Redistribution Under the ACA is Modest in Scope

Timely Analysis of Immediate Health Policy Issues
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Summary

Some observers describe the Patient Protection and Affordable Care Act (ACA) as involving a "massive redistribution of health resources" that caused "the largest wealth transfer in American history." Such claims are exaggerated. The Congressional Budget Office (CBO) projects that, **by 2019, the ACA's Medicaid expansion and new subsidy system for low- and moderate-income consumers will spend just 0.9 percent of Gross Domestic Product (GDP).** The tax preference for employer-sponsored insurance costs the Treasury more than twice as much, and Medicare and Social Security respectively spend 3.9 and 5.6 times as much as the ACA. The ACA's redistribution is thus real but modest in scope and far from unprecedented.

Higher-income Americans directly contribute only 16.9 percent of all ACA funding, representing 0.2 percent of GDP. The vast bulk (84 percent) of ACA revenue that specifically comes from affluent Americans consists of new taxes on individuals and families with incomes above $200,000 and $250,000, respectively. These taxes apply to only 2.4 percent of tax-filers and average just 0.5 percent of income.

Most ACA funding comes from recycling dollars within the health care industry. Almost 3 out of every 4 dollars that finance the ACA (74.3 percent) result from reimbursement cuts and higher taxes and fees on health care providers and insurers. Under the legislation's original design, the health care industry as a whole received enough increased revenue from the newly insured that, on balance, it was likely to be better off financially. However, some providers and insurers will be worse off, particularly in states that do not expand Medicaid. Many resulting shortfalls can likely be absorbed by increased efficiency or reduced profits. When that is not possible, services will be cut or prices raised. However, any such adverse consequences will likely be felt across the entire population served by affected providers or insurers, without the wealthy suffering more than others.

The ACA's Medicare cuts do not redistribute resources from the elderly to the working-age uninsured. These cuts primarily affect, not consumers, but Medicare providers, lowering their payments by $108.4 billion in 2019. As noted earlier, the health care industry as a whole will gain revenue due to the ACA's coverage expansion, but some particular providers may suffer net losses. If those reductions cannot be absorbed by increased efficiency, the remaining population-wide effects would generally not target seniors for special impact. By contrast, the ACA gives Medicare beneficiaries $15.2 billion worth of increased annual coverage of prescription drugs, preventive care, and long-term care. For the highest-income Medicare beneficiaries, these new benefits are offset by $7.3 billion in increased Part B and D premiums, but Medicare beneficiaries as a whole will experience net program improvements worth an estimated $7.9 billion.

Introduction

Critics describe the ACA as causing "the largest wealth transfer in American history,"[1] a "massive redistribution of health resources" that "pushes our country toward a welfare state" and "eviscerates Medicare."[2] Some of the legislation's supporters, on the other hand, argue that "virtually everything government does involves redistribution" either up or down the income scale,[3] and the ACA's redistribution embodies "a social compact in which those who are healthier and richer are willing to help those who are sicker and poorer."[4]

This paper does not explore whether federal law should compel the movement of significant resources from one group of Americans to another. Rather, we ask whether, as a factual matter, the ACA represents an enormous and unprecedented redistribution of income. We analyze, as a fraction of GDP, the ACA's spending on two insurance affordability programs: Medicaid expansion; and subsidies for low- and moderate-income consumers purchasing coverage in exchanges, or health insurance marketplaces (HIMs). We also investigate, taking into account income, employment, and the impact of Medicare cuts, how the ACA funds insurance affordability programs and the distribution of program spending.

