we know about those countries that have huge deficit problems and poor economic growth—and the United States is in that position—the playbook for success is one which keeps taxes low and reforms them to be simpler and more pro-growth and then cut spending. In particular, government employment—not a big deal in the United States—and transfer programs.

This legislation goes exactly in the wrong direction, from the lessons of economic history. It has, you know, \$500 billion to \$700 billion worth of tax increases, depending on how you count it. It makes the Tax Code, as the chairman mentioned, far more complex, not simpler and more pro-growth, and so, from a tax perspective, goes exactly in the wrong direction.

And this is additional transfer spending in the United States. And expansions of Medicaid, probably our least successful entitlement program, the invention of a new entitlement in the insurance subsidies—both of those are steps in the wrong direction, given the needs that face the United States.

So I think that it is broadly a step that is dangerous to our future budgetarily and from a growth perspective.

And, finally, if you look inside the law at some of the incentives, they have perverse anti-growth implications. The tax credits available to small businesses, for example, penalize those small businesses that actually grow and add employees or increase their compensation. The insurance subsidies themselves get phased out as people's income rises. That is an implicit tax on the success of our low-income workers and at odds with our desire to allow them get ahead.

And, last, I think the labor market consequences of the higher insurance market premiums that the law will inevitably produce by demanding more benefits get covered and applying taxes to all parts of the health supply chain, plus the cost of the employer mandate itself, are going to hurt low-wage workers in particular, harm the ability of all workers at this point in time to get jobs.

And so, taken as a whole, from the top-level macroeconomics to the labor market incentives, I think this is dramatically bad economic policy and will, in the end, be something that the United States regrets.

I thank you.

[The prepared statement of Mr. Holtz-Eakin follows:]

Introduction

Congressman Gowdy, Ranking Member Davis and Members of the committee, thank you for the privilege of appearing before you today. In this testimony I hope to make three major points:

- The United States faces a daunting federal budgetary outlook. As a result, there is a heightened importance attached to the fiscal implications of the Patient Protection and Affordable Care Act (PPACA);
- PPACA will contribute additional fiscal pressure that must be relieved in order to avoid a sovereign debt and related financial crisis in the United States, notwithstanding the contrary claims by proponents; and
- PPACA contains numerous provisions that will hinder economic growth, notably the costs of the employer mandate, its tax provisions, and the upward pressures on health insurance premiums.

Let me discuss each in turn.

The Threat of Future Debt

The federal government faces enormous budgetary difficulties, largely due to long-term pension, health, and other spending promises coupled with recent programmatic expansions. The core, long-term issue has been outlined in successive versions of the Congressional Budget Office's (CBO's) *Long-Term Budget Outlook*.¹ In broad terms, over the next 30 years, the inexorable dynamics of current law will raise federal outlays from an historic norm of about 20 percent of Gross Domestic Product (GDP) to anywhere from 30 to 40 percent of GDP. Any attempt to keep taxes at their post-war norm of 18 percent of GDP will generate an unmanageable federal debt spiral.

This depiction of the federal budgetary future and its diagnosis and prescription has all remained unchanged for at least a decade. Despite this, action (in the right direction) has yet to be seen.

Those were the good old days. In the past several years, the outlook has worsened significantly. Over the next ten years, according to the CBO's analysis of the President's

¹ Congressional Budget Office. 2011. *The Long-Term Budget Outlook*. Pub. No. 4277. http://www.cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf.

Budgetary Proposals for Fiscal Year 2012,² the deficit would never fall below \$750 billion. Ten years from now, in 2021, the deficit would be 4.9 percent of GDP, roughly \$1.2 trillion, of which over \$900 billion would be devoted to servicing debt on previous borrowing. As a result of the spending binge, in 2021, public debt would have more than doubled from its 2008 level to 87.4 percent of GDP and will continue its upward trajectory.

In the other direction, some may point to the impact of the Budget Control Act of 2011 (BCA), which ostensibly pared \$917 billion from projected deficits over the next 10 years. Perhaps so. But a word of caution is merited because the reductions accrue due to the assumed reductions in *future* annual discretionary spending. Perhaps this will occur. But to date *no* spending reductions have yet to occur.

Similarly, the BCA created the Joint Select Committee on Deficit Reduction, associated legislative procedures, and spending sequester enforcement. This collection of budgetary processes is intended to reduce future deficits by up to an additional \$1.5 trillion over the next decade. However, even if successful, the reductions will be insufficient to stabilize the ratio of federal debt (in the hands of the public) to Gross Domestic Product (GDP).

In short, regardless of one's view of BCA, it will be imperative that the federal government undertakes substantial additional deficit reduction. Research at the American Action Forum indicates that the most effective approach is to reduce federal transfer programs, while reforming the tax code to enhance the underlying trend rate of economic growth.

Notably, PPACA is an *expansion* of transfer programs at a time when the evidence suggests going in precisely the opposite direction. In addition, it contains a number of provisions at odds with the objective of enhancing economic growth.

The Budgetary Impact of the Patient Protection and Affordable Care Act

In light of the fiscal threat from growing spending, the budgetary impacts of PPACA are central to any discussion of its merits. I begin by reviewing the CBO cost estimate that concludes ppACA will serve to lower the deficit. In the final score of ppACA, the CBO and Joint Committee on Taxation estimated PPACA would lead to a net reduction in federal deficits of \$143 billion over ten years, with \$124 billion in net reductions from PPACA and \$19 billion derived from education provisions.

Total spending on subsidies in PPACA exceed \$1 trillion dollars over ten years. This includes insurance exchange tax credits for individuals, small employers' tax credits, the creation of reinsurance and high risk pools, as well as expansions to Medicaid and the Children's Health Insurance Program.

² Congressional Budget Office. 2011. *An Analysis of the President's Budgetary Proposals for Fiscal Year 2012*. Pub. No. 4258. <http://www.cbo.gov/ftpdocs/121xx/doc12130/04-15-AnalysisPresidentsBudget.pdf>.

To “pay for” the new entitlement, PPACA purports to impose nearly \$500 billion in reductions to annual updates to Medicare fee-for-service payment rates, Medicare Advantage rates, and Medicare and Medicaid disproportionate share hospital (DSH) payments. In addition, PPACA levies more than \$700 billion in new taxes from reinsurance and risk adjustment collections, penalty payments by employers and uninsured individuals, an excise tax on high-cost insurance (the “Cadillac” tax), fees on manufacturers and insurers, the so-called Medicare surtax and other revenue provisions.

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

The prospect of these savings is tantalizing given the daunting fiscal outlook. But they raise an important question: is it really likely that the creation of two new entitlement programs (insurance subsidies and long-term care insurance via the CLASS act) will reduce the long-run deficit? The answer, unfortunately, is no. HHS has recently halted implementation of the CLASS program. The current understanding of the Bill’s economic consequences, including the fact that the CLASS Act will no longer be implemented, tell a very different story.

A more realistic assessment likely emerges if one strips out gimmicks and budgetary games and reworks the calculus: PPACA will more likely raise, not lower, federal deficits, by \$554 billion in the first ten years and \$1.4 trillion over the succeeding ten years.

Why does the outlook change so much? The dubious budgetary provisions fall into four scenarios: unachievable savings, unscored budget effects, uncollectible revenue, and double-counting premiums.

To begin, it is unlikely that the Centers for Medicare and Medicaid Services (CMS) will ultimately be able to implement cost reductions through Medicare market basket updates, the Independent Payment Advisory Board (IPAB), and other projected savings. While the specifics of each differ, these provisions share common features. Most important, PPACA does not fundamentally reform Medicare in such a manner that will permit it to operate at lower budgetary cost. Indeed, CMS Actuary Richard Foster analyzed PPACA and concluded that the nation as a whole will spend \$310 billion *more* than it would have without it, large part because of the “negligible financial impact over the next 10 years” for most provisions in the legislation “intended to help control future health care cost growth.”

The increased demand for services will mean that health care shortages and price increases are “plausible and even probable” and that “supply constraints might interfere with providing the services desired by the additional 34 million insured persons.” One would expect in this setting that providers would be expected to negotiate for higher rates, so that health care costs and premiums would increase.

These impacts lead directly to the conclusion that PPACA “jeopardizes access to care” for seniors. As a result of the Bill’s payment reductions, “providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries).” He concludes that about “15 percent of Part A providers would become unprofitable within the 10-year projection period.”

It is not hard to imagine what will transpire when the automatic payment reductions are scheduled to occur. CMS will be faced with the possibility of strongly limited benefits, the inability to serve beneficiaries, or both. Congress, recognizing the danger, will be forced to regularly override the scheduled cuts, as we’ve seen them do with the SGR (Sustainable Growth Rate). A similar scenario will apply to proposals from the IPAB. Under PPACA, the IPAB will be obligated to constrain the growth rate of Medicare spending. When faced with the consequences of its proposals, Congress will quickly strip it of its mandate, its independence, or both.

The second misleading aspect of the CBO score is that it ignores acknowledged costs. To operate the new health care programs over the first ten years, future Congresses will need to vote for hundreds of billions in additional spending in the next ten years. The omitted spending begins with the discretionary costs for the Internal Revenue Service (IRS) to enforce and the CMS to administer insurance coverage and explicitly authorized health care grant programs. CBO recently acknowledged that these costs raise the price tag of PPACA³. In addition Congress will be forced to revise the SGR formula for physician reimbursement in Medicare, which could add in excess of \$300 billion to the overall tab. All of these provisions are noted in CBO’s report but none of them are factored into the final score of the Bill.

In a mirror image to the dubious spending cuts, there are reasons to question the political will of Congress to collect the excise tax on high-cost or “Cadillac” health insurance. This tax was supposed to start immediately according to the Senate’s version of PPACA. After intense lobbying by organized labor, Congress relented and pushed the tax back to 2018. This raises the possibility that it will prove politically infeasible to ever implement the tax leading to a failure to collect the associated tax revenue of \$78 billion over the next ten years.

Scoring for PPACA originally double counts premiums for the CLASS Act and Social Security. In principal, these receipts should be reserved to cover future payments and not be devoted to financing other spending. In the case of the CLASS Act, PPACA raises \$70 billion in premiums in the first ten years -- while there is a \$53 billion anticipated increase in Social Security tax revenue. In both cases, monies that should be dedicated to paying the corresponding long-term care and retirement benefits is being counted on to finance the

³ See

http://www.cbo.gov/ftpdocs/114xx/doc11493/Additional_Information_PPACA_Discretionary.pdf.

new entitlement spending for health subsidies. Now that the CLASS Act is basically dead, that revenue is off the table entirely.

CBO has also radically underestimated the number of individuals who will be purchasing insurance on the insurance exchanges with the help of tax-payer funded subsidies. The key driver of this will be a dramatic reduction in employer sponsored health insurance. According to an analysis I did with my colleague Cameron Smith, it would be cost-effective and rational behavior for a significant number (we estimate 35 percent) of companies to stop offering coverage and push employees onto the exchanges. The McKinsey study last summer backed up our findings with a survey that also predicts a large drop in employer-sponsored insurance.

What is the bottom line? Adding policy realism to the projections produces a radically different bottom line. PPACA would generate additional deficits in excess of \$500 billion in the first ten years. And, as the nation would be on the hook for the cost of subsidizing insurance purchased through the exchanges for a rapidly expanding number of people, the deficit in the second ten years would approach \$1.5 trillion.

The Economic Growth Impact of the Patient Protection and Affordable Care Act

The Need for Pro-Growth Policies.

The United States' economy has endured a severe recession and is currently growing slowly. The pace of expansion remains solid and unspectacular. In many ways this is not surprising. As documented in Rogoff and Reinhart (2009), economic expansions in the aftermath of severe financial crises tend to be more modest and drawn out than recovery from a conventional recession.⁴ Accordingly, it is imperative that policy be focused on generating the maximum possible pace of economic growth. More rapid growth is essential to the labor market futures of the millions of Americans without work. More rapid growth will be essential to minimizing the difficulty of slowing the explosion of federal debt to a sustainable pace. More rapid growth will generate the resources needed to meet our obligation to provide a standard of living to the next generation that exceeds the one this generation inherited.

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

Employer Mandate Costs

Among the key aspects of PPACA is its mandate to cover employees with health insurance. Focusing first on those employers with more than 50 workers, beginning in 2014, those firms must pay a penalty if any of their full-time workers receive subsidies for coverage

⁴ See *This Time Is Different: Eight Centuries of Financial Folly*, by Carmen M. Reinhart and Kenneth Rogoff, 2009.

through the exchange. The penalty is equal to the lesser of \$3,000 for each full-time worker receiving a premium credit, or \$2,000 for each full-time worker, excluding the first 30 full-time workers. The fees are paid monthly in the amount of 1/12th of the specified fee amounts. Firms with fewer than 50 employees are exempt from the so-called employer “play or pay” penalties if they do not offer coverage and their workers receive a subsidy in the exchange.

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

One might think that the same situation prevails for the smallest firms – those under 50 employees – who are exempt from the coverage mandate. Unfortunately, for these firms, the greatest impact is the tremendous impediment to expansion. Suppose for example that a firm does not provide health benefits. Hiring one more worker to raise employment to 51 will trigger a penalty of \$2,000 per worker multiplied by *the entire workforce*, after subtracting the first 30 workers. In this case the fine would be \$42,000 (21 (51-30) workers times \$2,000). How many firms will choose not to expand?

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

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

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

Even those studies that recognize the limitation imposed by the 25-employee limit tend to overstate the likely penetration of the credit. For example, the Small Business Majority and

Families USA recently estimated that 84 percent of the nation's 4.8 million businesses that employ 25 or fewer employees will be eligible for the tax credit.⁵ Unfortunately, the net impact of the credit in offsetting the cost burden of PPACA will depend not upon *eligibility* but rather on *receipt* of the tax credits. This distinction was noted early in the debate by CBO. In November 2009 when the law was being considered before Congress, CBO found that, "A relatively small share (about 12 percent) of people with coverage in the small group market would benefit from that credit in 2016."⁶

A more useful study focuses on the estimated number of small firms who would qualify for the small business health insurance tax credit. A recent analysis conducted by the National Federation of Independent Business (NFIB) found that the total number of firms that offer health insurance and pay more than half of their employees' premium costs, as mandated under PPACA, is more likely 35 percent of all firms with less than 25 employees.⁷

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

In the first, employers will have an incentive to avoid increases in the average rate of pay in their firm. Suppose that the average wage in a small (3 worker) firm is \$25,000 and the owner decides to add a more highly paid supervisor being paid \$50,000. This will raise the average wages in the firm to \$31,250 there by *reducing* the tax credit per worker from \$2,100 to \$1,596.⁸ In effect, the structure of the credit raises the effective cost of adding valuable supervisory capacity.

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

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

⁵ See

http://www.smallbusinessmajority.org/pdf/tax_credit/Helping_Small_Businesses.pdf.

⁶ See, <http://cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf>.

⁷ See, <http://www.nfib.com/nfib-on-the-move/nfib-on-the-move-item?cmsid=52099>.

⁸ This example assumes the employer contributes \$6,000 toward insurance for each employer.

workers would get a total tax credit of \$21,840 while a firm employing 24 workers would receive a total credit of only \$3,360.⁹

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

Tax Increases

PPACA raises more than \$700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions. There is no theory or empirical research on job creation that suggests that large tax increases will spur employment. Taken at face value, one should be skeptical PPACA will not harm the pace of overall economic recovery.

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

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

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

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

⁹ See, <http://www.ncpa.org/pdfs/ba703.pdf>.

trillion, roughly one-half, \$470 billion, will be reported on returns that are likely to be the new surtaxes.¹⁰

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

A final tax impact of PPACA is that the impact of phase-outs of refundable credits may have even more perverse growth consequences. As I have noted previously, the phase-outs in insurance subsidies contribute to high effective marginal tax rates.¹¹ The effect is to raise the effective marginal tax rate to as high as 41 percent on some of the lower-income U.S. workers. This has implications for the ability of families to rise from the ranks of the poor, or to ascend toward the upper end of the middle class. This growth and mobility is the heart of the American dream and is the most pressing issue at this time.

PPACA and Health Insurance Premiums

Health care reform was presumed to encompass both expansion of affordable insurance options and provision of quality medical care at lower costs. The reality of PPACA could not be more different. Objective analysts have uniformly concluded that the new law raises – not lowers – national health care spending.¹² The rising bill for national health care spending will, in turn produce sustained upward pressures on health insurance premiums.

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

These features of the law are increasingly well understood, much to the dismay of insurance consumers. However, other aspects of the new law are less appreciated. In

¹⁰ The Joint Committee on Taxation analysis does not take into account the impact on small, non-publicly-traded "C" corporations. There are several million of these entities, which will likely be adversely affected by the marginal rate increases on ordinary and capital income.

¹¹ Brill, Alex and Holtz-Eakin, Douglas, "Another Obama Tax Hike." *Wall Street Journal*, February 4, 2010. See also, Douglas Holtz-Eakin and Cameron Smith, "Labor Markets and Health Care Reform, 2010. http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10_0.pdf.

¹² See http://www1.cms.gov/ActuarialStudies/Downloads/S_ACA_2010-01-08.pdf or <http://www.cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf>.

particular, the financing of the health care law will have significant implications for purchasers of insurance as well.

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

The impact of fees on medical devices, insurers, and pharmaceutical companies is important and not well-understood. To understand better, consider the fee on health insurers. The fee amounts to a *de facto* “health insurance premium tax” that will raise the cost of health insurance for American families and small employers. Specifically, under the law, an annual fee applies to any U.S. health insurance provider, with the intent of raising nearly \$90 billion over the next 10 years. The aggregate annual fee for all U.S. health insurance providers begins at \$8 billion in 2014 and then rises thereafter. (See Table 1.)

Table 1 Aggregate Insurance Fees	
Year	Fee
2014	\$ 8 billion
2015	\$11.3 billion
2016	\$11.3 billion
2017	\$13.9 billion
2018 & Beyond ¹³	\$14.3 billion
Total through 2020	\$87.4 billion

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

¹³ The statute provides that after 2018 the insurance fee is equal to the amount of the fee in the preceding year increased by the rate of premium growth for the preceding calendar year.

Table 2 Fraction of Premiums Counted	
Annual Net Premiums	Fraction
Less than \$25 million	0
\$25 million to \$50 million	50 percent
\$50 million or more	100 percent

Some assume that the insurers will be the only ones hit by these new taxes. Unfortunately, this ignores the influence of market forces. For any company, as it sells more insurance policies it will incur a greater market share, and thus a greater share of the \$87 billion. That is, with each policy sold, the firm's total tax liability rises; precisely the structure of an excise tax. Firms don't really pay taxes; they attempt to shift them to suppliers, workers, or customers. Thus, it is important to distinguish between the *statutory incidence* of the premium tax – the legal responsibility to remit the tax to the Treasury – and the *economic incidence* – the loss in real income as a result of the tax.

A basic lesson of tax policy is that people pay taxes, firms do not. Accordingly, the economic burden of the \$87 billion in premium taxes must be borne by individuals. Which individuals will bear the economic cost?

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

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

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

If market conditions make it impossible for insurers to absorb the economic burden of the premium tax, they will have no choice but to build the new, higher costs into the pricing

structure of policies. In this way, the economic burden of the tax is shifted to the purchasers of health insurance. In particular, the more competitive markets are for equity capital and hired labor, greater is the fraction of the burden that will be borne by consumers.

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

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

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

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

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

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

In this regard, it is important to note that the interim final rules governing insurance copayments, deductibles, premium increases, and employer contributions are so strict that that even conservative estimates by the U.S. Department of Health and Human Services (HHS) indicate a majority of Americans will be unable to keep their existing health care coverage by 2013.¹⁴ A more realistic estimate, accounting for the response from American businesses since the rules were released, places the likely percentage of plans without grandfathered status well above the HHS' high-end estimate of 69 percent of plans by

¹⁴ "Group Health Plans and Health Insurance Coverage Rules Pertaining to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act," Federal Register. Volume 75. Page 34571.

2013.¹⁵ Thus it appears that the interim final rules ensure that grandfathered status will be lost in the near-future and that a substantial majority of Americans will face higher costs.

The Response of Small Businesses to Higher Costs

The previous sections have outlined the direct and indirect cost pressures that will prevail under the health care reform law. Small businesses will react to these incentives in order to prosper to the greatest extent possible. In the process, there will be attempts to shift these financial burdens away from the businesses themselves. That is, the ultimate cost of PPACA's small business provisions may be shifted to other parties.

One obvious strategy is to raise prices to cover the newly-imposed costs, thereby shifting the costs to consumers. At present, economic weaknesses undercut pricing power, making it unlikely that this channel will prevail for some time to come. However, to the extent that the economy recovers, shoppers relying on small business goods and services will find prices stiffening to match increases in health insurance costs.

An alternative route will be to pass increases in health care costs to workers in the form of slower wage growth. Of course, it may not be possible to pass along the full cost in the form of lower wages. If a full-time worker is at or near the minimum wage, it will not be possible to offset higher costs with lower wages. Instead, employer's will be forced to shorten hours or drop workers altogether. The Lewin Group estimates that there will be a loss of employment between 157,300 and 366,200 people if PPACA were fully implemented in 2011. Specifically for small businesses (less than 500 employees), Lewin estimates that employment losses will be between 50,200 and 113,000 jobs.¹⁶

The final possibility is that small business owners will attempt to absorb these cost increases out of scarce business capital. In this instance, the reduced liquidity (especially at a time of credit market tightness) will raise the probability of the failure of small businesses.¹⁷

PPACA and Employer-Sponsored Insurance

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

Roughly one-half of the \$900 billion of spending in PPACA is devoted to subsidies for individuals who do not receive health insurance from their employers. These subsidies are

¹⁵ "2010 UBA Health Plan Survey." United Benefit Advisors. October 2010.

