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THE IMPACTS OF THE AFFORDABLE CARE ACT:
HOW REASONABLE ARE THE PROJECTIONS?

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Forthcoming as part of a Forum on Health Care Reform and the U.S. Budget, National Tax Journal. Jonathan Gruber served as a paid advisor to the Romney Administration and Massachusetts Legislature during the development of health care reform in Massachusetts, and has since been a member of the Commonwealth Health Connector Board that oversees implementation of the law. He was also a paid technical consultant to the Obama Administration during the development of the Affordable Care Act. The views expressed herein are those of the author and do not necessarily reflect the views of the National Bureau of Economic Research.

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The Impacts of the Affordable Care Act: How Reasonable Are the Projections?

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ABSTRACT

The Patient Protection and Affordable Care Act (ACA) is the most comprehensive reform of the U.S. medical system in at least 45 years. The ACA transforms the non-group insurance market in the United States, mandates that most residents have health insurance, significantly expands public insurance and subsidizes private insurance coverage, raises revenues from a variety of new taxes, and reduces and reorganizes spending under the nation's largest health insurance plan, Medicare. Projecting the impacts of such fundamental reform to the health care system is fraught with difficulty. But such projections were required for the legislative process, and were delivered by the Congressional Budget Office (CBO). This paper discusses the projected impact of the ACA in more detail, and describes the evidence that sheds light upon the accuracy of the projections. It begins by reviewing in broad details the structure of the ACA and then reviews evidence from a key case study that informs our understanding of the ACA's impacts: a comparable health reform that was carried out in Massachusetts four years earlier. The paper discusses the key results from that earlier reform and what they might imply for the impacts of the ACA. The paper ends with a discussion of the projected impact of the ACA and offers some observations on those estimates.

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I. INTRODUCTION

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (ACA), the most comprehensive reform of the U.S. medical system in at least 45 years. The ACA transforms the non-group insurance market in the United States, mandates that most residents have health insurance, significantly expands public insurance and subsidizes private insurance coverage, raises revenues from a variety of new taxes, and reduces and reorganizes spending under the nation's largest health insurance plan, Medicare. If fully implemented, the ACA promises to lead to a dramatically different health care landscape for the United States in the years to come.

Projecting the impacts of such fundamental reform to the health care system is fraught with difficulty. But such projections were required for the legislative process, and were delivered by the Congressional Budget Office (CBO). CBO projected that the ACA would increase health insurance coverage by 32 million people and would raise federal government spending by almost \$1 trillion over the subsequent decade, but would raise revenues and reduce spending by even more so that the bill overall reduced the federal budget deficit. These CBO projections were central to the legislative debate over the ACA.

In this article, I discuss the projected impact of the ACA in more detail, and describe evidence that sheds light upon the accuracy of the projections. I begin by reviewing in broad detail the structure of the ACA. I then review the evidence from a key case study that informs our understanding of the ACA's impacts: a comparable health reform that was carried out in Massachusetts four years earlier. I discuss the key results from that earlier reform and what they

might imply for the impacts of the ACA. Finally, I discuss the projections of the impact of the ACA and offer some observations on those estimates.

II. THE AFFORDABLE CARE ACT

The ACA is an enormously detailed piece of legislation which touches on many aspects of our health care system. I begin by providing a broad outline of the ACA's key features to help guide the discussion of the bill's projected effects.

A. Background: U.S. Health Care

The United States spends 17 percent of its gross domestic product (GDP) on health care, by far the most of any nation in the world. Moreover, the rate of health care spending is rapidly outstripping the rate of growth of our economy, so that by 2080 health care spending is projected to account for 40 percent of the U.S. economy (CBO, 2010a).

Despite this high level of spending, there remain enormous disparities in access to health care in our nation. For example, the infant mortality rate for whites in the United States is 0.57 percent, while for blacks it is more than twice as high, at 1.35 percent.¹ Many of these disparities can be attributed to the fact that the United States is the only major industrialized nation without universal access to health care. Almost one in five of the non-elderly, 50 million Americans, have no health insurance coverage. The distribution of insurance coverage is shown in Table 1 (which is based on Fronstin, 2010).

