The Fiscal Effects of Repealing the Affordable Care Act

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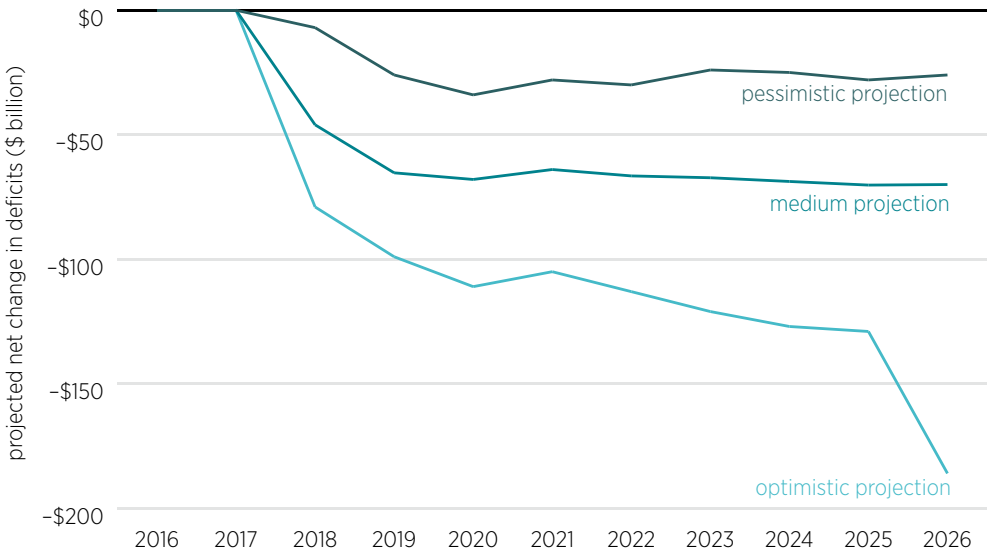
EXECUTIVE SUMMARY

Repealing the Affordable Care Act (ACA), considered separately from its possible replacement, would substantially reduce future federal budget deficits. The amount of projected deficit reduction varies greatly according to variables such as the effective dates for key repeal provisions, which provisions are repealed, assumptions for health insurance enrollment, and assumptions for legislative behavior in the absence of repeal legislation (see figure ES1 and table ES1).

To date, the ACA has failed to produce its initially projected fiscal benefits, primarily because many of its financing provisions have not been implemented as initially enacted. ACA repeal will improve the federal fiscal outlook irrespective of whether the ACA's Medicare cost-containment provisions are included among those repealed, but repealing these would accelerate Medicare Hospital Insurance trust fund depletion. Repeal, effective in 2018, of the ACA's various spending and tax increases is expected to reduce federal deficits by a combined $586 billion through 2026, with plausible outcomes ranging from $228 billion to $1.07 trillion in net deficit reduction. The higher deficit reduction estimates arise primarily in scenarios that recognize that many of the ACA's tax increases are not currently being implemented. Although Congressional Budget Office projections must assume these taxes will produce substantial future revenue, their implementation is highly uncertain even in the absence of ACA repeal.

Replacement provisions that add as much to federal deficits as the more conservative estimates of the savings from repeal run the risk of perpetuating the fiscal damage caused by the ACA. At the same time, the fiscal benefits of repeal are reasonably likely to exceed those estimated under Congress's current scorekeeping rules. This conclusion suggests that even repeal legislation that is scored as budget neutral could, in practical effect, achieve substantial fiscal corrections. For example, although CBO scored the American Health Care Act (AHCA) as reducing projected federal budget deficits by $337 billion from 2017 to 2026, it is plausible on the one hand that it might be approximately budget neutral (slightly reducing total deficits by $42 billion), or on the other hand that it could reduce 10-year deficits by as much as $657 billion (see figure ES2 and table ES2).

FIGURE ES1. PROJECTED CHANGES IN FEDERAL DEFICITS, ACA REPEAL SCENARIOS



Note: ACA = Affordable Care Act.

Source: Author's calculations based on Congressional Budget Office estimates.

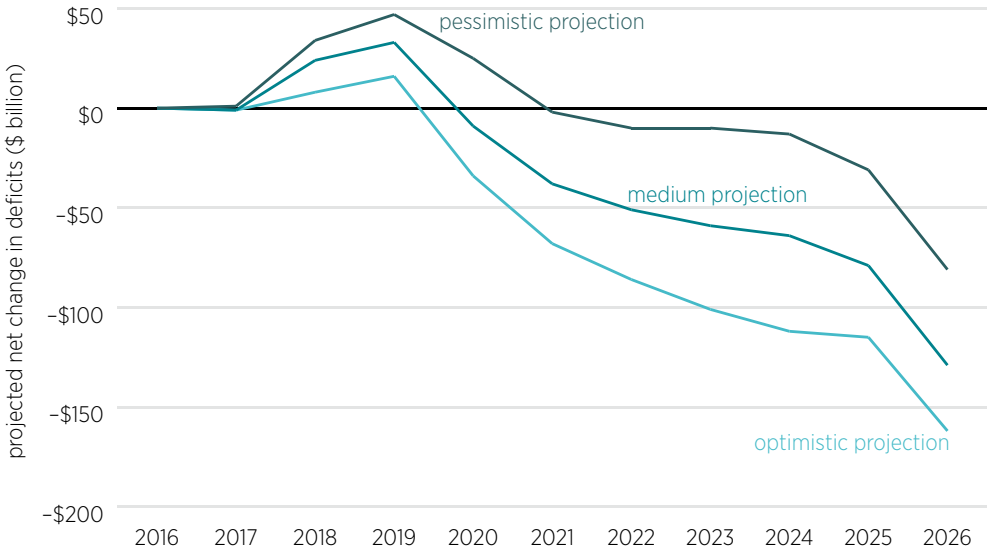
TABLE ES1. RANGE OF PROJECTED DEFICIT REDUCTION IF ACA SPENDING AND TAXES ARE REPEALED, EFFECTIVE 2018 ($ BILLION)

	Pessimistic projection	Medium projection	Optimistic projection
Federal deficit reduction, 2017–2026	$228	$586	$1,070

Note: ACA = Affordable Care Act.

Source: Author's calculations based on Congressional Budget Office estimates.

FIGURE ES2. PROJECTED CHANGES IN FEDERAL DEFICITS, AHCA SCENARIOS



Note: AHCA = American Health Care Act.

Source: Author's calculations based on Congressional Budget Office estimates.

TABLE ES2. RANGE OF PROJECTED DEFICIT REDUCTION FOR AHCA ($ BILLION)

	Pessimistic projection	Medium projection	Optimistic projection
Federal deficit reduction, 2017–2026	$42	$374	$657

Note: ACA = Affordable Care Act.

Source: Author's calculations based on Congressional Budget Office estimates.

The Affordable Care Act (ACA) was effectively enacted in two pieces: The first, the Patient Protection and Affordable Care Act (PPACA), was signed into law by President Barack Obama on March 23, 2010. The second, the Health Care and Education Reconciliation Act of 2010, was signed into law on March 30, 2010.[1] The combined provisions of these two laws have since become known colloquially as the ACA. The ACA was enacted in pursuit of multiple objectives, some of which were referenced in President Obama's statement at the law's presidential signing ceremony. Among those objectives were to guarantee lifetime health insurance coverage for individuals with preexisting health conditions, to "lower [health care] costs for families and for businesses," and to reduce the federal budget deficit.[2]

The ACA accordingly reflected a plethora of policy decisions and subjective value judgments. This study will analyze only one of its effects, namely its effect on the federal budget, with a particular focus on the budgetary effects of possible future legislation to repeal and replace the law. This emphasis should not be misinterpreted as a value judgment about how to best balance competing objectives, such as expanding health insurance coverage, with improving the federal fiscal outlook. The purpose of this study is narrower: to inform policymakers and the public about the fiscal effects of both the ACA and various options for repeal.

1. The unusual legislative tactic of splitting such a complex law with so many interdependent provisions into two bills was made necessary by the equally complex political environment surrounding its enactment. After the Senate and House initially passed their different versions of the legislation, but before a compromise agreement could emerge from a House-Senate conference, a special election in Massachusetts to fill the vacant US Senate seat formerly held by Edward Kennedy (D) deprived supporters of the 60th "aye" vote necessary to move the resulting conference report through that body. Consequently, the final form of the law was enacted by the House's first passing the Senate version (thereby obviating the need for another Senate vote on those provisions), followed by amendments to that law that reflected the results of House-Senate negotiations, which were moved nearly simultaneously through Congress's budget reconciliation process (which requires only a majority vote in the Senate).
2. President Barack Obama, "Remarks on Signing the Patient Protection and Affordable Care Act," March 23, 2010, http://www.presidency.ucsb.edu/ws/?pid=87660.

THE AFFORDABLE CARE ACT'S FISCAL EFFECTS OVER ITS FIRST SEVEN YEARS

Although a central stated purpose of the ACA was to function as a down payment on federal entitlement reform, specifically by reducing the projected costs of federal healthcare entitlements,[3] this fiscal improvement did not materialize for a number of reasons, of which three stand out. First, the enacted version of the ACA prioritized coverage expansion over cost containment, thus substantially increasing rather than decreasing federal expenditures on healthcare entitlements while aiming to collect sufficient additional taxes to finance the increased spending.

A simplified summary of the ACA might group its provisions into three broad categories: the first category increased federal payments to subsidize expanded health insurance coverage (e.g., through Medicaid expansion as well as refundable tax credits for certain health insurance buyers), the second category reduced the growth of payment schedules in Medicare (along with other smaller reductions in spending growth), and the third category raised a variety of taxes. Netting the provisions in the first two categories, the ACA substantially increased federal healthcare spending.[4] Specifically, an initial Congressional Budget Office (CBO) score found that the law would increase net federal spending on health care by $401 billion over the first 10 years, an estimate that steadily increased in subsequent projections (table 1).[5]

The second reason fiscal improvements did not materialize was that CBO's apparent initial projection that the ACA would reduce federal budget deficits compared the law's budgetary effects not with the relevant provisions of law in the absence of the ACA, but instead with a baseline constructed by Congress in

3. "Health care reform is entitlement reform. The path to fiscal responsibility must run directly through health care." Peter Orszag, "Opening Remarks at White House Fiscal Responsibility Summit," transcript in *New York Times: The Caucus*, February 23, 2009, http://www.nytimes.com/2009/02/23/us/politics/23text-summit.html.

4. This simplification necessarily misses some details. For example, not all the spending increases in the ACA were directly pursuant to expanding health insurance coverage. The estimates provided throughout this paper are complete, although the summary provided on this page is simplified. That is to say, the estimates that follow account for all the changes in spending and revenues that would occur under the various options described.

5. Congressional Budget Office, "H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)," table 2, March 20, 2010, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf. See also CBO, "Testimony on CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," table 1, March 30, 2011, by which time the net outlay increase for the updated 10-year budget window had grown to $604 billion. See https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/03-30-healthcarelegislation.pdf. The net outlay increase continued to grow as the evolving 10-year budget window shifted further outward.

TABLE 1. NET CHANGE IN FEDERAL BUDGET OPERATIONS, 2010–2019, INITIAL CBO SCORE OF ACA

Category of provisions	Net change ($ billion), 2010–2019
A. (Increased) federal outlays for health	+401
B. (Decreased) federal outlays for education	−19
C. (Increased) federal revenues	+525
D. Reduction in federal deficits (A + B − C)	−143
E. Reduction in federal deficits from health provisions alone (A − C)	−124

Note: ACA = Affordable Care Act; CBO = Congressional Budget Office.

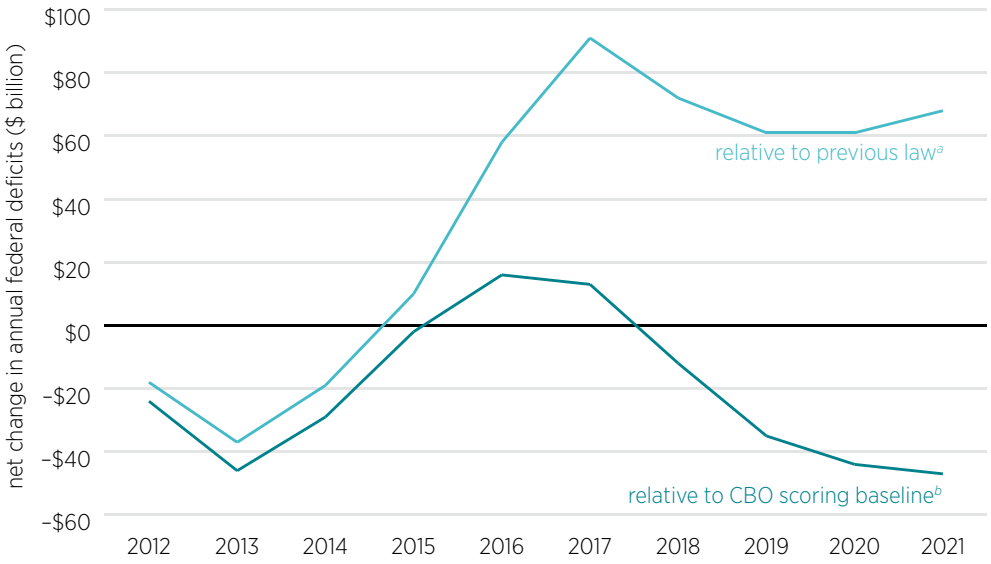
Source: Congressional Budget Office, "H.R. 4872 Reconciliation Act of 2010 (Final Health Care Legislation)," table 2, March 20, 2010, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf.

the Balanced Budget and Emergency Deficit Control Act of 1985 that differed from law in certain critical respects. The differences are complex and beyond the scope of this study, but in essence the "baseline incorporates the assumption that scheduled payments will continue to be made in full after a trust fund has been exhausted, although there is no current legal authority to make such payments."[6] This assumption is a significant deviation from the requirements of Social Security and Medicare law, which limit payments from Social Security's trust funds and Medicare's Hospital Insurance (HI) trust fund to the amount that can be financed from dedicated program revenues. In essence, therefore, CBO was required to assume that had the ACA not been enacted, lawmakers would have passed another law to substantially increase permissible Medicare HI spending. It was only in comparison with that hypothetical Medicare spending increase that the ACA was found to reduce federal deficits. Had Medicare law incorporating the ACA been compared to Medicare law in the ACA's absence, it would have been found that the ACA increased federal deficits.

This quirk of federal budget scoring was explained in detail in "The Fiscal Consequences of the Affordable Care Act," which estimated that if all the ACA's provisions were fully and effectively implemented, the law would increase federal deficits by roughly $346 billion over the next 10 years, spanning 2012–2021 (see figure 1).[7] This finding was controversial among ACA

6. Congressional Budget Office, "The 2016 Long-Term Budget Outlook," July 2016, p. 25, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51580-ltbo-one-col-2.pdf.
7. Charles Blahous, "The Fiscal Consequences of the Affordable Care Act" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2012), https://www.mercatus.org/system/files/the-fiscal-consequences-of-the-affordable-care-act_1.pdf. By the time of that paper's publication, the 10-year budget window had shifted to 2012–2021, with CBO's estimate of the ACA's 10-year deficit reduction effect increasing to $210 billion. See Congressional Budget Office,

FIGURE 1. PROJECTED CHANGES IN FEDERAL DEFICITS UNDER THE ACA AS ENACTED COMPARED WITH ALERNATIVE BASELINES



Note: ACA = Affordable Care Act; CBO = Congressional Budget Office; CLASS = Community Living Assistance Services and Support.
[a] Effect of the ACA after suspension of CLASS program, relative to previous law.
[b] February 2011 CBO score of ACA, relative to budget baseline.