To analyze the ACA's funding sources and spending levels, we begin with CBO's and the Congressional Joint Committee on Taxation's (Joint Tax) estimates for the legislation as enacted in 2010.[5] We focus on projections for FY 2019, the final year estimated by CBO and Joint Tax, as representing the ongoing "steady state" effects of the ACA, after most initial transitions are complete.[6] Since 2010, CBO revised its estimates of the ACA's effects

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to reflect changed economic conditions as well as refinements to cost estimation assumptions, amendments to the law, and the Supreme Court's 2012 decision that converted the ACA's original nationwide Medicaid expansion into a state option. However, CBO's most comprehensive post-enactment estimates, which examine the impact of proposed ACA repeal, contain less detail than its original analysis. In particular, they do not quantify ACA funding sources that CBO believes will likely continue even if the ACA is repealed.[7] For a comprehensive analysis of ACA's financing mechanisms, we therefore rely primarily on CBO's original estimates. We then adjust those numbers to reflect CBO's later estimates of the effects of post-enactment legal changes and refinements to CBO's modeling approaches, excluding as much as possible the impact of any changes to CBO's underlying economic forecasts.[8]

Spending on the ACA's Insurance Affordability Programs Amounts to 0.9 Percent of Gross Domestic Product

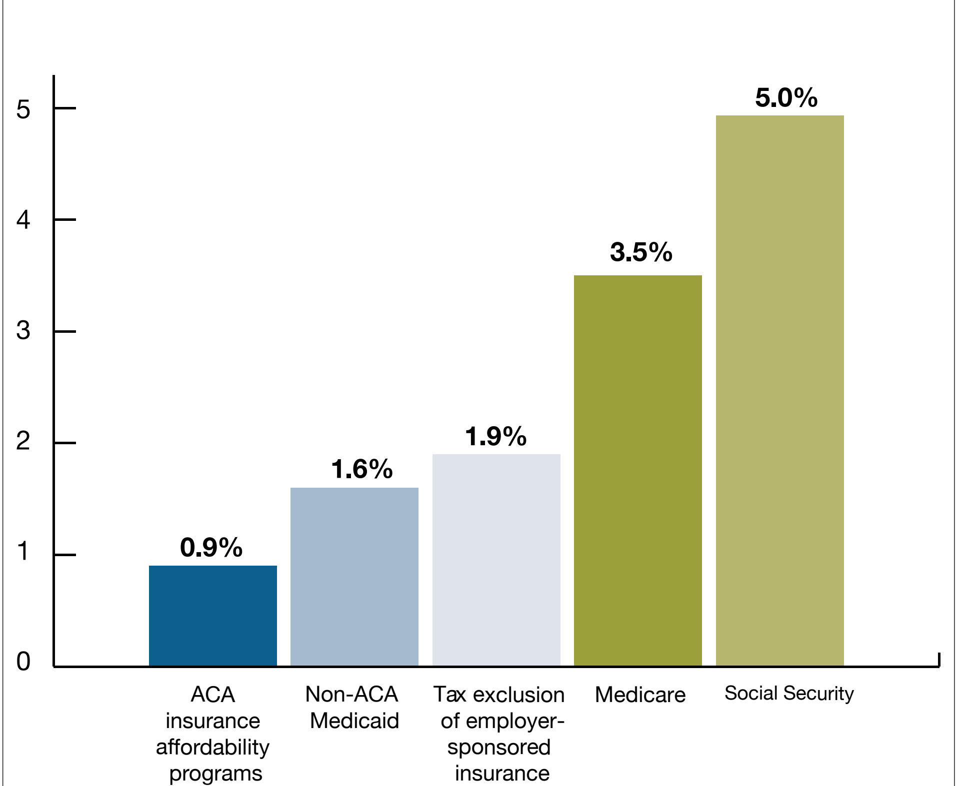
To calculate the relationship between the ACA's insurance affordability programs and GDP, we compare CBO's estimates, published in March 2010, to CBO's contemporaneous projections of GDP, published in January 2010. CBO found that, as enacted, the ACA's Medicaid expansion and new subsidies in health insurance marketplaces would cost the federal treasury $232 billion in fiscal year 2019, representing 1.1 percent of GDP (Table 1). However, following enactment of the ACA, the cost of insurance affordability programs was reduced by various legislative changes to the ACA[9] and the above-described Supreme Court decision.[10] We therefore modified CBO's original projections to reflect these post-enactment changes, as estimated by CBO, along with various refinements to CBO's estimation methods.[11] The resulting modified cost of the ACA's insurance affordability programs is $207 billion, or 0.9 percent of GDP (Table 1). An alternative analysis, using CBO's 2013 estimates of both GDP and the ACA coverage costs, reaches the identical