The primary source of insurance coverage in the United States is employer-sponsored insurance (ESI), which covers the majority of non-elderly Americans in the United States. This is due to both the risk pooling provided by the workplace setting and the large tax subsidy provided

¹ The Henry J. Kaiser Family Foundation, "Infant Mortality Rate (Deaths per 1,000 Live Births) by Race/Ethnicity, Linked Files, 2004–2006," <http://www.statehealthfacts.org/comparetable.jsp?cat=2&ind=48>.

to ESI. As discussed in more detail in Gruber (2011b), the federal government forgoes roughly \$250 billion per year by excluding compensation in the form of health insurance from income and payroll taxation. Since health insurance provided through employers is purchased with pre-tax dollars while insurance provided outside the employment setting is bought with post-tax dollars, there is a strong incentive for insurance to be provided in the employment setting.

There are also two major sources of public insurance coverage. The Medicare program is a universal insurance program for the elderly in the United States, while the Medicaid program provides coverage for many of the poor, with a particular focus on low income children. As a result, most uninsured are not the poorest Americans, but the “working poor” — those whose income and age leaves them ineligible for public insurance coverage and who are not offered insurance through their places of employment.

The only avenue available to such individuals is the non-group insurance market. In most states, however, this market discriminates against the sick. Non-group insurance often features “pre-existing conditions exclusions” that exclude from coverage any spending on illnesses that were present at the time of insurance purchase. Moreover, non-group insurance availability can be limited and prices very high for those who become ill. In a dynamic sense, this market does not provide real insurance protection against illness. As a result, those outside of the employer and public insurance systems face significant financial risk from illness.

B. Broad Outline of the Affordable Care Act

The core of the ACA is a “three-legged stool” designed to fix the broken non-employer insurance market in the United States and expand health insurance coverage as a result. The first leg of the stool includes reforms to the non-group insurance market. These include outlawing exclusions for pre-existing conditions and other discriminatory practices, guaranteeing access to

non-group insurance, and imposing limits on the ability of insurers to charge differential prices by health status — prices for a given product can only vary by age (subject to a 3:1 limit) and smoking status (subject to a 1.5:1 limit). In addition, minimum standards are set for insurance in the non-group and small group markets, including a list of “essential benefits” that must be included in an insurance package and a minimum “actuarial value” (the share of total spending on the essential benefits package that is covered, on average for a typical population, by insurance) of 60 percent.

While these reforms are viewed by most as long overdue, most experts argued that they cannot survive in a vacuum. In particular, if individuals are guaranteed insurance access at prices that are independent of health status, then many may “free ride” by remaining uninsured until they are sick and then buying insurance at average prices. Under these circumstances, insurers will have to charge high prices to all to account for the fact that the pool buying insurance is sicker than average. The resulting adverse selection cycle leads to high prices and a failed insurance market. Indeed, this point is not just a theoretical curiosity. In the 1990s, five states tried to reform their non-group insurance markets in such a manner, and by 2006 these were five of the most expensive states in the nation in which to purchase non-group insurance (Gruber, 2011a).

The second leg of the stool is therefore a requirement that individuals purchase insurance, or an individual mandate. More specifically, most individuals in the United States are required to have coverage or to pay a penalty, which ultimately (by 2016) amounts to the larger of 2.5 percent of income or \$695.

The problem with an individual mandate, however, is that it may be impossible to enforce — as well as inadvisable to enforce — if insurance is not affordable. This motivates the third leg

of the stool: government subsidies to make insurance affordable for lower income families. Under the ACA, these subsidies come in two forms. The first is an expansion of the Medicaid program to all individuals with incomes below 133 percent of the poverty line (which is \$10,830 for individuals and \$22,050 for a family of four). The second is tax credits to offset the cost of private non-group insurance. These tax credits are designed to cap the share of income that individuals have to spend to get insurance, beginning with a cap at 3 percent of income at 133 percent of the poverty level and rising to a cap of 9.5 percent of income at 300 percent of the poverty level (and remaining at 9.5 percent until 400 percent of the poverty level). In addition, if individuals have incomes below the threshold for income tax filing, or if the cheapest health insurance option available to them costs more than 8 percent of their income, they are exempt from the mandate penalty.