Source: Charles Blahous, "The Fiscal Consequences of the Affordable Care Act" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2012), https://www.mercatus.org/system/files/the-fiscal-consequences-of-the-affordable-care-act_1.pdf.

supporters, and even the Obama White House entered the fray by publishing a blog post stating flatly that asserting that the law "increases the deficit . . . is false."[8] Many publications before and since, however, have substantiated the study's qualitative conclusion. For example, several subsequent CBO publications have confirmed that the baseline relative to which the ACA appeared to reduce the deficit does not reflect actual Medicare law.[9] The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary also confirmed that the ACA's cost-saving provisions "cannot be simultaneously used to finance

"Testimony on CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," March 30, 2011, https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/03-30-healthcarelegislation.pdf.
8. Jeanne Lambrew, "Official Sources Agree: The Affordable Care Act Reduces the Deficit," White House, April 9, 2012, https://obamawhitehouse.archives.gov/blog/2012/04/09/official-sources-agree-affordable-care-act-reduces-deficit.
9. CBO, "2016 Long-Term Budget Outlook," 25.

other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions."[10] Social Security Advisory Board Chairman Henry Aaron similarly noted in 2015 that "CBO and other organizations assume that Social Security and Medicare Hospital Insurance can and will spend money they don't have and that current law bars them from spending."[11] The Committee for a Responsible Federal Budget subsequently recommended closing the budget scoring loophole that had created the appearance that the ACA reduced deficits.[12] In November 2016, then–House Budget Committee Chairman Tom Price introduced legislation to do so.[13]

The third reason the ACA did not produce its projected fiscal improvements was that many of its cost-saving provisions were weakened, scaled back, or simply not implemented at all. One of these was the ACA's Community Living Assistance Services and Support (CLASS) program, which the initial CBO score projected would produce $70 billion of net savings over the first 10 years.[14] The CLASS program was later suspended because of a provision inserted at the initiative of Senator Judd Gregg (R-NH) that required CLASS's actuarial soundness to be certified. In October 2011, Secretary of Health and Human Services (HHS) Kathleen Sebelius announced that "we have not identified a way to make CLASS work," on the basis of an HHS finding that the structure of the program would cause an imbalance in the beneficiary pool that would cause it to "quickly

10. Richard Foster, "Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended," Memorandum, Centers for Medicare and Medicaid Services, April 22, 2010, https://www.cms.gov/research-statistics-data-and-systems/research/actuarialstudies/downloads/ppaca_2010-04-22.pdf.
11. Henry Aaron, "The Myth behind America's Deficit," *Fortune*, September 10, 2015, http://fortune.com/2015/09/10/the-myth-behind-americas-deficit/.
12. "Prohibit double-counting of increased revenues and spending cuts involving trust funds. . . . The treatment of spending for programs funded through trust funds should be modified to reflect the limits on the amount of spending allowed under the law when trust fund assets are depleted. This change would mean that legislation increasing trust fund balances through general revenue transfers or increases in dedicated revenues would be scored with a cost for the increased spending, and legislation reducing trust fund spending would not be scored with savings that could be used to offset costs elsewhere in the budget." Committee for a Responsible Federal Budget, "The Better Budget Process Initiative: Strengthening Statutory Budget Enforcement, June 25, 2015, http://www.crfb.org/sites/default/files/bbpi_strengtheningstatutorybudgetenforcement.pdf.
13. Tom Price, "Proposed Rewrite of the Congressional Budget Process: Summary of Selected Provisions," US House of Representatives Committee on the Budget, November 30, 2016, http://budget.house.gov/uploadedfiles/bpr-shortsummary-30nov2016.pdf.
14. CBO, "H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)."

collapse."[15] The ACA's CLASS program was later fully repealed as part of the American Taxpayer Relief Act of 2012.[16]

The risks that several of the ACA's cost-saving provisions might not produce their projected fiscal benefits were anticipated by many scholars. It was observed in 2012, for example, that "also intensely controversial is the ACA's Independent Payment Advisory Board (IPAB), empowered to make further unspecified reductions in Medicare benefit payments sufficient to hold program cost growth to the rate of per capita GDP plus 1 percent. Should IPAB be weakened or eliminated, as many lawmakers have announced their intentions to do, post-ACA Medicare costs may well be higher than currently projected."[17] IPAB was never constituted, and indeed no individuals were ever nominated by President Obama or by congressional leaders to serve on the panel.[18] Inaction on constituting IPAB has persisted despite the 2016 Medicare Trustees report projecting that "the first determination that the Medicare per capita growth rate exceeds the per capita target growth rate (thereby triggering IPAB cost-saving recommendations) is projected to be made in 2017."[19] As of this writing, the likelihood that IPAB will become operational appears small.[20]

The ACA also relied on an excise tax on high-premium insurance plans, known as the "Cadillac plan" tax, for revenues to finance its coverage expansion as

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15. Secretary Kathleen Sebelius, "The CLASS Program," *Huffington Post*, October 14, 2011, http://www.huffingtonpost.com/sec-kathleen-sebelius/the-class-program_b_1011270.html?view=print&comm_ref=false. Office of the Assistant Secretary for Planning and Evaluation, "Memorandum on the Report on the CLASS Program," Department of Health and Human Services, October 14, 2011, https://aspe.hhs.gov/memorandum-report-class-program.
16. Text of American Taxpayer Relief Act of 2012, January 2, 2013, https://www.gpo.gov//fdsys/pkg/PLAW-112publ240/pdf/PLAW-112publ240.pdf; Charles Blahous, "The Fiscal Consequences of the Affordable Care Act," in *The Future of Healthcare Reform in the United States*, ed. Anup Malani and Michael H. Schill (Chicago: University of Chicago Press, October 2015), 129.
17. Blahous, "Fiscal Consequences of the Affordable Care Act," in *Future of Healthcare Reform*, 121.
18. Heather Drost, "What You Should Know about IPAB: The ACA Tool That Could Cut Provider Rates Next Year," Advisory Board, July 22, 2016, https://www.advisory.com/daily-briefing/2016/07/22/ipab-aca-cut-provider-rates.
19. Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," June 22, 2016, p. 182, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf.
20. This supposition does not necessarily mean that no spending cuts will be made pursuant to IPAB's enactment. Under the language of the ACA, in a year in which the board "is required, but fails" to submit a proposal, the task of developing and submitting such a proposal devolves to the Secretary of Health and Human Services. See Health Care and Education Reconciliation Act of 2010, 42 U.S.C. § 1395kkk—Independent Payment Advisory Board, https://www.law.cornell.edu/uscode/text/42/1395kkk.

well as to retard projected growth in health insurance costs. The ACA's finances depended to a significant extent on the Cadillac plan tax producing an escalating flow of federal revenues over time, as the tax was devised to capture a progressively increasing number of insurance plans. CBO's March 2010 evaluation anticipated $32 billion collected cumulatively from the tax through 2019, whereas its March 2011 estimate updated this estimate to $87 billion cumulatively through 2021, including $29 billion specifically in 2021. The rapid compounding of revenues was to be achieved by annually indexing plan value thresholds, above which the Cadillac plan tax would apply, to grow more slowly than the projected growth of healthcare costs.[21]

From the beginning, there was ample reason to doubt that the Cadillac plan tax would be implemented as enacted. I wrote in 2012 that "of all of the provisions of the ACA, the Cadillac-plan tax in its current-law form perhaps warrants the greatest skepticism. It is expressly designed to expose an increasing share of health insurance benefits to taxation over time. Moreover, it did not survive its initial clash with political pressures; the form of the tax enacted with the ACA was almost simultaneously amended in accompanying reconciliation legislation, changes that both postponed the effective date and increased the thresholds below which the tax would not apply."[22] The Cadillac plan tax in the original PPACA was set to take effect in 2013, affecting plans exceeding $8,500 (individuals) or $23,000 (families) in value.[23] Its effective date was immediately postponed to 2018 in the

"Even a conservative estimate of the . . . fiscal slippage caused by the various delays, suspensions, weakening, and repeals would find that the ACA has added substantially to federal deficits."

21. CBO, "H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)," table 2. The expected compounding of federal revenues from the tax was due in large part to the thresholds to which it was applied (annual plan values exceeding $10,200 for individuals and $27,500 for families in 2018) being indexed after 2020 to growth in the consumer price index, which has historically tended to be lower than the rate of healthcare cost inflation. See Blahous, "Fiscal Consequences of the Affordable Care Act" (Mercatus Research).
22. Blahous, "Fiscal Consequences of the Affordable Care Act" (Mercatus Research).
23. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat., Sec. 9001 (March 2010).

accompanying reconciliation bill, and the applicable plan value thresholds were lifted to $10,200 and $27,500, respectively.[24] More recently it was postponed for another two years, from 2018 to 2020, with employers now permitted to deduct it as a business expense.[25] Even without an effort to repeal the ACA, it is highly unlikely that the revenue collections initially projected for the Cadillac plan tax would ever have materialized.

Beyond these predictable (indeed predicted) erosions of the ACA's finances, several other financing provisions have not been implemented according to their original schedules. The Obama administration initially delayed enforcement of the ACA's employer coverage mandate from 2014 to 2015, and subsequently relaxed the mandate for larger employers while postponing it for an additional year for smaller ones (50 to 99 employees).[26] Individual mandate penalties were also relaxed by the Obama administration by the creation of additional exemptions.[27] In addition, the Consolidated Appropriations Act, passed on December 18, 2015, effectuated a one-year moratorium on the ACA's health insurance provider fees, lessening projected federal revenue collections for 2017 by roughly $11 billion.[28] The same law also enacted a two-year moratorium on the ACA's tax on medical devices, reducing projected revenue collections by a further $3.9 billion from 2016 to 2018.[29] Taken together, these and other actions undoubtedly caused the ACA's net fiscal effect to be much more adverse than originally projected.[30]

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24. Health Care and Education Reconciliation Act of 2010, 42 U.S.C., § 1401 (March 30, 2010).
25. Joint Committee on Taxation, JCX-142-15, December 16, 2015, https://www.jct.gov/publications.html?func=startdown&id=4859.
26. Juliet Eilperin and Amy Goldstein, "White House Delays Health Insurance Mandate for Medium-Size Employers until 2016," *Washington Post*, February 10, 2014, https://www.washingtonpost.com/national/health-science/white-house-delays-health-insurance-mandate-for-medium-sized-employers-until-2016/2014/02/10/ade6b344-9279-11e3-84e1-27626c5ef5fb_story.html?utm_term=.198430001149. Requirements on larger employers were temporarily relaxed from having to cover 95 percent of workers to only 70 percent.
27. Congressional Budget Office, "Payments of Penalties for Being Uninsured under the Affordable Care Act: 2014 Update," June 5, 2014, https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/45397-IndividualMandate.pdf. According to the update "the decrease in the number of people who are projected to pay the penalty largely stems from an increase in CBO and JCT's projection of the number of people who will be exempt from the penalty. That increase is attributable in part to regulations issued since September 2012 by the Departments of Health and Human Services and the Treasury."
28. Joint Committee on Taxation, JCX-142-15, December 16, 2015.
29. Joint Committee on Taxation, JCX-143-15, December 16, 2015, https://www.jct.gov/publications.html?func=startdown&id=4860.
30. Conversely, it should be noted that some subsequent legislation reduced allowable spending under the ACA at the margins, relative to initial estimates. These actions were generally of a considerably smaller magnitude than the instances of fiscal slippage described here.

The failure to implement many of the ACA's financing mechanisms creates complications for scholars attempting to measure the ACA's net fiscal effects. The estimates issued by key primary information sources such as CBO are essentially forward-looking; they project the expected future effects of legislation rather than estimating it retrospectively. Moreover, CBO is obliged to estimate the effects of law as it is currently written rather than as it is being applied. If, for example, laws were passed annually to repeatedly postpone the effect of a key ACA financing provision in one-year increments such that it ultimately never took effect, CBO would still be required to assume, based on the fact of the provision's remaining in law, that it would be fully enforced going forward.[31] Specifically in the case of the ACA, updated CBO projections would have to assume that provisions such as the Cadillac plan tax, health insurance provider tax, medical device tax, and IPAB would all produce future financing in a manner that none of them are currently doing.

There are other reasons why a precise up-to-date analysis of the ACA's net fiscal effects is elusive. Seven years into the ACA's enactment, it is nearly impossible to create a reliable counterfactual as to how federal finances would have evolved in its absence. In 2014, CBO stated, "CBO and JCT [Joint Committee on Taxation] can no longer determine exactly how the provisions of the ACA that are not related to the expansion of health insurance coverage have affected their [CBO and JCT's] projections of direct spending and revenues. . . . Isolating the incremental effects of those provisions on previously existing programs and revenues four years after enactment of the ACA is not possible."[32] Douglas Elmendorf, then CBO director, subsequently elaborated in a blog post:

> The ACA's provisions that are not related to insurance coverage largely modified existing federal programs and made changes to the existing tax code, so CBO and JCT cannot identify the incremental effects of many of those provisions. Consider the ACA's substantial changes to the Medicare program, many of

31. On occasion, CBO has produced alternative "current policy" fiscal scenarios that assume certain recurring legislative actions will continue to be repeated. However, the primary estimates that guide Congress's legislative process assume the literal application of current law (with some notable exceptions discussed earlier, such as the treatment of the Social Security and Medicare trust funds). CBO is also often reluctant to initiate subjective judgments about when repeated legislative behavior reflects current policy more than the literal application of law does. Hence, provisions such as those listed at the end of this paragraph are generally assumed to take effect in the future even if they are not currently being implemented.

32. Congressional Budget Office, "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014," p. 1, fn3, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf.

> which have taken effect during the past four years. CBO does not produce baseline projections for Medicare that are based on the program's statutes as of February 2010 to which the current baseline projections can then be compared. Moreover, the basis on which the agency could try to construct such a counterfactual baseline is unclear. With respect to the way Medicare pays certain providers, for example, CBO cannot determine the program rules and payment rates that the Centers for Medicare & Medicaid Services would have established over the past four years in the absence of the ACA. Moreover, CBO cannot determine how those program rules and payment rates under prior law would have affected the behavior of beneficiaries and providers—which in turn affects what federal spending would have been in the absence of the ACA. The basis for developing a counterfactual receipts baseline is also unclear because JCT cannot determine how taxpayers would have organized their financial affairs over the past four years in the absence of the ACA.[33]

These reasons underlie CBO's 2014 announcement that it would no longer attempt to estimate the net fiscal effects of the ACA as a whole. CBO did continue for a while thereafter to estimate the incremental fiscal effects of the ACA's provisions to expand health insurance coverage. However, even those residual estimates were discontinued after March 2016. CBO explained at that time that because "generating such estimates is becoming more difficult and less meaningful, . . . CBO and JCT will no longer make separate projections of all of the incremental effects of the ACA's insurance coverage provisions; instead, they will present their projections of overall insurance coverage levels and related subsidies, taxes, and penalties under current law."[34] In sum, even CBO no longer attempts to estimate any aspect of the ACA's net fiscal impact during the period since its enactment.

Despite the difficulty of constructing a precise estimate of the ACA's net fiscal effects to date, those net effects probably have been more adverse than the most pessimistic scenario described in "The Fiscal Consequences of the Affordable Care

33. Douglas Elmendorf, "Estimating the Budgetary Effects of the Affordable Care Act," June 17, 2017, https://www.cbo.gov/publication/45447.
34. Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People under Age 65: 2016 to 2026," March 24, 2016, https://www.cbo.gov/publication/51385#section2.

Act."[35] That study estimated that the ACA would add $346 billion to federal deficits through 2021 if all of its cost-saving provisions were fully enforced, and as much as $527 billion if several of these provisions were relaxed to track historical patterns. Among the provisions for which some fiscal slippage was modeled for the study's pessimistic scenario were the ACA's exchange subsidies, IPAB, the Cadillac plan tax, and the Unearned Income Medicare Contribution (UIMC).[36] Although the 2012 Blahous study's fiscally pessimistic assumptions have not yet come to pass for UIMC and the exchange subsidies, neither has IPAB been constituted, and the Cadillac plan tax has already been weakened far more than under the pessimistic scenario's assumptions (which merely assumed that the Cadillac plan tax's application thresholds would grow with GDP rather than with the consumer price index, instead of being postponed altogether as has since occurred). Moreover, in other subsequent actions going beyond the fiscal slippage modeled in the study's pessimistic scenario, the ACA's various mandate penalties were relaxed, and its medical device taxes and health insurance plan fees were both suspended (table 2).

A rough sense of how the ACA's finances have deteriorated relative to initial projections can be gleaned by comparing CBO's estimates of specific cost-

35. Blahous, "Fiscal Consequences of the Affordable Care Act" (Mercatus Research). Because of CBO's practice until 2016 of updating only its scores for the costs of the ACA's coverage provisions, rather than reevaluating the fiscal effects of the ACA as a whole, many are under the impression that the ACA's overall finances turned out as good or better than originally projected. This impression has been created specifically by the cost of the coverage expansion generally coming in below initial projections owing to lower-than-expected enrollment as well as to a deceleration in the growth of national health spending that began before the ACA's passage and continued afterward. Blahous, "No Grounds for Claim that Obamacare Lowers Healthcare Costs," e21 (Manhattan Institute for Policy Research), November 25, 2013, https://economics21.org/html/no-grounds-claim-obamacare-lowers-healthcare-costs-699.html. In CBO's questions for the record, submitted March 3, 2017, for recent testimony, CBO indicated that projected costs for the ACA's coverage expansion in 2019 were roughly one-third lower than initial projections (https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52468-outlookqfrs.pdf). This does not, however, indicate that the ACA's finances as a whole were more positive than initial projections, for several reasons. For example, slower-than-expected growth in healthcare spending reduced the cost of the ACA's coverage expansion, but it similarly reduced the net savings generated by many of its other cost-containment provisions. If one examines CBO's June 2015 projection, "Budgetary and Economic Effects of Repealing the Affordable Care Act," one finds that despite reduced estimates for the costs of coverage expansion, CBO projects that repeal would add only $7 billion to the deficit in that year (https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-Effects_of_ACA_Repeal.pdf). This projection in turn assumes that the Cadillac plan tax is imposed in 2019, and that the ACA's medical device tax and health insurance fees are imposed as well. The Cadillac plan tax has already been postponed beyond 2019 and the other taxes are currently suspended. Thus, while the costs of the ACA's coverage expansion have indeed been lower than original projections, these effects have been exceeded by reductions in the savings generated by the ACA's various financing sources.

36. The UIMC, sometimes called the investment income tax, is a 3.8 percent tax applied on investment income of higher-income taxpayers. Despite its name, the UIMC's revenues are not deposited in the Medicare trust funds.

TABLE 2. COMPARISON OF INITIAL COST-SAVING ESTIMATES FOR THE ACA VS. CERTAIN OF ITS PROVISIONS

Provision	Estimated federal deficit reduction under CBO baseline, 2010–2019 ($ billion)	Current status
Entire ACA	$124	Still in effect, albeit modified via statute and regulation
Fees on medical manufacturers and insurers	$107	Medical device and health insurance fees suspended until 2018
CLASS program	$70	Repealed
Employer mandate penalties	$52	Suspended for smaller employers and relaxed for larger employers until 2016
Cadillac plan tax	$32	Delayed until 2020
Individual mandate penalties	$17	Hardship exemptions expanded

Note: ACA = Affordable Care Act; CBO = Congressional Budget Office; CLASS = Community Living Assistance Services and Support.