¹⁶ See, <http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf>.

¹⁷ The importance of capital market constraints is demonstrated in Holtz-Eakin, Douglas, David Joulfaian, and Harvey S. Rosen. 1994. "Sticking it Out: Entrepreneurial Survival and Liquidity Constraints." *Journal of Political Economy* (February):53-75.

remarkably generous, even for those with relatively high incomes. For example, a family earning about \$59,000 a year in 2014 would receive a premium subsidy of about \$7,200. A family making \$71,000 would receive about \$5,200; and even a family earning about \$95,000 would receive a subsidy of almost \$3,000.

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

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

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

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

Table 3 Health Care Reform and Employer-Sponsored Insurance in 2014 (Employer Health Plan = \$11,941)							
Percent of Federal Poverty Level	Income ¹	Tax Bracket ²	Wage Equivalent of Employer Health Plan ³	Federal Subsidies ⁴	Required Pay Raise ⁵	Employer Free Cash Flow ⁶	Employer Drop Decision ⁷
133%	\$31,521	15%	\$14,048	\$14,176	(\$128)	\$9,941	Drop
150%	\$35,550	15%	\$14,048	\$13,385	\$663	\$9,941	Drop
200%	\$47,400	25%	\$15,921	\$10,985	\$4,936	\$9,941	Drop
250%	\$59,250	25%	\$15,921	\$7,530	\$8,391	\$9,941	Drop
300%	\$71,100	25%	\$15,921	\$5,187	\$10,734	\$9,941	Keep
400%	\$94,800	28%	\$16,585	\$2,935	\$13,650	\$9,941	Keep
1. Income calculated based on 2009 FPL for a family of four of \$22,050 (HHS), indexed to CPI projections (CBO) 2. Tax bracket calculated based on 2010 tax brackets, indexed to CPI projections (CBO) 3. Computed as CBO estimate of Silver Plan in 2016, indexed to 2014 (\$11,941), and divided by (1-Tax Rate) 4. Estimated federal insurance subsidy 5. Wage equivalent minus subsidies 6. Value of insurance plan minus \$2,000 penalty 7. Drop if required pay raise is greater than free cash flow							

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

The remaining rows of Table 3 repeat this calculation for workers at ascending levels of affluence. For example, at 200 percent of the FPL (federal poverty level), the "surplus" between the pay raise required to hold a worker harmless (\$4,936) and the firm's cash-flow benefit from dropping coverage (\$9,941) has narrowed, but the bottom line decision in the final column is the same. Indeed, the incentives are quite powerful up to 250 percent of FPL, or \$59,250. Only for higher-income workers do the advantages of untaxed health insurance make it infeasible to drop insurance and re-work the compensation package.¹⁸

¹⁸ Notice that what this really means is that an existing federal subsidy (via the tax code) trumps the new federal subsidy!

How big could this impact be? In round numbers, at present there are 123 million Americans under 250 percent of the FPL. Roughly 60 percent of Americans work and about 60 percent of those receive employer-sponsored insurance. This suggests that there are about 43 million workers for whom it makes sense to drop insurance.¹⁹

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

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

Concluding Remarks

In light of the federal budgetary outlook it is troubling that PPACA contains numerous provisions that will hinder economic growth and further increase the deficit. A more realistic look at the economic incentives created by the Act’s provisions show that it will in effect hurt employment, hinder growth and far from providing affordable coverage to the majority of Americans will dramatically raise premium costs, hurting both individuals and employers.

As our country is just recovering from a deep recession and still struggling to create jobs, PPACA only undermines those efforts. Far from being simply a healthcare bill, PPACA’s impact will reverberate throughout the economy, affecting businesses small and large and ultimately increasing healthcare spending and with it our nation’s growing and unsustainable debt.

I look forward to answering your questions.

¹⁹ This is likely an upper bound estimate as there is a positive correlation between wage levels and the probability of having insurance.

Mr. GOWDY. Thank you, Dr. Holtz-Eakin.
Dr. Furchtgott-Roth.

STATEMENT OF DIANA FURCHTGOTT-ROTH

Ms. FURCHTGOTT-ROTH. Thank you for inviting me to testify here today.

I am a senior fellow at the Manhattan Institute, and I am the author of "Women's Figures: An Illustrated Guide to the Economic Progress of Women in America" that looks at how women have moved increasingly into the work force over the past half-century.

I fully agree that everybody should have access to health care, but the way this bill is structured, there are disincentives for women to marry and disincentives for women to work. And for a bill that is supposed to make Americans healthier, these disincentives are truly startling. Beginning in 2014 when the bill takes effect, Americans will find it more advantageous to stay single than to marry, even more so than under the current Tax Code.

Marriage penalties from taxes in general and from the new health-care law in particular fall into two categories: disincentives to marry and disincentives to work. And the way the new health-care law is structured, health insurance premium credits in the new law are linked not directly to income but to the poverty line, resulting in a particularly steep marriage penalty for low-income Americans. And this arises because with \$10,890 as the poverty line for one person and an additional \$3,820 for a spouse, marriage means less government help with health insurance when a couple gets married.

Since the new qualified benefit plans offered in the health insurance exchanges are going to be generous and expensive, with no lifetime maximums, no co-payments for preventive services, no exclusions for pre-existing conditions, and the requirement to accept all applicants, it is going to be especially important for low-income individuals to have help with their health insurance premiums.

So here is how the system will work when it is implemented in 2014: The new health-care bill will offer refundable, advance premium credits to singles and families with incomes of between 133 percent and 400 percent of the poverty line. The credits can only be used to buy health insurance through the exchanges. So if you earn up to 133 percent of the poverty line, your premium can only be 2 percent of your income; it cannot be more than 2 percent of your income. Moving up, if you earn between 150 percent and 200 percent of the poverty line, your premium can be 4 percent to 6.3 percent of your income. Up to 400 percent of the poverty line, it can only be 9 percent. So the more you move up, the higher premium you have to pay.

So two singles would be able to earn \$43,000 and have help from the Federal Government with their premiums. But if they got married and combined their earnings to \$86,000, they would be far above the limit because they would be above 400 percent of the poverty line. As a married couple, the most they could earn and still get government help with health insurance premiums would be \$58,000, which is a difference of almost \$30,000 or 32 percent. And this is a substantial disincentive to get married.

Such marriage penalties exist even for couples below the poverty line when they are married. So if we look at the example of June and Jake, for example, living alone, each one earns, say, \$21,780, putting them at 200 percent of the poverty line. Unmarried, their premium would be about 6.3 percent of their income or \$2,744 in total. But let's say June and Jake were to marry. Their combined income would be \$43,560, about 300 percent of the poverty line for a family of two. That would push their premium close to 9.5 percent of the bracket or \$4,138 out of their combined income. That is a marriage penalty equal to about \$1,200, which is a substantial disincentive to getting married.

The penalty also exists for single mothers. Say Sally is a single mother earning \$44,130, putting her and her baby at the 300 percent of the poverty line. They would be eligible for the health insurance premium assistance credit. But what if she were to marry Sam, the father of her child, who earns \$43,560 and who is at 400 percent of the poverty line? Their total earnings at \$87,000 would exceed the 400 percent poverty line for a family of three. Married, they would no longer get help with their premiums from the government; unmarried, they would.

So I would argue that even though health care is something that every American should have, the way we have structured the program provides a disincentive to marry, and when couples are married, a disincentive for the woman to work. And this needs to be addressed.

Thank you very much.

[The prepared statement of Ms. Furchtgott-Roth follows:]

The Effects of the Affordable Care Act on Work and Marriage

Diana Furchtgott-Roth
Senior Fellow, Manhattan Institute

Mr. Chairman, members of the Committee, I am honored to be invited to testify before you today on the subject of the effects of the Patient Protection and Affordable Care Act on work and marriage. I am a senior fellow at the Manhattan Institute. From 2003 until April 2005 I was chief economist at the U.S. Department of Labor. From 2001 until 2002 I served at the Council of Economic Advisers as chief of staff. I have also been a senior fellow at the Hudson Institute and a resident fellow at the American Enterprise Institute. I have served as Deputy Executive Secretary of the Domestic Policy Council under President George H.W. Bush and as an economist on the staff of President Reagan's Council of Economic Advisers.

Marriage Penalties Rise under the New Healthcare Law

For a bill that is supposed to make Americans healthier, the disincentives for marriage and work under the new health care law are truly startling. Beginning in 2014, when the new law takes effect, Americans at both ends of the income scale will find it more advantageous to stay single than to marry, even more so than under the current tax code. And women will face greater incentives to leave the workforce.

For some couples, love conquers all, and crude financial considerations will not enter into their decision as to whether to tie the knot. Still, under the new law, some might defer marriage either temporarily or permanently, or get divorced, contributing to a host of social problems, such as increases in fatherless families and crime. Other couples might conclude that it makes sense for one earner, most likely the woman, not to work, in order for the family to qualify for government help with health insurance premiums.

Marriage penalties from taxes in general and from the new healthcare law in particular fall into two categories, disincentives to marry and disincentives to work. Lower-income individuals will be primarily affected by the interaction between government-provided health insurance credits and the poverty line, and upper-income married taxpayers will face earnings losses due to increases in the Medicare tax on earned and unearned income, which begin at \$200,000 for singles and \$250,000 for couples.

Health insurance premium credits in the new law are linked not directly to income, but to the poverty line, resulting in a particularly steep marriage penalty for low-income Americans. With \$10,890 as the poverty line for one person and an additional \$3,820 for a spouse, marriage means less government help with health insurance. Since the new qualified benefit health plans offered in the health exchanges will be generous and therefore expensive — no copayments for preventive services, no lifetime maximums, no exclusions for pre-existing conditions, and the requirement to accept all applicants will drive up prices — getting government help with premiums will become vital.

Here is how the system will work when it is implemented in 2014. The new health care bill will offer refundable, advance premium credits to singles and families with incomes between 133 percent and 400 percent of the federal poverty line. These credits can only be used to buy health insurance through the new health exchanges. The amount of the credits will be linked to the second lowest cost plan in the area, and are structured so that health insurance premium contributions are limited to the following percentages of income for specified income levels, as is shown in Table 1.

Table 1: Premium Tax Credits

Household Income as Percent of Federal Poverty Line	Premium Payment as Percentage of Income
Up to 133%	2%
133% - 150%	3% to 4%
150% - 200%	4% to 6.3%
200% - 250%	6.3% to 8.05%
250% - 300%	8.05% to 9.5%
300% - 400%	9.5%

Source: Health Care and Education Reconciliation Act of 2010, Section 1001(a)

In addition to the premium credits, under the new law the government also gives cost-sharing subsidies to singles and to families. These subsidies reduce amounts that people pay for health insurance.

Since premium credits and cost subsidies are calculated with reference to the federal poverty line, there exists every incentive not necessarily to have as low income as possible, but to be on the lowest possible poverty line. In that way the government pays a higher share of health insurance.

An examination of the Department of Health and Human Services poverty guidelines for 2011 in Table 2 shows that one person earning \$10,890, or two

married people earning \$14,710, are at 100 percent of the poverty line. Moving up the income scale, a single earning \$43,560 and a married couple, earning \$58,840 would be at 400 percent of the poverty line.

Table 2: Department of Health and Human Services 2011 Poverty Guidelines

Persons in Family	48 Contiguous States and DC
1	\$10,890
2	14,710
3	18,530
4	22,350
5	26,170
6	29,990
7	33,810
8	37,630
for each additional person, add	3,820

source: U.S. Department of Health and Human Services, 2011 Poverty Guidelines, released January 18, 2011.

Two singles would each be able to earn \$43,000 and still receive help to purchase health insurance, but if they got married and combined their earnings to \$86,000, they would be far above the limit. As a married couple, the most they could earn and still get government help with health insurance premiums would be \$58,000, a difference of almost \$30,000, or 32 percent. This is a substantial disincentive to getting married, or to working while married.

Such marriage penalties exist even for those couples who earn below 400 percent of the poverty line when married. Let's look at the example of June and Jake. Living alone, each earns \$21,780, putting them at 200 percent of the federal poverty guideline. Unmarried, their premium would be about 6.3 percent of their income, or \$1,372 each, \$2,744 in total.

Let's say that June and Jake were to marry. Their combined income would be \$43,560—approximately 300 percent of the poverty line for a family of two. This would push their premium close to the 9.5 percent bracket, or \$4,138 of their combined income. This would be a marriage penalty equal to \$1,394, even before income taxes and phase-outs of the Earned Income Tax Credit. The temptation would be either not to marry, or, if married, to work fewer hours. If either June or Jake were to drop out of the workforce, they would not be affected by the marriage penalty.

The penalty extends also to single mothers. Say Sally is a single mother earning \$44,130, putting her and her baby at 300 percent of the poverty line. They would be eligible for the health insurance premium assistance credit. But what if she wants to marry Sam, the father of her child, who earns \$43,560, and is at 400 percent of the federal poverty line? Their total earnings, at \$87,690, would exceed the 400 percent poverty line for a family of three (\$74,120). Married, they would no longer receive help with their health insurance premiums, despite both earning the credit when unmarried. In order to keep her government health insurance benefit, Sally could only marry someone earning less than \$30,000.

Although affecting far fewer people, the new healthcare law increases the marriage penalty at higher incomes. An additional 0.9% Medicare tax falls on wage and salary income, and a new 3.8% Medicare tax is levied on investment income for singles and couples earning over \$200,000 and \$250,000 respectively. Two singles earning \$180,000 each would not be subject to the surtax, they would be affected by the tax if they married.

As well as discouraging marriage, the healthcare law gives an incentive to the lower-earning spouse, generally the woman, to leave the labor force, lowering the returns to her education.

The penalty would be greatest for women who have invested the most in their education, hoping to shatter the glass ceiling and compete with men. The tax discourages married women not just from working, but also from seeking the next promotion, from pursuing upwardly-mobile careers.

Women are more affected by the marriage penalty than men because they have a greater tendency to move in and out of the labor force, depending on the ages of their children. The majority of American women have children, and many want to take time out of the workforce at some point to look after them. Government policy should not discourage these women from returning to the workforce. Rather, government policy should maximize workplace flexibility, making it easy for women to take time off and resume working as family circumstances allow.

In summary, the new taxes and premium subsidies in the healthcare law discourage couples from getting married. When couples are married, they discourage women from working. Hence, the Affordable Care Act is not a well-structured piece of legislation.

Thank you for giving me the opportunity to testify today. I would be glad to answer any questions you might have.

Mr. GOWDY. Thank you, Ms. Furchtgott-Roth.
Dr. Burkhauser.

STATEMENT OF RICHARD V. BURKHAUSER, PH.D.

Mr. BURKHAUSER. Thank you for the opportunity to submit a summary of my research with Sean Lyons and Kosali Simon on the Affordable Care Act.

In a series of proposed rules, the Obama administration confirmed what the ACA's supporters have feared: The law's requirement that employers must make health insurance coverage affordable only applies to single coverage, not family coverage.

Those familiar with all the law's moving parts know exactly what this means. Because any offer of single employer coverage, if it is considered affordable, blocks access to generous subsidies via tax credits in the insurance exchanges, millions of families will be stuck in a no man's land without affordable coverage through either their employers or the exchanges.

The law's advocates are pushing the administration to change this by requiring employers to make coverage affordable for employees and their families. But our new research demonstrates why this decision isn't so cut and dried. Using this broader ACA definition of "affordable" could incent millions of employees to willingly shift from an employee plan to a government-subsidized insurance exchange at significant cost to the taxpayers, even if their employers continue to offer coverage.

How the ACA's provisions will actually impact the insurance market depends on the answers to two questions: First, does affordable coverage refer to coverage just for employees alone or for the employees and their families? We suspect the administration's proposed answer to the first question came as a surprise to the average Congressperson, who believed, as we did at the start of our research, that the law levies a fine if a large employer doesn't provide affordable coverage to employees and their families. But a close reading of the bill shows that the employer fine is only triggered when coverage isn't affordable for the employee, not the employee and their family.

That brings us to the second question, which interacts in important ways with the administration's answer to the first: Will employers keep their current insurance plans but adjust them to allow lower- or moderate-income families, up to \$89,000 for a family of four, to qualify for entry into the subsidized exchanges? The CBO assumed not. Yet for income-eligible employees, subsidy dollars will make exchanges coverage more affordable than their current employer plan, even when purchased with after-tax dollars. It is also attractive for employers, who would pay less in per-employee fines than by providing affordable insurance in the first place. By increasing pre-tax health insurance premiums, making coverage unaffordable for some, employers will free their lower- to moderate-income employees to actually obtain subsidized exchange coverage and still maintain their plan for higher-income workers.

We use Census Bureau data to model the impact of the health-care law on the sources of insurance coverage among private-sector workers. Assuming the three main insurance provisions of the ACA take effect and the administration's definition of "affordable" sticks

and people act as the government assumes they will, we find that employer-sponsored coverage will rise slightly from its current levels to about 75 percent and, in response to the ACA mandates, by another 11 percent via the previously uninsured workers taking advantage of the exchanges.

However, when we alter our model by allowing employees and employers to work together to take advantage of exchange subsidies, the picture changes. Employer-sponsored coverage falls to 70 percent; the number of employees insured in the exchanges rises by about 4 million to 16 percent. This all occurs despite our very optimistic assumption that all large firms actually offer coverage and no small firms drop coverage.

But if we allow the broader interpretation in the employee mandate—that is, where employers must make coverage affordable to workers and their families—the changes are even more dramatic. Employer-sponsored coverage drops to 63 percent, with nearly one-quarter of all workers, over 14.7 million or 23 percent, receiving their insurance through the exchanges.

We offer no unique insight on whether the administration's proposed single coverage rule will hold, but we do know that this unpopular definition and its possible revisions hold significant implications for everyone impacted by the law's provisions. Either millions of dependents of employees with affordable single coverage will be stuck without an offer of affordable coverage—we estimate between 7 million and 16 million—or taxpayers will be stuck with as much as \$50 billion more per year in gross subsidy costs than originally projected.

This is a Sophie's choice embedded in the ACA as a consequence of the pile of open-ended taxpayer money it leaves on the table in the form of exchange subsidies intended for the minority 20 percent of workers without affordable coverage that will inevitably tempt a significant number of the vast majority of employees with affordable coverage to gain access to it.

Thank you for the opportunity to speak before you today.
[The prepared statement of Mr. Burkhauser follows:]

The Importance of the Meaning and Measurement of “Affordable” in the
Affordable Care Act

Richard V. Burkhauser
Sean Lyons
Cornell University

Kosali Simon
Indiana University
October 2011

Abstract:

This paper focuses on whether “affordable” in the Affordable Care Act refers to the cost of single coverage alone, or to family or single coverage as applicable to the worker, in determining the employer’s mandated coverage requirement and workers’ (and their dependents’) access to subsidized exchange coverage. Since the average annual total premium for family coverage is substantially higher than that for single coverage (on average \$12,298 vs. \$4,386 in 2008) this is a non-trivial distinction.

Using data on workers from the Current Population Survey merged with estimates of employer and exchange policy premiums, we investigate the impact of the affordability decision on the fraction of workers who could then access exchange coverage subsidies and on the correspondingly lower employer sponsored insurance (ESI) coverage rates. We do via a series of calculations for each worker that first shows the financial incentives at stake in deciding between ESI and subsidized exchange coverage. We then show how many of those who stand to gain from exchange coverage could do so under two these alternative affordability rules and different levels of employee contributions. Finally, we show the extent to which a single affordability rule would cause the dependents of low-income workers with families to fall into a “no-man’s land” with no source of affordable coverage.

We estimate that a family affordability rule could initially lead to as many as 1.3 million more workers accessing exchange subsidies for themselves and their families than under a single affordability rule. If employees pay 50 percent of the premiums in the future, this number increases to 6 million. Increased use of exchange subsidies would be accompanied by reductions in ESI coverage and increased costs to taxpayers. Alternatively, a single affordability rule would initially result in close to 4 million dependents of workers with affordable single coverage not having affordable health insurance. This would grow to close to 13 million if employees pay 50 percent of the premium.

Acknowledgments: This is an abbreviated version of Burkhauser, Lyons and Simon (2011). The authors acknowledge receiving partial funding for this study from the Employment Policies Institute, in the amount of a total budget of \$40,000. We are grateful for helpful conversations with several individuals.
Conflict of Interest Statement (Last three years) The authors have worked in the past as paid consultants for the Pew Charitable Trust (Burkhauser and Simon), and the Center for American Progress (Simon) on research related to health reform.

1. Introduction

The Affordable Care Act (ACA) represents a major change in the provision and organization of health insurance. Under the ACA, low- to-middle-income families are eligible for subsidized exchange health insurance only if employer coverage is not offered, or if it is offered but with an unaffordable employee contribution of greater than 9.5 percent of household income. Furthermore, if employers do not offer coverage or offer unaffordable coverage and employees receive subsidized exchange coverage, employers with more than 50 full-time equivalent workers are subject to fines. It was assumed that these “firewall” (CBO, 2010) conditions would both prevent firms from dropping coverage and prevent those who had such coverage from moving out of employer-sponsored insurance (ESI) because they were otherwise eligible for subsidized exchange coverage. Here we focus on the impact of firewall condition defined by the cost of single coverage alone (henceforth referred to as the “single” definition), or to family or single coverage as applicable to the worker (henceforth referred to as the “family” definition), on estimates of exchange and ESI coverage, and the ability of lower income workers to obtain affordable coverage for their dependents.