The ACA primarily finances these subsidies through six sources (with their associated share of financing): (1) a reduction in reimbursements to private “Medicare Advantage” programs that provide an alternative to the government Medicare program for seniors (14%); (2) reductions in Medicare reimbursement, primarily through a reduction of the inflation adjustment provided to hospitals each year for their reimbursements under Medicare (33%); (3) an increase in the Medicare payroll tax by 0.9 percent, and the extension of that tax to capital income, for singles with incomes of more than \$200,000 per year and families with incomes of more than \$250,000 per year (21%); (4) new excise taxes on several of the sectors that are likely to benefit from the expanded coverage of medical spending in the United States, including insurers, pharmaceutical companies, and medical device manufacturers (11%); (5) the “Cadillac tax,” a non-deductible 40 percent excise tax on insurance products that cost more than \$10,200 for an individual or \$27,500 for a family in 2018, with those limits indexed each year to the consumer

price index (3%); and other revenue sources such as penalty payments by individuals and employers, and taxes on the higher wages that result from reduced employer spending on insurance (21%).

The ACA also includes a number of provisions to address the problem of rapidly rising health costs in the United States. The first is the Cadillac tax, which should reduce the incidence of very generous health insurance plans and thereby excessive demand for health care. The second is new health insurance “exchanges,” state-organized marketplaces where non-group and small group insurers must compete in a transparent marketplace that is designed to maximize competition and lower premiums. The third is the Independent Payment Advisory Board, which is charged with re-designing reimbursement of providers under Medicare to lower costs and ensure quality; this board’s recommendations are subject to an up or down vote by Congress. The fourth is a new research institute — with sizeable funding — to study the comparative effectiveness of medical treatments, in an effort to understand which treatments are most cost effective. Finally, there are many pilot programs examining alternative organizations and reimbursement structures for medical providers in an attempt to find ways to undo the pernicious incentives of our retrospective “fee-for-service” medical reimbursement system. There are dozens of other provisions in the ACA that are not reviewed here as well, on topics ranging from incentives for improving the quality of health care, to a new social insurance program for long-term care, to incentives to increase primary care provision, and so on.

III. THE MASSACHUSETTS CASE STUDY

Projecting the impacts of a fundamental reform such as that described above is an enormous challenge. The effects of the ACA will depend on dozens of behavioral responses by firms and individuals (as well as state governments). There are several decades of empirical

research in health economics that can help inform our understanding of these behavioral responses; Gruber (2002) provides a review of some of that evidence. But this past evidence is by necessity based on changes to the existing health insurance environment, and may not be fully indicative of the impacts of a fundamental change in the environment as sweeping as ACA.

A. The Massachusetts Experiment

Fortunately, our understanding of the impacts of the ACA can be further informed by the experience of Massachusetts. In April 2006, Massachusetts passed a health reform that was based on the same “three-legged stool” as the ACA, and in many ways inspired the federal program. Massachusetts was one of the five states that had already reformed its non-group markets in the 1990s and, as a result, had a small and expensive non-group market. Part of the goal of reform in the state was to fix that market, while covering the majority of the roughly 600,000 uninsured residents of the state.

The key aspects of reform in Massachusetts were to supplement the existing reforms of the non-group market with the introduction of an individual mandate to purchase insurance and the creation of a new program, Commonwealth Care, which provides heavily subsidized insurance for those below 300 percent of the poverty line. In addition, a new marketplace for non-group insurance, the Connector, was created to facilitate purchase for those who did not have access to employer-sponsored insurance.² The Massachusetts reform did not include much of what is incorporated into the ACA, in particular the revenue sources — reform in Massachusetts was financed jointly by the federal government and by an existing tax that financed care for the uninsured — and the efforts at cost control discussed above. But it does

² For more information on the Connector and Massachusetts health reform in general, see www.mahealthconnector.org.

provide an excellent case study of the three-legged stool approach to covering the uninsured and fixing the non-group market.