Source: Congressional Budget Office, "H.R. 4872 Reconciliation Act of 2010 (Final Health Care Legislation)," table 2, March 20, 2010, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf.

saving provisions to its projections for the fiscal effects of the law as a whole. Even a conservative estimate of the amount of fiscal slippage caused by the various delays, suspensions, weakening, and repeals would find that the ACA has added substantially to federal deficits, even without taking into account the dual commitment of the proceeds of its Medicare cost-containment provisions.[37]

Whereas it may be of analytical interest to know the ACA's net fiscal effects to date more precisely, these effects are less relevant to lawmakers' decision-making than the policy choices they currently face. This renders it more appropriate going forward to analyze the fiscal consequences of options for repealing the ACA than to know the consequences of its enactment seven years ago. Fortuitously, such a forward-looking analysis is aided by the fact that CBO and JCT continue to estimate "the effects of proposed legislation related to the ACA, including proposals to modify certain provisions of the law or to repeal it entirely."[38]

37. As noted earlier, Medicare HI payments are limited by law to the amount that can be financed from its trust fund, irrespective of program benefit payment schedules. In essence, the budget rules assume that future lawmakers will enact legislation increasing Medicare's benefit payments substantially beyond what its trust fund resources allow. This scorekeeping quirk effectively permitted the ACA's Medicare cost-saving measures to be credited twice for budgeting purposes: once to extend the period over which full Medicare HI benefits would be paid, and a second time to finance the ACA's broader coverage expansion. CBO, "2016 Long-Term Budget Outlook," 25.
38. CBO, "Federal Subsidies for Health Insurance Coverage for People under Age 65: 2016 to 2026," March 24, 2016.

The following sections of this study present estimates of the fiscal effects of repealing the ACA, accompanied by analyses of specific factors and policy choices that could tilt the outcomes in either direction. The caveat should be issued that the fiscal effects of repeal are not the mere opposite of the fiscal effects of the ACA itself.[39] Also, this study will not attempt to model economic feedback expected from repeal of the ACA or portions thereof; for instance, repeal is projected by CBO to increase GDP by roughly 0.7 percent over the 2021–2025 period.[40] Although such feedback embodies an important policy consideration, it is beyond the scope of this study, which relies heavily on publicly available estimates of various modifications to the ACA that have only been published in a form that excludes economic feedback effects.

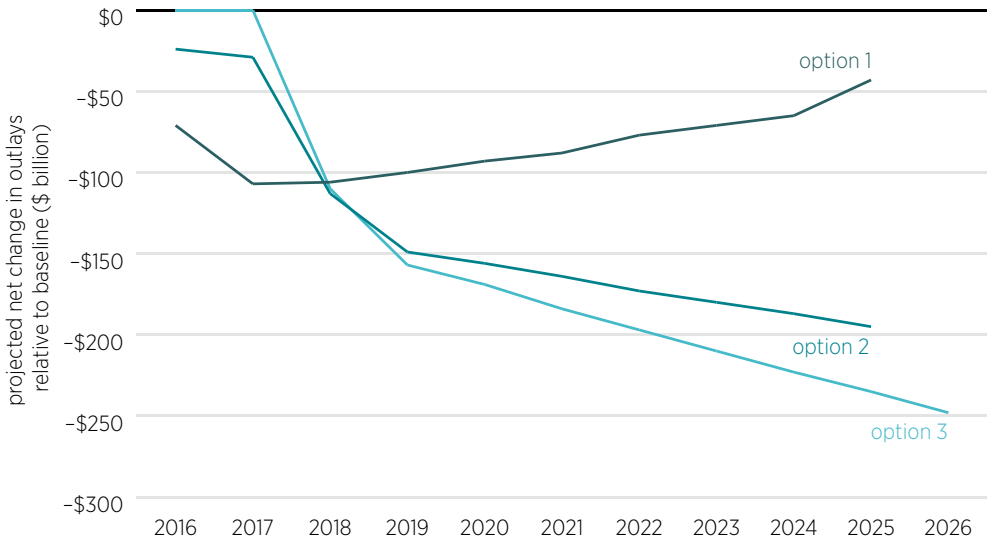
ESTIMATES OF COMPLETE OR PARTIAL ACA REPEAL USING THE CBO BASELINE

This study analyzes the fiscal effects of repealing all or major portions of the ACA; an addendum supplements this analysis with another that examines a specific approach to repealing and replacing the law. During the last session of Congress, CBO published three comprehensive analyses that bear directly on the fiscal effects of ACA repeal:

- A June 2015 estimate of the budgetary and economic effects of repealing the entirety of the ACA. This option will be referred to as option 1. This analysis contained estimates that both include and exclude economic feedback (as mentioned previously, this study will reference only the estimates excluding economic feedback).[41]
- A January 2016 estimate of the fiscal effects of H.R. 3762, which was passed by Congress but vetoed by President Obama. The bill would have repealed major portions of the ACA, including its coverage expansion subsidies and its tax increases, but not its insurance market rules or its Medicare cost-containment provisions. This bill will be referred to as option 2. This

39. For more on the reasons why, see Congressional Budget Office, "Budgetary and Economic Effects of Repealing the Affordable Care Act," June 2015, p. 6, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-Effects_of_ACA_Repeal.pdf. For example, many people signed up for Medicaid coverage under the ACA's outreach processes who were eligible for Medicaid coverage before passage of the ACA. The ACA had an effect of increasing Medicaid costs by bringing these individuals onto the Medicaid rolls. This effect would not be reversed on its repeal, however, as these individuals would remain eligible for Medicaid coverage and would likely continue to receive it.
40. CBO, "Budgetary and Economic Effects of Repealing the Affordable Care Act," June 2015, p. 1.
41. Ibid., whole document.

FIGURE 2. CONGRESSIONAL BUDGET OFFICE ESTIMATES OF FEDERAL HEALTH SPENDING CHANGES, COMPLETE AND PARTIAL ACA REPEAL



Source: Congressional Budget Office, "Budgetary and Economic Effects of Repealing the Affordable Care Act," June 2015; Congressional Budget Office, "H.R. 3762 Cost Estimate," January 4, 2016; Congressional Budget Office, "Options for Reducing the Deficit: 2017 to 2026," December 2016.

analysis also contained estimates both including and excluding economic feedback.[42]

- A December 2016 analysis of a budget option to repeal the insurance coverage provisions of the ACA, including its Medicaid expansion, insurance purchase subsidies, insurance rules, individual and employer mandate penalties, and Cadillac plan tax. This will be referred to as option 3. This analysis did not include estimates that incorporated economic feedback.[43]

Figure 2 displays the estimated effects on federal spending of these three alternatives relative to CBO's projection baseline. Figures 2–7 and 10–15 refer to options 1, 2, and 3 as just described in this section.

42. Congressional Budget Office, "H.R. 3762 Cost Estimate," January 4, 2016, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762followingenactmentofconsolidatedappropsactof2016.pdf.
43. Congressional Budget Office, "Options for Reducing the Deficit: 2017 to 2026," December 2016, p. 233, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/52142-budgetoptions2.pdf.

All three options for complete or partial ACA repeal would significantly reduce federal spending relative to current projections. (This does not mean that overall spending would decline, but that it would grow more slowly than under current estimates.) The smallest reduction of the three options would arise under option 1 (total repeal), which would result in a projected savings of $821 billion through 2025. The difference between this and the other two options largely stems from option 1's repeal of the ACA's Medicare cost-containment provisions.[44]

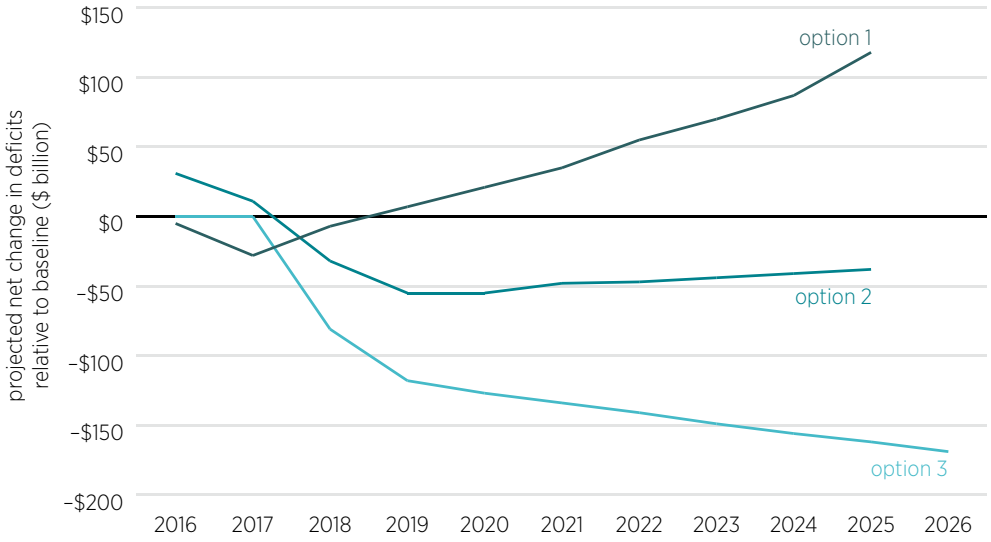
Options 2 and 3 would each leave the ACA's Medicare cost-containment provisions in place and are thus scored as reducing federal spending by much greater amounts. Option 2 would reduce spending by $1.370 trillion through 2025, and option 3 would reduce it by $1.485 trillion over the same period. Some of the difference between them arises because option 2 would not have repealed the ACA's rules governing health insurance, including "guaranteed issue and renewability of coverage, the requirement that health insurance cover certain health benefits, and rating rules that limit the extent to which premiums can vary based on individual characteristics."[45] These rules raise the cost of insurance for most participants in the nongroup (individual insurance) market. Hence, leaving these rules in place while repealing the ACA's subsidies and mandate penalties (both of which incentivize participation in the nongroup market) would precipitate additional movement out of that market, including some movement into tax-advantaged employer-sponsored coverage, thereby reducing the savings associated with repeal. Somewhat counteracting this effect is the fact that some repeal provisions of option 2 would have had immediate effects, whereas none of the provisions of option 3 would be effective until 2018. This accounts for option 2 producing some savings in 2016 and 2017, years during which option 3 would not.

Figure 3 shows the projected effects of the three alternatives on federal deficits, again relative to the CBO baseline. The qualitative differences between the three approaches are readily visible. Option 1 (total ACA repeal) is scored as adding to federal deficits by $353 billion through 2025, largely because of the prescribed

44. These Medicare provisions, as noted previously, score under current budget conventions as a substantial and compounding reduction in federal spending relative to the CBO baseline, although their net effect relative to actual Medicare law is substantially different. Because of this discrepancy, under Congress's scoring conventions, the ACA's Medicare provisions are credited both toward extending Medicare HI solvency and financing the ACA's coverage expansion. Hence repeal of these Medicare provisions, as scored by CBO, cuts significantly into the projected savings from repealing the ACA. This phenomenon will be discussed in greater detail later in this study.

45. Congressional Budget Office, "Estimate of Direct Spending and Revenue Effects of H.R. 3762, the Restoring American's Healthcare Freedom Reconciliation Act, as Passed by the Senate on December 3, 2015," footnote c, December 8, 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762aspassedbythesenate.pdf.

FIGURE 3. CONGRESSIONAL BUDGET OFFICE ESTIMATES OF CHANGES TO FEDERAL DEFICITS, COMPLETE AND PARTIAL ACA REPEAL



Source: Congressional Budget Office, "Budgetary and Economic Effects of Repealing the Affordable Care Act," June 2015; Congressional Budget Office, "H.R. 3762 Cost Estimate," January 4, 2016; Congressional Budget Office, "Options for Reducing the Deficit: 2017 to 2026," December 2016.

scorekeeping treatment of repealing the ACA's Medicare cost-containment provisions. Options 2 and 3 would both reduce federal deficits considerably (option 2 by $318 billion through 2025; option 3 by $1.067 trillion). The substantial difference between these latter two options is that option 2 would also have repealed several of the ACA's taxes, which would be left in place under option 3. Among the larger of these tax increases are the ACA's UIMC, its 0.9 percentage point payroll tax increase on higher-income earners, and its health insurance fees.[46]

In sum, repealing the ACA's coverage expansion provisions alone (option 3) would reduce currently projected spending and deficits by amounts compounding into the trillions of dollars over the upcoming decades. Repealing the ACA's new taxes in addition to its coverage subsidies (option 2) would similarly reduce federal spending while resulting in hundreds of billions in deficit reduction over the upcoming decade, although substantially less than if the ACA's taxes were left in place. Current budget conventions would score total repeal (option 1) as adding to the federal deficit, although as in the partial repeal options, total repeal would reduce

46. CBO, "H.R. 3762 Cost Estimate," January 4, 2016.

federal deficits relative to Medicare law in the absence of the ACA.[47] At the same time, repeal of the entire ACA (option 1) would introduce a new policy problem: accelerated insolvency of the Medicare HI trust fund, as this study will explore later.

UPDATING OF PROJECTIONS FOR RECENT HEALTH INSURANCE ENROLLMENT TRENDS

A key difference between the CBO scores of these three options is that the first two were evaluated under baseline budget assumptions published in March 2015, whereas option 3 was scored using assumptions published in March 2016.[48] The updated assumptions introduced a number of significant differences. One is that the March 2016 baseline incorporates statutory changes effected in the Consolidated Appropriations Act of December 2015, which included a postponement and weakening of the Cadillac plan tax as well as suspensions of the ACA's health insurance fees and medical device taxes. Incorporating these changes into the baseline lessens the net reduction in tax revenues under option 3, relative to the assumptions in place when options 1 and 2 were initially scored.[49]

Another major difference between the 2015 and 2016 baseline projections reflects updated data on participation in the ACA's subsidized coverage expansion. In 2016 CBO adopted "a lower projection for subsidized enrollment through the [ACA's] marketplaces, particularly over the next two years."[50] This revision occurred largely because, as noted by Brian Blase and other scholars, the ACA's exchanges failed to attract nearly as many enrollees as forecasters, including CBO, previously anticipated.[51] CBO thus significantly lowered its near-term projections for ACA marketplace participation, although it continues to project rising participation going forward. At the same time, "CBO boosted its projections of federal

47. This reduction is substantiated later in this study in the section entitled, "Implications of Repealing the ACA's Medicare Provisions." See table 4.
48. CBO, "Budgetary and Economic Effects of Repealing the Affordable Care Act," June 2015; CBO, "H.R. 3762 Cost Estimate," January 4, 2016; CBO, "Options for Reducing the Deficit: 2017 to 2026," December 2016.
49. The final score of option 2 (H.R. 3762), being performed after the passage of the Consolidated Appropriations Act, 2016, also incorporated these provisions' effects. CBO, "H.R. 3762 Cost Estimate," January 4, 2016. The net effects on options 2 and 3 of these updates differ because option 3 would repeal only some of these ACA taxes, whereas option 2 would have repealed them all.
50. Congressional Budget Office, "Updated Budget Projections: 2016 to 2026," March 2016, p. 1, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51384-marchbaselineonecol.pdf.
51. The revisions were anticipated by Brian Blase in "Downgrading the Affordable Care Act: Unattractive Health Insurance and Lower Enrollment" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2015), https://www.mercatus.org/system/files/Blase-ACA-Underperforming.pdf.

TABLE 3. KEY CHANGES IN CBO BASELINE ASSUMPTIONS FROM MARCH 2015 TO MARCH 2016

	2016		2020		2024	
Projection	3/15 estimate	3/16 estimate	3/15 estimate	3/16 estimate	3/15 estimate	3/16 estimate
ACA exchange subsidies and related spending /revenues ($ billion)	53	43	84	83	99	99
ACA Medicaid/ CHIP outlays ($ billion)	63	74	83	91	**102**	**125**
Gains in coverage through ACA insurance exchanges (M)[a]	**21**	**13**	23	20	22	19
Gains in coverage through ACA Medicaid/CHIP expansion (M)	12	13	14	16	14	18

Note: ACA = Affordable Care Act; CBO = Congressional Budget Office; CHIP = Children's Health Insurance Program.
[a] This projection includes those covered under the ACA's Basic Health Program, an optional program through which states can provide coverage for low-income people who would otherwise be eligible to use the ACA's exchange marketplaces. CBO sometimes combines estimates for enrollment in marketplaces and the Basic Health Program.

Sources: Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline," March 2015, https://www.cbo.gov/sites/default/files/recurringdata/51298-2015-03-aca.pdf; CBO, "Federal Subsidies for Health Insurance Coverage for People under Age 65," March 24, 2016, https://www.cbo.gov/publication/51385#section2.

outlays for Medicaid to reflect higher-than-expected spending and enrollment for newly eligible beneficiaries under the Affordable Care Act."[52] Essentially, CBO updated its projections to account for the fact that much more of the ACA's coverage expansion was taking place through Medicaid, at higher costs than previously projected, and much less consisted of enrollment through the ACA's exchanges. A comparison of the March 2015 and March 2016 CBO baseline projections illustrates the changes (table 3).