We use data from the Current Population Survey (CPS) merged with employer health insurance data from the Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) and exchange premium estimates from the Kaiser Family Foundation (KFF) Web site to measure potential gains and losses for workers and their firms if affordability is defined by the single or by the family option. We present stylized cases to answer the following question: what fraction of those with “money on the table” would be classified as having unaffordable coverage under the single vs. the family definition of affordability? The answer also depends on the way that employers set the employee contributions to health insurance.

Since the average annual total premium for family coverage is roughly \$8,000 higher than that for single coverage (\$12,298 vs. \$4,386 in 2008, shown in Table 1), there is the potential for substantially more families to obtain subsidized coverage through the exchanges if affordability is based on family coverage, if employee premium contributions are set sufficiently high. The affordability definition could significantly impact the ability of lower income workers’ dependents to find affordably priced coverage if single ESI coverage is affordable but family ESI coverage is not; this is a distinction that does not affect single workers. Thus, as the second component of our analysis, we show the consequence of adopting the single affordability definition on the number of low-income workers with families that would find themselves in a “no-man’s land” with no source of affordable coverage for their dependants. When ESI single coverage is affordable, both the worker and dependents would be restricted from receiving exchange subsidies, regardless of how unaffordable family ESI coverage might be.

Our results show that a family affordability rule could initially lead to as many as 1.3 million more workers accessing exchange subsidies for themselves and their families than under

a single affordability rule. If employees pay 50 percent of the premiums in the future, this increases to 6 million. Increased use of exchange subsidies would be accompanied by reductions in ESI coverage and increased costs to taxpayers. Alternatively, a single affordability rule would initially result in close to 4 million dependents of workers not having affordable health insurance from any source. This grows to close to 13 million if employees pay 50 percent of the premium.

2. An Illustration of the Importance of the Affordability Definition

Table 1 illustrates the importance of affordability definition and the employee contribution level with examples of three families each containing a worker and three dependents. Column 1 lists their annual before-tax income of 133, 250 and 400 percent of the federal poverty line respectively—the full income range for exchange subsidies. Columns 2 and 3 display the total average national premiums for single and family coverage based on the 2008 MEPS-IC. The average total single premium in 2008 was \$4,386 (column 2) and the average employee single premium was \$882 or a 20.1 percent share. The average total family premium was \$12,298 (column 3) and the corresponding employee premium was \$3,394 or a 27.5 percent share. Column 4 shows the typical amount of subsidy each family would receive towards exchange coverage, using the KFF exchange premium calculator. The actual amount would be lower to offset the employer fine and because ESI premiums are tax exempt while out of pocket payments for exchange coverage are not.

Column 5 shows that if employers keep single coverage employee contributions at 20.1 percent, they never exceed 9.5 percent of family income. Hence if single coverage is used to define affordability and employee contributions do not change, none of these families are eligible for exchange subsidies even if their family ESI coverage is unaffordable. While the worker would have affordable single coverage, his/her dependents would be in a “no-man’s land” with unaffordable ESI family coverage and no access to exchange subsidies despite meeting the income criteria for such coverage. If employers keep family coverage employee contributions at 27.5 percent, families with income of 250 and 400 percent of poverty would have affordable coverage (Column 6 of Table 1). Hence, they and their dependents would not be eligible for an exchange subsidy. But the worker with family income of 133 percent of poverty would now be eligible for an exchange subsidy even though the worker’s single coverage was affordable. Hence when the family affordability criterion is used, no dependents will ever find themselves in “no-man’s land.” But the tradeoff in this example is that the exchange subsidy firewall will be breached by the lowest income worker, who now has an incentive to seek exchange subsidized insurance for his/her family despite having an offer of affordable single ESI.

Columns 7 and 8 show how the ability to breach the firewall depends on the employee contribution to health insurance. In this extreme case, we assume labor contracts are re-negotiated so that the worker will pay 100 percent of the ESI premium. Column 7 shows that even using a single affordability definition, the worker with family income at 133 percent of

poverty now pays more than 9.5 percent of that income in ESI premiums. Hence that worker and his/her dependents can gain access to exchange subsidies. In column 8 the firewall breach is even greater since using the family affordability definition results in all families having unaffordable ESI coverage and gaining access to exchange subsidies. Although not shown in Table 1, an employer is fined for not offering affordable coverage. However, at \$3,000 or \$2,000 a worker, the fine is low relative to the cost of family health insurance. These examples illustrate the impact of alternative affordability definitions and employee ESI premiums on the ability of income eligible families to claim unaffordable coverage and access exchange subsidies.

3. Relevant Prior Reports

The CBO (CBO, 2007a) estimates the number of Americans likely to be covered by specific provisions of the ACA over a 10-year horizon based on a sophisticated approach that integrates all the complex aspects of the law. By 2019, CBO expects the number of ESI coverage to fall on net by 3 million people, primarily because of firms dropping ESI coverage offsets the number of workers coming onto the rolls because of the mandates. Holtz-Eakin and Smith (2010) suggest the net decline will be much greater. They argue that the ACA's exchange subsidies are so substantial that they will encourage employers and employees to change their labor contracts to gain access to the "money on the table." By examining the possibility that employers may drop ESI, they abstract from whether affordability is defined by single or family coverage, and do not comment on the possibility that employers may change employee contributions as an alternative strategy. Holtz-Eakin and Smith note that whether firms will actually fully adjust in the manner they describe will depend on certain inflexibilities in the labor market, but that "the massive federal subsidies are money on the table inviting a vast reworking of compensation packages." (Holtz-Eakin and Smith, 2010, p. 4.)

Unlike Holtz-Eakin and Smith (2010), or the CBO (2010), we assume that no firms drop ESI coverage to highlight an alternative possibility through which workers and their employers can gain access to that "money on the table," by resetting the employer-employee sharing of the ESI premium within a firm. In this case we show why low-wage workers may remain with their current employer after the ACA and become subject to higher premium sharing rules, rather than sort to exclusively low-income firms.

In 2007 Massachusetts became the first state to initiate pay or play health insurance reforms that resemble those in the ACA. However, while the fine for failing to providing "fair and reasonable" insurance is nominal, there may be less "money on the table" because Massachusetts requires employers to pay a large share of workers' uncompensated care through the Health Safety Net (HSN) (Commonwealth of Massachusetts, 2011). Papers analyzing the Massachusetts experience find no evidence of ESI reductions in the general population in response to the law (Long and Masi, 2008, and Gruber, 2011) although there is some evidence that private coverage may have fallen in the hospitalized population (Kolstad and Kowalski,

2010). While early evidence from Massachusetts suggests that the ACA may not have a major impact on ESI coverage, a large literature on the impact of Medicaid or CHIP on the ESI coverage of children suggests ESI coverage fell. A review of the literature in CBO (2007b) concluded that “for every 100 children who gain coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children.” (p.11-12).

4. Our Conceptual Framework

In our calculations, workers in families earning between 133 to 400 percent of the poverty line are assumed to weigh their options between ESI, exchange coverage or being uninsured if they are either currently ESI policy holders in the CPS or if they are uninsured but would be affected by the employer mandate because they are full-time workers in large firms. We assume workers consider costs and benefits and will find exchange coverage financially preferable (setting aside the “affordability” firewall for now) if the net cost of obtaining that coverage is lower than the net benefits of foregoing their ESI offer, incurring the “employer mandate” penalty and losing the tax benefit given to ESI.¹

Next, we add the firewall provision into our analysis and consider the effect of increases in employee contribution levels on the extent to which workers are able to become eligible for subsidized coverage in an exchange. In the short run, employer attempts to increase employee cost sharing across the board so that lower-income workers can qualify for subsidies would be viewed unfavorably by higher income workers, unless the employer were able to convince workers that the corresponding wage increases simply offset the increased employee cost sharing. In the longer run, inflation, new job creation and old job destruction aid the process of adjusting employee contributions. Because IRS rules allow both employers and employees to contribute to health insurance premiums on a pre-tax basis (as long as employers establish the necessary paperwork) the split between employee and employer contributions for health insurance can be viewed as largely artificial in the long run as long as wages are adjusted.² We solely focus on those workers who could gain by choosing exchange coverage and calculate the fraction who will be able to breach the affordability firewall and obtain subsidized exchange coverage depending on the level of employee contributions and the definition of affordability.

¹ This is captured by the expression: $[1] \quad [(P_x - S_x)] < [(P_f + P_e - F_e)(1 - \tau)]$

Where the left hand side of the equation represents the cost of obtaining exchange coverage and the right hand side represents the benefits to foregoing ESI. P_x is the total price charged in the exchange, S_x is the subsidy, τ is the marginal tax rate, and P_e is the employee contribution to the ESI premium and P_f is the firm's contribution to the ESI premium. F_e is the employer fine (\$3,000). The right hand side of the equation represents “the money on the table” that the employee or employer stands to save if he or she were to no longer receive ESI, assuming that the full employer saving is passed on through higher wages.

² Consider the following simple example. Suppose that in the long run employers require \$10,000 as a contribution towards health insurance from employees and contribute \$2,000 as the employer contribution. Workers at the firm should be indifferent (i.e. they have the same take home pay and the same fringe benefit package) if the employer had instead decided to ask for \$11,000 as an employee contribution, but paid all workers at the firm \$1,000 extra. Since the change in employee contribution and the change in wage is across the board at the firm, it does not involve any assumptions about whether wage-fringe tradeoffs occur at the worker or firm level.

5. Data Sources

Our calculations are based on 2009 March CPS data merged with average health insurance premiums data from the MEPS-IC and KFF. We limit our sample to private sector non-self-employed working age individuals (aged 17 to 64). When we consider the worker decisions, we include characteristics of their family (such as the number of dependents) and create family health insurance units, grouping together parents and children under the age of 26 who live in the same family. We merge data on health insurance costs (total premiums, as well as the employee and employer portions) from 2008 MEPS-IC public-use summary tables using state and firm size (above and below 50 workers), separately by single and other types of family plans and obtain estimates of exchange premiums from the KFF exchange premium calculator. (See Burkhauser et al. (2011) and <http://www.nber.org/data-appendix/w17279> for details).

6. Results

Financial Incentives Calculations

Using 2009 March CPS data and Equation 1, we first calculate the extent to which workers gain or lose from switching to subsidized exchange coverage, if they are able to overcome the affordability firewall. Of workers who are income eligible for exchange subsidies (133 percent to 400 percent of poverty) and are either currently covered by ESI or would be affected by the ACA employer mandate, only 40 percent have a financial incentive to obtain exchange coverage. This is an indication of the effectiveness of the individual fines and tax penalties in the ACA in reducing the potential crowd out of ESI.

Coverage Under Alternative Employee Contribution Levels and Affordability Definitions

We next consider the extent to which the 40 percent of our workers with financial incentives to obtain exchange coverage would be able to overcome the affordability firewall under the single and family definitions. Figure 1 first shows ESI coverage rates and then exchange coverage rates in its two graphs, in the context of all workers in our full sample. The solid line depicts the single definition and the dotted line depicts the family definition, for the full range of possible employee contributions. Although the data presented are for all workers, variation in affordability definition and employee contribution level are solely the result of workers in families with incomes between 133 and 400 percent of poverty.

Figure 1 shows a flat line indicating that exchange and ESI rates do not vary with employee premium contribution shares, in either the single or the family affordability definitions, until employee contribution shares reach approximately 20 percent. This is because average employee premium contributions for both single and family coverage are low enough that no worker with family income between 133 and 400 percent of poverty breaches the affordability firewall until employee premiums reach approximately 20 percent of total premium costs. There is a large amount of movement into exchange coverage and out of ESI under the family

definition, as employee contributions rise from current levels (20.1 percent for single and 27.5 percent for family coverage), until they reach the 50-60 percent of premiums range. We find that ESI coverage rates decline from 72.94 percent (at current levels) to 65.14 percent (at 50 percent employee contributions) and 62.57 percent (at 100 percent employee contributions) under the definition of family affordability. The corresponding increase in exchange coverage rates are 13.02, 20.82 and 23.33 percent, respectively. In contrast, there are only small changes in ESI coverage under the single definition as employee contributions rise from current levels to 50 percent, moving from 74.57 percent to 73.19 percent, respectively. ESI coverage rates decline from 73.19 to 69.97 percent when employee contributions move from 50 percent to 100 percent. The difference in patterns for family vs. single coverage is unsurprising. Even at high levels of cost sharing (such as employees paying half the cost—\$2,193—of the average national single premiums of \$4,386), single premiums are affordable for most workers, since those with income lower than 133 percent of poverty are eligible for Medicaid rather than exchange subsidies. But even at lower levels of cost sharing than 50 percent, family premiums are high enough that ESI employee contributions become unaffordable for many workers.

While one might have expected successively more workers to have both the incentive and the ability to opt for exchange coverage rather than ESI coverage as employee contributions rise under the family affordability definition, the line in Figure 1 flattens out after about the 60 percent employee contribution mark. This is because the marginal family whose coverage is made unaffordable by a further increase in the employee contribution beyond this point has relatively higher income. At higher levels of income, exchange subsidies taper off, and the cost of the foregone tax benefit and employer penalties make exchange coverage less attractive even if the affordability criterion has been met.

While our Figures and Tables thus far have shown fractions of our population of workers, Table 2 shows the relevant weighted numbers of workers with exchange coverage corresponding to Figure 1. If employee premiums remain at current levels, 5.8 million workers would receive exchange subsidies under a single affordability rule and 7.1 million under a family affordability rule. If employees pay 50 percent of premiums, these numbers rise to 7.1 million, and 13.1 million respectively. At 100 percent premium contributions, they are 9.9 million and 14.8 million. Even with a 50 percent employee contribution, roughly 6 million more workers would receive subsidized exchange coverage if the affordability definition is family rather than single.

The Size of No Man's Land Under Alternative Employee Contribution Levels

While choosing a single coverage definition will reduce movement onto the exchanges, it will leave some percentage of workers with affordable single coverage but unaffordable family coverage for their dependents. This occurs because such workers and their dependents, even though income eligible for subsidized exchange coverage are prevented from obtaining it by the single coverage affordability definition. Figure 2 shows the relationship between workers' single

coverage ESI contribution and how many find themselves in this “no-man’s land” with no source of affordable coverage for dependents. The Figure 2 sample is restricted to workers (with dependents) who would gain from access to subsidized family exchange coverage. Figure 2 is the result of two offsetting changes. As employee contributions for single and family coverage rise, dependent coverage becomes increasingly unaffordable for workers seeking to insure their families, thus increasing the likelihood of dependents being trapped in “no-man’s land.” But at the same time workers’ likelihood of having unaffordable single coverage rises, allowing both workers and their dependents access to the exchanges and an escape from “no-man’s land.”

Table 3 shows the number of workers and dependents not able to find affordable family coverage at current employee contribution shares and at 50 and 100 percent of employee premiums using a single definition. The number of workers in “no-man’s land” is the difference between the number of workers with unaffordable family and unaffordable single coverage. As employee contributions rise, family coverage begins to become unaffordable for many families. However, single coverage does not become unaffordable until employee contributions exceed 30 percent. Eventually, as the employee contribution rises, more workers and their families escape “no-man’s land” than enter it, and the totals fall because they become eligible for subsidies.

Figure 2 and Table 3 show that under single affordability, as many as 2.6 million workers and their 7.5 million dependents could find themselves without affordable ESI or exchange health insurance, even if employee premiums stayed at current levels. Table 3 also shows that the number of dependents without affordable ESI or exchange insurance could rise to 16 million if rising health care costs lead employees to pay half of total premiums in the future. Since these numbers do not take into account the many currently uninsured children eligible but not signed up for CHIP, we also calculate the numbers assuming that all of these uninsured but eligible children will do so. This lowers our numbers to 1.4 million workers and 4 million dependents without affordable family coverage using the single affordability definition, even if employee premiums remain at the current level. This would be 3.7 million workers with 9.9 million dependents if employee contributions are 100 percent of the premium, and 5.8 million workers with 12.7 million dependents if employee contributions are 50 percent of employee premiums.

7. Discussion and Summary

Our stylized calculations illustrate the sensitivity of subsidized exchange coverage and ESI take-up to two understudied factors that are important for understanding the potential impact of the ACA. We show that under a family definition, relatively small changes in the middle of the cost sharing levels (such as 50 percent of the full premium) could have large consequences for exchange coverage and ESI rates. We also show there is a difficult tradeoff involved, as setting affordability on the single coverage definition would leave many dependents without any affordable source of coverage. In fact, if single coverage affordability is adopted, close to 6

million workers (and close to 13 million dependents) will be unable to find affordable family coverage even if employee contributions are set in the future to be only half of the total premium.

Selecting a definition for the affordability rule involves a difficult tradeoff because while single coverage rules do not leave as much room for employers and employees to change behavior in ways that would reduce ESI coverage rates, they would leave many millions of workers in a “no-man’s land” of finding no source of affordable coverage. A valuable next step for policy analysis research in this regard would be to examine how coverage impacts may be affected by these different possible affordability interpretations using more sophisticated analyses, and the assumptions regarding employer and employee responses in premium cost sharing.

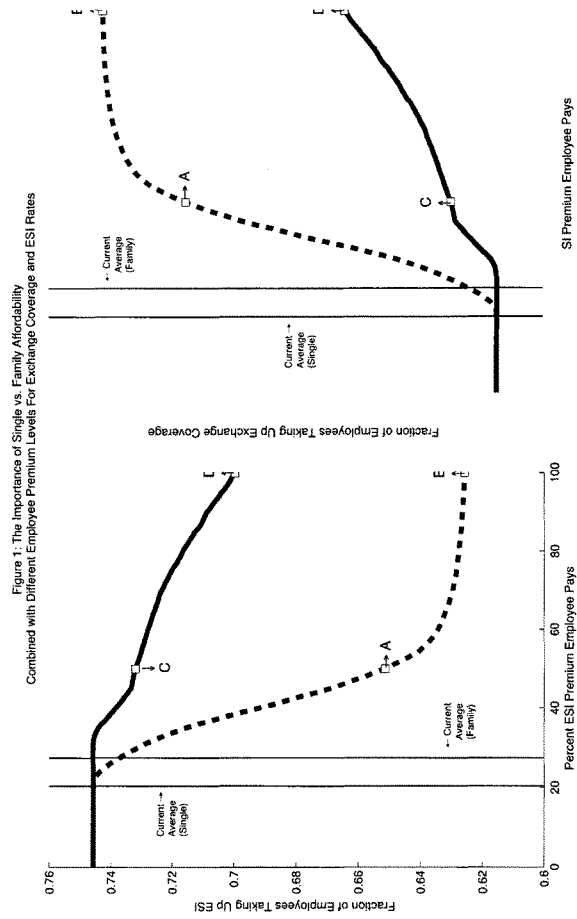
References

- Adamy, J. 2011. "Study Sees Cuts to Health Plans". Wall Street Journal. June 8. Available at <http://online.wsj.com/article/SB10001424052702304906004576371802092308600.html>
- Abraham, J., and R. Feldman. 2010. "What Will Happen If Employers Drop Health Insurance? A Simulation of Employees' Willingness To Purchase Insurance In the Individual Market." *National Tax Journal* 63, p.191-213.
- Commonwealth of Massachusetts. 2011. "The Employer Free Rider Surcharge." Available at http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/11/Free_Rider_2011.pdf
- Congressional Budget Office (CBO) 2010: *Letter from CBO Director Elmendorf to Nancy Pelosi*. March 20 2010. Available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.
- Congressional Budget Office (CBO) 2007a: Health Insurance Simulation Model: A Technical Description, (October).
- Congressional Budget Office (CBO) 2007b: State Children's Health Insurance Program. Available at <http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf> (May)
- Dafny, L., K. Ho and M. Varela. 2010. An Individual Healthplan Exchange: Which Employees Would Benefit and Why? *American Economic Review, Papers and Proceedings*. 100: 485-489.
- Gabel, J. R. McDevitt, L. Gandolfo, J. Pickreign, S. Hawkins, C. Fahlman. 2006. "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii is Up, Wyoming is Down." *Health Affairs*, 25(3): 832-843.
- Graves, J. 2011. "The Optimal Design of Prospective Subsidies for Health Insurance Under the Patient Protection and Affordable Care Act" Harvard University Working Paper, http://people.fas.harvard.edu/~jagraves/optimal_design_111910.pdf
- Gruber, J. "The Impacts of the Affordable Care Act: How Reasonable Are the Projections?" NBER Working Paper 17168
- Gruber, J. and K. Simon. 2008. "Crowd-out 10 years later: Have recent public insurance expansions crowded out private health insurance?" *Journal of Health Economics*. V.27. 201-217
- Holtz-Eakin, D. and C. Smith. 2010 *Labor Markets and Health Care Reform: New Results*, May 2010. American Action Forum. www.americanactionforum.org. available at <http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10.pdf>.
- Kolstad, J. and A. Kowalski. 2010 "The Impact of Health Care Reform on Hospital and Preventive Care: Evidence from Massachusetts." October. NBER WP #16012.
- Long, S. and P. Masi. 2008. "How Have Employers Responded to Health Reform in Massachusetts? Employees' Views at the End of One Year," *Health Affairs*, 27 no.6 w576-583 2008.
- U.S. Senate, 2009. "America's Health Future Act of 2009" October 19. Calendar no 184., report 111-89. Committee on Finance. Online version available at <http://www.gpo.gov/fdsys/pkg/CRPT-111srpt89/html/CRPT-111srpt89.htm> (accessed August 2011)