Table 1. Federal Cost of ACA Insurance Affordability Programs Compared to GDP: CBO and Joint Tax Estimates for Fiscal Year 2019 (Billions of Dollars)

		2019 Amounts
GDP as Projected by CBO in 2010		$21,882
CBO's Original 2010 Cost Estimates	Medicaid Expansion	$97
	Exchange Subsidies	$135
	Total (Dollars)	$232
	Total (Percentage of GDP)	1.1%
Modified 2010 Cost Estimates, Reflecting Post-Enactment Changes to CBO's Original Estimates	Medicaid Expansion	$62
	Exchange Subsidies	$145
	Total (Dollars)	$207
	Total (Percentage of GDP)	0.9%

Source: CBO 2010-2013, Joint Tax 2010, and authors' adjustments (for modified 2010 estimates).
Note: Exchange subsidies include revenue losses on premium tax credits. Since we classify, as does CBO, risk-adjustment payments from health plans as part of ACA's funding, we also include risk-adjustment payments to health plans here as part of ACA's cost. If such payments were excluded, insurance affordability programs would be estimated to cost 1.0 percent and 0.8 percent of GDP under CBO's original and modified estimates, respectively. Post-enactment changes reflect CBO's estimated effects of: (a) statutory changes to the ACA that increased income-based caps on advance premium tax credit reconciliation for taxpayers with incomes below 400 percent FPL, that added tax-exempt Social Security income to modified adjusted gross income, and that altered expected levels of employer-sponsored insurance by changing federal income and payroll taxes; (b) the U.S. Supreme Court decision that made Medicaid expansion optional for states; and (c) revised CBO assumptions about the average risk level of adults newly eligible for Medicaid and the pace of initial enrollment into insurance affordability programs.

Figure 1. Estimated 2019 Federal Cost of ACA's Insurance Affordability Programs, Compared to Other Federal Costs (Percentage of GDP)



Source: CBO 2010, 2013, OMB 2013.
Note: Tax exclusion includes income tax and payroll tax effects. Medicare and Social Security costs include outlays, without payroll tax or premium offsets.

conclusion about ACA spending as a percentage of GDP (Appendix Table A1).

To provide some context for this result, in 2019:

- Federal Medicaid costs, other than those resulting from the ACA, are projected to equal 1.6 percent of GDP,[12] or 1.8 times expected spending on the ACA's insurance affordability programs;
- The exclusion of employer-sponsored insurance from federal income and payroll taxes will cost the Treasury an amount equal to 1.9 percent of GDP,[13] or 2.1 times the amount spent by insurance affordability programs;
- Medicare spending is expected to consume 3.5 percent of GDP,[14] or 3.9 times the cost of the ACA's insurance affordability programs; and
- Social Security payments will equal 5.0 percent of GDP,[15] which is 5.6 times the expense of insurance affordability programs.

These estimates are displayed in Figure 1. One cannot plausibly claim that the ACA represents the historical high-water mark of federal redistribution of resources.