As table 3 shows, estimated coverage gains through the ACA's exchanges and Basic Health Program dropped precipitously (from 21 million to 13 million individuals covered) in CBO's updated 2016 baseline, although CBO continues

52. Congressional Budget Office, "The Budget and Economic Outlook: 2016 to 2026," January 2016, p. 8., https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51129-2016outlookonecol-2.pdf.

to project rising enrollment going forward assuming the ACA remains in place.[53] CBO's increased cost projection for Medicaid expansion is also striking, with the annual cost estimate rising by over 20 percent by 2024 (from $102 billion to $125 billion). Though part of this increased projection is due to higher-than-expected Medicaid enrollment, some of it also derives from per capita Medicaid expansion costs exceeding prior projections. Blase has studied the evolution of CBO's Medicaid expansion cost projections and noted that they would be higher if CBO were not still assuming "a lower average cost for the ACA expansion population after 2017."[54]

Taken together, an updated view of the ACA's effects would find higher cost savings from repealing its coverage expansion provisions and smaller revenue losses from repealing its tax provisions than CBO estimated in 2015. Figures 4 and 5 adjust CBO's 2015 projections for options 1 and 2 for these updated data.[55]

Although superficially resembling figure 2, figure 4 illustrates more closely how the three options might compare if all were scored under the same updated assumptions CBO used for option 3.[56] Updating these assumptions increases the net outlay savings projected for option 1 to $882 billion through 2025 relative to the scorekeeping baseline. It also increases the projected outlay savings for option 2 to $1.424 trillion through 2025. In both cases, most of the additional

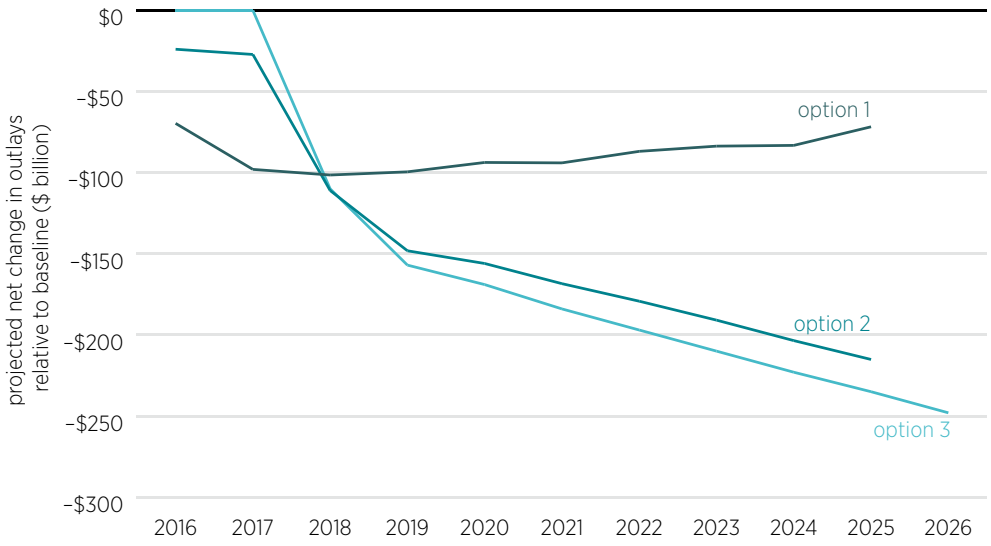
53. Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline," March 2015, https://www.cbo.gov/sites/default/files/recurringdata/51298-2015-03-aca.pdf. CBO, "Federal Subsidies for Health Insurance Coverage for People Under Age 65," March 24, 2016.

54. Brian Blase, "Evidence Is Mounting: The Affordable Care Act Has Worsened Medicaid's Structural Problems" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2016), 19, https://www.mercatus.org/system/files/mercatus-blase-medicaid-structural-problems-v1.pdf.

55. The adjustments also incorporate changes in Medicare projections calculated for this report based on data from the 2014, 2015, and 2016 annual Medicare trustees' reports. Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf. Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf. Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf.

56. CBO, "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline," March 2015. CBO, "Federal Subsidies for Health Insurance Coverage for People under Age 65," March 24, 2016. Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, annual reports for 2014, 2015, and 2016 (see links in note 55).

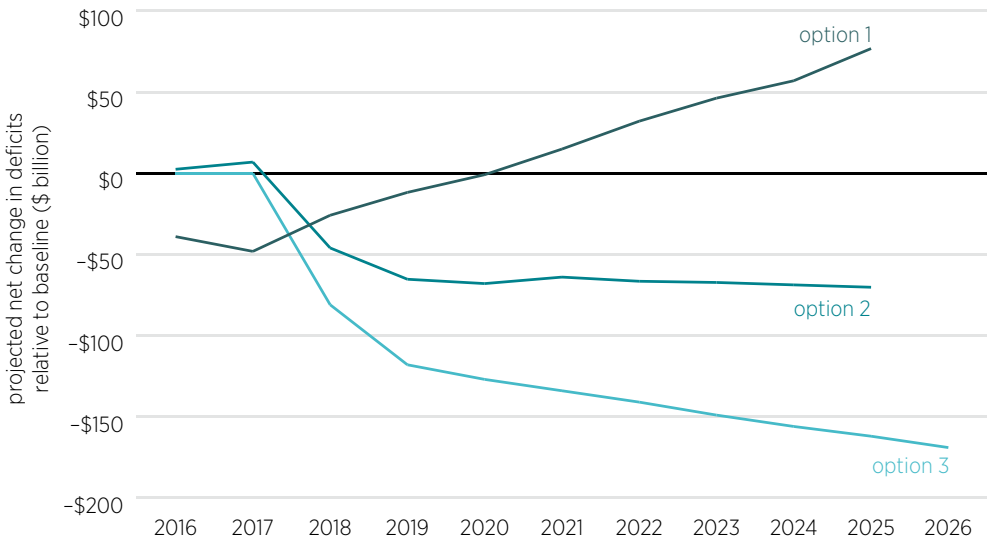
FIGURE 4. PROJECTED FEDERAL HEALTH SPENDING CHANGES, COMPLETE AND PARTIAL ACA REPEAL, UPDATED FOR 2016 BASELINE



Note: ACA = Affordable Care Act.

Source: Author's calculations based on Congressional Budget Office estimates.

FIGURE 5. PROJECTED CHANGES IN FEDERAL DEFICITS, COMPLETE AND PARTIAL ACA REPEAL, UPDATED FOR 2016 BASELINE



Note: ACA = Affordable Care Act.

Source: Author's calculations based on Congressional Budget Office estimates.

savings in the update derives from greater projected savings from repealing the ACA's Medicaid expansion, the cost of which has exceeded prior projections.

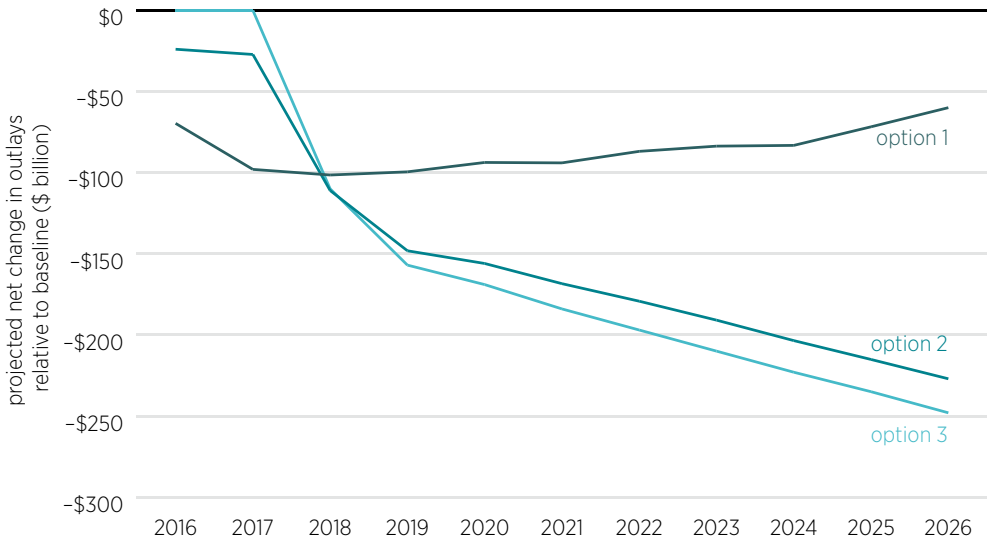
The effects of updated assumptions become even clearer when reviewing projections for the three options' effects on federal deficits, as shown in figure 5. As the figure shows, updating assumptions for more recent data improves the projected fiscal effects of options 1 and 2.[57] These updates increase the net deficit reduction in option 2 to $507 billion through 2025. Notably, they also eliminate the vast majority of the projected deficit increase from repealing the entirety of the ACA, even under the conventional scorekeeping baseline (lowering it from $353 billion to $101 billion through 2025). In other words, even when dually crediting the savings from the ACA's Medicare cost-containment provisions, total repeal (option 1) would be scored as nearly deficit-neutral through 2025.[58] Moreover, under the reasonable assumption that ACA provisions such as the Cadillac plan tax, IPAB, medical device taxes, and health insurance fees would continue not to be implemented going forward, repeal of the entire ACA would reduce federal deficits irrespective of whether it is scored relative to actual Medicare law or to the scorekeeping baseline.

CBO estimates for options 1 and 2 extend through 2025 only, whereas its projections for option 3 extend through 2026. Figures 6 and 7 extrapolate the projections for options 1 and 2 through 2026, on the basis of data provided with CBO's March 2016 budget baseline.

Extrapolation of options 1 and 2 through 2026 continues the trend lines in evidence through 2025 on the previous figures. For option 1, net outlay savings (figure 6) are slightly lower for the 10-year budget window over 2017–2026 relative to the 2016–2025 window, owing to the loss of growing long-term savings from the ACA's Medicare cost-containment provisions, which are otherwise assumed to compound over time relative to the scorekeeping baseline. Also, due in large part to its repeal of these Medicare provisions, option 1 would add more to federal deficits ($242 billion) over 2017–2026 than it would over 2016–2025 under the scorekeeping baseline. By contrast, both the outlay savings and deficit reduction projected under option 2 would be more favorable over 2017–2026 than over 2016–2025, rising to $1.627 trillion in outlay savings and $579 billion

57. Part of the reason for the improvement is the aforementioned increase in outlay savings that would arise from repealing the ACA's coverage expansion provisions. Updated assumptions also lessen the projected revenue losses from repealing the ACA's various taxes, many of which have already been suspended, postponed, or weakened in recent legislation. See Joint Committee on Taxation, JCX-142-15, December 16, 2015; Joint Committee on Taxation, JCX-143-15, December 16, 2015.
58. See footnote 37.

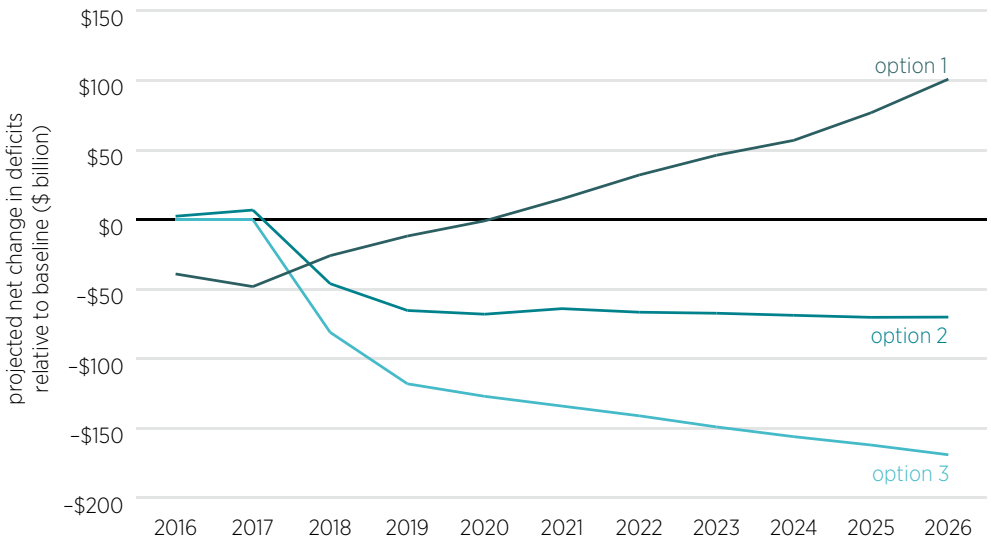
FIGURE 6. PROJECTED FEDERAL HEALTH SPENDING CHANGES THROUGH 2026, COMPLETE AND PARTIAL ACA REPEAL, 2016 BASELINE



Note: ACA = Affordable Care Act.

Source: Author's calculations based on Congressional Budget Office estimates.

FIGURE 7. PROJECTED CHANGES IN FEDERAL DEFICITS THROUGH 2026, COMPLETE AND PARTIAL ACA REPEAL, 2016 BASELINE



Note: ACA = Affordable Care Act.

Source: Author's calculations based on Congressional Budget Office estimates.

in deficit reduction. CBO estimates that over 2017–2026, option 3 would reduce federal outlays by $1.733 trillion and federal deficits by $1.236 trillion.[59]

IMPLICATIONS OF REPEALING THE ACA'S MEDICARE PROVISIONS

The ACA contained several provisions designed to improve Medicare program finances, concentrating on the operations of Medicare's Hospital Insurance trust fund. These provisions included reductions in the growth rate of Medicare HI provider payments, as well as an increase in the Medicare payroll tax rate paid by higher-income workers (single taxpayers with incomes over $200,000 and married couples with combined incomes over $250,000) from 2.9 percent to 3.8 percent.[60]

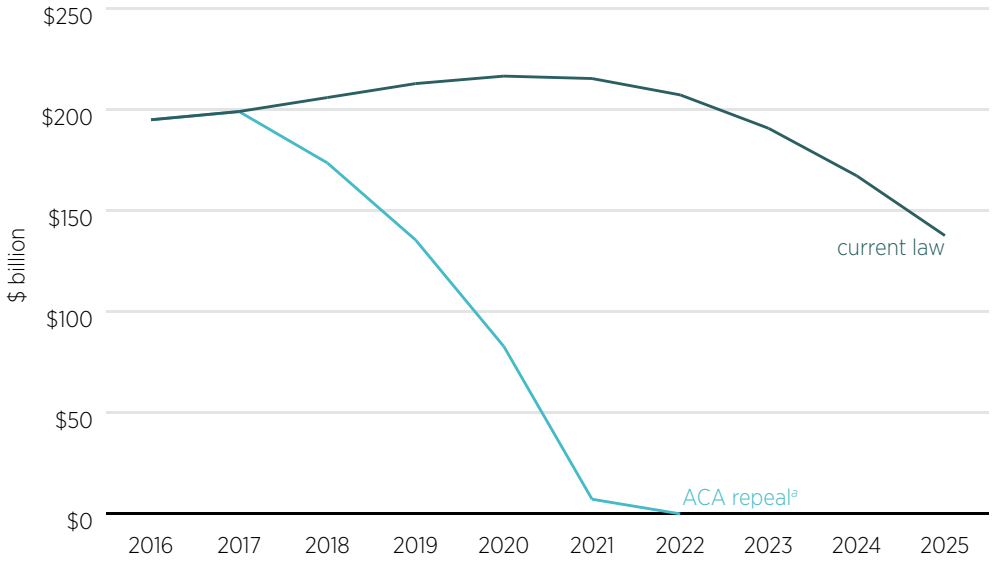
The ACA's Medicare cost-saving provisions extended the projected period during which HI trust fund revenues would be sufficient to finance full scheduled benefit payments, thereby avoiding sudden payment reductions that would otherwise have occurred as a result of HI trust fund depletion. These fiscal effects of extending HI solvency are not recognized in Congress's scorekeeping rules.[61] This scorekeeping quirk causes full ACA repeal to be scored as increasing rather than reducing federal deficits, as shown earlier in this study.[62]

Although ACA repeal legislation would reduce projected deficits even if repeal of the ACA's Medicare cost-containment provisions were included, it is nevertheless unlikely that lawmakers will choose to include such provisions if and when such legislation is again pursued. The primary reason is that doing so would accelerate Medicare HI trust fund insolvency, as this section will illustrate.

Figure 8 provides estimates for the end-of-year balance in the Medicare HI trust fund for current law as well as for total ACA repeal, with provisions

59. CBO, "Options for Reducing the Deficit: 2017 to 2026," December 2016.
60. Foster, "Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended." Internal Revenue Service, "Questions and Answers for the Additional Medicare Tax," https://www.irs.gov/businesses/small-businesses-self-employed/questions-and-answers-for-the-additional-medicare-tax. The ACA also included various reductions in the growth of payments for Medicare Advantage, many of which were scaled back through subsequent administrative action. See "Obama Administration Reverses Proposed Cut to Medicare Plans," *Washington Post*, April 7, 2014, https://www.washingtonpost.com/news/wonk/wp/2014/04/07/obama-administration-reverses-proposed-cut-to-medicare-plans/?utm_term=.441e1836cc27.
61. See footnote 37.
62. Dual crediting of the ACA's Medicare savings caused the law to be scored as reducing rather than increasing federal deficits. Blahous, "Fiscal Consequences of the Affordable Care Act" (Mercatus Research).

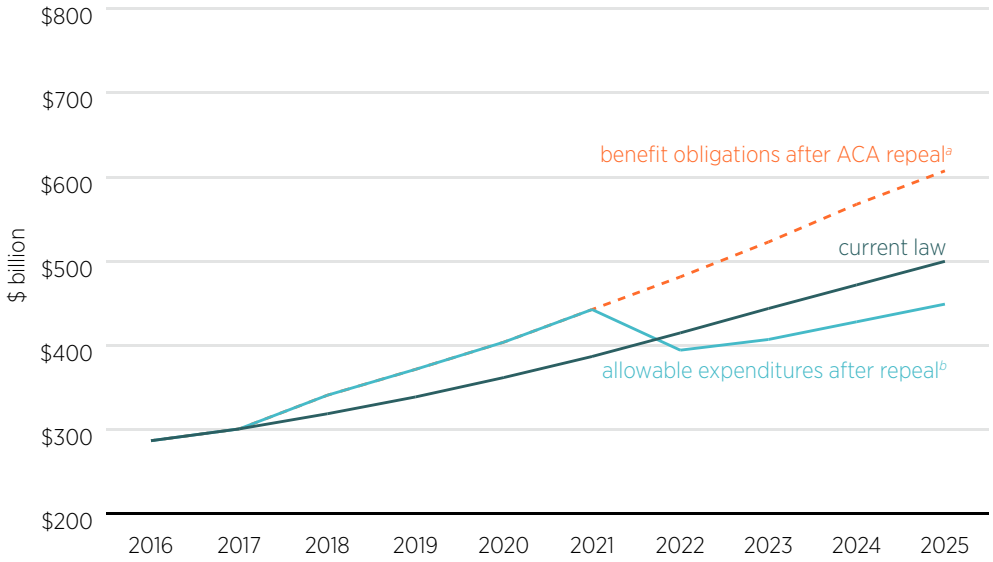
FIGURE 8. ESTIMATED END-OF-YEAR MEDICARE HI TRUST FUND BALANCES



Note: ACA = Affordable Care Act; HI = hospital insurance.
[a] Medicare HI trust fund balances with repeal of ACA Medicare provisions, effective 2018.