B. Results

The results of the Massachusetts reform have been encouraging along a number of dimensions.³ First, there has been a dramatic expansion of health insurance coverage in the state. The data vary across sources, with state-level data from the Current Population Survey (CPS) showing a 60 percent decline in the uninsured since 2006 — over a period of time where the share of the national population without insurance was rising by 6 percent — and data collected by the state’s Division of Health Care Finance and Policy showing a decline of 70 percent.⁴ Either number indicates a sizeable reduction in the number of uninsured, with Massachusetts having by far the lowest uninsurance rate in the nation.

A major concern with such a large expansion in access to care is that it will cause congestion on the supply side of the market. Indeed, many have argued that we have a chronic shortage of primary care physicians in the United States and that expanding coverage will only worsen that shortage. This has not been the case in Massachusetts, however. A recent study by the Massachusetts Medical Society found that average wait times for both family and internal medicine were basically flat in the period since the law passed (Massachusetts Medical Society, 2011).

Moreover, this expansion in insurance coverage has been associated with a rise in access to care. The share of the population with a usual source of care, the share with a doctor’s visit in

³ This section draws heavily on and updates Gruber (2011a).

⁴ The former figure comes from data tabulations from the U.S. Census Bureau, Current Population Survey, www.census.gov; the latter figure comes from the state’s Division of Health Care Finance and Policy, *Health Care in Massachusetts: Key Indicators*, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/key_indicators_november_2010.pdf.

the last 12 months, the share receiving preventive care, and the share receiving dental care all rose significantly from the fall of 2006 to the fall of 2008 (Long and Masi, 2009). Miller (2011) finds a modest reduction in the rate of utilization of emergency care in the state, while the Division of Health Care Finance and Policy (2009) reports a 40% decline in uncompensated care in the first year after reform

Second, rather than a crowd-out of private insurance through the expansion of a publicly funded entitlement, there has been a “crowd-in” through a rapidly rising rate of employer-insured individuals. According to estimates from the Current Population Survey, the share of the Massachusetts population with employer-sponsored insurance rose by 0.6 percent from 2006–2009, while over the same period the share of the national population with employer-sponsored insurance fell by 4 percent. Some of this “crowd-in” is due to increased enrollment in employer-sponsored insurance by those endeavoring to meet the requirements of the mandate, but some has actually been through *higher* rates of employer insurance offering. The rate of employer-provided insurance offering in Massachusetts rose from 70 percent in 2005 to 76 percent in 2009, while it remained flat at 60 percent nationally (Massachusetts Division of Health Care Financing and Policy, 2010). There is no obvious explanation for this increase in employer offering as the law introduces incentives for employers to drop insurance (by covering their low income employees outside the employer setting) and does little to penalize those firms that do drop coverage. The best potential explanation for this result is that there was a non-market impact of the mandate on employer behavior, with employees demanding coverage to meet the mandate and employers increasing coverage to meet the demand.

Fourth, the mandate implementation has been very smooth. Over 98 percent of tax filers required to file health insurance information with their tax returns have complied with the filing

requirement. Out of the at least 500,000 individuals who were uninsured before reform, only 53,000 ended up being assessed penalties for not having insurance in 2008 (the remainder either having gained insurance or were exempt from penalties) (Massachusetts Department of Revenue, 2009). Only 2,500 of those individuals filed and followed through on appeals of their penalty; the penalty was waived in about three quarters of the cases.⁵

Fifth, the costs of administering health reform have been quite low. The Connector was given only \$25 million in seed funding, and its net worth remains at \$20 million. The ongoing administrative costs are funded by an insurance charge of only 3 percent, which is very small compared to the typical loads found in the non-group and small group markets.⁶

Sixth, the reform has generally been popular. Sixty-nine percent of state residents supported reform in 2006, and that number has remained essentially unchanged, with 67% support in 2009 (Long and Stockley, 2009).