Table 1: Illustrating the Importance of Family vs. Single Affordability with Hypothetical Families

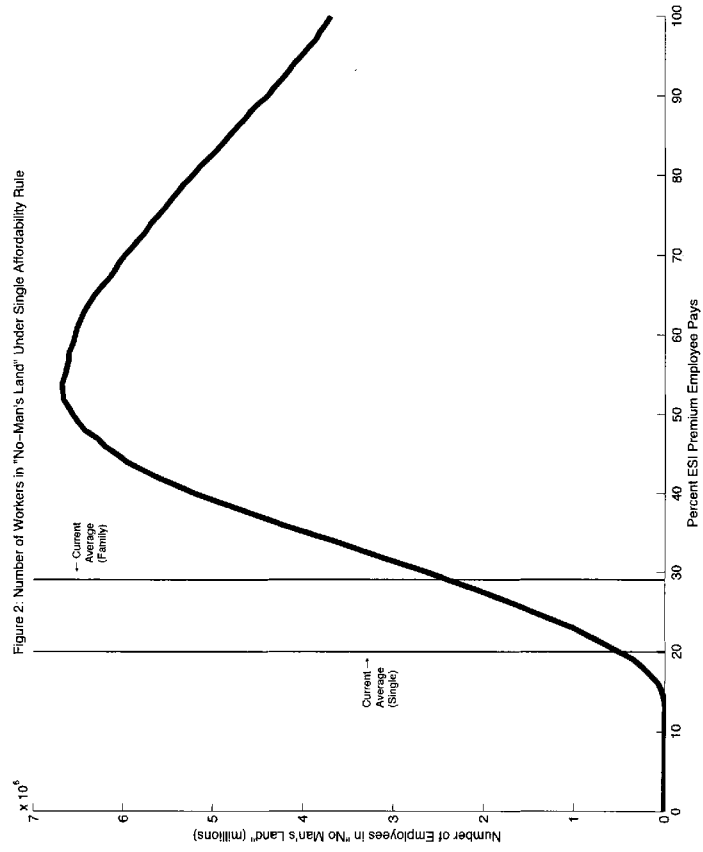
Income (Percent of the Federal Poverty Level, 2008) (1)	Single Premium (2)	Family Premium (3)	Potential subsidy for exchange family coverage (4)	Current single premium share, as % family income (5)	Current family premium share, as % family income (6)	100% single premium share, as % family income (7)	100% family premium share, as % family income (8)
\$28,196 (133)	\$4,386	\$12,298	\$11,406	3.08%	11.9%	15.3%	43%
\$53,000 (250)	\$4,386	\$12,298	\$7,793	1.7%	6.4%	8.3%	23.2%
\$84,800 (400)	\$4,386	\$12,298	\$4,242	1.04%	4%	5.2%	14.5%

Notes: These hypothetical families are comprised of four members each. While the ACA language refers to household income in some parts and family income in others, we consistently use only the concept of family income (Columns 1 and onwards).
The first column shows the incomes of these hypothetical families, and the percent of the federal poverty level corresponding to that level of income, in 2008.
The second column shows the average national single level premium for employer-based insurance in 2008 (Source: http://www.mega.altrq.gov/megaweb/data_states/summ_tables/insr/national/series_1/2008/ins2.pdf).
The third column shows the average national family total premium for employer-based insurance in 2008 (Source: http://www.mega.altrq.gov/megaweb/data_states/summ_tables/insr/national/series_1/2008/ins1.pdf).
The fourth column shows the gross subsidy that would be available to such a family in the exchange. This number is obtained by taking the Kaiser Family Foundation estimate of the exchange plan premium for a family of 4 and subtracting out the maximum out of pocket for which this family is eligible. This number does not take taxes or fines into account, and is a gross simplification for illustrative purposes relative to how we perform our calculations later in the paper.
The fifth column shows at the current level of employee contributions for single coverage (\$382), what the employee contribution for single coverage would be as a percent of the family's income.
The sixth column shows at the current level of employee contributions for family coverage (\$3,394), what the employee contribution for family coverage would be as a percent of the family's income.
The seventh column shows what the employee contribution for single coverage would be as a percent of the family's income, if the employee has to contribute 100% of the single premium.
The eighth column shows what the employee contribution for family coverage would be as a percent of the family's income, if the employee has to contribute 100% of the family premium.



Notes:

1. Data from the 2009 March CPS merged with estimates of employer health insurance costs in 2008 from the MEPS-IC and estimates of exchange coverage costs from the KFF premium calculator. We select workers from the March CPS in private sector non self-employed jobs aged 17-64, representing 95,392,412 workers.
2. This Figure shows how the percentage of workers with ESI changes with the definition of affordability (single or family) and the employer's contribution rule (percent of the full ESI premium paid by the worker). Points noted here correspond to points described in further detail in Table 2 (100%, 50% and the current average level of employee contributions). Since the current level of employee contributions differs by state and firm size, there is no direct equivalent number to indicate in this figure, thus we have drawn in a line corresponding to the average national rate of employee contributions for single and family coverage.



Notes: I. See Notes to Figure 1.

Table 2
Number of Workers With Exchange Subsidized Coverage

Employee Contribution Level	Single Affordability	Family Affordability	Difference
Current	5,803,944	7,092,138	-1,288,195
50%	7,120,189	13,109,899	-5,989,710
100%	9,870,451	14,748,991	-4,878,541

Notes:

1. See Notes to Figure 1.
2. This Table shows the points indicated on Figure 1 corresponding to employee cost sharing of 100 percent, 50 percent and the current level of employee contributions. We show only insurance rates for the income ranges that are eligible for subsidies.

Table 3: Number of Workers and Number of Dependents in "No-Man's Land"

Employee Contribution Level	Number of Workers with Unaffordable Family Coverage	Number of Workers with Unaffordable Single Coverage	Number of Workers in "No-Man's Land"	Number of Dependents of Workers in "No-Man's Land"
Current	2,561,827	0	2,561,827	7,542,726
50%	6,951,141	390,401	6,560,740	16,063,536
100%	7,643,769	3,948,638	3,695,131	10,841,965

Notes:

1. This table assumes that CHIP take-up stays at current levels. If one assumes full take-up of CHIP, then the values in the last column would be 4,017,351 at the current, 12,657,387 at 50 percent and 9,881,903 at 100 percent.
2. See notes to Figure 2.

Mr. GOWDY. Thank you, Dr. Burkhauser.
Dr. Collins.

STATEMENT OF SARA R. COLLINS, PH.D.

Ms. COLLINS. Thank you, Mr. Chairman, for this invitation to testify on the premium tax credits that are available to families under the Affordable Care Act.

Recent trends in the numbers of people who are uninsured or underinsured demonstrate how critical these premium tax credits and the law's related insurance affordability programs and reforms will be to ensure both the health and financial security of working families.

The number of people without health insurance climbed to nearly 50 million people in 2010, over 13 million more than were uninsured a decade ago. Among people who do have health insurance, The Commonwealth Fund estimates that, in 2010, 29 million working-age adults had such high out-of-pocket costs relative to their income that they were underinsured. This is an increase from 16 million in 2003.

Both these trends have had serious financial and health consequences for families. An estimated 75 million adults under age 65, both with and without health insurance, reported a time in 2010 when they did not get needed health care because of the cost. And 73 million adults said that they had difficulty paying medical bills or were paying off debt over time.

With its array of affordable health insurance programs and new consumer protections, the Affordable Care Act will substantially reverse these trends, ensuring that all Americans will have access to affordable and comprehensive health insurance coverage.

Indeed, the law's new provision that allows children up to age 26 to stay on or join their parents' insurance policies reversed a decade-long increase in uninsured rates of young adults, providing coverage to nearly 800,000 19 to 25-year-olds in the past year.

The law's most significant coverage provisions will begin in 2014 with a substantial expansion in Medicaid eligibility for adults earning up to 133 percent of poverty, or about \$29,700 for a family of four, as well as subsidized coverage available—private coverage available through new State insurance exchanges for families earning up to 400 percent of poverty, or \$89,400 for a family of four.

The State insurance exchanges will create a new marketplace that will serve as a central portal through which people can get coverage if they do not have an affordable employer-based health plan. People will fill out one application for all insurance affordability programs, including Medicaid, the Children's Health Insurance Program, the Basic Health Program, or premium tax credits for private plans, which are known as qualified health plans, sold in the exchanges.

Taxpayers eligible for premium credits will make contributions to their premiums as a share of their income, from 2 percent to 9.5 percent. Those eligible for tax credits will have a choice of private plans that will offer an essential benefit package. Insurers will offer these plans at four levels of cost-sharing: bronze plans, covering an average of 60 percent of someone's annual medical costs;

silver, 70 percent of costs; gold, 80 percent of costs; and platinum, 90 percent of costs.

The average cost covered by the silver plan will be increased for low- and moderate-income families. As an example, a family of four with an income of \$35,000 would make a premium contribution of 4 percent of their income, or \$1,400. If the policyholder's age is 40, this family's premium for a benchmark plan, which would be the second-lowest-cost silver plan offered in the family's region of the country, would be about \$12,130 in 2014. Their tax credit would thus be equal to the benchmark premium minus their required contribution, or \$10,700.

About 90 percent of legal residents who are currently uninsured in the United States right now would gain premium tax credits or Medicaid. In addition, if the reforms were implemented today, there would be 21 million fewer underinsured adults in the United States.

The Congressional Budget Office estimates that the Affordable Care Act will reduce the Federal deficit by \$124 billion over the period 2012 to 2021. Cutler, Davis, and Stremikis estimate even greater savings than the Congressional Budget Office from the law's health-care delivery system reforms. They project an additional \$406 billion in savings by 2019 and, consequently, a much greater net decrease in the deficit of about \$400 billion.

In 2009, as health reform was being debated, total national health expenditures were projected to reach \$4.9 trillion in 2020. Expenditures are now projected to reach \$4.6 trillion in 2020, 5 percent below original estimates. If scorekeepers were to redo the original estimates based on these new projections, the deficit reduction generated by health reform would be even greater.

The trends in uninsured and underinsured Americans over the last decade really do underscore the need for Federal and State policymakers to continue their work implementing the Affordable Care Act. When the law is fully implemented, U.S. families will have new affordable and comprehensive insurance options, both in good economic times and in bad.

In addition, while much of the recent debate has focused on lowering the costs of Medicare and reducing the Federal deficit, the same forces that are driving up public program costs are also increasing costs for working families. With this extensive set of delivery system and insurance market reforms, the Affordable Care Act focuses on improving quality and affordability throughout the entire health-care system.

For the 50 million adults and children who were without coverage in 2010 and the additional 29 million adults who are underinsured, the 2014 reforms cannot come soon enough.

Thank you.

[The prepared statement of Ms. Collins follows:]

**PREMIUM TAX CREDITS UNDER THE AFFORDABLE CARE ACT: HOW THEY WILL HELP MILLIONS OF
UNINSURED AMERICANS GAIN AFFORDABLE, COMPREHENSIVE HEALTH INSURANCE**

**Sara R. Collins, Ph.D.
The Commonwealth Fund**

Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on the premium tax credits that will be available to families under the Patient Protection and Affordable Care Act beginning in 2014. Recent trends in the numbers of people in the United States who are uninsured or underinsured demonstrate how critical premium tax credits and the law's related insurance affordability programs and reforms will be to ensure both the health and financial security of working families. In September, the Census Bureau reported that the number of people without health insurance climbed to 49.9 million people in 2010, over 13 million more than were uninsured a decade ago. Among people who do have health insurance, The Commonwealth Fund estimates that in 2010, 29 million working-age adults had such high out-of-pocket costs relative to their income that they were effectively underinsured, an increase from 16 million in 2003.

Both these trends have resulted in serious financial and health consequences for working families. An estimated 75 million adults under age 65, both with and without health insurance, reported a time in 2010 when they did not get needed health care because of the cost, up from 47 million in 2001. And 73 million adults said that they had had difficulty paying medical bills or were paying off medical debt, up from 58 million in 2005. With its array of affordable health insurance programs and new consumer protections set to launch in 2014, the Affordable Care Act will substantially reverse these trends, ensuring that all Americans will have access to affordable and comprehensive health insurance coverage.

The Health Insurance Coverage of U.S. Families in 2010: Increases in Uninsured and Underinsured

- Nearly 50 million people in the U.S. were without health insurance in 2010, an increase of 13 million people over the last decade.
- Families with incomes under \$50,000 are the most at risk for not having health insurance. Twenty-seven percent of people with incomes under \$25,000 were without health insurance in 2010, with nearly a million more people in this income range losing coverage in 2010.
- Massachusetts, which implemented a reform law similar to the Affordable Care Act in 2006, leads the nation in coverage rates, with just 5.7 percent of its under-65 population lacking

health insurance. Texas has the highest rate of uninsured people: 27.7 percent of its nonelderly population is uninsured.

- The Affordable Care Act's new provision that allows children up to age 26 to stay on or join their parents' insurance policies reduced the percentage of uninsured young adults ages 19 to 25 to 29.7 percent in 2010, down from 32.7 percent in 2009. This is the largest one-year decline in the uninsured rate for young adults in the last decade, and it translates into 787,000 more young adults with coverage.
- The nation's high unemployment rate continues to take a toll on families' health insurance. The percentage of people with coverage through an employer declined to 55.3 percent in 2010, with 1.5 million fewer people enrolled in employer plans than in 2009.
- More than half (57%) of working-age adults who lost a job with health benefits became uninsured over the 2008–2010 period.
- In 2011, the average family premium for employer plans has climbed to \$5,429 per year for single coverage and \$15,073 for a family coverage, placing COBRA coverage out of reach for low- and moderate-income people when they lose their jobs. Just 14 percent of Americans who lost a job with benefits in the last two years enrolled in COBRA.
- Similarly, the individual insurance market is often unaffordable because of underwriting on health status and high premiums. In 2010, 60 percent of adults under age 65 who shopped for coverage in the individual market found it very difficult or impossible to find a plan they could afford, and 35 percent were turned down by an insurance carrier or had a specific health problem excluded from coverage.
- 72 percent of working-age adults who lost a job with benefits and became uninsured between 2008 and 2010 delayed needed health care because of the cost. The same percentage reported they had problems paying medical bills or were paying off medical debt over time.
- A combination of rapid growth in the cost of health insurance, greater exposure to health care costs, and declining incomes means that growing numbers of families are spending more of their earnings on health care. Nearly one-third (32%) of working-age adults, or an estimated 49 million people, spent 10 percent or more of their income on out-of-pocket costs and premiums in 2010, up from 21 percent, or 31 million people, in 2001.
- Twenty-nine million working age adults who had health insurance in 2010 had such high out-of-pocket costs relative to their incomes that they were effectively underinsured; this is an increase from 16 million in 2003. People with low and moderate incomes were underinsured at the highest rates: 26 percent of working-age adults with incomes below 200 percent of the federal poverty level were underinsured in 2010.

The Affordable Care Act Will Substantially Reduce the Number of Americans Who Are Uninsured or Underinsured

- Current trends in uninsured and underinsured rates will be significantly reversed under the provisions in the Affordable Care Act.
- The law's most significant coverage provisions will begin in 2014, with a substantial expansion in Medicaid eligibility that will cover adults earning up to 133 percent of the poverty level, or \$29,726 for a family of four, as well as subsidized private coverage, available through new state insurance exchanges, for families earning up to 400 percent of poverty, or \$89,400 for a family of four.
- The state insurance exchanges are the centerpiece of the law's coverage provisions, providing options for individuals and small businesses. The exchanges will create a new marketplace that will serve as the central portal through which people can get coverage if they do not have an affordable employer-based health plan. People will fill out one application for all insurance affordability programs: Medicaid, the Children's Health Insurance Program, the Basic Health Program (at state option), or premium tax credits for private plans known as qualified health plans (QHPs) sold in the exchanges. Consumers will have an array of health plan choices, with clear information on what their health plans cover and what their cost-sharing responsibilities are.
- Governors of 11 states have signed legislation since the passage of the Affordable Care Act to establish insurance exchanges. Governors in four states have signed legislation that signals an intent to establish an exchange or to study the establishment of an exchange. Governors in eight states have pursued or are considering alternatives to establishing exchanges through nonlegislative means.
- Starting in 2014, people with household incomes between 100 percent and 400 percent of poverty (\$22,350–\$89,400 for a family of four) who lack access to affordable insurance will be eligible for a tax credit to offset the cost of premiums for private health plans purchased in the exchanges.
- Taxpayers eligible for tax credits are required to make contributions to their premiums as a share of their income, from 2 percent to 9.5 percent. Those eligible for tax credits will have a choice of private qualified health plans sold through the exchanges that will offer a comprehensive set of benefits known as the essential benefit package. Insurers will offer these plans at four levels of cost-sharing: bronze plans (covering on average 60% of someone's annual medical costs), silver (70% of costs), gold (80% of costs), and platinum (90% of costs). However, for people with low incomes, the average costs covered by the silver plan will be increased to 94 percent (for those with incomes up to 149% of poverty), 87 percent (150%–199% of poverty),

and 73 percent (200%–249% of poverty). In addition, qualified health plans will have limits on out-of-pocket spending related to income.

- As an example, a family of four with an income of \$35,000 who is eligible for a tax credit would make a premium contribution of 4 percent of their income, or \$1,405. If the policyholder is age 40, this family's premium for a benchmark plan in a medium-cost area of the country would be about \$12,130 in 2014. Their tax credit would thus be equal to the benchmark premium minus their required contribution, or \$10,725.
- About 90 percent of legal residents who are currently uninsured would gain premium tax credits or Medicaid. Of the 49 million people under age 65 who are uninsured, 43 percent have incomes under 133 percent of the poverty level and would be eligible for Medicaid. A quarter have incomes between 133 and 249 percent of poverty and would be eligible for premium tax credits that would cap their premium contribution at between 3 percent and 8.05 percent of their income, as well as reduced cost-sharing. Thirteen percent have incomes between 250 percent and 399 percent of poverty and would be eligible for tax credits that would cap their premium contributions at from 8.05 percent to 9.5 percent of income. Ten percent of those currently uninsured have incomes of 400 percent of poverty or more and would not be eligible for tax credits; however they would be eligible to buy coverage through the exchanges or in the individual market that features new consumer protections against underwriting, includes the essential benefit package, and limits cost-sharing. About 10 percent of those currently uninsured are undocumented immigrants who would not be eligible to purchase coverage through the exchanges.
- The Congressional Budget Office (CBO) estimates that under the law, 34 million adults and children will become newly covered by 2020. An estimated 16 million uninsured people will gain coverage through Medicaid, and 18 million will gain coverage through the state insurance exchanges or employer plans. Those newly covered in the exchanges are estimated to be joined by 8 million people shifting from the individual market and employer plans—in large part because of more affordable premiums and lower out-of-pocket costs. Of those purchasing health plans through the exchanges, CBO estimates that about 20 million people will be eligible for premium tax credits, with an average credit of \$6,740.
- The Affordable Care Act's new consumer protections, income-based cost-sharing tax credits, and limits on out-of-pocket costs, and a new essential health benefit package are estimated to reduce the number of people who are underinsured by 70 percent. If the reforms were implemented today, there would be 20 million fewer underinsured adults in the U.S.

The Affordable Care Act Will Reduce the Federal Deficit over 2012–2021 and Lower Premiums

- The CBO estimates the Affordable Care Act will reduce the federal deficit by \$124 billion over the period 2012–2021. The net cost of the Medicaid expansion, premium and cost-sharing tax

credits, and small-business tax credits (\$1,151 billion) over 2012–2021 will be more than offset by savings from new revenues and from health care delivery system reforms aimed at improving the quality and cost of care.

- Cutler, Davis, and Stremikis estimate greater savings than CBO does from the law's health care delivery system reforms. They project \$406 billion in savings by 2019, and consequently a much greater net decrease in the deficit: \$400 billion.
- If the combination of insurance and delivery system reforms are effective in slowing the growth in premiums by just 1 percent below annual projected rates of increase, based on historical trends, the cost of family health insurance will drop by an average of \$995 annually by 2015 and by \$2,323 by 2020.
- Health care cost growth has begun to moderate. In 2009, as health reform was being debated, total national health expenditures were projected to reach \$4.9 trillion in 2020. This baseline was used by federal scorekeepers evaluating the law and estimating the cost of providing coverage for the uninsured and premium subsidies for working families. Expenditures are now projected to reach \$4.6 trillion in 2020, 5.6 percent below original estimates.
- By using the higher 2009 health system spending baseline, analysts assumed that covering the uninsured and providing premium subsidies would be more expensive for the federal government than now appears to be the case. The offsetting revenue estimates, by contrast, are less sensitive to the slowdown in health expenditures—legislative provisions such as taxes on wealthy individuals, lower Medicare Advantage payments, and productivity adjustments for hospitals can still be expected to produce significant federal budget savings. If scorekeepers were to redo the original estimates based on these new projections, the deficit reduction generated by health reform would be greater.
- The slowdown in health care costs in the last two years has saved substantially more in national health expenditures (\$274 billion less by 2020 than originally estimated) than the amount the Centers for Medicare and Medicaid Services (CMS) had estimated health reform will have increased expenditures in 2020 (\$74 billion).
- The slowdown also benefits employers, households, and state governments. In 2009, CMS estimated that total health expenditures would consume 21 percent of the GDP in 2020. Now, with health reform, it estimates that health spending will be 19.8 percent of GDP. And instead of increasing at an annual rate of 6.8 percent between 2015 and 2020, as projected prior to reform, health spending with health reform in place is now projected to grow 6.3 percent annually.