Source: Author's calculations based on Congressional Budget Office estimates and Medicare trustees' estimates.

FIGURE 9. ESTIMATED ANNUAL MEDICARE HI COSTS UNDER ACA REPEAL



Note: ACA = Affordable Care Act; HI = hospital insurance.
[a] Estimated benefit obligations after ACA repeal, effective 2018.
[b] Estimated allowable expenditures after ACA repeal, effective 2018.

Source: Author's calculations based on Congressional Budget Office estimates and Medicare trustees' estimates.

effective in 2018.[63] Under these projections, the HI trust fund would be depleted early in 2022.

The hastening insolvency of the Medicare HI trust fund under total repeal would arise from both higher near-term expenditures (because of repeal of the ACA's cost-containment provisions) and lower revenues (because of repeal of the ACA's Medicare payroll tax increase). Upon depletion of the HI trust fund, allowable HI expenditures would drop to levels that could be financed from annual incoming revenues (see figure 9).

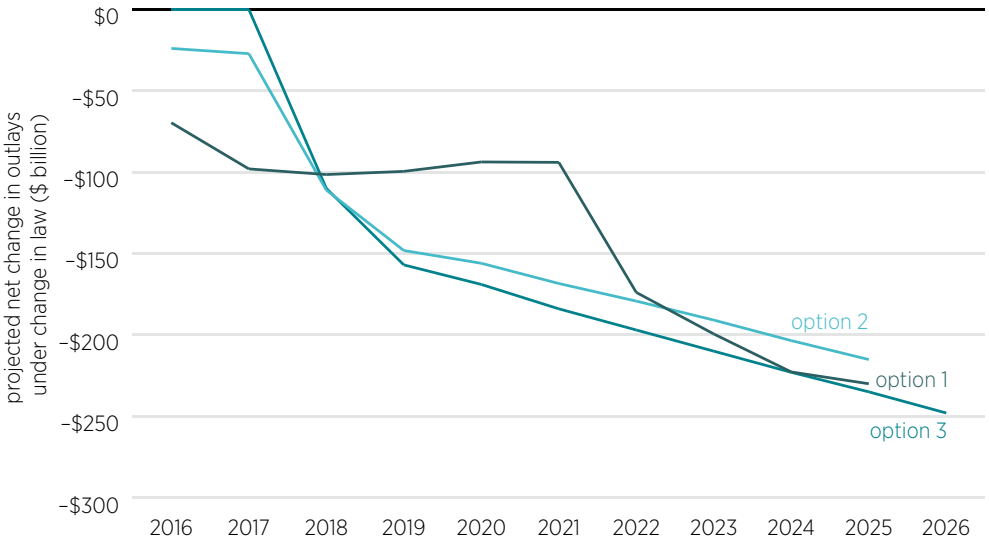
Whereas CBO finds under current scorekeeping rules that Medicare outlays would be increased by $802 billion from 2016 to 2025 if the ACA is completely repealed, roughly $500 billion of these expenditures would be impermissible under law owing to depletion of the HI trust fund, as shown in figure 9. The effects of these sudden required reductions in Medicare expenditures on the larger fiscal effects of repeal can be seen in figures 10 and 11.

As figures 10 and 11 and table 4 show, both federal spending and deficits would be substantially reduced whether the ACA were partially repealed as in options 2 and 3 or wholly repealed as in option 1. Options 2 and 3 would reduce projected outlays by $1.424 trillion and $1.485 trillion, respectively, through 2025, and option 1 by $1.383 trillion. Options 2 and 3 would reduce projected deficits by $507 billion and $1.067 trillion through 2025, respectively, and option 1 by $399 billion.

Although it is unlikely that the ACA's Medicare cost-containment provisions will be repealed as part of broader ACA repeal, the same cannot be said of the ACA's Medicare payroll tax increase. Indeed, option 2 (H.R. 3762) would have repealed it along with the ACA's other tax increases, and the recently introduced American Health Care Act (AHCA) would have as well. Depending on the effective date of such repeal, Medicare HI insolvency could be accelerated to occur within Congress's 10-year budget window. Applying the earlier-referenced methodology to the assumption that repeal of the tax increase becomes effective in 2018 produces

63. The estimates were performed as follows. First, estimates of the savings from repeal of the ACA's Medicare cost-containment provisions were obtained from CBO, "Budgetary and Economic Effects of Repealing the Affordable Care Act," June 2015. These estimates were updated by adjusting for changes in the Medicare trustees' projections in the 2014, 2015, and 2016 Medicare trustees' reports. Estimates were subsequently adjusted for the assumption that repeal provisions would take effect in 2018. Estimates of annual Medicare noninterest revenues were taken from the Social Security Administration at https://www.ssa.gov/OACT/TR/2016/lr6g10.html. Estimates of revenues lost from repealing the ACA's payroll tax provisions were taken from CBO, "H.R. 3762 Cost Estimate," January 4, 2016, and subsequently adjusted for an assumed effective date of 2018. These revenue estimates were also adjusted for changes in the Medicare trustees' projections in the 2014, 2015, and 2016 Medicare trustees' reports. The proportion of Medicare cost-saving provisions coming from the HI trust fund operations was taken from Blahous, "Fiscal Consequences of the Affordable Care Act" (Mercatus Research).

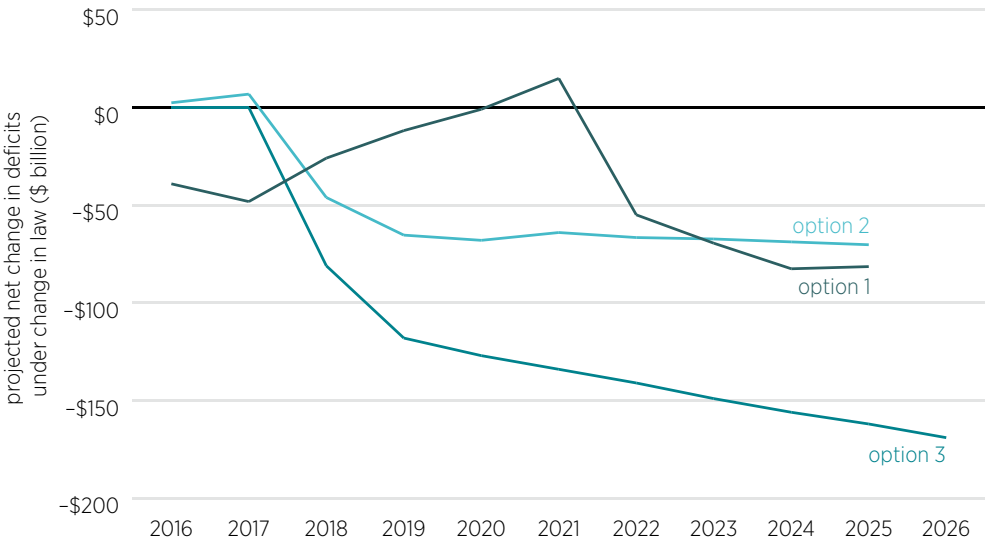
FIGURE 10. PROJECTED FEDERAL HEALTH SPENDING CHANGES, COMPLETE AND PARTIAL ACA REPEAL



Note: ACA = Affordable Care Act.

Source: Author's calculations based on Congressional Budget Office estimates and Medicare trustees' estimates.

FIGURE 11. PROJECTED CHANGES IN FEDERAL DEFICITS, COMPLETE AND PARTIAL ACA REPEAL



Note: ACA = Affordable Care Act.

Source: Author's calculations based on Congressional Budget Office estimates and Medicare trustees' estimates.

TABLE 4. NET REDUCTIONS IN FEDERAL SPENDING AND DEFICITS UNDER MEDICARE LAW, THREE OPTIONS

Option	Net federal spending reduction, 2016–2025 ($ billion)	Net federal deficit reduction, 2016–2025 ($ billion)
1	$1,383	$399
2	$1,424	$507
3	$1,485	$1,067

a finding that the HI trust fund would be depleted in 2026, constraining Medicare expenditures in that year by roughly $52 billion below scheduled benefit payments.

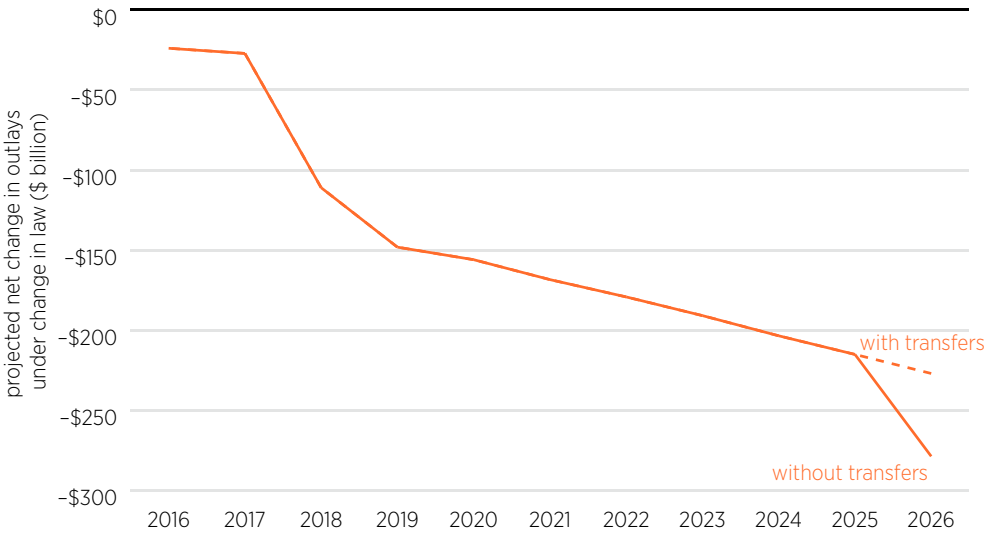
To prevent such a sudden reduction in benefit payments, H.R. 3762 included a provision to reimburse the Medicare HI trust fund with revenues from the general government fund.[64] Such transfers would embody a substantial subsidy of Medicare HI financed by general federal taxpayers, departing from the historical ethic of Medicare HI self-financing. Under Congress's scorekeeping rules, which assume the payment of scheduled Medicare benefits irrespective of trust fund balances, the revenue transfers have no measurable budget effect.[65] Under Medicare law, however, they do have a budget effect because they increase permissible spending by the Medicare HI trust fund.

Without offsetting measures, repealing the ACA's Medicare payroll tax increase would accelerate Medicare HI trust fund insolvency, forcing reductions in Medicare benefit payments and thus causing option 2 to lower federal spending and deficits by larger amounts (see figures 12 and 13 and table 5). However, the general revenue transfers also contained in option 2 would exactly reverse these effects within the 10-year budget window, while permitting additional Medicare spending afterward.

With or without repeal of the ACA's Medicare provisions, ACA repeal would considerably improve the federal fiscal outlook. If repeal of all of the ACA's Medicare provisions is included, however, much of the fiscal improvement would come by way of substantial and sudden reductions in Medicare benefits upon HI trust fund depletion—reductions that would deepen to equal more than 25 percent of annual Medicare HI benefits by 2025. To avoid this problem, lawmakers will be unlikely to include repeal of the ACA's Medicare cost-containment provisions as part of any broader ACA repeal. Because of this, the remainder of this study will analyze scenarios for repealing various combinations of the ACA's other spending and tax provisions, while leaving the ACA's Medicare cost constraints in place.

64. CBO, "H.R. 3762 Cost Estimate," January 4, 2016, § 223.
65. Ibid.

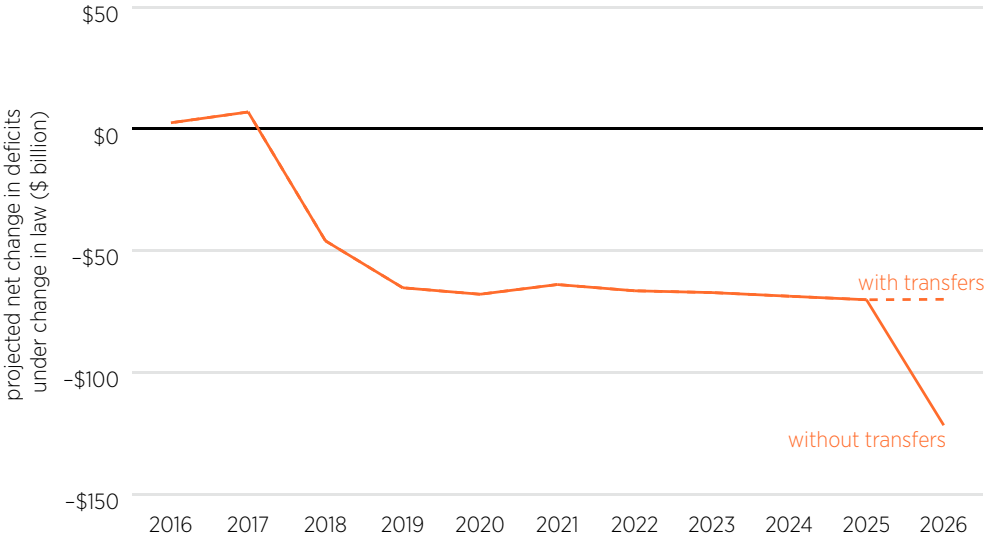
FIGURE 12. PROJECTED FEDERAL HEALTH SPENDING CHANGES, OPTION 2 (REPEAL OF ACA SUBSIDIES AND TAXES), WITH AND WITHOUT GENERAL REVENUE TRANSFERS TO MEDICARE



Note: ACA = Affordable Care Act.

Source: Author's calculations based on Congressional Budget Office estimates and Medicare trustees' estimates.

FIGURE 13. PROJECTED CHANGES IN FEDERAL DEFICITS, OPTION 2 (REPEAL OF ACA SUBSIDIES AND TAXES), WITH AND WITHOUT GENERAL REVENUE TRANSFERS TO MEDICARE



Note: ACA = Affordable Care Act.

Source: Author's calculations based on Congressional Budget Office estimates and Medicare trustees' estimates.

TABLE 5. FISCAL IMPROVEMENT IF MEDICARE GENERAL REVENUE TRANSFERS ARE EXCLUDED FROM OPTION 2 ($ BILLION), UNDER MEDICARE LAW

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
Variable 1: Exclude Medicare general revenue transfers	0	0	0	0	0	0	0	0	0	52	52

ILLUSTRATIVE EFFECTIVE DATES

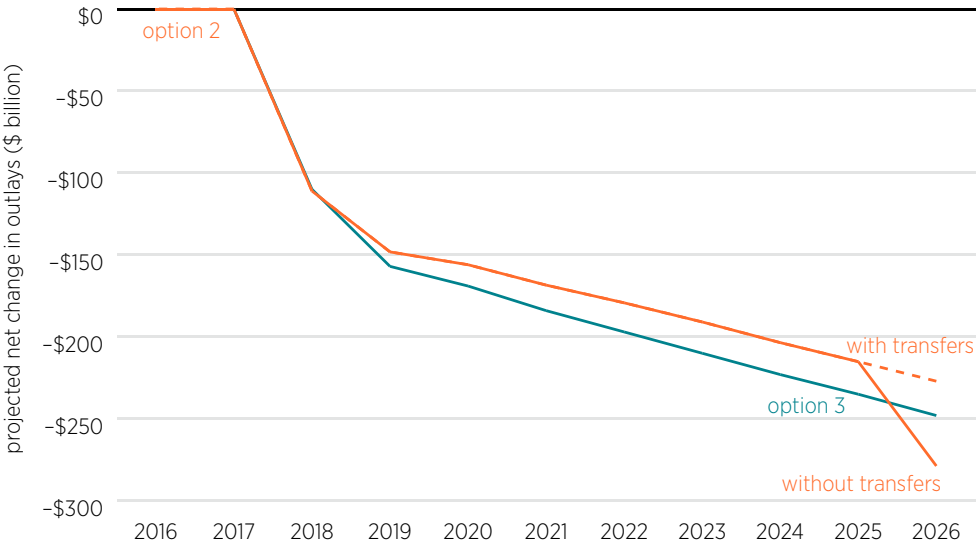
The fiscal effects of ACA repeal depend enormously on the dates by which repeal of specific provisions become effective. CBO scored its hypothetical option 1 (total repeal of the ACA) as though all of its provisions became effective on January 1, 2016.[66] Option 3, another hypothetical option for repealing the ACA's coverage expansion provisions, was scored on the assumption that its provisions would all become effective on January 1, 2018.[67] H.R. 3762 as passed (option 2) had multiple effective dates that varied from provision to provision. The repeal of the individual and employer mandate penalties would have taken effect essentially immediately, whereas repeal of many other provisions (e.g., repeal of reinsurance, risk corridor and risk adjustment provisions, medical device taxes, and health insurance taxes) would have taken effect in 2016. Repeal of the ACA's various tax credits to subsidize insurance coverage would not have taken effect until 2018.[68]

To allow apples-to-apples comparisons between different policy approaches, this study will assume effective dates of 2018 for all repeal provisions. Figures 14 and 15 present such illustrations for options 2 and 3.