Seventh, premiums have fallen dramatically in the non-group market. According to America's Health Insurance Plans (2007, 2009), from 2006–2009 non-group premiums rose by 14 percent nationally; over that same period, they fell by 40 percent in Massachusetts. Some of that decline was due to a reduction in the level of non-group benefits, but this is a sizeable decline in any case.

Eighth, there has been no meaningful impact on employer-sponsored insurance premiums. Cogan, Hubbard, and Kessler (2010) argue that group premiums rose in Massachusetts from 2006–2008. Using state-level data from the Medical Expenditure Panel Insurance Component, they show that over this period single group premiums rose by 8.7 percent in Massachusetts, but only 6.5 percent nationally, for a 2.2 percent excess growth rate in

⁵ This figure is based on private communication with Connector staff.

⁶ This figure is based on private communication with Connector staff.

Massachusetts; for families, premiums grew by 12.2 percent in Massachusetts but only 8.1 percent nationally, for a 4.1 percent excess growth rate.

But these tabulations are very imprecise due to the very noisy nature of premium movements over time at the state level. Over the 2006–2008 period, the standard deviation of the state premium change was 4.6 percent for single premiums and 5.3 percent for family premiums. This implies that the changes documented by this article are not statistically meaningful in that they are well below a one standard deviation change in premiums. To illustrate this point further, consider Figure 1, which shows the change in single premiums from 2006–2008 by state, graphed against the state rankings of premium change. Massachusetts is ranked 31st, which is somewhat higher than the median, but clearly not distinguishable from states around it. The change in premiums for Massachusetts, for example, is well below that of other neighboring New England states such as Vermont (ranked 46) or New Hampshire (ranked 47).⁷

Finally, the costs of reform at full implementation have been very close to original projections. Legislative staff in 2006 projected that the Commonwealth Care program would cost \$750 million when fully implemented. In FY 2009, the first full year of implementation, costs were \$800 million. The Massachusetts Taxpayers Foundation (2009) undertook a comprehensive study of the net cost of reform, taking into account the costs of Commonwealth Care and Mass Health expansions, as well as savings through uncompensated care and supplemental payments to safety net hospitals. The study concluded that the net cost of reform in the state has been \$707 million, roughly half of which is borne by the federal government. Given that the state has newly insured about 300,000 individuals according to survey evidence, that is a cost to the state of only \$2,350 per newly insured. This is a very low cost per newly insured compared to earlier

⁷ Note that the change in uninsurance rate and non-group premiums *are* both highly significant relative to other states over this time period.

estimates of the cost of alternative approaches to expanding insurance coverage (Gruber, 2008). This largely reflects the fact that so much of the increase in insurance coverage has been through private coverage.

IV. IMPLICATIONS FOR THE ACA

The projections of the impacts of the ACA from CBO (2010b) are summarized in Table 2. The top panel shows projected impacts on coverage. CBO projects that there will be a very modest erosion of employer-sponsored insurance, with large increases in both public insurance and non-group insurance, so that there is an overall reduction in the number of uninsured of 32 million people. They also project about \$940 billion in new spending, offset with \$1,080 billion in spending reductions and revenue increases, for a first decade deficit reduction of about \$140 billion. Moreover, in their discussion of the bill, CBO notes that they project the deficit reduction to increase over time, and reach more than \$1 trillion in the second decade.

A. Population Movements

Perhaps the most surprising aspect of the CBO estimates is the rather modest erosion of employer-sponsored insurance that they project. But, in fact, this estimate is consistent with past evidence as well as with the experience of Massachusetts.

This small erosion occurs for several reasons. First, more than half of employees covered by health insurance are in firms with more than 100 employees, and past evidence suggests that such firms are not price sensitive in their decisions to offer insurance (Gruber and Lettau, 2004).