Conclusion

The early provisions of the Affordable Care Act that went into effect one year ago are already having an effect on Americans' health insurance coverage, with 787,000 more young adults covered in 2010 compared with 2009. But the erosion in employer coverage resulting from job losses, coupled with fewer companies offering health insurance, underscores the need for federal and state policymakers to continue implementing the Affordable Care Act. After 2014, when the law is fully implemented, U.S. families will have new affordable and comprehensive health insurance options through the substantial expansion of Medicaid and new premium tax credits, and cost-sharing limits that will substantially improve the affordability of both coverage and care. New consumer protections against basing coverage and premiums on a family's health, plus a new standard for benefits, will enhance the ability of people to shop for coverage on their own and make an informed health plan choice. In addition, while much of the recent national debate has focused on lowering the costs of Medicare and reducing the federal deficit, the same forces that are driving up public program costs are also increasing costs for working families. With its extensive set of delivery and insurance market reforms, the Affordable Care Act focuses on improving quality and affordability throughout the entire health care system. In combination, these reforms will significantly reduce the number of people in each state who either lack health insurance or have such high out-of-pocket costs that they are underinsured. For the 50 million adults and children who were without coverage in 2010 and the additional 29 million adults who were insured but not protected from high out-of-pocket costs, the 2014 reforms cannot come soon enough.

Thank you.

**PREMIUM TAX CREDITS UNDER THE AFFORDABLE CARE ACT: HOW THEY WILL HELP MILLIONS OF
UNINSURED AMERICANS GAIN AFFORDABLE, COMPREHENSIVE HEALTH INSURANCE**

Thank you, Mr. Chairman, for this invitation to testify on the premium tax credits that will be available to families under the Patient Protection and Affordable Care Act starting in 2014. Recent trends in the numbers of people in the United States who are either uninsured or underinsured demonstrate how critical premium tax credits and the law's related insurance affordability programs and reforms will be to ensure both the health and financial security of working families. In September, the Census Bureau reported that the number of people without health insurance climbed to 49.9 million people in 2010, more than 13 million more than were uninsured a decade ago. Among people who do have health insurance, The Commonwealth Fund estimates that in 2010, 29 million working-age adults had such high out-of-pocket costs relative to their income that they were effectively underinsured, an increase from 16 million in 2003.

Both these trends have had serious financial and health consequences for working families. An estimated 75 million adults under age 65, both with and without health insurance, reported a time in 2010 when they did not get needed health care because of the cost, up from 47 million in 2001. And 73 million adults said that they had had difficulty paying medical bills or were paying off medical debt, up from 58 million in 2005. With its array of affordable health insurance options and new consumer protections set to launch in 2014, the Affordable Care Act will substantially reverse these trends, ensuring that all Americans will have access to affordable and comprehensive health insurance coverage.

Health Insurance Coverage of U.S. Families in 2010: Increases in Uninsured and Underinsured People

New data from the Census Bureau in September show that nearly 50 million people in the U.S. were without health insurance for all of 2010. This continues a steady increase in the number of people who are uninsured over the last decade. Over 13 million more people were without health insurance in 2010 than in 2000 (Exhibit 1).¹

Families with incomes under \$50,000 continue to be the most at risk for not having health insurance. Twenty-seven percent of people with incomes under \$25,000 were without health coverage in 2010, with nearly a million more people in this income range losing coverage in 2010 (Exhibit 2). Nearly 22 percent of those in families with incomes between \$25,000 and \$50,000 were uninsured.

Massachusetts leads the nation in the rate of coverage, with just 5.7 percent of its under-65 population and 6.6 percent of its 19-to-64-year-old population lacking health insurance (Exhibit 3). This stands in stark contrast to Texas, where 27.7 percent of the nonelderly population and 32.8 percent of

¹ United States Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, Sept. 2011.

the 19-to-64-year-old population is uninsured, the highest rates in the U.S. In 2006, Massachusetts implemented a universal health insurance system much like the one advanced by the Affordable Care Act, and the state has since experienced a steady improvement in insurance coverage across its population.

High Unemployment Continues to Take a Toll on Coverage

Employer-based health plans continues to be the primary source of coverage for the majority of people in the United States. But rising health care costs have helped erode coverage, particularly for small-business employees, over the last decade. In addition, continuing high rates of unemployment in have left increasing numbers of people without job-based health insurance. The percentage of people with insurance coverage through an employer declined to 55.3 percent in 2010, with 1.5 million fewer people enrolled in employer plans than in 2009 (Exhibit 4). The Census Bureau reports that 48.4 million people ages 18 to 64 did not work at least one week in 2010, up from 45.4 million in 2009. Among people in that age group who were not working, nearly 30 percent were uninsured, two times the rate of people who were employed full-time.

A recent Commonwealth Fund report found that more than half (57%) of working-age adults who lost a job with health benefits became uninsured over the period 2008 to 2010 (Exhibit 5).² Families with low and moderate incomes have been particularly hard hit. Adults with incomes under 200 percent of the federal poverty level, about \$44,700 for a family of four, were less likely to have benefits through a job that was lost, but those who did have benefits through their former job were much more likely to become uninsured than adults with higher incomes.

While employees of companies with more than 20 workers who lose a job can stay on their employer's policy for up to 18 months under COBRA (Consolidated Omnibus Budget Reconciliation Act), they must pay the full premium. Average family premiums in employer plans climbed to \$5,429 per year for single coverage and \$15,073 for a family plan in 2011, placing coverage out of reach for workers who have also lost a significant amount of their income (Exhibit 6).³ Just 14 percent of people who lost a job with benefits in the last two years enrolled in the COBRA program. Those with low incomes were least likely to enroll in COBRA: only 8 percent continued their coverage through COBRA, compared to 21 percent of those with higher incomes.

Other than COBRA, there are few options for workers who lose their jobs and their health benefits. In most states, insurance coverage through public insurance programs like Medicaid and the Children's Health Insurance Program is available only to pregnant women, children, and parents with very low incomes; less than half of states cover childless adults. People who buy insurance in the individual insurance market must pay the full premium, and, in most states, policies are underwritten on

² M. M. Doty, S. R. Collins, R. Robertson, and T. Garber, *Realizing Health Reform's Potential—When Unemployed Means Uninsured: The Toll of Job Loss on Health Coverage, and How the Affordable Care Act Will Help* (New York: The Commonwealth Fund, Aug. 2011).

³ Kaiser Family Foundation/Health Research and Educational Trust, 2011 Employer Health Benefits Survey, September 2011, <http://ehbs.kff.org>.

the basis of health—meaning that a health plan can charge people a higher premium, exclude a health condition from coverage, or turn down someone for coverage altogether because of a preexisting condition. The Commonwealth Fund found that in 2010, 60 percent of adults under age 65 who shopped for coverage in the individual market found it very difficult or impossible to find a plan they could afford, and 35 percent were turned down by an insurance carrier or had a specific health problem excluded from coverage (Exhibit 7).⁴

Unemployed adults who become uninsured suffer significant health and financial consequences. In the Commonwealth Fund report, 72 percent of working-age adults who lost a job with benefits and became uninsured said that they had either not gone to a doctor when they were sick, had not filled a prescription, did not get a recommended test or follow-up visit, or did not get recommended specialist care (Exhibit 8).⁵ And 72 percent reported problems with medical bills, including not being able to pay, being contacted by a collection agency about unpaid bills, having to change their way of life to pay bills, or having to pay off bills over time (Exhibit 9).

Young Adults Gain Coverage in 2010

While young adults have among the highest unemployment rates of any age group, the Affordable Care Act's new provision that allows children up to age 26 to stay on or join their parents' insurance policy has reversed a decade-long increase in the number of young adults without health insurance since it went into effect in September 2010.⁶ The percentage of uninsured young adults ages 19 to 25 without health insurance declined by 3 percentage points in the last year, dropping to 29.7 percent in 2010, down from 32.7 percent in 2009.⁷ This is the largest one-year decline in the uninsured rate for young adults in the last decade, and it translates into 787,000 more young adults with insurance coverage in 2010 compared with 2009, with most of the increase coming from employer-based coverage. Young adults made gains across the country: in California, 131,000 young adults gained health insurance; in Texas, 83,000 young adults gained coverage.

Health Care Cost Growth and the Growing Numbers of Underinsured Adults

A combination of rapid growth in the cost of health insurance, greater exposure to health care costs, and declining incomes means that growing numbers of families are spending more of their earnings on health care. A 2010 report by The Commonwealth Fund found that premiums in employer

⁴ S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010*, The Commonwealth Fund, March 2011.

⁵ M. M. Doty, S. R. Collins, R. Robertson, and T. Garber, *Realizing Health Reform's Potential—When Unemployed Means Uninsured: The Toll of Job Loss on Health Coverage, and How the Affordable Care Act Will Help*, The Commonwealth Fund, August 2011.

⁶ S. R. Collins, T. Garber, and R. Robertson, *Realizing Health Reform's Potential: How the Affordable Care Act Is Helping Young Adults Stay Covered*, The Commonwealth Fund, May 2011.

⁷ Analysis of the March 2011 Current Population Survey by Nick Tilipman and Bhaven Sampat of Columbia University for the Commonwealth Fund.

health plans climbed by 41 percent between 2003 and 2009, while deductibles in those plans jumped by 77 percent.⁸ Yet over the last decade, real family incomes have hardly budged, barely regaining their levels prior to the recession of 2000–2001, before falling again during the 2008 economic downturn.⁹

In a March 2011 report, The Commonwealth Fund found that in 2010, nearly one-third (32%) of working-age adults, or an estimated 49 million people, spent 10 percent or more of their income on out-of-pocket health care costs and insurance premiums (Exhibit 10).¹⁰ This is an increase of more than 10 percentage points since 2001, when about 21 percent of families, or 31 million people, spent that much of their income on health care.

The burden of health care costs has spread most dramatically among Americans with the lowest incomes. In 2010, fully half of adults in families with incomes less than 100 percent of the federal poverty level (\$22,050 for a family of four) spent 10 percent or more of their income on health care costs and premiums, more than double the share who spent that amount in 2001.

Health care costs as a share of household budgets grew among adults who were insured all year as well as among those who were uninsured for a time during the year. In 2010, 35 percent of adults who had been uninsured for at least part of the year spent more than 10 percent of their income on health care costs, up from 27 percent in 2001. Among adults who were insured all year, 31 percent spent 10 percent or more of their income on out-of-pocket costs and premiums, up from 19 percent in 2001.

Increasing numbers of adults are in health plans with high health insurance deductibles. The proportion of insured adults with deductibles of \$1,000 or more nearly doubled over the past five years, increasing from 10 percent in 2005 to 18 percent in 2010 (Exhibit 8). People with private insurance and higher incomes were slightly more likely to have a health plan with a high deductible than were those with lower incomes.

Cathy Schoen and colleagues at The Commonwealth Fund found that 29 million working-age adults who had health insurance in 2010 had such high out-of-pocket costs relative to their incomes that they were effectively underinsured (Exhibit 11).¹¹ This is an increase from 16 million underinsured adults in 2003. People with low and moderate incomes are underinsured at the highest rates: 26 percent of

⁸ C. Schoen, K. Stremikis, S. K. H. How, and S. R. Collins, *State Trends in Premiums and Deductibles, 2003–2009: How Building on the Affordable Care Act Will Help Stem the Tide of Rising Costs and Eroding Benefits* (New York: The Commonwealth Fund, December 2010).

⁹ Council of Economic Advisors, *Economic Report of the President*, February 2011, Table B-33, <http://www.gpoaccess.gov/eop/tables11.html>.

¹⁰ S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010*, The Commonwealth Fund, March 2011.

¹¹ C. Schoen, M. M. Doty, R. H. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs*, Sept. 2011 30(9): 1762–71.

working-age adults with incomes under 200 percent of the poverty level (\$21,780 for an individual and \$44,700 for a family of four) were underinsured in 2010.

How the Affordable Care Act Will Bring Additional Relief to Working Families

These long-term upward trends in both the uninsured and underinsured rates in the U.S. will be significantly reversed by provisions in the Affordable Care Act, among the most important of which focus on softening the growing health care cost burden for low- and moderate-income families. A large number of provisions went into effect last year and are continuing to be rolled out this year (Exhibit 12). They include young adults being able to stay on or join their parents' policies, no preexisting condition exclusions for children under 19, a ban on lifetime benefit limits, coverage of preventive services with no cost-sharing, and preexisting condition insurance plans that are enrolling people with chronic health problems in all 50 states.¹² But the biggest changes brought about by the law will begin in 2014, when Medicaid eligibility will be substantially expanded for adults earning up to 133 percent of poverty, or \$29,726 for a family of four, and subsidized private coverage will be available through new state insurance exchanges for families earning up to 400 percent of poverty, or \$89,400 for a family of four.

State Insurance Exchanges

The state insurance exchanges are the centerpiece of the Affordable Care Act's coverage changes, providing insurance options for individuals and small businesses. The exchanges will create a new marketplace that will serve as the central portal through which people will go to for coverage if they do not have an affordable employer-based health plan. The individual and small-group markets will continue to function outside of the exchanges, but new insurance market regulations against underwriting on the basis of health will apply to plans sold inside and outside the exchanges. People will come to the exchanges, either in person or online, fill out one application, and receive a determination of eligibility, depending on their income, for the law's insurance affordability programs: Medicaid, the Children's Health Insurance Program, the Basic Health Program (at state option), or premium tax credits for private "qualified health plans" (QHPs) sold in the exchanges.¹³ Consumers will have an array of health plan choices with clear information about what their health plans cover and what their cost-sharing responsibilities are. This is a significant departure from the individual market of today, where consumers often have scant information about the health plans they must choose among.

In order to establish an exchange, states must give themselves the legal authority to do so. State legislatures are accomplishing this by passing legislation for their governors to sign, or governors are pursuing other mechanisms to establish and operate exchanges, such as an executive order. As of October, governors of 11 states have signed legislation since passage of the Affordable Care Act to

¹² J. P. Hall and J. Moore, *Realizing Health Reform's Potential: Early Implementation of Pre-Existing Condition Insurance Plans: Providing an Interim Safety Net for the Uninsurable*, The Commonwealth Fund, June 2011.

¹³ S. R. Collins, "HHS's Proposed Regulation for Health Insurance Exchanges: An Emphasis on State Flexibility, Part I," *The Commonwealth Fund Blog*, July 2011.

establish insurance exchanges in their states (Exhibit 13).¹⁴ Governors in four states have signed legislation that signals an intent to establish an exchange or to study the establishment of an exchange. Governors in eight states have pursued or are considering alternatives to establishing exchanges through nonlegislative means.

The federal government is providing considerable assistance to states to establish their exchanges. Nearly all states received \$1 million grants last year to get started. So far this year, 16 states and the District of Columbia have been awarded multimillion-dollar establishment grants over the last few months.

States that decline to establish an exchange, or that have not made sufficient progress toward creating an exchange by January 2013, will work with the U.S. Department of Health and Human Services (HHS) to set up a federally facilitated exchange in their state. But new proposed regulations from HHS would allow for the conditional approval of an exchange if states are at an advanced stage in the development of their exchanges but cannot demonstrate complete readiness by January 2013.¹⁵ In addition, states that do not have exchanges ready for operation in 2014 may apply to operate the exchange in 2015 or in subsequent years.

Premium Tax Credits

Starting in 2014, people with household incomes between 100 percent and 400 percent of the poverty level (\$22,350 to \$89,400 for a family of four) who lack access to affordable insurance will be eligible for a tax credit to offset the cost of premiums for private health plans purchased through the insurance exchanges. To be eligible for the tax credits, someone may not be eligible for "minimum essential coverage" through an employer or other insurance program and must be enrolled in a qualified health plan offered through the exchange. Minimum essential coverage is health insurance that is considered affordable and provides a minimum level of cost protection.

In general, people with incomes under 133 percent of poverty will be eligible for Medicaid, but legal immigrants in the five-year waiting period for Medicaid are eligible for tax credits (Exhibit 14). Under the law, taxpayers eligible for tax credits are required to make contributions to their premiums, as a share of their income, of from 2 percent to 9.5 percent. Those eligible for tax credits will have a choice of private QHPs sold through the exchanges that will offer a comprehensive set of benefits known as the essential benefit package. Insurers will offer these plans at four levels of cost-sharing: bronze plans (covering on average 60% of someone's annual medical costs), silver (70% of costs), gold (80% of costs), and platinum (90% of costs). However, for people with low incomes, the average costs covered by the silver plan will be increased to 94 percent (for those with incomes up to 149% of poverty), 87 percent (150%–199% of poverty), and 73 percent (200%–249% of poverty). In addition,

¹⁴ S. R. Collins, T. Garber, "State Health Insurance Exchange Legislation: A Progress Report," *The Commonwealth Fund Blog*, Sept. 2011, <http://bit.ly/oymb14>.

¹⁵ S. R. Collins, "HHS's Proposed Regulation for Health Insurance Exchanges: An Emphasis on State Flexibility, Part I," *The Commonwealth Fund Blog*, July 19, 2011, <http://bit.ly/qUQ5bS>.

QHPs will have limits on out-of-pocket spending related to income that range from \$1,983 for a single policy and \$3,967 for a family policy for those earning up to 199 percent of poverty (\$44,700 for a family of four) to \$3,967 for a single policy and \$5,950 for a family policy for those earning up to 400 percent of poverty (\$89,400 for a family of four). For those earning 400 percent of poverty or more, out-of-pocket limits are set at the level for health saving accounts or \$5,950 for a single policy and \$11,900 for a family policy.

If these coverage options were available this year, of the 49 million people under age 65 who are uninsured, the 43 percent of those with incomes under 133 percent of poverty would be eligible for Medicaid (Exhibit 15).¹⁶ The quarter (24%) with incomes between 133 percent and 249 percent of poverty would be eligible for premium tax credits that would cap their premium contribution at 3 percent to 8.05 percent of their income, as well as for reduced cost-sharing. The 13 percent with incomes between 250 percent and 399 percent of poverty would be eligible for tax credits that would cap their premium contributions at 8.05 percent to 9.5 percent of their income. The 10 percent who are currently uninsured and have incomes of 400 percent of poverty or more and would not be eligible for tax credits; however, they would be eligible to buy coverage through exchanges or the individual market, with new consumer protections against underwriting, the essential benefit package, and limits on cost-sharing. About 10 percent of those currently uninsured are undocumented immigrants and would not be eligible to purchase coverage through the exchanges.

What Will Be the Amount of the Premium Tax Credit?

In its proposed rule released in August regarding the premium tax credits, the U.S. Treasury Department clarifies that the amount of the credit will be equal to the difference between someone's required premium contribution and the premium of the "benchmark" health plan—the second-lowest-cost "silver plan" offered through the exchange.¹⁷ This means that someone may choose a plan that is not the benchmark plan, but the amount of the tax credit will be determined based on the premium for the benchmark plan, not the plan they enroll in, which could be less or more than the benchmark. In addition, the tax credit amount cannot exceed the amount of the full premium.

To illustrate, a family of four has an income of \$35,000, putting them at 150 percent of the poverty level (Exhibit 16). This means that their required premium contribution would be 4 percent of their income, or \$1,405. If the policy holder is age 40, the Kaiser Family Foundation estimates that this family's premium for a benchmark plan in a medium cost area of the country would be about \$12,130. The family's tax credit would thus be equal to the benchmark premium minus their required contribution, or \$10,725. A family with slightly older parents would be charged a higher premium in the

¹⁶ Analysis of the March 2011 Current Population Survey by Nick Tilipman and Bhaven Sampat of Columbia University for the Commonwealth Fund; estimates of uninsured undocumented immigrants by Jonathan Gruber and B. Dylan Bannon of MIT using the Gruber Microsimulation Model for the Commonwealth Fund.

¹⁷ S. R. Collins, Proposed Rule on Premium Tax Credits: Who's Eligible and How Much Will They Help?, The Commonwealth Fund Blog, August 2011.

exchange. But the tax credit would also be higher, since the premium contribution for the family is a fixed share of its income.

A single person with an income of \$17,000 is also at 150 percent of the poverty level (Exhibit 17). Her required premium contribution is also 4 percent of her income, or \$690. If she is 40, the Kaiser Family Foundation estimates that her premium for a benchmark plan in a medium-cost area of the country would be about \$4,500. Her tax credit would thus be equal to the benchmark premium minus her required contribution, or \$3,810.