Presentation of a single illustrative effective date of 2018 for these two options should not be interpreted as a prediction or a policy recommendation. Indeed, many observers and experts have mirrored former Office of Management and Budget Director Peter Orszag in predicting that "repeal will probably be set to become effective in the future, perhaps 2019 or 2020," whereas the subsequently introduced AHCA would repeal several major ACA provisions only in 2020.[69] This study has chosen 2018 for ease of comparison with CBO's published estimates for option 3, which assume an effective date of 2018.

66. CBO, "Budgetary and Economic Effects of Repealing the Affordable Care Act," June 2015.
67. CBO, "Options for Reducing the Deficit: 2017 to 2026," December 2016.
68. Text of H.R. 3762 as enacted, https://www.congress.gov/114/bills/hr3762/BILLS-114hr3762enr.pdf.
69. Peter Orszag, "Here's How Trump Will Change Obamacare," *BloombergView*, February 14, 2017, https://www.bloomberg.com/view/articles/2017-02-14/here-s-how-trump-will-change-obamacare.

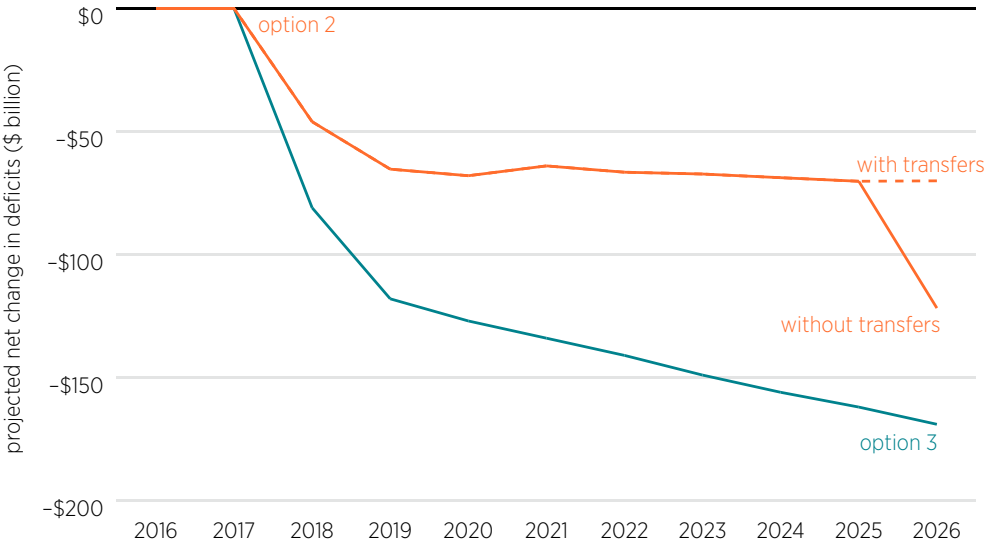
FIGURE 14. PROJECTED FEDERAL HEALTH SPENDING CHANGES THROUGH 2026, ACA REPEAL OPTIONS 2 (WITH AND WITHOUT GENERAL REVENUE TRANSFERS TO MEDICARE) AND 3, EFFECTIVE 2018



Note: ACA = Affordable Care Act.

Source: Author's calculations based on text of H.R. 3762, Congressional Budget Office estimates, and Medicare trustees' estimates.

FIGURE 15. PROJECTED CHANGES IN FEDERAL DEFICITS THROUGH 2026, ACA REPEAL OPTIONS 2 (WITH AND WITHOUT GENERAL REVENUE TRANSFERS TO MEDICARE) AND 3, EFFECTIVE 2018



Note: ACA = Affordable Care Act.

Source: Author's calculations based on text of H.R. 3762, Congressional Budget Office estimates, and Medicare trustees' estimates.

Delaying the effective date of repeal beyond 2018 would considerably reduce the amount of deficit reduction associated with the options above ($586 billion through 2026 under option 2). This is primarily because delay would extend the period of time during which the ACA's various coverage expansion subsidies, such as its elevated federal matching payment rate for Medicaid expansion and its tax credits against insurance premiums, continue to be paid from the federal Treasury. On the other hand, once termination of the ACA's various subsidies is scheduled for a specific year, insurers may begin to exit the nongroup market before the cutoff date, thereby lowering near-term participation and aggregate subsidy payments, and restoring some of the deficit reduction otherwise lost as a consequence of delay. Indeed, this is one reason why figures 2 through 7 and figures 10 through 13 show outlay reductions before 2018 under option 2. Figures 14 and 15 provide a more direct comparison between options 2 and 3 by assuming each becomes effective on January 1, 2018, while not being enacted so much earlier as to precipitate anticipatory action by participating insurers.

It should also be noted that in H.R. 3762 as well as various other repeal bills, the effective dates for repealing the ACA's various tax increases have been set earlier than for repeal of the ACA's various subsidy outlays.[70] If that tendency is reproduced in eventual repeal legislation, the resulting deficit reduction amounts would be less than shown in the examples above, which assume every repeal provision becomes effective on the same date of January 1, 2018.

FACTORS THAT COULD AFFECT PROJECTION ACCURACY IN EITHER DIRECTION

The following sections of this study examine factors that could cause inaccuracies in the main fiscal projections for repeal of the ACA's various subsidies and taxes. These will be used to illustrate the range of reasonable uncertainty surrounding the fiscal effects of repeal.

ACA Taxes That Have Already Been Suspended or Postponed

Some of the ACA's various tax increases, such as its Medicare payroll tax rate increase and UIMC, are already being collected according to ACA specifications. Consequently, repeal of these provisions should be expected to reduce federal revenue and increase federal deficits. Other ACA taxes, however, have not been

70. Text of H.R. 3762 as enacted.

implemented as originally enacted and are highly uncertain of being implemented in the future even if the rest of the ACA remains law. Such taxes are thus likely to provide less financing for the ACA than current scorekeeping methods assume. Ergo, their repeal would result in less of a revenue loss than now projected.

Such ACA taxes include the following:

- An excise tax on high-cost health insurance plans, the so-called Cadillac plan tax. Virtually upon the tax's enactment policymakers limited its application and postponed its effective date until 2018. The tax was more recently postponed until 2020 and its effects further limited.[71]
- A medical device tax. This tax was recently suspended until 2018.[72]
- Health insurance fees. These taxes on health insurers were also recently suspended until 2018.[73]

Notably, the fiscal effects of the recent suspensions of these taxes were simply added to the federal deficit without being offset by other revenue increases.[74] If this precedent continued to be followed it would lessen the marginal fiscal effects associated with formally repealing these taxes as part of ACA repeal. Current projections assume that ACA repeal would eliminate substantial revenues that these taxes would otherwise generate. Compared with a scenario in which the taxes are not collected, however, repeal would not result in revenue loss. Table 6 summarizes the spectrum of possibilities for the net effect of these provisions on ACA repeal, ranging from the assumption that the full amount of these taxes would otherwise be collected to the assumption that they would not be.

The observations that the Cadillac plan tax is not currently being enforced, and that its repeal would likely increase deficits less than currently projected, should not be interpreted as a recommendation that the tax be repealed without a replacement policy designed to accomplish its primary objectives. A central purpose of the Cadillac plan tax was to constrain the tax advantage applied to employer-sponsored health insurance, as a means of slowing the growth of national health expenditures and increasing the share

71. Joint Committee on Taxation, JCX-142-15, December 16, 2015.
72. Ibid.
73. Internal Revenue Service, "Affordable Care Act Provision 9010—Health Insurance Providers Fee," https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010.
74. Congressional Budget Office, "Estimated Effects on Direct Spending and Revenues of H.R. 2029," December 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/cboestimateofhr2029asclearedforthepresidentssignatureondecember182015.pdf.

TABLE 6. IMPROVEMENT IN FISCAL EFFECTS OF ACA REPEAL UNDER ALTERNATIVE TAX ASSUMPTIONS ($ BILLION)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
Variable 2: Cadillac tax suspension continued	0	0	0	5	7	9	10	12	16	19	79
Net fiscal improvement from variable 2 (options 2 and 3)	0	0	0	5	7	9	10	12	16	19	79[a]
Variable 3: Medical device tax suspension continued	0	1	2	2	2	2	3	3	3	3	20[b]
Variable 4: Health insurance tax suspension continued	0	14	15	16	17	18	19	20	21	22	162[c]
Net fiscal improvement from variables 2, 3, and 4 (option 2)	0	15	17	23	26	29	32	35	40	44	261

Note: ACA = Affordable Care Act. In this table, the word *improvement* is used in a relative sense, comparing the effects of ACA repeal with policy in its absence. In this case, the relative fiscal improvement of ACA repeal would occur because of a worsening in the outlook under alternative policies.

[a] This is a net of both outlay and revenue effects. The revenue effect is $98 billion, $19 billion for outlays. The outlay effect arises primarily from projected changes in taxable compensation if the Cadillac plan tax is in effect. In general, it is an especially complex task to estimate projected revenue and outlay effects of changes to the Cadillac plan tax. Assumptions must be made with respect to how many employers will reconfigure their plans to avoid paying the tax, and these assumptions involve considerable speculation. Figures above are derived by author's calculations cross-referenced with Congressional Budget Office, "Options for Reducing the Deficit: 2017 to 2026," December 2016, p. 234.

[b] Author's calculations based on Congressional Budget Office, "H.R. 3762 Cost Estimate," January 4, 2016.

[c] Internal Revenue Service, "Affordable Care Act Provision 9010—Health Insurance Providers Fee." Cross-referenced with Congressional Budget Office, "H.R. 3762 Cost Estimate," January 4, 2016.

of worker compensation received as take-home pay. Although lawmakers have not permitted the Cadillac plan tax to achieve that objective, there is widespread agreement among health economists that a federal policy should remain in place to phase out the long-standing tax distortion favoring worker compensation in the form of health benefits.[75] The illustrations provided here are informational with respect to budgetary effects and do not constitute a policy recommendation.

75. Charles Blahous, "Five Lessons of the Cadillac Plan Tax's Failure," e21 (Manhattan Institute for Policy Research), December 29, 2015, https://www.mercatus.org/expert_commentary/five-lessons-cadillac-plan-tax-failure.

TABLE 7. CMS MEDICAID ACTUARIAL REPORT ESTIMATES OF EXPENDITURES PER NEWLY ELIGIBLE ADULT

Year	2014	2015	2016
2013 Report	$4,636	$3,976	$3,625
2014 Report	$5,517	$4,281	$3,606
2015 Report	$5,488	$6,366	$5,910
2016 Report	$5,511	$6,365	$5,926

Note: CMS = Centers for Medicare and Medicaid Services.

Source: CMS, "Actuarial Report on the Financial Outlook for Medicaid," 2013 through 2016, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.html.

Medicaid Expansion

Two primary sources of potential error reside in projections of the costs of the ACA's Medicaid expansion: errors in projecting the numbers of people brought into Medicaid under the ACA, and errors in projecting the per capita cost of covering the Medicaid expansion population. These sources of potential projection error could cause the fiscal gains of ACA repeal to be either underestimated or overestimated.

Current CBO projections for the per capita cost of Medicaid expansion appear to approximate a lower bound on possible outcomes. Thus far, federal government projections of per capita expansion costs have underestimated actual costs with some consistency. Table 7 shows how the CMS Medicaid actuary's estimates of the per capita cost of covering newly eligible adults under Medicaid have had to be repeatedly revised upward as incoming data have replaced prior projections.

Explanations are as yet incomplete for this persistent underestimation of per capita Medicaid expansion costs. The CMS actuary's office initially expected that health services for newly eligible individuals would cost less per capita than for the previously eligible Medicaid population, because the previously eligible populations had certain specific health care needs (such as pregnancy) and were generally lower-income individuals in poorer health on average.[76] When the costs of expansion instead began to come in higher than previous estimates, this result was attributed in part to "pent-up demand" for health services. This created the expectation that per capita costs would soon decline after the initial enrollments,

76. Department of Health and Human Services, "2014 Actuarial Report on the Financial Outlook for Medicaid," https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2014.pdf.

which were assumed to be concentrated among those with the greatest health needs, and were to be followed by healthier enrollees. Yet per capita costs continued to come in well above previous projections, in part because states were setting higher-than-expected capitation rates on the basis of higher "acuity and morbidity."[77] Blase has noted that under the ACA, states have little incentive to constrain these unexpectedly high capitation rates because almost the entire cost of covering the expansion population is borne by the federal government.[78]

Accordingly, policymakers should be cognizant that the future costs of the ACA's Medicaid expansion may still be underestimated. The CMS Medicaid actuary currently assumes that the slight recent decline in the per capita costs of covering newly eligible adults will extend to further declines, falling from $6,365 in 2015 to $5,370 in 2018, before rising again.[79] If per capita costs do not decline as projected, aggregate costs may continue to surpass current CMS projections. Similarly, CBO has incorporated previous projection errors, not by raising its future estimates for long-term per capita costs but by lowering its estimates for interim annual cost growth.[80] If CBO and CMS are continuing to underestimate per capita Medicaid expansion costs, this could mean that the aggregate costs of the ACA's Medicaid expansion are currently underestimated, and thus that the fiscal gains of repeal are also underestimated.

Table 8 provides estimates for the change in budget effects under a scenario in which annual per capita expansion costs remain roughly at 2015 levels ($6,400) through 2021 before rising gradually again to reach $7,900 per newly eligible adult in 2025. This is well within the range of plausible outcomes, and it is quite feasible that coverage expansion cost growth could run still higher.

The projected fiscal effects of ACA repeal might also be distorted if forecasters are inaccurately tracking the so-called "woodwork" population in the ACA's Medicaid expansion. The woodwork population encompasses those individuals previously eligible for Medicaid pre-ACA who only "came out of the woodwork" to sign up for Medicaid under the ACA's outreach processes. Although enrollment of these previously eligible individuals was part of the ACA's initial costs, ACA repeal would neither remove their eligibility nor result in cost savings.

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77. Department of Health and Human Services, "2015 Actuarial Report on the Financial Outlook for Medicaid," https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2014.pdf.
78. Blase, "Evidence Is Mounting."
79. Department of Health and Human Services, "2016 Actuarial Report on the Financial Outlook for Medicaid," https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2014.pdf.
80. Blase, "Evidence Is Mounting," figure 7, p. 20.

TABLE 8. IMPROVEMENT(+)/WORSENING(–) OF FISCAL EFFECTS OF REPEALING MEDICAID EXPANSION ($ BILLION)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
Variable 5: Medicaid expansion costs underestimated (options 2 and 3)	0	7	5	7	6	6	10	10	5	5	62
Variable 6: Medicaid woodwork population underestimated (options 2 and 3)	0	–10	–8	–8	–9	–9	–9	–9	–9	–10	–81

In March 2016 CBO estimated that in 2015, 10 million people who received Medicaid coverage because of the ACA were made newly eligible by the law, whereas another 2 million who gained coverage were "people who would have been eligible without the ACA but who chose to enroll as a result of the ACA's enactment." CBO cautioned that the latter estimate "cannot be verified because there is no way to know whether new enrollees who would have been eligible without the ACA would have signed up if the ACA had never been enacted."[81] Although CBO did not provide annual estimates of the woodwork population, comparisons of its estimates of those made newly eligible for Medicaid by the ACA, with its estimates for total changes in Medicaid coverage owing to the ACA, suggests that CBO sees the woodwork population growing from roughly 2 million today to 4 million by 2026. The share of Medicaid expansion that CBO implicitly identifies as the woodwork population, when broken down into annual estimates for 2016–2026, produces proportions ranging from 14 percent to 24 percent and averaging around 19 percent, which this study rounds to 20 percent in recognition of gross imprecision.

Recent analysis by Molly Frean, Jonathan Gruber, and Benjamin Sommers, however, found that roughly 44 percent of the total ACA coverage increase that occurred in 2014 (the first year the ACA's elevated federal Medicaid payment rate took effect) consisted of individuals "already eligible for the program before 2014."[82] Blase has calculated that this enrollment of previously

81. CBO, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026," March 24, 2016, p. 19.
82. Molly Frean, Jonathan Gruber, and Benjamin Sommers, "Disentangling the ACA's Coverage Effects—Lessons for Policymakers," *New England Journal of Medicine* 375 (2016): 1605–8, http://www.nejm.org/doi/pdf/10.1056/NEJMp1609016.

eligible individuals translates into roughly 70 percent of Medicaid coverage gains specifically in 2014, or 60 percent of Medicaid coverage gains between the ACA's enactment and 2014.[83]

The difficulty with translating these figures into estimates of the ACA's woodwork effect is that, as CBO notes, there is simply no way to know how rapidly enrollment of previously eligible individuals would have grown in the absence of the ACA. However, cross-referencing historic patterns for ACA enrollment growth with the figures in the Frean, Gruber, and Sommers study produces an estimate that the proportion of the ACA's Medicaid expansion resulting from the woodwork population could plausibly be as high as 40 percent.[84] If the woodwork population turns out to be this much higher than current CBO estimates, then repeal of the ACA might result in a considerably smaller reduction in Medicaid coverage as well as less budget savings. These effects are also estimated in table 8.

"Policymakers should be cognizant that the future costs of the ACA's Medicaid expansion may still be underestimated."

83. Brian Blase, "New Gruber Study Raises Major Questions about Obamacare's Medicaid Expansion," *Forbes*, November 27, 2016, https://www.forbes.com/sites/theapothecary/2016/11/27/new-gruber-study-raises-major-questions-about-obamacares-medicaid-expansion/#39e6d523601b.