Second, the subsidies under the ACA are not very generous above about 250 percent of the poverty line, so that for most firms the majority of workers will not see substantially better deals outside of the employment setting rather than inside. To illustrate this point, I draw on the Gruber Microsimulation Model (GMSIM), a large-scale econometric simulation model that I

have developed over the past dozen years to model health care reforms. To the extent that CBO has made details of their model public, in many ways the GMSIM mirrors the CBO approach to modeling health reform.⁸

To model firm behavior in such microsimulation models, it is important to understand that firms make decisions based on the firm-wide aggregate effects of a policy. To mimic this in GMSIM, we construct “synthetic firms” that are meant to reflect the demographics of actual firms. The core of this computation comes from U.S. Bureau of Labor Statistics (BLS) data providing the earnings distribution of co-workers for individuals of any given earnings level, for various firm sizes and regions of the country. Using these data, the model randomly selects individuals in the same firm size/region/health insurance offering cell as a given CPS worker in order to statistically replicate the earnings distribution that the BLS data would predict for that worker. These workers then become the co-workers in a worker’s synthetic firm.

Using these synthetic firms, we can look at the composition of firms below 100 employees to assess the extent to which low-income workers are concentrated in such firms. In fact, we find that only one-quarter of small firms have more than 10 percent of their employees in families with incomes of less than 133 percent of the poverty line, and virtually none have more than 50 percent of their employees with incomes less than that amount. Only 21 percent of firms have more than 10 percent of their employees in families with incomes of 133–250 percent of the poverty line, and once again virtually no firms have more than half of their employees earning in that range.

Third, this modest effect may be offset if the Massachusetts experience, where the individual mandate appears to have led more firms to offer insurance, is repeated at the national

⁸ A detailed appendix that describes GMSIM is available at MIT Department of Economics, “Documentation for the Gruber Microsimulation Model,” <http://econ-www.mit.edu/files/5939>.

level. It is unclear how large this effect will be relative to the case of Massachusetts, as federal subsidies to non-group insurance are much less generous, although they do extend to four times (rather than three times) the poverty line.

Fourth, there is an offsetting increase in ESI enrollment due to the mandate. A large share of the uninsured (perhaps one-quarter) are offered and eligible for ESI but do not enroll. These individuals will now enroll in large numbers due to the mandate.

Finally, an additional offset will be any pressure on firms to offer insurance due to the “free rider” penalty in the ACA. This section of the ACA charges firms of more than 50 employees a large \$2,000–\$3,000 charge if their employees receive subsidies on the health insurance exchange.⁹ This provides a strong countervailing financial incentive to firms to offer insurance. The Massachusetts reform featured a much more modest (\$300) charge.

With only a modest reduction in ESI, and an enormous expansion of public and subsidized private insurance, CBO (2010b) projects that 32 million uninsured will gain coverage by 2019, relative to a pre-law baseline estimate of 55 million uninsured. This estimate of a 58 percent reduction in the uninsured is somewhat lower than the reduction in Massachusetts, but this is partly because the ACA does *not* provide subsidies or public insurance to undocumented immigrants, who make up almost one-quarter of the uninsured nationally but much less than that in Massachusetts.

B. Premium Impacts

⁹ In particular, if any employee joins the exchange and receives tax credits and the firm does not offer insurance, the firm must pay \$2,000 per employee (minus a 30 employee “exemption”). If the firm offers insurance, but an employee still ends up getting tax credits in the exchange (which can happen if the employee’s insurance contribution exceeds 9.5 percent of their income), then the firm owes \$3,000 per employee who gets tax credits.

CBO (2009) provided estimates of the impact of the ACA on health insurance premiums in the non-group and employer markets. For the non-group market, CBO compares premiums in the state-based health insurance exchanges to premiums that would exist in the non-group market absent reform, which they compute by projecting current non-group premiums forward. Their headline estimate is that exchange premiums will be 10–13 percent higher, on average, with reform than in the non-group market absent reform — although for any family below 400 percent of poverty this cost could be partially offset by tax credits. As they discuss, however, this result reflects the net impact of three effects. First, premiums will drop 7–10 percent due to an improved health mix in that market (due to the mandate). Second, premiums will drop another 7–10 percent due to lower prices arising from enhanced competition and other factors in the non-group market. Finally, premiums would rise by 27–30 percent due to individuals buying more generous policies in the exchange than they do in today’s non-group market.