Advance credit payments vs. actual tax credits. When someone becomes eligible for a tax credit, the Treasury Department will pay the credit in advance directly to the insurance company, based on his or her most recent tax return. This means that recipients do not have to wait to get the tax credit as part of next year's tax return. But Treasury will reconcile the advance credit payments against the actual tax credit based on the tax return in the year in which the credit is applicable. In other words, if their household income is different in the year in which the advance credits were paid to the insurer, taxpayers will either: a) receive a refund on their return, if their income is lower and they were entitled to a larger tax credit, or b) owe a tax liability, if their income is higher and they were actually entitled to a smaller credit. In the latter case, repayments are capped for people with incomes under 400 percent of poverty to no more than \$600 for married couples (\$300 for singles) under 200 percent of poverty to \$2,500 for married taxpayers (\$1,250 for single) with incomes between 300 percent and 399 percent of poverty.

Are Employees with Employer Health Benefits Eligible for the Tax Credits?

Those whose employers offer minimum essential coverage that meets affordability and benefit standards will be generally ineligible for the tax credits. Under the Treasury Department's proposed rule, workers and their dependents who have an opportunity to enroll in their employers' health plans during an open enrollment period but fail to do so are not eligible. Conversely, someone who is laid off or leaves their job and becomes eligible for COBRA continuation coverage would be ineligible for premium tax credits only if he or she actually enrolled in COBRA.

Workers with unaffordable premiums or poor coverage. There will be one notable exception to the exclusion of those with access to employer coverage: when an employer plan does not meet the criteria for minimum essential coverage—that is, the plan offered would require employees to spend more than 9.5 percent of household income on premium contributions, or would provide less than a minimum level of cost protection (with minimum level defined as at least 60 percent of an individual's total medical costs on average for the year). In either case, a worker could become eligible for premium tax credits if her income was between 100 percent and 400 percent of poverty, unless she had already enrolled in the employer plan.

Under the law, if an employer has 50 or more workers and one of their employees becomes eligible for a tax credit, the employer would have to pay a fee to the Treasury. The fee would be the

lesser of \$3,000 for each full-time worker who receives a premium tax credit or \$2,000 for each full-time worker, excluding the first 30 workers.

Criteria for determining affordability of an employer plan. Treasury's proposed rule provides guidance to employers on how to determine whether an employee's premium contribution is affordable, but Treasury defers guidance on the minimum level of cost protection to a future regulation. Treasury notes that forthcoming guidance will provide flexibility to employers to meet the minimum standard. Regardless of whether an employee has a family plan or "self-only coverage," his employer coverage is considered unaffordable if the required contribution for self-only coverage exceeds 9.5 percent of household income. Someone may thus have a family plan for which he pays more than 9.5 percent of his household income, but if the contribution for self-only coverage is less than 9.5 percent of his income, he would be defined as having affordable coverage.

Employer "safe harbor" regarding penalties. In another simplification for employers, Treasury's proposed rule notes that in future guidance it will likely allow employers to determine whether coverage they offer to employees is affordable based on wages, rather than household income. This is because employers cannot easily determine their employees' household incomes. So for purposes of the fee, if a worker became eligible for a premium tax credit because his contribution for self-only coverage exceeds 9.5 percent of his household income, the employer would not be assessed a payment if the contribution is less than 9.5 percent of the employee's wages.

The Affordable Care Act Will Substantially Reduce the Number of Americans Who Are Uninsured or Underinsured

The Congressional Budget Office (CBO) estimates that 34 million adults and children will become newly covered by 2020 under the law (Exhibit 18).¹⁸ An estimated 16 million uninsured people will gain coverage through Medicaid and 18 million will gain coverage through the state insurance exchanges or employer plans. Those newly covered in the exchanges are estimated to be joined by 8 million people shifting from the individual market and employer plans. Of those purchasing health plans through the exchanges, CBO estimates that about 20 million people will be eligible for premium tax credits, with an average credit of \$6,740. With small firms expected to offer plans to about 5 million workers and their families through the exchanges, an estimated 30 million people may gain private insurance coverage through exchanges by 2020. More than 50 million people will be covered by Medicaid by 2020.

The effect of the Affordable Care Act on health insurance coverage in states across the country will be dramatic, with most states approaching the low uninsured rates that Massachusetts has achieved

¹⁸ Congressional Budget Office, March 2011 Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Washington, D.C.: CBO, 2011).

over the last five years (Exhibit 19).¹⁹ In Texas, where 27 percent of the under 65 population is currently uninsured, fewer than 8 percent are estimated to be uninsured by 2019.

The Affordable Care Act's new consumer protections, income-based cost-sharing tax credits and limits on out-of-pocket costs, and new essential health benefit package will also dramatically reduce the numbers of people who are underinsured. The majority of people who are underinsured are in families with incomes under 250 percent of the poverty level. Families in this income group who become eligible for premium and cost-sharing tax credits will make the greatest gains both in the affordability of their insurance and its comprehensiveness. Schoen and colleagues estimate that the provisions of the law will reduce the number of underinsured Americans by 70 percent.²⁰ If the reforms were implemented today, that would mean that there would be 20 million fewer underinsured adults in the U.S.

The Affordable Care Act Will Reduce the Federal Deficit over 2012–2021 and Lower Premiums

The Congressional Budget Office estimates the Affordable Care Act will reduce the federal deficit by \$124 billion between 2012 and 2021 (Exhibit 20).²¹ The net cost of the Medicaid expansion, premium and cost-sharing tax credits, and small business tax credits (\$1,151 billion) over 2012–2021 will be more than offset by savings from health care delivery system reforms and new revenues. The law includes an extensive set of new demonstration programs and incentives aimed at improving the quality and cost of health care. Such changes include innovations in payment, including higher reimbursement for preventive care services and patient-centered primary care, bundled payment for hospital, physician, and other services provided for a single episode of care, shared savings for accountable provider groups that assume responsibility for the continuum of a patient's care, and pay-for-performance incentives for Medicare providers.²² Cutler, Davis, and Stremikis estimate greater savings than CBO does from the law's delivery system reforms. The authors estimate \$406 billion in savings through delivery system reforms in the law by 2019, and consequently a much greater net decrease in the deficit: \$400 billion by 2019.

Several additional provisions in the Affordable Care Act provisions may help lower the rate of premium growth over time. Requiring everyone to have health insurance will pool risks much more broadly than they are today by bringing in younger and healthier people. CBO estimates that this provision could lower premiums in the individual market and exchanges by 7 percent to 10 percent. CBO estimates that premiums would decline by an additional 7 percent to 10 percent because of lower administrative costs and greater economies of scale in the provision of insurance.²³

¹⁹ The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011*, The Commonwealth Fund, October 2011.

²⁰ C. Schoen, M. M. Doty, R. H. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs*, Sept. 2011 30(9): 1762–71.

²¹ This estimate excludes the CLASS Act.

²² D. M. Cutler, K. Davis, and K. Stremikis, *The Impact of Health Reform on Health System Spending* (Center for American Progress and The Commonwealth Fund, May 2010).

²³ Congressional Budget Office, Letter to the Honorable Evan Bayh, Nov. 30, 2009.

The law also places controls on insurance premiums. Beginning in August 2012, health plans in the large-employer group market that spend less than 85 percent of their premiums on medical care and quality improvement activities, and plans in the small-employer group and individual markets that spend less than 80 percent on the same, will be required to offer rebates to enrollees.²⁴ Carriers will pay rebates to enrollees in the form of a reduction in premiums or a rebate check. People with employer-based plans will receive rebates that are proportional to their premium contribution. Also beginning this year, any insurance carrier that increases its premiums by 10 percent or more in the individual or small-employer group insurance markets, effective on or after September 1, 2011, will have to justify the increase to states and the Department of Health and Human Services.²⁵ Starting in 2014, states can recommend that health plans be excluded from participation in the insurance exchanges if they have demonstrated a pattern of excessive or unjustified premium increases.

Cutler, Davis, and Stremikis estimate that if the combination of insurance and delivery system reforms are effective in slowing the growth in premiums by just 1 percent below annual projected rates of increase, based on historical trends, the cost of family health insurance would drop by an average of \$995 annually by 2015 and by \$2,323 by 2020.

Health care cost growth has begun to moderate.²⁶ In 2009, as health reform was being debated, total national health expenditures were projected to reach \$4.9 trillion in 2020. This baseline was used by federal scorekeepers evaluating the law and estimating the cost of covering the uninsured and providing premium subsidies for working families. Today's figures show that expenditures are now projected to reach \$4.6 trillion in 2020, 5.6 percent below original estimates.

By using the higher 2009 health system spending baseline, analysts assumed that providing coverage for the uninsured and premium subsidies would be more expensive for the federal government than now appears to be the case. The offsetting revenue estimates, by contrast, are less sensitive to the slowdown in health expenditures—legislative provisions such as taxes on wealthy individuals, lower Medicare Advantage payments, and productivity adjustments for hospitals can still be expected to produce significant federal budget savings. If scorekeepers were to redo the original estimates based on these new projections, the deficit reduction generated by health reform would be greater. More broadly, any reduction in health spending growth is reason for cautious optimism, as premium growth moderates and the public cost of providing affordable coverage to all is reduced. Indeed, the slowdown in health care costs in the last two years has already saved the nation substantially more in national health expenditures (\$274 billion less by 2020 than originally estimated)

²⁴ S. R. Collins, "Medical Loss Ratio Regulations Good for Consumers," *The Commonwealth Fund Blog*, Nov. 2010.

²⁵ S. R. Collins, "New Review Process for 'Unreasonable' Premium Hikes," *The Commonwealth Fund Blog*, Dec. 2010.

²⁶ K. Davis, "Health Spending Continues to Moderate, Cost of Reform Overestimated," *The Commonwealth Fund Blog*, July 2011.

than the amount CMS had estimated health reform will have increased expenditures in 2020 (\$74 billion).

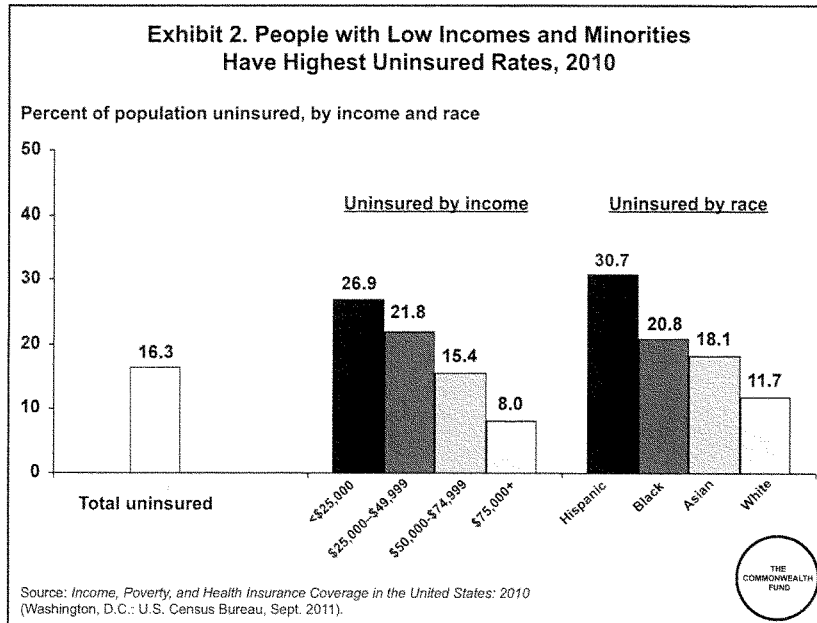
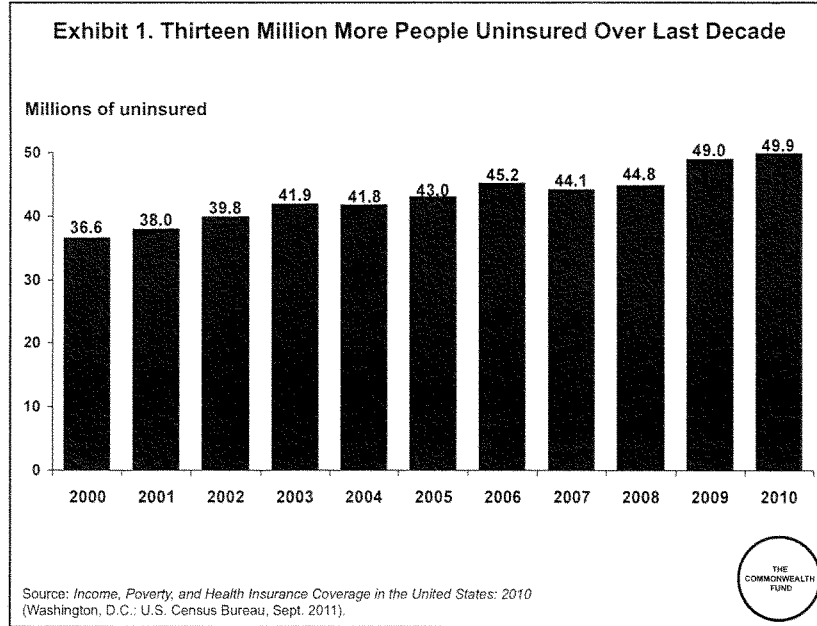
The slowdown also benefits employers, households, and state governments. In 2009, CMS estimated that total health expenditures would consume 21 percent of the gross domestic product (GDP) in 2020. Now, with health reform, it estimates that health spending will be 19.8 percent of GDP. And instead of increasing at an annual rate of 6.8 percent between 2015 and 2020, as projected prior to reform, health spending with health reform is now projected to grow at 6.3 percent annually.

Conclusion

The early provisions of the Affordable Care Act that went into effect one year ago are already having an effect on American's health insurance coverage, with 787,000 more young adults covered in 2010 compared with 2009. But the erosion in employer coverage resulting from job losses, coupled with fewer companies offering health insurance, underscores the need for federal and state policymakers to continue implementing the Affordable Care Act. After 2014, when the law is fully implemented, U.S. families will have new affordable and comprehensive health insurance options through a substantial expansion in Medicaid and new premium tax credits and cost-sharing limits that will substantially improve the affordability of health insurance and health care. New consumer protections against basing coverage and premiums on a family's health and a new standard for benefits will enhance the ability of people to shop for coverage on their own and make informed health plan choices. In addition, while much of the recent national debate has focused on lowering the costs of Medicare and reducing the federal deficit, the same forces that are driving up public program costs are also increasing costs for working families. With its extensive set of delivery and insurance market reforms, the Affordable Care Act focuses on improving quality and affordability throughout the entire health care system.

In combination, these reforms will significantly reduce the number of people in each state who either lack health insurance or have such high out-of-pocket costs that they are underinsured. For the 50 million adults and children who were without coverage in 2010, and the additional 29 million adults who were insured but not protected from high out-of-pocket costs, the 2014 reforms cannot come soon enough.

Thank you.



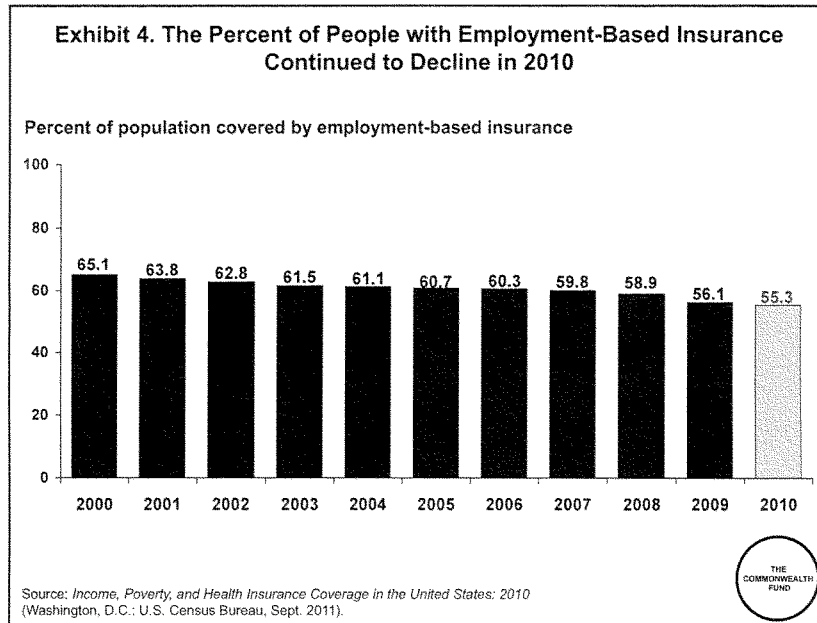
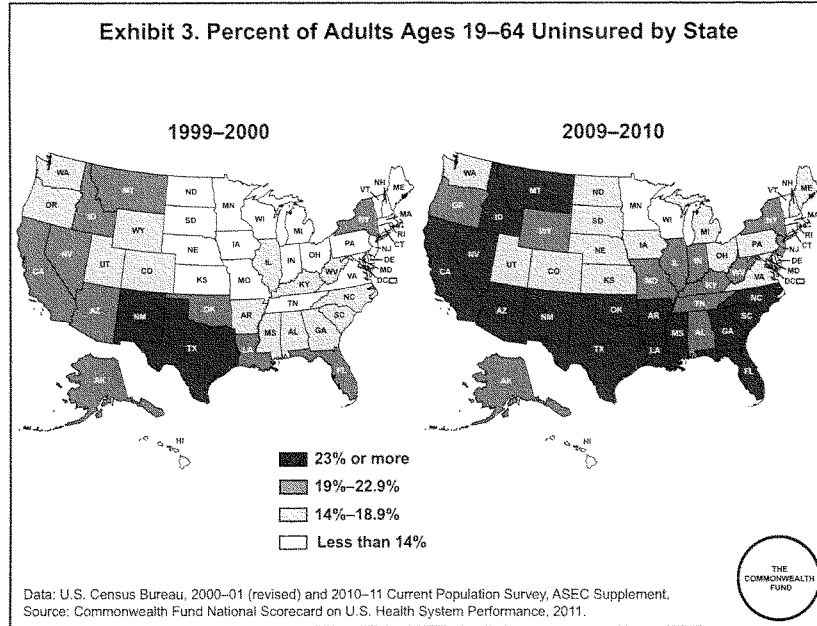


Exhibit 5. Nearly Three of Five Adults Who Lost a Job with Health Benefits in the Past Two Years Became Uninsured

Percent of adults ages 19–64 who lost their job with employer-based benefits*

	Total^	<200% FPL	200% FPL or more	White	Black or Hispanic
Respondent lost job in past two years	18% 33 million	28% 20 million	11% 10 million	15% 18 million	25% 13 million
Respondent had insurance through job that was lost	46% 15 million	36% 7 million	69% 7 million	53% 10 million	41% 5 million
What happened when you lost your employer-based health insurance?					
Became uninsured	57	70	42	49	73
Went on spouse's insurance or found insurance through other source	25	22	29	27	21
Continued job-based coverage through COBRA	14	8	21	19	5

Note: FPL refers to federal poverty level.

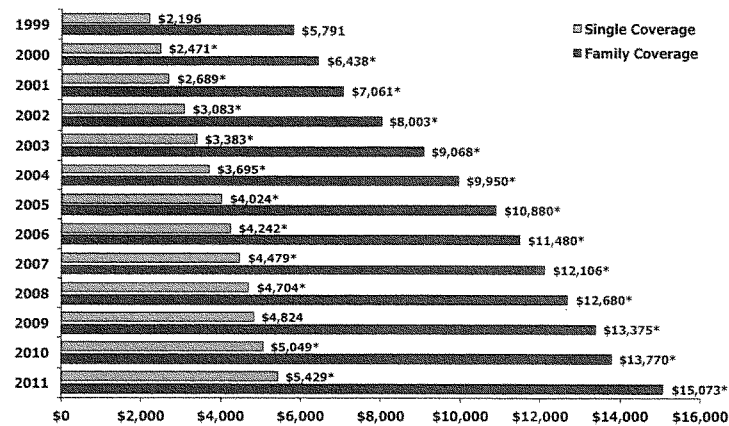
* Job lost in the past two years.

^ Includes respondents who did not state their income level.

Source: M. M. Doty, S. R. Collins, R. Robertson, and T. Garber, *Realizing Health Reform's Potential—When Unemployed Means Uninsured: The Toll of Job Loss on Health Coverage, and How the Affordable Care Act Will Help* (New York: The Commonwealth Fund, Aug. 2011).



Exhibit 6. Average Annual Premiums for Single and Family Coverage, 1999–2011



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2011.



Exhibit 7. The Individual Insurance Market Is Not an Affordable Option for Many People

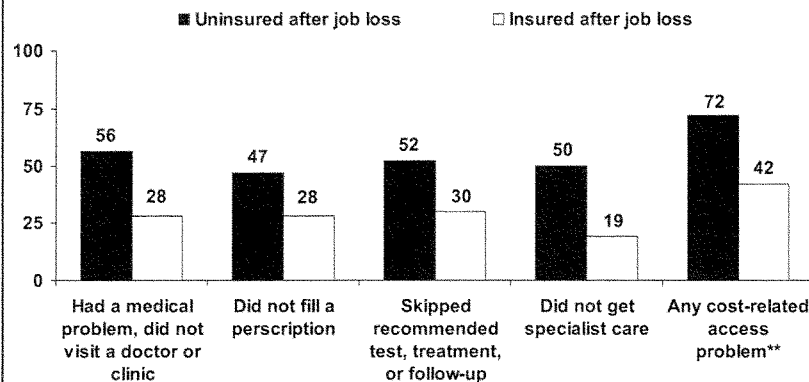
Adults ages 19–64 with individual coverage* or who tried to buy it in past three years who:	Total 26 million	Health problem**	No health problem	<200% FPL	200%+ FPL
Found it very difficult or impossible to find coverage they needed	43% 11 million	53%	31%	49%	35%
Found it very difficult or impossible to find affordable coverage	60% 16 million	70	46	64	54
Were turned down, charged a higher price, or had condition excluded because of a preexisting condition	35% 9 million	46	20	38	34
Any of the above	71% 19 million	83	56	77	64

Note: FPL refers to federal poverty level. * Bought in the past three years. ** Respondent rated their health status as fair or poor, has a disability or chronic disease that keeps them from working full time or limits housework/other daily activities, or has any of the following chronic conditions: hypertension or high blood pressure; heart disease, including heart attack; diabetes; asthma, emphysema, or lung disease; high cholesterol.
Source: S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010* (New York: The Commonwealth Fund, March 2011).