84. This estimate is produced as follows. Department of Health and Human Services, "2015 Actuarial Report on the Financial Outlook for Medicaid," indicates total Medicaid coverage growth from 2010 to 2014 was roughly 9.3 million. Blase's estimate that 60 percent of this population growth consisted of individuals eligible for Medicaid before passage of the ACA produces an estimate that 5.6 million previously eligible individuals gained coverage from 2010 to 2014. Examination of Medicare enrollment trends before 2014 suggests a fairly persistent residual annual enrollment growth trend of at least 1.2 percent; on only two occasions between 2000 and 2013 did annual enrollment growth lag that amount despite fluctuations in economic conditions, demographics, and occasional legislation. Applying this 1.2 percent annual growth figure to 2010 enrollment totals results in a projection that even in the absence of the ACA, Medicaid enrollment would have increased by roughly 2.7 million from 2010 to 2014. This suggests that the enrollment of 2.9 million (5.6 million minus 2.7 million) previously eligible individuals under the ACA was a woodwork effect, or more than 40 percent of the total coverage growth owing to the ACA, above and beyond the expected residual growth (9.3 million minus 2.7 million, or 6.6 million).

Health Insurance Mandates and Rules

The ACA included a number of rules governing the scope and pricing of health insurance. Among those rules are that insurers may not "deny coverage or vary premiums because of an enrollee's health status or limit coverage because of pre-existing medical conditions."[85] It also imposed rules "that limit the extent to which premiums can vary based on individual characteristics," such as age.[86]

The final version of H.R. 3762 (option 2) that passed Congress during the past session would have left these rules in place. This decision was in large part because of uncertainty as to whether repeal of such provisions would be considered extraneous, and therefore in violation of the Senate requirements under the budget reconciliation process used to pass H.R. 3762. Because it is likely that future efforts to repeal and replace the ACA would also use the budget reconciliation procedure, similar uncertainty surrounds whether repeal of these rules can and will be attempted as part of such future legislation.[87]

The same ambiguity surrounds how Congress's procedural rules apply to other ACA provisions, including its mandates that employers offer minimum essential health coverage and that individuals carry it. There is no question that the penalties associated with these mandates are considered germane for budget reconciliation purposes because of their direct and considerable impact upon the federal budget. Accordingly, repeal of the penalties was included in H.R. 3762 and moved through the budget reconciliation process. However, H.R. 3762 did not include repeal of the underlying mandate, and it remains controversial whether the mandates themselves (in isolation from their associated penalties) have a nonincidental budget effect that renders their repeal germane to the budget reconciliation process.[88]

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85. Congressional Budget Office, "How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums," January 2017, https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52371-coverageandpremiums.pdf.

86. CBO, "Estimate of H.R. 3762 as Passed by the Senate December 3, 2015."

87. Danielle Kurtzleben and Ailsa Cheng, "Senate Takes First Step to Repeal Obamacare – So What's Next?," National Public Radio, January 12, 2017, http://www.npr.org/2017/01/12/509441874/senate-takes-first-step-towards-repeal-of-obamacare. Repeal of these rules was not included in the AHCA bill recently introduced in the US House of Representatives.

88. Capitol Hill Consulting Group, "What Is Budget Reconciliation?," December 5, 2016, https://www.capitolhillcg.com/2016/12/05/what-is-budget-reconciliation/. "When the bill reached the Senate in January 2016, the Senate parliamentarian reviewed the House-passed bill to see if provisions of the bill met the extraneous matter requirements of the Byrd Rule. She determined that repeal of the individual mandate and employer mandate, were extraneous policies, and not primarily budgetary in nature. As a result, they were dropped from the bill and Senate Majority Leader Mitch McConnell (R-KY) offered an amended version of the reconciliation bill that retained the policy of the individual and employer mandates, but eliminated the penalty for non-compliance."

CBO appears to have found that all of these aforementioned rules have significant budgetary effects. When legislative language repealing the entirety of the individual and employer mandates and penalties was replaced by language repealing only the penalties while leaving the mandates in place, CBO's budget score changed by roughly $30 billion over 10 years.[89] In addition, CBO found that "the projected savings from the coverage provisions of this amendment (H.R. 3762 as amended by the Senate) are smaller than those that would stem from repealing all the coverage provisions of the Affordable Care Act" because H.R. 3762 (option 2) would leave in place the ACA's rules "including guaranteed issue and renewability of coverage, the requirement that health insurance cover certain health benefits, and rating rules that limit the extent to which premiums can vary based on individual characteristics."[90] Perhaps most illustrative is that CBO's score of option 3, which would repeal these insurance rules and mandates, differs from its score of the coverage provisions of option 2 (which would not have) by significantly more than can be accounted for by intervening baseline changes alone.[91] The parliamentary question at issue is not whether these various rules have a budget impact (they do), but whether the impact is considered incidental for budget reconciliation purposes.[92]

It is therefore currently unknown whether lawmakers will want to repeal or to modify these various rules, as well as whether such repeal can move through Congress's budget reconciliation process or must use another legislative vehicle. Policy merits aside, adding the repeal of all of these provisions to the others in option 2 could increase its positive fiscal effects to an extent roughly estimated in table 9 (their repeal is already incorporated into CBO's score of option 3).

COST-SHARING SUBSIDIES

An ongoing controversy with the implementation of the ACA has been whether the executive branch could lawfully deliver subsidy payments to insurers, which

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Repeal of these mandates was not included in the AHCA bill recently introduced in the US House of Representatives, though repeal of their associated penalties was.

89. Comparison of CBO score of H.R. 3762, November 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762aspassed.pdf, with CBO score of H.R. 3762, December 2, 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762amendment2874.pdf.

90. CBO, "Estimate of H.R. 3762 as Passed by the Senate December 3, 2015," footnote c.

91. CBO, "H.R. 3762 Cost Estimate," January 4, 2016; CBO, "Options for Reducing the Deficit: 2017 to 2026," December 2016.

92. Charles Blahous, "CBO Shows How to Repeal Obamacare Regs," e21 (Manhattan Institute for Policy Research), February 3, 2017, https://economics21.org/html/cbo-shows-how-repeal-obamacare-regs-2199.html.

TABLE 9. IMPROVEMENT IN FISCAL EFFECTS IF REPEAL OF INSURANCE RULES AND MANDATES IS INCLUDED ($ BILLION)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
Variable 7: Include repeal of insurance rules and mandates (option 2)	0	11	12	13	9	10	11	11	11	11	98[a]

[a] This is a sum of outlay and revenue effects. The outlay effect is $73 billion and the revenue effect is $25 billion. The estimate is based on CBO score of H.R. 3762, November 2015; CBO score of H.R. 3762, December 2, 2015; CBO, "Estimate of HR3762 as passed by the Senate December 3, 2015"; CBO, "H.R. 3762 Cost Estimate," January 4, 2016; CBO, "Options for Reducing the Deficit: 2017 to 2026," December 2016; CBO, "Updated Budget Projections: 2016 to 2026," March 2016.

they in turn would use to reduce cost-sharing responsibilities for low-income participants in so-called silver plans.[93] These subsidies were authorized by the ACA, but lawmakers did not subsequently appropriate funds for them. The Obama administration argued that making the payments was lawful nevertheless, but Congress disagreed, which led to a lawsuit and a US district court decision that such payments must cease unless and until funding is appropriated by lawmakers.[94] Subsequent action in appeals court in December 2016 stayed further proceedings, effectively deferring the decision until after the Trump administration took office.[95]

Broader ACA repeal would encompass repeal of these cost-sharing subsidies, and this is reflected in the CBO scores for options 1, 2, and 3. If, however, the subsidies would have been terminated anyway by judicial or administrative action, the marginal savings from legislated repeal would be less than currently

93. A plan is designated a silver plan if it covers 70 percent of costs. See https://www.healthcare.gov/choose-a-plan/plans-categories/. Cost-sharing subsidies were to cover individuals with incomes between 100 percent and 250 percent of the federal poverty line. Kaiser Family Foundation, "Explaining Health Care Reform: Questions about Health Insurance Subsidies," November 2016, http://kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health.

94. United States District Court for the District of Columbia, Ruling in House v. Burwell, filed May 12, 2016, http://premiumtaxcredits.wikispaces.com/file/view/4716780-0--18395.pdf/582934821/4716780-0--18395.pdf.

95. US Court of Appeals for the District of Columbia Office, Ruling in House v. Burwell, filed December 5, 2016, http://premiumtaxcredits.wikispaces.com/file/view/House%20v.%20Burwell%20abeyance%20order.pdf/601446774/House%20v.%20Burwell%20abeyance%20order.pdf. "So far, the Trump Administration and current congressional leaders have not declared whether they favor continuing or discontinuing these payments, so both sides have asked the court to pause the court case while they determine what they want to do." In Mark Hall and Michael McCue, "The Financial Consequences of Terminating the ACA's Cost-Sharing Reduction Payments," Commonwealth Fund, March 2, 2017, http://www.commonwealthfund.org/publications/blog/2017/mar/terminating-aca-financial-consequences.

TABLE 10. LOSS OF MARGINAL BUDGET SAVINGS IF COST-SHARING SUBSIDIES ARE ALREADY TERMINATED ($ BILLION)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
Variable 8: Cost-sharing subsidies already terminated (options 2 and 3)	0	–11	–12	–13	–13	–13	–14	–14	–15	–16	–121

scored. Table 10 presents estimates of the potential loss of marginal budget savings from repeal legislation if it occurs after cost-sharing subsidies have already terminated.[96]

In all likelihood, the fiscal effects of terminating cost-sharing subsidies would be substantially larger than shown here. Table 10 only reflects the direct outlay effect of terminating the cost-sharing payments. It is reasonable to expect that if these payments were terminated, many low-income people who benefit from them would drop their insurance coverage, thereby reducing federal premium tax credit outlays as well. As of this writing, there are no indications that these effects will come into play before ACA repeal legislation is considered.

Independent Payment Advisory Board

The ACA established a new board within Medicare named the Independent Payment Advisory Board. IPAB was charged with making recommendations to limit the growth of Medicare spending to statutorily prescribed rates. The recommendations were to be implemented unless overridden in legislation, which in turn could only be passed if various procedural restrictions were overcome.[97]

As noted earlier in this study, IPAB was never constituted even though the most recent Medicare trustees' report contained projections indicating that its recommendations would be triggered in 2017. Neither the Obama administration nor congressional leaders nominated individuals to serve on the board.

96. CBO, "Federal Subsidies for Health Insurance Coverage for People under Age 65," March 24, 2016, p. 31. These estimates were updated later in January 2017, but the March 2016 estimates are used here for direct comparability with other estimates based on those earlier assumptions. Termination of these subsidies would likely precipitate additional movement out of health exchange coverage by affected participants, affecting the stability of exchange plans and causing additional budgetary effects. These ancillary effects are not incorporated here because of the difficulty of estimating the relative stability of exchange plans if the cost-sharing subsidies are terminated via administrative decision versus legislation.

97. Blahous, "Fiscal Consequences of the Affordable Care Act" (Mercatus Research).

TABLE 11. FISCAL IMPROVEMENT OF REPEAL ASSUMING IPAB IS ALREADY INEFFECTIVE ($ BILLION)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
Variable 9: Assuming IPAB ineffective (option 2)	0	0	0	0	0	1	1	2	3	4	11

Regardless of whether the broader ACA remains on the books, it seems unlikely that IPAB would ever be convened, rendering its repeal more of a formality than an event of budgetary significance.

Despite the unlikelihood of IPAB ever producing cost-saving recommendations, program spending cuts could still be triggered by the ACA's IPAB provisions, which require the secretary of Health and Human Services to develop and transmit a proposal to reduce Medicare spending in any year that IPAB "is required, but fails, to submit a proposal."[98] Lawmakers may not be inclined to allow any Medicare cuts to be implemented pursuant to previous legislation establishing a still-nonexistent board. In any case, IPAB repeal still involves a change in law and is thus scored as increasing projected outlays. Table 11 presents estimates of the amount by which the CBO score of option 2 would improve if it were assumed that no cost-saving recommendations would otherwise have been implemented as a result of IPAB's enactment.

Other Potential Deviations from Projections

The number of sources of potential deviations from current fiscal projections is too great for this study to analyze all of them. This brief section will cursorily review some of the additional sources of potential projection error.

One factor is that because enrollment in the ACA's exchanges has persistently lagged behind prior projections, CBO may still be overestimating the expected cost of federal subsidies for exchange participants, and thus also overestimating the savings arising from repeal. CBO's March 2016 assumptions, on which many of the estimates cited in this study are based, had already taken account of a significant decline in enrollment relative to its March 2015 assumptions. Yet CBO's January 2017 update revised these participation assumptions

98. Health Care and Education Reconciliation Act of 2010, 42 U.S.C. § 1395kkk—Independent Payment Advisory Board.

TABLE 12. LOSS OF MARGINAL BUDGET SAVINGS IF ACA EXCHANGE PARTICIPATION IS OVERESTIMATED ($ BILLION)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
Variable 10: ACA exchange participation overestimated (options 2 and 3)	0	–18	–19	–13	–14	–15	–20	–21	–18	–18	–156[a]

[a] This number is a sum of outlay and revenue effects. The outlay effect is $134 billion, and the revenue effect is $22 billion.

further downward, in some cases to a great extent. For example, CBO's January 2017 baseline projected that in 2019 only 11 million subsidized individuals will be enrolled in the ACA's marketplaces, in contrast with a 2016 baseline projection for 2019 of 16 million.[99] Table 12 provides estimates for potential reductions in savings arising from repealing the ACA's Basic Health Program and marketplace tax credits, if March 2016 participation assumptions prove to have been overstated.

CBO estimates for operations of the ACA's budget-neutral risk adjustment program could also be quite imprecise, given that insurers participating in the ACA's exchanges have experienced bigger losses than projected and have consequently made higher claims.[100] These projection uncertainties carry the potential for current estimates of risk adjustment collections and payments to deviate significantly from eventual reality, thereby affecting total federal outlays. CBO projections continue to assume this program will be operated in a budget-neutral manner in keeping with established legislative intent.[101] Because the estimates in this section of the study emphasize net effects on federal deficits rather than total outlays, separate estimates of variance in risk adjustment payments are not presented here.

99. CBO, "Federal Subsidies for Health Insurance Coverage for People under Age 65," March 24, 2016; Congressional Budget Office, "Federal Subsidies under the Affordable Care Act for Health Insurance Coverage Related to the Expansion of Medicaid and Nongroup Health Insurance: Tables from CBO's January 2017 Baseline," January 2017, https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf.

100. Brian Blase et al., "Affordable Care Act Turmoil: Large Losses in the Individual Market Portend an Uncertain Future" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016), https://www.mercatus.org/system/files/Blase-Individual-Market-Upheaval-v1.pdf.

101. CBO, "Federal Subsidies under the Affordable Care Act," January 2017. Also, Thomas McGuire et al. state that "Section 1343 of the ACA requires risk-adjustment to be budget neutral." In "Integrating Risk Adjustment and Enrollee Premiums in Health Plan Payment," *Journal of Health Economics* 32, no. 6 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3855655/.

SUMMARY AND CONCLUSIONS

The preceding survey of factors influencing the fiscal effects of ACA repeal shows many sources of projection uncertainty, some of them rooted in the significant variability of key assumptions, others rooted in the impossibility of constructing a reliable counterfactual legislative path. The following tables group these uncertainties into four categories. Table 13 presents a baseline projection for option 2 (repeal of spending and taxes originating under the ACA, starting in 2018), along with several factors that could increase the deficit reduction achieved under this approach. Table 14 presents the same baseline projection for option 2, along with several factors that could cause this approach to reduce deficits less than projected. Table 15 presents a baseline projection for option 3 (repeal of the ACA's coverage expansion provisions), along with factors that could increase the deficit reduction achieved under this approach. Table 16 repeats the baseline projection for option 3 and also shows factors that could cause this approach to have fewer fiscal benefits than projected.

Assuming an effective date of 2018 for all provisions, repeal of the ACA's various spending and tax provisions (option 2) is projected to reduce federal deficits by $586 billion from 2017 to 2026, but the savings could be as little as $228 billion or as much as $1.07 trillion, depending on various assumptions. Savings might be only $228 billion if (a) the Medicaid woodwork population has been underestimated, (b) the ACA exchange enrollment has been overestimated, and (c) the law's cost-sharing subsidies have been terminated before legislative action. On the other hand, fiscal improvements could be as much as $1.07 trillion from 2017 to 2026 if (a) some of the ACA's taxes otherwise continue to remain uncollected, (b) the law's various insurance rules are repealed as part of the legislation, and (c) Medicaid expansion costs have been underestimated. See table 17 and figure 16.

A similar exercise was applied to the option of repealing the ACA's coverage expansion provisions while leaving its various other (non-coverage-related) tax increases in place (option 3). That estimate finds that fiscal improvements could be as little as $878 billion or as much as $1.377 trillion from 2017 to 2026, bracketing CBO's recent estimate of $1.236 trillion. With both options, these estimates are highly sensitive to assumed effective dates; the amount of deficit reduction would drop considerably under alternatives in which repeal of key ACA provisions is postponed until later years.

Important lessons can be drawn from these analyses. As noted in the introduction, the ACA's intended beneficial effect on the federal budget did not materialize for a number of reasons, but especially because its Medicare cost-saving proceeds were dually committed and various other financing measures were not implemented as originally enacted. Accordingly, while it is

TABLE 13. PROJECTED DEFICIT REDUCTION UNDER OPTION 2, AND FACTORS THAT COULD INCREASE SAVINGS ($ BILLION)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
Option 2	0	46	65	68	64	67	67	69	70	70	586
Variable 1: Exclude Medicare general revenue transfers	0	0	0	0	0	0	0	0	0	52	52
Variable 2: Cadillac tax suspension continued	0	0	0	5	7	9	10	12	16	19	79
Variable 3: Medical device tax suspension continued	0	1	2	2	2	2	3	3	3	3	20
Variable 4: Health insurance tax suspension continued	0	14	15	16	17	18	19	20	21	22	162
Variable 5: Medicaid expansion costs underestimated	0	7	5	7	6	6	10	10	5	5	62
Variable 7: Repeal of insurance rules and mandates included	0	11	12	13	9	10	11	11	11	11	98
Variable 9: Assuming IPAB ineffective	0	0	0	0	0	1	1	2	3	4	11
Total potential deficit reduction, option 2	0	79	99	111	105	113	121	127	129	186	1,070

understandable that lawmakers may seek to avoid a precipitous decline in health insurance coverage upon repeal of the ACA, lawmakers should be cognizant that budget-neutral "repeal-and-replace" legislation could have the effect of continuing the entirety of the fiscal damage caused by the ACA even after it is repealed. Moreover, replacement legislation that worsens federal deficits would compound that fiscal damage.