Therefore, CBO estimates imply that for a given level of policy generosity in the exchange, premiums would actually *fall* by 14–20 percent. This is consistent with the findings of declines in non-group premium in Massachusetts. Thus, the overall rise occurs because individuals buy more generous policies than the limited policies purchased in the non-group market today. CBO (2009) does not discuss the key question of *why* these more generous policies are purchased — that is, to what extent is this due to voluntary upgrades versus forced “buying up” to meet the new minimum standards in this market? Given that the minimum standards are fairly modest, however, it seems likely that most of the increase in plan quality reflects voluntary upgrades.

The CBO estimates show essentially no change in group premiums: for small groups, they estimate a range from a reduction of 2 percent to an increase of 1 percent; for large groups,

they estimate a range from a reduction of 3 percent to no effect. This is once again consistent with the evidence from Massachusetts, which showed no significant impact on group premiums.

C. Budgetary Implications

CBO (2010b) estimates that the ACA subsidies and public insurance expansion will cost \$940 billion by 2019. In 2019, CBO estimates that the government will spend \$214 billion to cover 32 million people, or \$6,690 per person. Deflating at 6 percent per year, health care premium inflation to 2009 yields a cost of \$3,730 per person. This is about 50 percent higher than the cost of \$2,350 per person newly covered in Massachusetts, which is plausible since incomes are lower nationally than in Massachusetts. So once again CBO's estimates are consistent with — or perhaps a bit more conservative than — what was observed in Massachusetts.

CBO also estimates that the revenue increases and spending cuts will exceed the new level of spending, reducing the federal deficit by more than \$100 billion in the first decade and more than \$1 trillion in the second decade. In the first decade alone this would be the most fiscally responsible legislation passed by Congress since 1997.

Some have questioned the likelihood of this deficit reduction — claiming, for example, that the numbers are “cooked” because some of the revenue raisers begin before 2014, whereas the majority of spending doesn't start until after 2014. But CBO estimates that the trend under the law will actually be toward larger deficit reduction over time; indeed, the reduction in the deficit is increasing in the last two years of the budget window. Thus, the cuts in spending and increases in taxes are actually back-loaded — not front-loaded, as these critics imply.

Others have raised the possibility that the cuts that provide much of this financing will never take place — and point to the experience with the physician-payment cuts required by the

Balanced Budget Act of 1997, which have been repeatedly delayed by Congress. As Van de Water and Horney (2010) have highlighted, however, Congress has passed many Medicare cuts over the past 20 years, and the physician-payment cut is the only one that has not taken effect. That said, the fiscal responsibility promised by this legislation does depend on the ability of future Congresses to hold to the reimbursement reductions and tax increases laid out in the ACA.

D. Health Care Costs

The best available projections of the impact of the ACA on the level and growth of health care costs in the near term come from the Center for Medicaid and Medicare Services Office of the Actuary (CMS).¹⁰ With U.S. health care spending already accounting for 17 percent of GDP and growing, there is also concern about policies that increase this spending. And, as the CMS actuary points out, the ACA will increase national health care expenditures. At the peak of its effect on spending in 2016, the law will increase health care expenditures by about 2 percent; by 2019, the ACA-related increase will be 1 percent, or 0.2 percent of GDP.

It is worth noting that these increases are quite small relative to the gains in coverage under the new law. The CMS predicts that 34 million more people will be insured by 2019 (which is similar to the independent estimate of CBO) relative to a base of 254 million insured. The agency also estimates that without this reform, health care costs would grow by 6.6 percent per year between 2010–2019. So the ACA will be increasing the ranks of the insured by more than 13 percent at a cost that is less than one sixth of one year's growth in national health care expenditures.