Table 2. Distribution of Federal Spending on Insurance Affordability Programs by Income Group and Insurance Affordability Program Eligibility for Fiscal Year 2019

Income Group		2013 Income, 1-Person Family	2013 Income, 4-Person Family	2019 Insurance Affordability Program Spending	
				(Billions)	Estimated Share of Total Spending
<200% FPL	Medicaid-Eligible	<$22,980	<$47,100	$62	30%
	HIM-Subsidy Eligible	<$22,980	<$47,100	$99	48%
200-300% FPL		$22,980-$34,470	$47,100-$70,650	$36	17%
300-400% FPL		$34,470-$45,960	$70,650-$94,200	$10	5%
Total:		Up to $45,960	Up to $94,200	$207	100%

Source: U.S. Department of Health and Human Services Poverty Guidelines and Urban Institute analysis.
Note: The Urban Institute's distributional analysis for HIM subsidies assumed that all states implement Medicaid expansion, placing the lower income bound for subsidy eligibility at 138 percent FPL. To the extent that states do not implement the expansion, HIM subsidy spending on households under 200 percent FPL will exceed the amount shown here. The table assumes that all Medicaid spending on new enrollees will go to consumers below 200 percent FPL, even though some newly enrolled, previously eligible children will have incomes above that threshold.

Low-Income Individuals and Families Benefit from the ACA's Insurance Affordability Programs

New Medicaid spending under the ACA will primarily help previously ineligible adults with incomes below 138 percent FPL, the income threshold for expanded eligibility; 138 percent FPL is $15,856 for an individual and $32,499 for a family of four in 2013. Some new Medicaid spending will benefit previously eligible but uncovered people who enroll due to ACA outreach efforts or learning of their Medicaid/CHIP eligibility in the course of seeking enrollment in health insurance marketplaces. Except for children, most of the latter will also have incomes at or below 138 percent FPL.

In states that expand Medicaid, spending on marketplace premium subsidies and cost-sharing subsidies will benefit individuals and families with incomes between 138 percent and 400 percent of FPL; the latter is $45,960 for individuals and $94,200 for four-person families in 2013. In states that do not expand Medicaid, subsidy eligibility will include those with incomes as low as 100 percent of FPL—$15,856 for individuals and $21,404 for families of four.

Because subsidies are provided on a sliding scale, they will disproportionately benefit people in the lower part of this range.[16] According to Urban Institute estimates, 69 percent of total subsidies will benefit the lowest income group (<200% FPL), 25 percent will benefit a middle income group (200-300% FPL), and 7 percent will benefit the highest income group eligible for subsidies (300-400% FPL).[17] By applying this distribution to CBO projections of exchange subsidies and adding CBO projections of Medicaid costs, we find that 78 percent of all insurance affordability program spending will be for consumers with incomes below 200 percent FPL (Table 2).

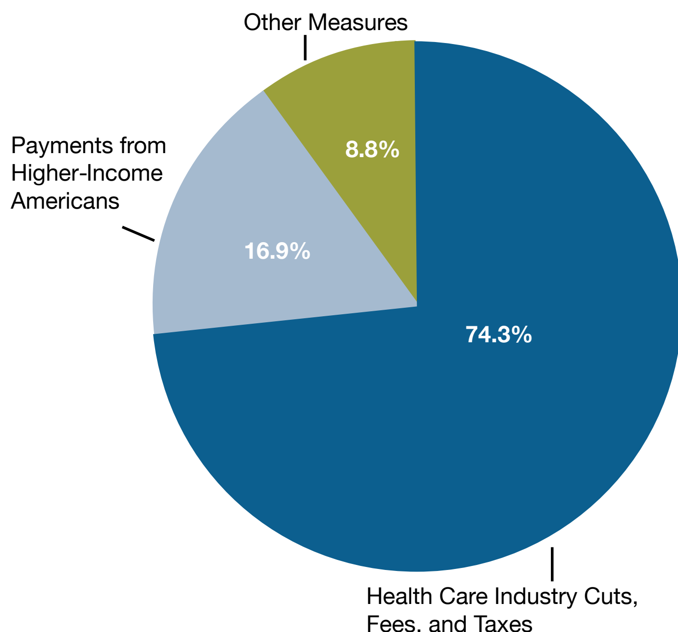
For low-income people, HIM subsidies can be considerable, relative to total income. But even with those subsidies, consumers can still pay significant amounts for health care. For example, a single 30-year-old with $20,000 in income who enrolls in a national average cost silver plan[18] will receive a premium tax credit of $1,956 for a $2,976 premium, leaving the consumer responsible for $1,020 in premiums. At 174 percent FPL in 2013, such a consumer also qualifies for $648 in cost-sharing reductions, for a total of $2,604 in subsidies, equaling 13 percent of income. The cost-sharing reduction still requires