The estimates generated in this study suggest that if lawmakers pursue repeal of the ACA's various spending and revenue provisions, the cost of replacement provisions should prudentially be limited to $228 billion or less through 2026 to provide a margin of error that will forestall increases to the federal deficit. This cushion increases to $349 billion if the ACA's cost-sharing

TABLE 14. PROJECTED DEFICIT REDUCTION UNDER OPTION 2, AND FACTORS THAT COULD REDUCE SAVINGS ($ BILLION)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
Option 2	0	46	65	68	64	67	67	69	70	70	586
Variable 6: Medicaid woodwork population underestimated	0	–10	–8	–8	–9	–9	–9	–9	–9	–10	–81
Variable 8: Cost-sharing subsidies already terminated	0	–11	–12	–13	–13	–13	–14	–14	–15	–16	–121
Variable 10: ACA exchange participation overestimated	0	–18	–19	–13	–14	–15	–20	–21	–18	–18	–156
Pessimistic scenario deficit reduction, option 2	0	7	26	34	28	30	24	25	28	26	228

TABLE 15. PROJECTED DEFICIT REDUCTION UNDER OPTION 3, AND FACTORS THAT COULD INCREASE SAVINGS ($ BILLION)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
Option 3	0	81	118	127	134	141	149	156	162	169	1,236
Variable 2: Cadillac tax suspension continued	0	0	0	5	7	9	10	12	16	19	79
Variable 5: Medicaid expansion costs underestimated	0	7	5	7	6	6	10	10	5	5	62
Total potential deficit reduction, option 3	0	88	123	139	147	156	169	178	183	193	1,377

TABLE 16. PROJECTED DEFICIT REDUCTION UNDER OPTION 3, AND FACTORS THAT COULD REDUCE SAVINGS ($ BILLION)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
Option 3	0	81	118	127	134	141	149	156	162	169	1,236
Variable 6: Medicaid woodwork population underestimated	0	–10	–8	–8	–9	–9	–9	–9	–9	–10	–81
Variable 8: Cost-sharing subsidies already terminated	0	–11	–12	–13	–13	–13	–14	–14	–15	–16	–121
Variable 10: ACA exchange participation overestimated	0	–18	–19	–13	–14	–15	–20	–21	–18	–18	–156
Pessimistic scenario deficit reduction, option 2	0	42	79	93	98	104	106	112	120	125	878

TABLE 17. RANGE OF PROJECTED DEFICIT REDUCTION IF ACA SPENDING AND TAXES ARE REPEALED EFFECTIVE 2018 ($ BILLION)

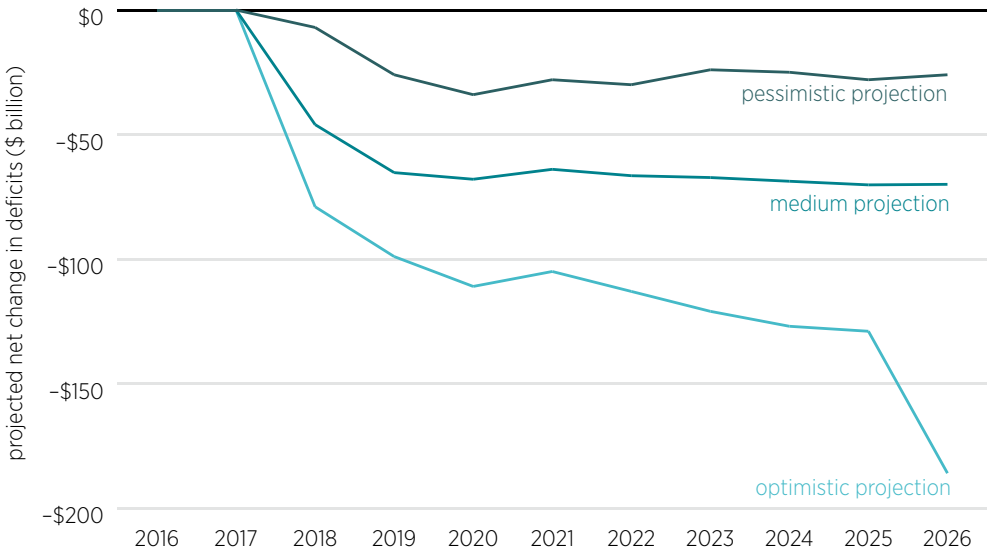
	Pessimistic projection	Medium projection	Optimistic projection
Federal deficit reduction, 2017–2026	$228	$586	$1,070

Source: Author's calculations based on Congressional Budget Office estimates.

subsidies remain effective up to the time of legislation. The cushion allowing for budget-neutral repeal-and-replace legislation could be further substantially increased if lawmakers include a provision implementing the recommendation of many health economists that the current tax preference for employer-sponsored health insurance be constrained and eventually phased out as part of healthcare reform.

Perhaps the most encouraging news to emerge from this study is that repeal of the ACA's new spending and tax provisions could reduce federal deficits by more than $1 trillion through 2026 even if an official CBO score under existing budget conventions finds it would save significantly less. This conclusion suggests that by enacting a replacement for the ACA that complies with minimum budget-neutrality targets for scorekeeping purposes, lawmakers could in effect undo much of the fiscal damage that would otherwise have continued under the ACA.

FIGURE 16. PROJECTED CHANGES IN FEDERAL DEFICITS, ACA REPEAL SCENARIOS



Note: ACA = Affordable Care Act.

Source: Author's calculations based on Congressional Budget Office estimates.

ADDENDUM: UPDATE FOR THE INTRODUCTION OF THE AMERICAN HEALTH CARE ACT

After this study was completed, the American Health Care Act was introduced in the US House of Representatives. Whereas this study has focused only on the fiscal effects of repealing certain Affordable Care Act provisions, the AHCA would combine repeal of some ACA provisions with modifications to others, while also instituting a replacement system of refundable tax credits for the purchase of health insurance. This addendum applies the methodology used earlier in this paper to study the range of possible fiscal effects of the AHCA.

CBO published its analysis of the AHCA on March 13, 2017.[102] As noted earlier, CBO's estimates of deficit reduction could be either understated or overstated owing to various factors bearing upon the projections. Specifically, CBO projected that the AHCA would reduce federal deficits by $337 billion from 2017 to 2026. The following analysis suggests that plausible fiscal outcomes for the AHCA range from as much as $657 billion in deficit reduction over 10 years to as little as $42 billion (see table 18).

Employing the methodology presented earlier in this paper produces a finding that the Medicare payroll tax reduction contained in the AHCA would result in depletion of the Medicare Hospital Insurance trust fund in 2026 (variable 1), limiting benefit payments to a level approximately $37 billion lower than the projected cost of scheduled benefits. These payment reductions are not reflected in Congress's scorekeeping rules. Recognizing the reductions would, other things being equal, increase the deficit reduction projected for the AHCA under all three sets of assumptions presented in this addendum.[103]

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102. Congressional Budget Office, "Congressional Budget Office Cost Estimate: American Health Care Act," March 13, 2017, https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf.

103. CBO has also projected that the AHCA would increase Medicare outlays by $43 billion from 2017 to 2026, "stemming from changes in payments to hospitals that serve a disproportionate share of low-income payments." CBO, "Congressional Budget Office Cost Estimate: American Health Care Act," March 13, 2017. CBO's score of the AHCA indicates that these outlays would come "mostly" from changes in disproportionate share hospital payments, although a more specific breakdown is not provided. Under the assumption that the entirety of this $43 billion Medicare spending increase is paid from the Medicare HI trust fund, the CBO estimates that the date of its projected depletion under the AHCA would move forward to 2025 under 2016 Medicare trustees assumptions. Furthermore, the amount of additional cost restraint arising under variable 1 would increase from $37 billion to $87 billion, with $9 billion of the additional cost restraint appearing in 2025 and the other $41 billion in 2026. This would increase the total 2017–2026 deficit reduction to $707 billion for this addendum's optimistic scenario, $424 billion for the medium scenario, and $92 billion for the pessimistic scenario. The labeling of variable 1 is somewhat different in this addendum than it was in the study's preceding analysis of option 2. The reason is that the scoring issue previously described for option 2 pertained to whether

TABLE 18. PROJECTED DEFICIT REDUCTION UNDER AHCA, AND FACTORS THAT COULD INCREASE SAVINGS ($ BILLION)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
AHCA as scored by CBO	1	−24	−33	9	38	51	59	64	79	92	337
Variable 1: Effect of Medicare HI trust fund depletion	0	0	0	0	0	0	0	0	0	37	37
Variable 2: Cadillac tax suspension continued	0	0	0	3	7	9	11	14	5	0	49
Variable 3: Medical device tax suspension continued	0	1	2	2	2	2	2	2	3	3	20
Variable 4: Health insurance tax suspension continued	0	13	13	14	15	16	17	18	19	20	145
Variable 5: Medicaid expansion costs underestimated	0	2	2	6	6	7	11	12	6	6	58
Variable 9: Assuming IPAB ineffective	0	0	0	0	0	1	1	2	3	4	11
Total potential deficit reduction, AHCA	1	−8	−16	34	68	86	101	112	115	162	657

Note: AHCA = American Health Care Act; CBO = Congressional Budget Office; HI = Hospital Insurance; IPAB = Independent Payment Advisory Board.

Variables 2, 3, and 4 pertain to various ACA taxes (the Cadillac plan tax, the medical device tax, and health insurance fees) that are currently suspended or postponed. Recognizing the possibility that these taxes might remain uncollected even if the ACA as a whole is not repealed increases the potential relative deficit reduction under the AHCA by $214 billion.[104]

general revenue transfers to the Medicare HI trust fund would be included in legislation. The AHCA contains no general revenue transfers; hence Medicare HI spending would be constrained on trust fund depletion irrespective of variance in the other assumptions studied here. For this reason, each of the three scenarios would show higher budget savings under a score reflecting the constraints of Medicare law than they would under a score reflecting Congress's scorekeeping baseline.

104. CBO, "Congressional Budget Office Cost Estimate: American Health Care Act," March 13, 2017. Unlike earlier estimates in this study, this cost estimate for the AHCA presents the effects of Cadillac plan tax repeal only on federal revenues; it does not incorporate potential effects on outlays. Previous projections have found that offsetting effects on federal outlays would result from lower growth

Variable 5 reflects the possible underestimation of the per capita cost of Medicaid expansion. As described earlier in this study, CBO and other forecasters are possibly underestimating these per capita costs, for example, if a currently projected decline in per capita cost does not fully come to pass. The methodology applied earlier in recognition of this variable would increase the potential savings under the AHCA relative to the ACA by $58 billion.

Earlier in this study, variable 6 was introduced to reflect the possibility that savings from repealing Medicaid expansion might be smaller than under current projections. The overestimation would arise if CBO has underestimated the share of the ACA Medicaid expansion population who were already eligible under pre-ACA law—and who would likely remain covered even after ACA repeal—thereby reducing the budget savings from repeal. Examination of the latest CBO score suggests that the potential overstatement of savings from Medicaid repeal is much greater than would likely arise solely from errors in estimating this so-called "woodwork" population.[105] Under more conservative assumptions for the eventual number of Medicaid expansion states under the ACA, and for the number of current expansion enrollees who under the AHCA would no longer be supported at the ACA's elevated match rate, both the amount of deficit reduction and the decline in coverage under the AHCA would be substantially less than under CBO projections. The adjusted estimate of $226 billion less in deficit reduction is reflected in the row for variable 6 in table 19.

Variables 7 and 8 both represent discretionary policy choices modeled earlier in this study, when the contents of proposed repeal-and-replace legislation

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in taxable wage compensation and therefore in Social Security benefit outlays upon repeal of the Cadillac plan tax. These outlay effects are comparatively small within the 10-year budget window, and their omission here is consistent with the objective of showing a fuller range of potential projection uncertainty.

105. CBO currently projects that if the ACA is not repealed, the number of states participating in its Medicaid expansion will rapidly expand such that by 2026, 80 percent of potentially newly eligible beneficiaries will reside in expansion states. CBO also projects that if the AHCA is enacted, some expansion states would reverse their expansion decisions such that only 30 percent of potentially newly eligible beneficiaries will reside in expansion states by 2026. CBO further projects that despite the AHCA "grandfathering" beneficiaries enrolling under expansion match rates before 2020, the vast majority of these will subsequently drop coverage at least temporarily so that by the end of 2024, only 5 percent of such eligible beneficiaries will be supported by the ACA's elevated match rate. CBO's assumptions for growth in Medicaid enrollment under the ACA are sufficiently aggressive that, in combination with the AHCA's other Medicaid cost-containment provisions, Medicaid spending under the AHCA is scored as being lowered after 2021 by significantly more than the entirety of the ACA's spending on newly eligible beneficiaries as estimated in CBO's January 2017 baseline. CBO, "Congressional Budget Office Cost Estimate: American Health Care Act," March 13, 2017. Compare with CBO, "Federal Subsidies under the Affordable Care Act for Health Insurance Coverage," January 2017.

TABLE 19. PROJECTED DEFICIT REDUCTION UNDER AHCA, AND FACTORS THAT COULD REDUCE SAVINGS ($ BILLION)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
AHCA as scored by CBO	1	−24	−33	9	38	51	59	64	79	92	337
Variable 1: Effect of Medicare HI trust fund depletion	0	0	0	0	0	0	0	0	0	37	37
Variable 6: Medicaid coverage decline overestimated	−2	−10	−14	−34	−23	−27	−28	−29	−30	−29	−226
Variable 10: ACA exchange participation overestimated	0	0	0	0	−13	−14	−21	−22	−18	−19	−106
Pessimistic scenario deficit reduction, option 2	−1	−34	−47	−25	2	10	10	13	31	81	42

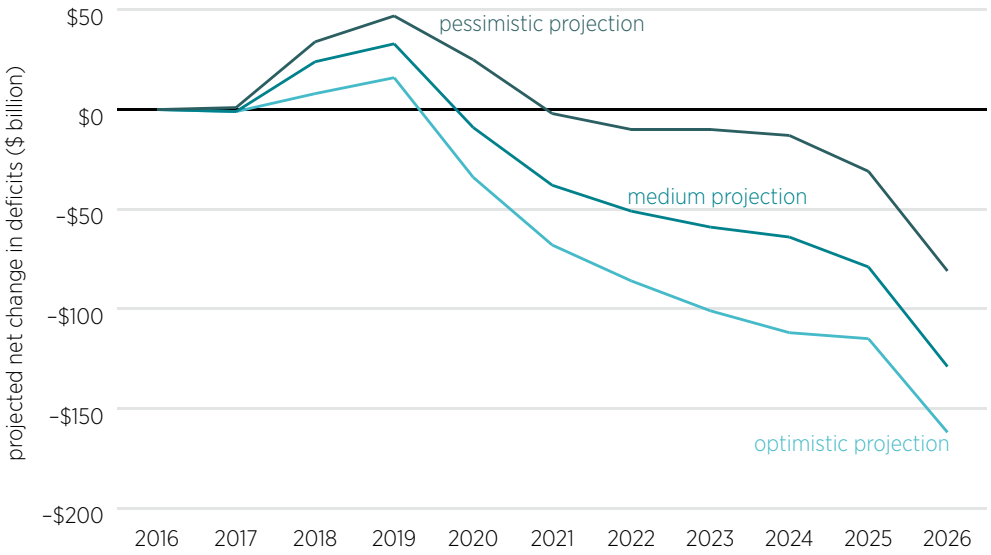
Note: AHCA = American Health Care Act; CBO = Congressional Budget Office; HI = Hospital Insurance.

were as yet unknown. Because the AHCA embodies specific legislation, there is no need to model potential variance arising from variable 7 (alternative policies with respect to repealing the ACA's insurance market rules) or variable 8 (executive branch decisions to eliminate cost-sharing subsidies in advance of legislation).

Variable 9, as described earlier in this study, reflects an alternative assumption that no Medicare cost reductions (totaling $11 billion) would occur in accordance with IPAB even if the ACA is not repealed.[106] Variable 10 reflects the possibility that CBO is continuing to overstate future enrollment in the ACA's marketplaces. If so, the relative savings from repealing ACA subsidies would be less than projected—in this estimate $106 billion less. CBO's current assumptions already reflect somewhat lowered estimates for marketplace participation relative to those cited earlier in this study; the estimate in table 19 reflects the remainder of the earlier-modeled adjustment that was not reflected in CBO estimates for the AHCA.

106. A failure to enforce IPAB's cost-saving measures under the ACA would slightly accelerate Medicare HI trust fund insolvency. But under 2016 Medicare trustees' report assumptions, the fiscal effects of this accelerated trust fund depletion would occur outside the 2017–2026 budget window and so are not factored into this study's estimates for the ACA.

FIGURE 17. PROJECTED CHANGES IN FEDERAL DEFICITS, AHCA SCENARIOS



Note: AHCA = American Health Care Act.

Source: Author's calculations based on Congressional Budget Office estimates.

CBO's score for the AHCA of $337 billion in deficit reduction from 2017 to 2026 under Congress's scorekeeping baseline would equate to roughly $374 billion under actual Medicare law. Other variables affecting the savings from the AHCA's various repeal provisions could cause the total deficit reduction achieved to be as high as $657 billion or as low as $42 billion (figure 17).

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