Exhibit 8. Three-Quarters of Adults Who Became Uninsured When They Were Laid Off Had Problems Getting the Care They Needed

Percent of adults ages 19–64 who lost a job with employer-based benefits*



* Job lost in the past two years.

** Includes any of the following because of cost: had a medical problem, did not visit a doctor or clinic; did not fill a prescription; skipped recommended test, treatment, or follow-up; did not get specialist care.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).



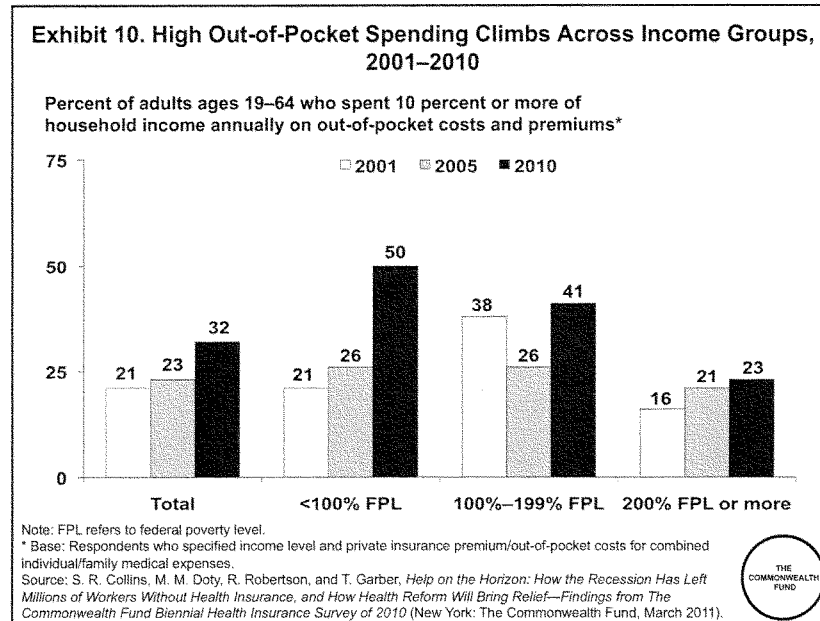
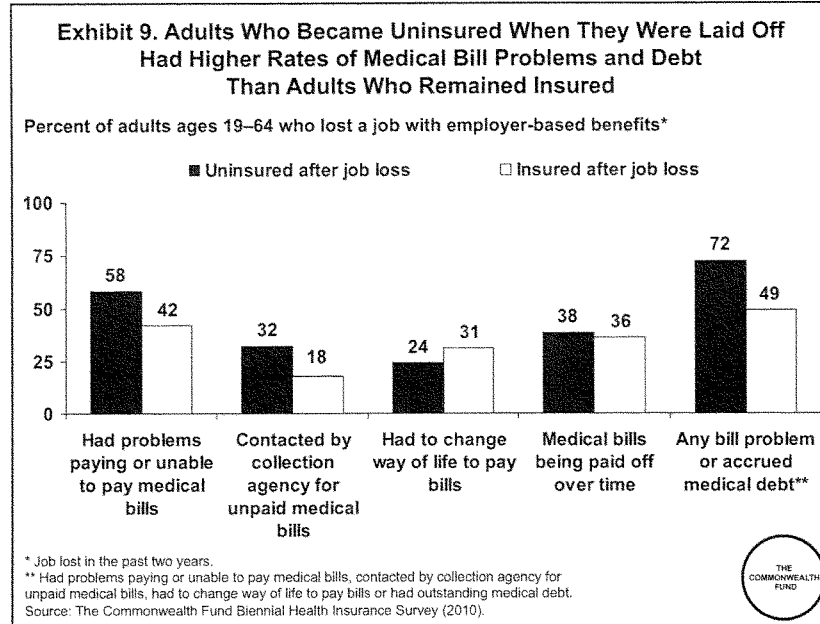
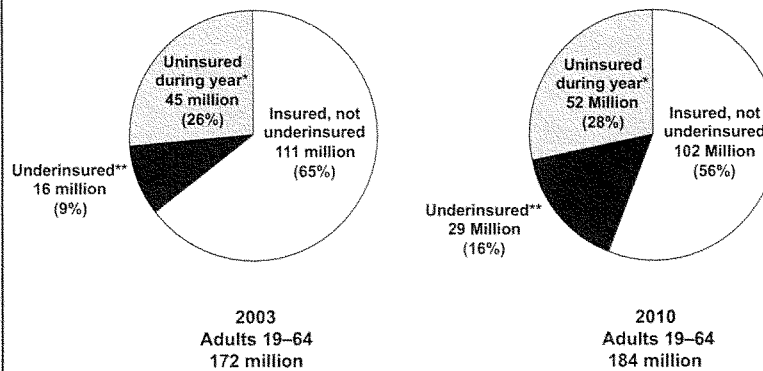
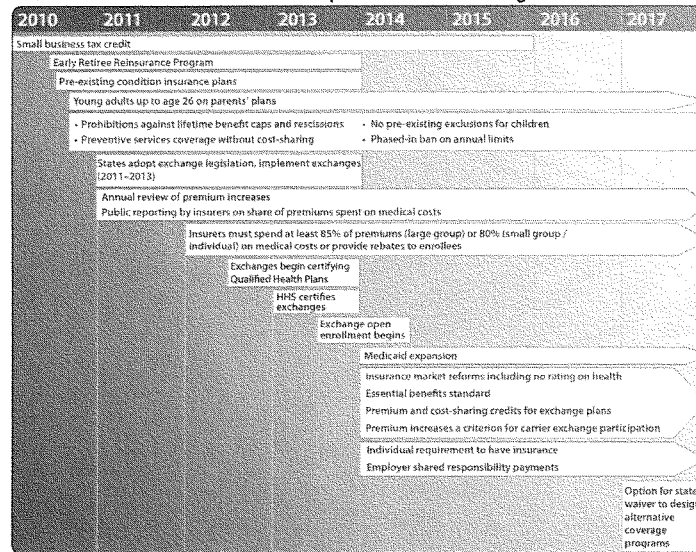


Exhibit 11. 2010: 29 Million Adults Under Age 65 Underinsured

* Uninsured during the year combines "insured now, time uninsured in the past year" and "uninsured now."
 ** Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low income (<200% of poverty); or deductibles equaled 5% or more of income.
 Source: C. Schoen, M. M. Doty, R. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs*, Sept. 2008 30(9):1762-71.
 Data: 2003 and 2010 Commonwealth Fund Biennial Health Insurance Surveys.

**Exhibit 12. Timeline for Health Reform Implementation: Coverage Provisions**

Source: National Association of Insurance Commissioners, Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111-148 and 111-152), <http://www.commonwealthfund.org/health-reform/health-reform-resources.aspx>.



Exhibit 13. Status of State Legislation to Establish Exchanges, as of October 2011

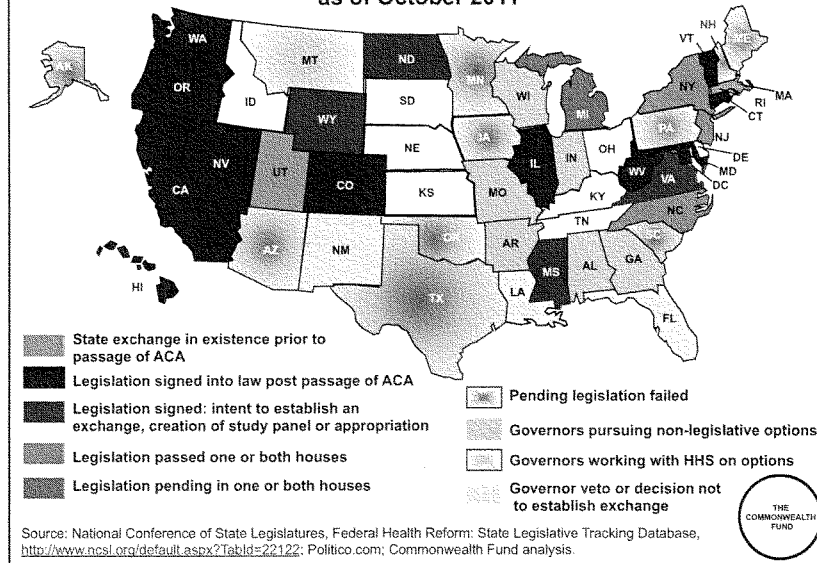


Exhibit 14. Premium Tax Credits and Cost-Sharing Protections Under the Affordable Care Act

Federal poverty level	Income	Premium contribution as a share of income	Out-of-pocket limits	Actuarial value: Silver plan
<133%	S: <\$14,484 F: <\$29,726	2% (or Medicaid)	S: \$1,983 F: \$3,967	94%
133%–149%	S: \$16,335 F: \$33,525	3.0%–4.0%		94%
150%–199%	S: \$21,780 F: \$44,700	4.0%–6.3%		87%
200%–249%	S: \$27,225 F: \$55,875	6.3%–8.05%	S: \$2,975 F: \$5,950	73%
250%–299%	S: \$32,670 F: \$67,050	8.05%–9.5%		70%
300%–399%	S: \$43,560 F: \$89,400	9.5%	S: \$3,967 F: \$7,933	70%
≥400%	S: ≥\$43,560 F: ≥\$89,400	—	S: \$5,950 F: \$11,900	—

Four levels of cost-sharing: 1st tier (Bronze) actuarial value: 60%
2nd tier (Silver) actuarial value: 70%
3rd tier (Gold) actuarial value: 80%
4th tier (Platinum) actuarial value: 90%

Catastrophic policy with essential benefits package available to young adults and people who cannot find plan with premium ≤8% of income

Notes: In the income and out-of-pocket limits columns, S refers to single and F refers to family. Actuarial values are the average percent of medical costs covered by a health plan. Premium and cost-sharing credits are for silver plan. Source: Federal poverty levels are for 2011; Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? <http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx>.



Exhibit 15. Distribution of Uninsured Nonelderly Individuals in 2010, by Income Level and Provisions of the Affordable Care Act

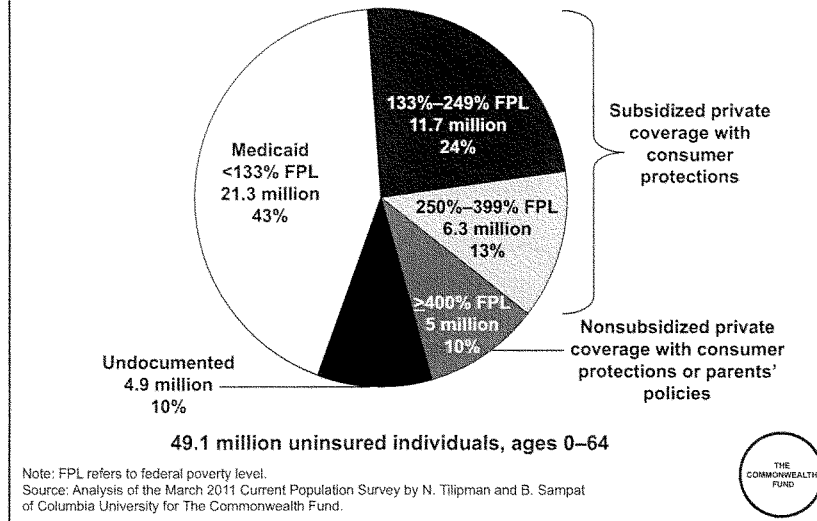
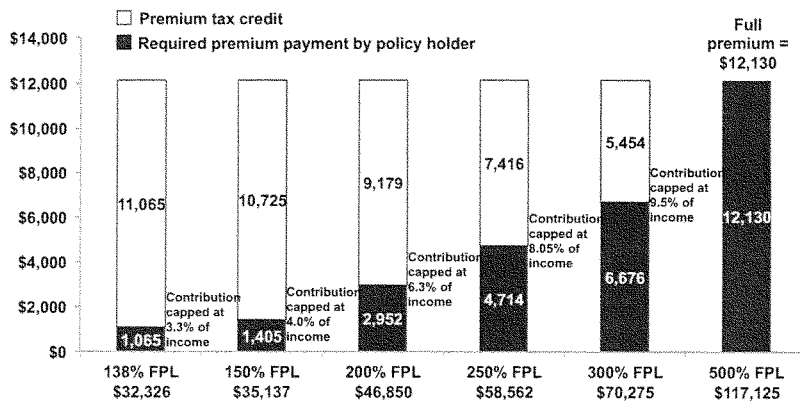


Exhibit 16. Annual Premium Amount and Tax Credits for a Family of Four Under the Affordable Care Act, 2014

Annual premium amount paid by policy holder and premium tax credit*



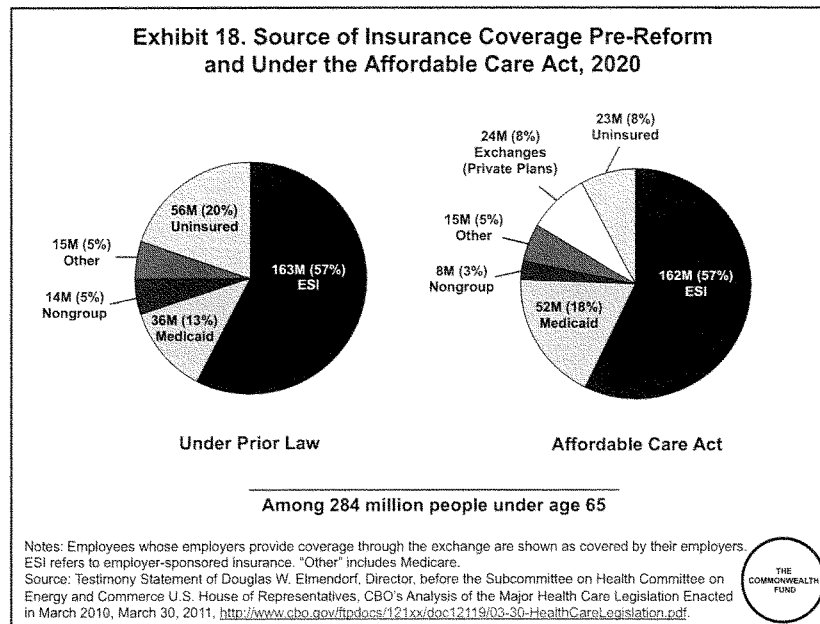
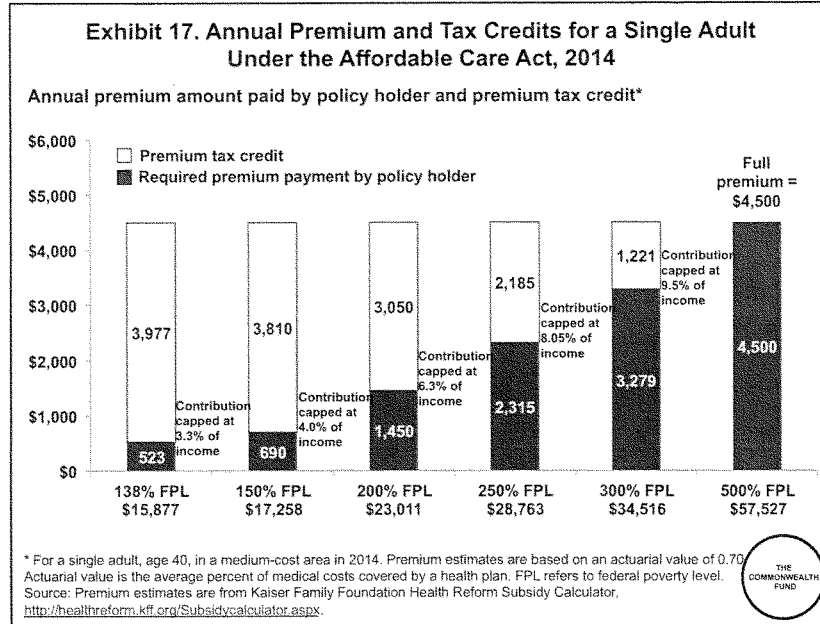


Exhibit 19. Post-Reform: Projected Percent of Adults Ages 19–64 Uninsured by State

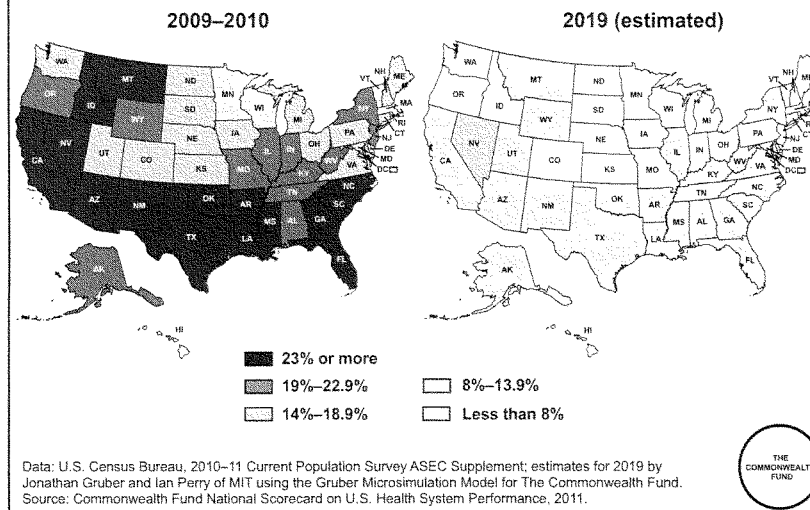


Exhibit 20. Estimated Budgetary Effects of Enactment of the Affordable Care Act and the Health Care Provisions of the Reconciliation Act, 2012–2021

Dollars in billions

	Revised February 2011 CBO Estimate
Total Net Impact on Federal Deficit, 2012–2021	–\$124
Total Federal Cost of Coverage Expansion and Improvement	\$1,151
Gross Cost of Coverage Provisions	\$1,390
• Medicaid/CHIP outlays	674
• Exchange subsidies	677
• Small employer subsidies	40
Offsetting Revenues and Wage Effects	–\$239
• Payments by uninsured individuals	–27
• Pay-or-pay payments by employers	–82
• Associated effects on taxes and outlays	–130
Total Savings from Payment and System Reforms	–\$646
Total Revenues	–\$631
• Excise Tax on High-Premium Insurance Plans	–111

Note: Totals do not reflect net impact on deficit because of rounding. Discontinuing the CLASS program eliminates an estimated \$86 billion of the \$732 billion in payment and system reform savings the health reform law was projected to generate over 2012–2021.

Source: D. Elmendorf, *Letter to the Honorable John Boehner* (Washington: Congressional Budget Office, Feb. 18, 2011).

THE COMMONWEALTH FUND

**Exhibit 21. Comparison of CMS 2009, 2010, and 2011
National Health Expenditure (NHE) Spending Projections**

		Total NHE (\$ billions)	% difference from 2009	NHE per capita	NHE/ GDP	NHE CAGR 2015–2020
2020	2009 CMS estimate without reform*	\$4,912.5		\$14,517.0	21.0%	6.8%
	2010 CMS estimate without reform**	\$4,757.6	–3.2%	\$14,059.0	20.3%	6.7%
	2010 CMS estimate with reform**	\$4,861.1	–1.0%	\$14,365.0	20.8%	6.6%
	2011 CMS estimate without reform	\$4,564.3	–7.1%	\$13,487.9	19.5%	6.4%
	2011 CMS estimate with reform	\$4,638.4	–5.6%	\$13,708.8	19.8%	6.3%

Notes: * Assumes 10-year 2009–2018 NHE CAGR continues in 2019 and 2020;

** Assumes 10-year 2010–2019 NHE CAGR continues in 2020.

Sources: K. Davis, "Health Spending Continues to Moderate, Cost of Reform Overestimated," Commonwealth Fund Blog, July 29, 2011; CMS Spending Projections from 2009, 2010, and 2011; Commonwealth Fund estimates.



**Exhibit 22. The Number of Adults Without Insurance, Forgoing Health
Care Because of Cost, and Paying Large Shares of Their Income on
Health Care Has Increased, 2001–2010**

Adults ages 19–64

	2001	2005	2010
In the past 12 months:			
Uninsured any time during the year	24% 38 million	28% 48 million	28% 52 million
Any bill problem or medical debt*	—	34% 58 million	40% 73 million
Any cost-related access problem**	29% 47 million	37% 64 million	41% 75 million
Spent 10% or more of household income on premiums***	11% 10 million	14% 14 million	15% 14 million
Spent 10% or more of household income on premiums and total out-of-pocket costs****	21% 31 million	23% 35 million	32% 49 million
Any of the above	—	62% 107 million	67% 123 million

* Includes: Had problems paying or unable to pay medical bills; contacted by collection agency for unpaid medical bills; had to change way of life to pay bills; medical bills being paid off over time. ** Includes any of the following due to cost: Had a medical problem, did not visit doctor or clinic; did not fill a prescription; skipped recommended test, treatment, or follow-up; did not get needed specialist care. *** Base: Respondents who reported their income level and premium costs for their private insurance plan. **** Base: Respondents who specified income level and private insurance premium/out-of-pocket costs for combined individual/family medical expenses.