Table 3. Annual Care Costs and Subsidies for an Average 30-Year-Old Single Consumer With $20,000 Income (174 Percent FPL in 2013) Covered Through a Silver-Level Plan

Total Costs		Subsidies				Consumer Payments			
Premiums	Cost-Sharing	Premiums	Cost-Sharing	Total		Premiums	Cost-Sharing	Total	
				Dollars	Percent of Income			Dollars	Percent of Income
$2,976	$1,432	$1,956	$648	$2,604	13%	$1,020	$784	$1,804	9%

Source: U.C. Berkeley Labor Center 2013; CMS 2013.
Note: Estimate assumes the estimated national average cost for silver plans. Cost-sharing amounts and subsidies were calculated based on CMS' proposed 2015 methodology for determining advance payments for cost-sharing reductions.[19]

Figure 2. ACA Funding Sources: CBO and Joint Tax Estimates for Fiscal Year 2019



Source: CBO 2010, Joint Tax 2010.
Note: Estimates exclude two funding sources that were repealed by post-ACA legislation: premium payments for the Community Living Assistance Services and Supports (CLASS) Act; and tax revenues resulting from new income reporting requirements that applied to small firms and others. Payments from higher-income households and industry taxes and fees are detailed in the next sections. Appendix Table A2 provides additional information about "other measures," which primarily consist of individual and employer penalty payments.

the average such consumer to pay $784 in service costs not covered by insurance.[20] The consumer's total health care payments thus equal $1,804, or 9 percent of income (Table 3).

The Contribution of Very-High-Income Americans to the ACA Amounts to 0.2 Percent of GDP

Increased levies on the affluent are not the ACA's principal revenue source. Instead, most financing comes from health care providers and insurers. The ACA cuts the payments they were scheduled to receive from the federal government and imposes new taxes and fees. However, the coverage funded by these dollars ultimately translates into increased revenue for providers and insurers. Put simply, ACA funding mostly involves, not redistribution from rich to poor, but recycling dollars within the health care industry.

For the final year of CBO's original ACA estimates (fiscal year 2019), reimbursement cuts and higher taxes and fees on health care providers and insurers provide 74.3 percent of ACA's funding; higher-income Americans contribute just 16.9 percent (Figure 2).[21]

Comparing the $45.8 billion in ACA funding contributed by affluent Americans, as originally estimated by CBO, to CBO's contemporaneous projections of GDP, we find that the ACA's levies on the wealthy will represent just 0.2 percent of GDP in 2019.[22]

The Joint Tax Committee estimated that the ACA's increase to Medicare's hospital insurance tax (including a new tax on investment income) would raise $38.5 billion in 2019.[23] This represents 84 percent of the total raised from the most affluent Americans; the remainder comes from increased Part B and D premiums on the highest income Medicare beneficiaries (Table 4).[24] Starting in the 2013 tax year, the ACA raised the hospital insurance tax rate, which applies to payroll earnings, from 1.45 percent to 2.35 percent for single workers earning more than $200,000 and joint filers earning more than $250,000 per year. The higher tax rate applies only to income above these thresholds. In addition, the ACA introduced a new tax of 3.8 percent on nonwage income such as interest, dividends, rental income, and capital gains. The tax applies to either: (a) total investment income; or (b) the excess of modified adjusted gross income (MAGI) over threshold amounts ($200,000 for individuals and $250,000 for joint filers), whichever is lower, and it is limited to people with total income above those amounts.[25]