Alternatively, consider the fact that under this legislation, by 2019, the United States will be spending \$46 billion more on medical care than we do today. In 2010 dollars, this amount to

¹⁰ The discussion in this section draws on Gruber (2010).

only \$800 per newly insured person, quite a low cost compared, for example, to the \$5,050 average single premium for employer-sponsored insurance (Kaiser Family Foundation, 2010).

U.S. spending on health care is very high and a source of great concern, but it is the growth rate of medical spending, not its level, that ultimately determines our country's financial well-being. If current trends persist, we will be spending an unsustainable 40 percent of our GDP on health care by 2080, as the growth of health care costs continues to outstrip the growth rate of the overall economy. In this environment, whether health care costs rise or fall by 1 percent or even 5 percent is irrelevant — all we do is move the day of reckoning less than 1 year closer or further away. Clearly, the key to the long-term viability of our health care system is to “bend the cost curve.”

On this count, the CMS actuary's news is (slightly) good: although the ACA will boost medical spending somewhat, its incremental impact on spending will decrease over time (as noted above, from 2 percent in 2016 to 1 percent in 2019). These declining estimates imply that by the second decade the ACA will actually lower national health spending. This is due to provisions such as the Cadillac tax, for which the definition of a high-cost plan is indexed to the growth in overall prices in the economy, not the (projected to be higher) growth in health insurance premiums. As a result, an increasing proportion of plans will be taxed, and more people will shift into lower-cost insurance options in order to avoid paying the tax, lowering national health expenditures.

V. CONCLUSION

The ACA is a transformative piece of legislation that, if fully implemented, will reshape the U.S. health care system for decades to come. As such, it is very difficult to accurately predict its impacts. In this article, I have reviewed the basis for the projections that do exist, particularly based on the experience of Massachusetts with a similar program.

The real question is how far the ACA will go in slowing cost growth. Here, there is great uncertainty—mostly because there is such uncertainty in general about how to control cost growth in health care. There is no shortage of good ideas for ways of doing so, ranging from reducing consumer demand for health care services, to reducing payments to health care providers, to reorganizing the payment for and delivery of care, to promoting cost-effectiveness standards in care delivery, to reducing pressure from the threat of medical malpractice claims. There is, however, a shortage of evidence regarding which approaches will actually work—and therefore no consensus on which path is best to follow.

In the face of such uncertainty, the ACA pursued the path of considering a range of different approaches to controlling health care costs, from those that work on the demand side (the Cadillac tax), to those that work on the supply side (innovative provider payment models), and to those that promote the type of evidence-based medicine that is key to ensuring cost effectiveness. Whether these policies by themselves can fully solve the long run health care cost problem in the United States is doubtful. They may, however, provide a first step towards controlling costs—and understanding what does and does not work to do so more broadly.

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Table 1
Sources of Health Insurance Coverage in the United States, 2009

	People (millions)	Percentage of Population
Total Population	304.3	100
Private	194.5	63.9
Employment-based	169.7	55.8
Direct purchase	27.2	8.9
Public	93.2	30.6
Medicare	43.4	14.3
Medicaid	47.8	15.7
Uninsured	50.6	16.7

Source: Fronstin (2010).

Table 2
CBO Estimates of the Impact of the ACA

Population Effects in 2019 (\$Million)		
	Baseline (No ACA)	Effect of the ACA
Uninsured	54	-32
Employer	162	-3
Non-group & other	30	-5
Exchange	0	24
Medicaid	35	16
Budget Effects (\$Billion)		
	2019	2010-2019
Coverage Provisions		
Medicaid	97	434
Exchange Subsidies	113	464
Small Employer Tax Credits	4	40
Gross Coverage Costs	214	938
Offsets		
Spending Reductions	-117	514
Revenue Increases	-108	562
Gross Offsets	-225	1076
Net Budgetary Impact	-15	-143

Notes: Subcomponents do not add to totals due to rounding and other small differences in definitions. The difference between net budgetary impact and spending minus revenues is due to these issues as well as other non-coverage provisions.

Source: CBO (2010b).

Figure 1
Percentage Change in Premiums against State Rank, 2006–2008