Source: S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010* (New York: The Commonwealth Fund, March 2011).



Mr. GOWDY. Thank you, Dr. Collins.

Dr. Holtz-Eakin, recently I was privileged to be on the committee where you spoke or testified more globally about the state of our fiscal health as a Nation. Can you go back into that with specific reference to health-care costs and how the cost of health care will impact our fiscal state in the near and long-term future?

Mr. HOLTZ-EAKIN. Well, certainly, if you go back to the beginning of this year and look, for example, at the administration's budget, it showed we are running a deficit this year of about \$1.3 trillion. And that is, in and of itself, troubling. And our current gross debt relative to GDP is over 90 percent. And that is the region in which the evidence suggests you pay a growth penalty of 1 percent per year, roughly, and have a much higher probability of encountering international sovereign debt problems. So, that is where we are.

If you roll the clock forward 10 years in that budget, assume that we are not fighting any overseas military operations, the financial crisis is in distant memory, we are back to full employment, we are growing nicely, the deficit is still \$1.2 trillion in that budget projection, and \$900 billion of it is interest on previous borrowings.

We are spiraling out of control. This is true despite the fact that revenues are up to 19.5 percent of GDP, above the historic norm. The administration raises all the taxes they want in that budget. And that tells you that we have a spending problem. And if you look inside that spending problem, it is driven by Medicare, Medicaid, and, soon, the Affordable Care Act. And that has to be the focus in controlling our future debt increase and the threats that it faces the United States with.

Nothing that has happened since that budget really changes that picture. The Budget Control Act in August puts discretionary spending caps on. They will be as effective as future Congresses are effective with living with them. We haven't touched any of the mandatory spending programs, which are at the heart of that problem. And so I view it as inescapable that this committee and the Congress as a whole will be back to look at that whole array of Federal health programs again and again.

Mr. GOWDY. Dr. Holtz-Eakin, I know you are going to be reluctant to do what I ask you to do because it will make you assume that you are a Member of Congress and our public approval rating is such—

Mr. HOLTZ-EAKIN. I must respectfully decline, sir.

Mr. GOWDY [continuing]. That you will probably not accept my invitation. But what should the tax treatment be for health care? How would you reform it if you were king for a day?

Mr. HOLTZ-EAKIN. Well, I have been on record for years as removing the exclusion from tax of employer-sponsored health insurance. It is a perverse subsidy that, number one, diminishes the awareness of consumers of health insurance to its real cost. Number two, the subsidy is bigger for higher-income individuals, so it is at odds with the conventional American notions of equity. And I would eliminate that.

And instead, to the extent that we wanted to support the purchase of private health insurance in the United States, I would provide low-income support in a fixed credit that didn't vary by income and which didn't have this open-ended subsidy aspect.

Mr. GOWDY. Ms. Furchtgott-Roth, I was struck, as I am sure all of us up here were unless they had heard it before, about the systemic penalty for marriage that is, I am sure, inadvertently, unwittingly built into this law, but, nonetheless, it is there.

Were there other examples you could give? I was just struck by June and Jack, I believe it was, that their decision to get married is going to have a deleterious impact on their bottom line. That fact alone is going to cause their health-care costs to go up.

Are there other examples that you would have given had you had more than 5 minutes, or were those the most probative?

Mr. FURCHTGOTT-ROTH. Those are the most salient examples. But what I was going to say is that it also gives an incentive, if the couple gets married, for one of them not to work. And usually it is the woman who decides not to go back into the labor market. About 80 percent of women have children at some point in their lives; they tend to go in and out of the labor market. And if there is this big penalty on their earnings—in other words, if the family says, “Okay, June, you go back to work, but then we are going to lose government help with our health insurance,” then the big incentive, on top of the extra tax penalty, is for the woman to drop out of the labor force and not work.

And with the higher taxes in Europe, we have seen that there are lower levels of female labor force participation. Here in the United States, we have some of the highest levels of female labor force participation. Women have invested in their education, they plan to have many years with productive jobs, and this marriage penalty would basically throw them for a loop.

Mr. GOWDY. I want to follow the same admonitions I gave everyone else, and my time is up. So I would recognize the distinguished gentleman from Illinois, the ranking member of the subcommittee, Mr. Davis.

Mr. DAVIS. Thank you very much Mr. Chairman. You know, I always say, you can’t lead where you don’t go. And so I appreciate very much your approach to the timing.

Dr. Holtz-Eakin, I was somewhat fascinated by your testimony. And I was wondering, as I listened to you, if people are living longer, using emergency rooms less frequent, using tertiary care, which is very expensive, because the state of their health has gotten to the point where they need this kind of care, I was trying to figure out how those factors would be detrimental to our economy and how those would be negatives as opposed to positives.

Could you respond to that?

Mr. HOLTZ-EAKIN. Well, as in any policy issue, there are benefits and costs to the legislation and in the health-care issue in general.

It is certainly the case that we want a high-quality health-care system and Americans living in better health and longer. No one disagreed with that at the outset of the debate. I think the issue is, does this legislation meet the objectives we want in terms of delivery system reforms? My judgment would be, no, that it will not, in fact, solve some of the problems we see in the delivery of American medicine that leads us to have a very low-value system. We spend a lot of money with very substandard results. We can have a longer discussion about why I think that.

And then the second question is the financing. And in the process of financing that consumption of health care, do we do it in an efficient fashion that allows us to meet other objectives for economic growth and other policy objectives? And, again, my judgment is, this approach, which essentially wrote, you know, a trillion dollars' worth of checks and raised \$500 billion of taxes and pretended to cut \$500 billion out of Medicare isn't going to meet that objective.

And so I think there was, at the beginning of 2009, a shared understanding of the need for health-care reform, a shared understanding that the objectives should be higher-quality care at lower cost and an efficient insurance system. I just don't think we met those objectives.

Mr. DAVIS. Thank you.

Ms. Furchtgott-Roth, have you ever known anyone to not get married because they were concerned about the cost of health care or how it would impact them and, as a result, they would decide, "Well, you know, I am not going to get married because this is going to have a negative impact on my being?" Have you ever known anyone to—

Mr. FURCHTGOTT-ROTH. Well, the provisions—the answer to your question is no. But the provisions of this health-care act have not yet kicked in. Now, say two young people who—first of all, they don't have the mandate to have health insurance, they are people who are uninsured for short periods of time between jobs, you can buy a low-cost health insurance program right now with a high deductible and a health savings account and catastrophic health care.

So this hasn't arisen right now, but it will if the government mandates expensive health insurance, requires people to have it, and gives people subsidies depending on where they are in the poverty line. Because the poverty line for one person is \$10,890, but for two people it is \$14,710.

Mr. DAVIS. Well, let me ask you, are the marriage rates going up or down?

Mr. FURCHTGOTT-ROTH. I would have to check those data and get back to you. And I would be happy to do that.

Mr. DAVIS. Let me ask you, Dr. Collins, why do you think overwhelmingly people feel a need to reform our approach to health care and what we have been doing?

Ms. COLLINS. I think the major motivation for the Affordable Care Act was to cover the 50 million people who are without coverage. That number has been growing over time. And we also know that rising health-care costs are making it increasingly difficult for employers to offer coverage, so more employers have dropped coverage, particularly small employers have dropped coverage over the last few years.

In this recession, we know that high employment rates are related to people losing their coverage through their jobs. About 57 percent of people who lost a job with health benefits became uninsured.

And the other major piece of this is also addressing the underlying cost growth in the health-care system. Half of the law is really directed at significant delivery system reforms that will achieve the kinds of cost savings that Mr. Holtz-Eakin mentioned that are necessary to bring our deficit under control. And, in fact, if you see

the Congressional Budget Office estimates, it, in fact, over 10 years, does reduce our deficit, in large part because of those reforms.

Mr. DAVIS. Thank you very much, Mr. Chairman.

Mr. GOWDY. I thank the gentleman from Illinois.

The chair would now recognize the gentleman from Tennessee, Dr. DesJarlais.

Mr. DESJARLAIS. Thank you, Mr. Chairman.

And thank you, panel, for your testimony today.

I guess, after listening to the testimony here and prior to coming to Congress in January being a practicing primary-care physician for 20 years, I will maybe start with Dr. Collins and say, what makes the Affordable Health Care Act affordable?

Ms. COLLINS. There are several insurance coverage expansions that will make coverage far more affordable for people than is the case today.

Most people who try to buy on their own, as was mentioned earlier, don't actually end up buying a health plan through the individual market because they are underwritten on the basis of their health and they actually face the full premium, their health-care conditions can be excluded from their coverage. So the new Medicaid expansion will dramatically increase coverage for people, as well as the premium tax credits increasing coverage for people up to 400 percent of the poverty line.

Jonathan Gruber did an analysis that he published in May that looked at whether health care will become more affordable for people. And the majority of people in the United States would find premiums and their out-of-pocket costs affordable under the Affordable Care Act.

Mr. DESJARLAIS. Who is going to eat the cost? I mean, it isn't free to provide health care. You said 50 million uninsured, 70 million uninsured. I think the President talked about 30 million uninsured when this came into effect, so I guess it has grown by 20 million in the last year and a half.

Who is going to pay for that? Where is that money going to come from? Who are they going to take it from?

Ms. COLLINS. Well, there are several offsetting provisions in the law that do pay for the expansion completely and, in fact, save money over time.

Mr. DESJARLAIS. So the taxpayer then? I mean, the government doesn't have any revenue other than tax. So the taxpayers are going to pay for it?

Ms. COLLINS. The provisions in the law require changes to the delivery system, changes to Medicare Advantage plans, bringing them more in line with regular Medicare—

Mr. DESJARLAIS. Do you think health care is going to improve, or is the quality of care going to go down?

Ms. COLLINS. The quality of care, under the provisions of the law, are absolutely expected—is absolutely expected to increase. The delivery system—

Mr. DESJARLAIS. How so?

Ms. COLLINS. The delivery system reforms are actually directed not only toward saving money but also improving the way in which people receive their care, making the system more patient-centered,

focusing on coordinating people's care over their lifetime and over a disease experience. So, bringing much more rationality to the system than is the case today.

Mr. DESJARLAIS. Uh-huh.

Dr. Holtz-Eakin, I think you said Medicare is maybe one of the worst examples of the management of an entitlement program.

Mr. HOLTZ-EAKIN. I certainly think it is a clear fiscal problem; we know that. I mean, right now the gap between premiums and payroll taxes coming in and spending going out is \$280 billion a year. It is going to get worse, not better.

It also promotes a lot of bad medicine. We have a Part A for hospitals, a Part B for doctors, a Part C for insurance companies, a Part D for pharmaceuticals. It is not integrated in any way. It is not coordinated around a beneficiary. You know, hospitals are paid a fixed amount for a diagnosis; doctors are paid for volume. Doctors practice in hospitals. The conflicting incentives are enormous.

So I think reforming Medicare should have been the top priority, not something that was left behind.

Mr. DESJARLAIS. Yeah. And right now, as Medicare patients will tell you, it is getting harder and harder to find primary-care doctors. And so I guess you are disagreeing with Dr. Collins where she says, we can add more and more people to Medicaid and yet we are going to maintain a quality of care and somehow we are going to reduce costs.

Mr. HOLTZ-EAKIN. The Medicaid expansion is the most problematic, in my view. Medicaid beneficiaries are in ERs for normal care at far higher rates than are the uninsured. And they have great difficulty finding primary-care physicians. And to expand that program, rather than fix it, I think was an enormous mistake.

And I just want to say, on the affordability issue, there is a fundamental problem with a country that spends nearly 20 percent of its national income on health care and defines care to be affordable when it is under 10 percent. That can't add up.

Mr. DESJARLAIS. And, you know, I don't think people in general want to look at it like a Better Homes and Gardens, good, better, best health care. I mean, everybody wants the best, but the best costs money. And we are saying, this is an affordable health care act, but yet we are trying to increase the number of participants and we are trying to decrease the cost. Someone is going to have to pay for it. Ultimately it is going to be taxpayers who will bear the burden.

You know, physicians, we have an SGR problem right now for physicians, where they are trying to cut another 29 percent from physician pay. As a primary-care physician, I don't set my own fees. That was set by Medicare over a decade ago. We have not had an increase in 10 years, and they are proposing a 10-year freeze. I don't know what the incentive is going to be to other physicians to go into medicine to help expand this improved quality of care that Dr. Collins spoke of.

But my time has expired, and I thank you for your input.

Mr. GOWDY. I thank the gentleman from Tennessee.

The chair would now recognize the gentleman from Maryland, the ranking member of the full committee, Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Dr. Collins, it is not just a question of being affordable; it is also a question of being available, is that right? I mean, this is what the affordable care law is trying to make health care available, because there are so many Americans that don't—even if they could afford it, it is not available. I have people in my family who could not even get an insurance policy if they were willing to spend \$50,000 a year because of pre-existing conditions. And we talk about women and we look at the—I think there was some research done that showed women having far more pre-existing conditions than men.

And then we also found that if a woman has a woman-owned firm, she is going to spend a lot more money on women in that firm than, say, if a firm were, say, 50/50 male/female, is that right?

Ms. COLLINS. That is absolutely correct. And right now, if a woman goes to the individual insurance market to buy a health plan, as was mentioned, if they lose their job or if they are between jobs, those plans generally do not come with maternity benefits. So insurers will not cover maternity because it is a cost to them. So, under the Affordable Care Act, insurance plans will be required to offer maternity coverage.

For small businesses, the law is very much geared toward making it much easier for small businesses to offer coverage. The requirement on the penalties that was mentioned earlier only applies to companies with more than 50 employees. Employers can come into the exchanges, have a much broader array of health plans to offer their employees at likely lower cost.

So these are very much geared toward both improving women who are buying individual coverage on their own and women who own small businesses and are trying to do the best thing for their employees.

Mr. CUMMINGS. In my district, in the real world, about 40 miles away from here, we often see people very sick ending up in the emergency rooms, Mr. Holtz-Eakin. And I think one of the aims of the Affordable Care Act was to try to zero in on wellness as opposed to treating people after they are sick. We need a new normal in this country. See, some people think that the only time you go to a doctor is when you are sick—or when you should go to a doctor is when you are sick. Sometimes you need to go so that you can stay well.

And I think one of the major aims of all of this is to try to keep people well. Is that right, Dr. Collins?

Ms. COLLINS. Absolutely. And you see that in the provisions of the law, one of which went into effect last year. Insurers have to cover preventive care with no cost-sharing. Very little increase in premiums as a result of this provision, but will affect millions of people who get coverage right now. We want people to go to the hospital when they are sick or we want people to get primary care before they get sick, so the law is absolutely directed toward encouraging that.

It is very, very troubling that, over the recession, people who have lost their jobs have gone without insurance coverage. Seventy percent, more than 70 percent, have said they didn't get needed health care because of cost, including filling a prescription because

of cost. So we really want to change those incentives in the system, making it much more available to people.

Mr. CUMMINGS. Thank you.

Now, Dr. Holtz-Eakin, your written testimony characterizes CBO's conclusion that the PPACA will result in budget savings as, "misleading"—that is page 5—and, "dubious," page 4.

You were once the director of the CBO. You oversaw scoring on many bills. Is it your testimony today that CBO did something wrong or violated any of the principles of budgetary scoring in coming to this conclusion, that the PPACA would generate a budget savings? Is that what you are saying?

Mr. HOLTZ-EAKIN. Absolutely not.

Mr. CUMMINGS. Okay. Well, isn't it true that you would have likely concluded a budgetary savings given the same facts and same bill language had you been CBO director when the PPACA was scored?

Mr. HOLTZ-EAKIN. Had Congress directed me the way they directed the currency bill, I would have received the same bottom line.

Mr. CUMMINGS. Dr. Collins, whether we like it or not, we have to live by the rules. And the rules of budgetary scoring led the CBO to conclude that PPACA would generate budget savings.

Have you heard anything today to cast doubt on the validity of the CBO's conclusion that PPACA would result in significant budgetary savings?

Ms. COLLINS. I have not. And, if anything, Congressional Budget Office is very conservative in their estimates. Other estimates have actually shown much greater cost-savings as a result of delivery system reforms that we talked about earlier. David Cutler and colleagues have found an additional \$400 billion in savings as a result of the delivery system reforms. So, if anything, the Congressional Budget Office estimates are conservative.

Mr. CUMMINGS. I see my time has expired. Thank you, Mr. Chairman.

Mr. GOWDY. I thank the gentleman from Maryland.

The chair would now recognize the distinguished gentleman from Arizona, the vice chairman of the subcommittee, Dr. Gosar.

Mr. GOSAR. Dr. Holtz-Eakin, what is the current state of Medicaid, the Medicaid program? And can it handle an additional 20 million new individuals coming on to these programs?

Mr. HOLTZ-EAKIN. At the moment, you could think of Medicaid as essentially all deficit-financed at the Federal level, and the States are struggling to meet their current obligations in Medicaid, given their budgets. And to expand it I think the Governors have said quite clearly is something they do not want to have to do.

Mr. GOSAR. So, really, when we are talking about this health-care system, the biggest problem was the Federal Government. Now, I mean, I was a practicing dentist out in a very poor area of this country—actually, one of the poorest districts in the country.

And to the ranking member, I do know people that will get a divorce to stay together to make the rules work. I do know that. And it is all too often. I mean, we are rewarding a bad behavior. And I want to address that in a minute.

But part of the problem is the Federal Government. Because I see my colleague over here, who is—all fees and all insurance rates were based off of insurance reimbursements by the Federal Government. They were part of the problem.

And I keep bringing up, the group of people that have been on government health care the longest are the ones that are rebelling the most. It happens to be our Native American friends. They can't stand it; they want off. Because what we have done is we have institutionalized, away from what Dr. Collins said is—and she made reference that when you are sick you go to the emergency room. Because what we did is we didn't reimburse the primary-care physicians. We distorted these numbers.

Dr. Burkhauser, I think you hit the nail on the head, that this plan is based on unplausible applications. It doesn't fit the normal dynamics of the way life on Main Street America actually works. Commonsense applications were thrown at the wall. We have a lot of cost-shifting going on that Dr. Holtz-Eakin was talking about.

Do you believe that the government takeover of health care will result in millions of additional workers who don't prefer ESI and will ask their employer to either drop their ESI or make their personal contributions unaffordable?

Mr. BURKHAUSER. Yes, that is exactly what will happen. What we have is an opportunity for workers who currently have ESI to get much cheaper coverage on the exchanges. So this bill really is going to dramatically change the way health-care insurance is provided in the United States.

You are going to get some very weird outcomes. Because the affordability is based on single coverage, people who are employed by firms who were providing them with affordable single coverage are going to beg their employers to increase the cost of their single coverage so that they can get their families onto the exchange. Because, right now, if you have affordable single coverage but unaffordable family coverage, you are in a no man's land. You neither have affordable coverage from your ESI, and you are barred from the exchanges.

So this is an effort by a bunch of economists, like myself, in a little room trying to figure out the way the world works and trying to square the circle. They are trying to provide affordable care to people who don't have ESI coverage, which is about 20 percent of workers, and not affect everybody else. That can't be done. And we are going to see dramatic changes in the way health insurance is provided because of the perverse rules that we have in the system.

Mr. GOSAR. And that would have something to do with the recent decision—we see these dynamics playing out with the Wal-Mart decision, wouldn't you say that?

Mr. BURKHAUSER. Yes, I think the Wal-Mart decision is the beginning of a re-evaluation by all large employers on exactly how they are going to respond to the new incentives that are set into the ACA. So Wal-Mart now realizes that there is no reason to provide affordable health care to their part-time workers. Part-time workers can go and get large subsidies on the exchanges.

They will probably change their system for all workers and actually increase the percentage of the Wal-Mart health care that is provided by their workers so that those workers will also, there-

fore, not have affordable coverage and can go to the exchange, while at the same time allowing their higher-income workers to maintain Wal-Mart health-care insurance.

Mr. GOSAR. Thank you.

Real quick, Dr. Furchtgott-Roth, there is a ripple effect in broken homes and single families, the dysfunctional family. And what we are trying to create is the benefit of a broken family. There is higher costs associated with dysfunctional families.

Do you think the Tax Code should punish marriage, be neutral toward marriage, or encourage marriage?

Ms. FURCHTGOTT-ROTH. I think the Tax Code should encourage marriage. And the marriage rate over the past decade has actually gone down, from 8.2 per thousand in 2000 to 6.8 per thousand in 2009, the latest data available.

So, with marriage going down, according to the Centers for Disease Control, it is even more important to support and encourage marriage. That makes healthier families, makes smarter children, because it is easier for two parents to manage children than one parent to manage children.

Mr. GOSAR. Thank you.

My time is you up.

Mr. GOWDY. I thank the gentleman from Arizona.

The temptation for a second round of questioning is enormous, given the talents and acumen of our panelists. However, we want to be good stewards of your time, and votes are imminent, and we are not going to make you wait on us to vote.

So, with that, on behalf of all of us, thank you for your collegiality toward one another, your perspective, your expertise.

And, with that, the committee is adjourned.

[Whereupon, at 10:34 a.m., the subcommittee was adjourned.]