According to the Urban-Brookings Tax Policy Center estimates for tax year 2013 (the latest year for which data are provided), these taxes will affect 16.7 percent of individual/family tax filing units in the top fifth of the income distribution—only 2.4 percent of all tax filing units.[26] For those in the 95th to 99th income percentiles, with cash income between $227,000 and $593,000, the average tax increase will be about $834, representing 0.3 percent of this group's $278,000 average income. For those in the top 1 percent, whose cash incomes exceed $593,000, the average tax increase is $21,200. This is a substantial amount on its face, but it represents about 1.2 percent of the $1.77 million in average cash income

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Table 4. Increased Payments from Higher-Income Americans: CBO and Joint Tax Estimates for Fiscal Year 2019 (Billions of Dollars)

		2019 Payments
Hospital Insurance Taxes		$38.5
Medicare Premiums	Part B	$4.9
	Part D	$2.4
	Total:	**$45.8**

Source: CBO 2010, Joint Tax 2010.
Note: The ACA raised Part B premium payments for higher-income beneficiaries by suspending indexing of income thresholds for means-tested premium payments. The ACA also created new means-tested Part D premium surcharges, applied to the same beneficiaries who are subject to means-tested Part B premium payments.

for this group. Among all households subject to the tax, the average payment equals just 0.5 percent of income.

Most ACA Funding Comes from the Health Care Industry; the Ultimate Impact of This Revenue Source Is Uncertain

As explained in the previous section, nearly 3 out of every 4 dollars that finance the ACA (74.3 percent) come from reimbursement cuts, taxes, and fees that apply to insurers and health care providers, which also benefit financially from the ACA's coverage expansion. Based on CBO estimates, the ACA, as enacted, was likely to improve the health care industry's overall financial posture—not a surprising result, given that most provider and insurer groups either supported or acquiesced to the legislation.[27] Between reimbursement cuts and increased taxes and fees, insurers and health care providers were slated to contribute $201.6 billion in ACA funding during 2019 (Table 5). They also expected to incur additional costs to serve newly insured consumers.

Offsetting those losses and costs were several sources of revenue. First, new federal spending on insurance affordability programs was originally projected at $232 billion for 2019, or 15 percent more than industry's contribution to ACA financing (Table 1). Second, the ACA increased health care spending by consumers. HIM subsidy beneficiaries are expected to spend, on premiums and cost-sharing, an amount equal to 45 percent of total HIM premiums.[28] In addition, among the estimated 14.3 million uninsured adults whose incomes are too high for subsidies,[29] many will purchase individual insurance because of the ACA's coverage requirement and insurance reforms.[30] Altogether, the ACA's original federal subsidies plus consumer health care payments likely exceeded industry's contribution to ACA funding plus the increased costs of serving the newly insured.[31]

However, the ACA's boost to estimated federal health care spending has fallen by 11 percent, to $207 billion, since the initial enactment of the ACA (Table 1), primarily because of the Supreme Court decision that permitted states to avoid the Medicaid expansion. The health care industry as a whole may still be better off financially as a result of the ACA, but some providers and insurers are likely to be worse off. Average net revenues per previously insured patient will fall. For some (but not all) hospitals, those losses will be offset by significant reductions in uncompensated care. Newly insured patients will bring additional revenue, but new costs will accompany that revenue. The extent to which new customers yield net financial gains will be affected by the extent to which industry costs are fixed vs. incremental. If a particular provider or insurer experiences net financial losses, they might be absorbed through increased efficiency or reduced profits. If such absorption does not occur, the losses could reduce levels of service or increase prices.

Outcomes that adversely affect consumers are particularly likely in states that do not expand Medicaid. In such states, providers and insurers will experience all of the ACA's reimbursement cutbacks, fees, and taxes but only part of the revenue increase provided under the ACA's original design. Ironically, the states that are not expanding Medicaid are often the ones where Medicaid expansion would have the

Table 5. Reduced Payments and Increased Taxes and Fees for the Health Care Industry: CBO and Joint Tax Estimates for Fiscal Year 2019 (Billions of Dollars)

		2019 Effects
Reduced Payments to Providers and Insurers	Reimbursement Reductions for Medicare Advantage Plans	$42.2
	Reduced Fee-For-Service Payment Increases for Medicare Hospitals	$40.5
	Reduced Payments to Medicare Home Care Providers	$10.3
	Other Reductions to Medicare Provider Payments	$15.4
	Reductions to Medicaid Providers	$17.2
	Reductions to Providers Outside Medicare and Medicaid	$8.9
Taxes, Fees, and Assessments on Providers and Insurers	Insurance Taxes and Fees	$31.9
	Reinsurance and Risk-Adjustment Payments	$22.0
	Drug Rebates and Fees	$8.7
	Device Manufacturer Fees	$3.4
	Other Health Industry Taxes and Fees	$1.1
	Total:	**$201.6**

Source: CBO 2010, Joint Tax 2010.
Note: Reimbursement reductions for Medicare Advantage plans include interactive effects, as estimated by CBO. Insurance taxes and fees include assessments on high-value plans.

greatest impact on revenue. Put simply, it is difficult to forecast the ultimate impact of net financial losses experienced by providers or insurers. In general, they seem likely to affect the entire population served by affected providers without disproportionately harming high-income Americans.

The ACA Does Not Reduce Medicare Enrollees' Benefits and Redistribute Resources to the Uninsured

Some observers characterize the ACA as moving resources from Medicare beneficiaries to uninsured consumers under age 65, as suggested earlier.[32] However, the ACA's funding taken from the Medicare program primarily involves reimbursement cuts for providers and Medicare Advantage (MA) plans, which will total $108.4 billion in fiscal year 2019, according to CBO (Table 6). Only a small amount comes from beneficiaries themselves, in the form of increased Part B and Part D premiums for higher-income seniors. In fact, the ACA made Medicare coverage more generous for beneficiaries through the following measures:

- Before the ACA, Medicare Part D coverage of prescription drugs contained a so-called "donut hole." Once a beneficiary's medication costs passed a specified level, Part D coverage ceased until the beneficiary's total prescription drug costs exceeded a much higher, "catastrophic" threshold. The ACA phases out and eventually eliminates this gap in prescription drug coverage.
- The ACA adds Medicare coverage of an annual wellness visit and other preventive services, free of out-of-pocket cost-sharing.
- The ACA expands coverage of home and community-based care and other long-term care services and supports for seniors and people with disabilities who qualify for both Medicare and Medicaid.

The CBO estimated that these improvements in Medicare benefits will cost $15.2 billion in 2019. Even taking into account the $7.3 billion in increased Part D and Part B premium payments required from the highest-income Medicare beneficiaries, the ACA's net gains for Medicare beneficiaries will total $7.9 billion in 2019 (Table 6). While comparatively affluent Medicare beneficiaries will experience both positive and negative effects, for beneficiaries as a whole, the ACA created clear, net gains, and for the more than 90 percent of Medicare beneficiaries whose incomes are too low for increased premium charges,[33] the ACA's direct effects will be entirely positive.

Of course, provider cuts can affect beneficiaries. But the ACA's revenue increases plus provider efficiency gains and profit reductions may be enough to absorb those cuts without adversely affecting services to consumers, as explained earlier. If services are affected, the impact is likely to be felt by the entire population served by affected providers, not just seniors. On the other hand, some provider and insurer groups disproportionately serve Medicare beneficiaries. Some—such as home care providers and skilled nursing facilities[34] —will experience at least partially offsetting revenue gains through the ACA's expansions to Medicaid benefits and commercial coverage. Others—principally MA plans—will not.

One cannot assume that provider rate cuts will necessarily harm beneficiaries' access to care. Considering the three above provider/insurer groups in succession:

- The Medicare Payment Advisory Commission (MedPAC) found that Medicare's pre-ACA home health care payment levels were sufficiently excessive that, despite the ACA's 6.8 percent reduction to total home care revenue over the 2013-22 period,[35] providers will retain "margins well in excess of cost," and Medicare will continue "overpaying for home health care services."[36]
- When all sources of reimbursement are considered, the ACA caused just a 2.0 percent reduction in total payments for skilled nursing facilities.
- Critics predicted that the ACA would "force the Medicare Advantage plans to cut back on the benefits they offer and to charge higher cost-sharing," claiming that "millions of seniors and disabled Americans are being forced out of plans they prefer today into the government-managed fee-for-service Medicare."[37] In fact, from 2010 through 2012, MA enrollment grew and quality ratings improved, according to MedPAC, which found "evidence of increased efficiency."[38] The ACA's cuts vary geographically

Table 6. ACA Effects on Medicare Providers, Insurers, and Beneficiaries for Fiscal Year 2019 (Billions of Dollars)

		2019 Cost Effects
1. Cuts to Providers and Insurers		**$108.4**
2. Increased Premiums for High-Income Beneficiaries		
Part B		$4.9
Part D		$2.4
	Total:	**$7.3**
3. Increased Benefits		
Part D Coverage		$10.9
Wellness Visits and Other Preventive Care		$1.5
Long-Term Care and Social Supports		$2.4
Other		$0.4
	Total:	**$15.2**
Net Beneficiary Gains (3-2)		**$7.9**

Source: CBO 2010.
Note: Part D coverage effects include, in addition to measures that shrink and eventually end the current "donut hole," changes to low-income subsidies, reduced cost-sharing for dual Medicare/Medicaid eligibles, expanding benefits for widows and widowers, and provisions involving programs that serve American Indians, Alaskan Natives, and people with HIV or AIDS. Long-term care and social supports include spousal impoverishment protections. Other increased benefits include higher caps on certain therapies, coverage of bone density tests, coverage of certain diagnostic lab tests, and coverage of services to address environmental hazards. This table does not include interactive effects identified by CBO.

The Brookings Institution Analysis

On January 24, 2014, Henry J. Aaron and Gary Burtless of the Brookings Institution released an analysis of the ACA's impact on income inequality.[41] They conclude that, when the dollar value of health insurance is measured most comprehensively, the poorest one-fifth of Americans will see their average incomes rise by roughly 6 percent. Americans in other income brackets will experience average income declines of approximately 1 percent or less, due to increased taxes and Medicare Parts B and D premiums on high-income people, penalties on the uninsured, and reimbursement cuts to MA plans, which Aaron and Burtless assume will be experienced by MA enrollees. The authors did not incorporate the effects of the ACA's other funding mechanisms, including taxes, fees, and (other than MA cuts) reimbursement reductions imposed on the health care industry, or the ACA's increases in Medicare benefits. They and we address different questions, and their findings are largely consistent with ours.

based on underlying fee-for-service payments, but through 2013 MA enrollment rose in both high- and low-payment areas.[39] At some point efficiency gains may no longer be large enough to prevent adverse effects on beneficiaries, but the ACA gradually scales up the level of savings required of plans, providing some time for industry to adjust.[40]

Conclusion

Some claim that the ACA involves an enormous and unprecedented transfer of resources from high-income Americans to those with lower incomes. In fact, the money taken from the affluent and given to people with low and moderate incomes is tiny, as a percentage of GDP—only a small fraction of what the country spends on Social Security, Medicare, pre-ACA Medicaid, or tax preferences for employer-sponsored insurance, for example. The vast bulk of ACA funding comes, not from wealthy Americans, but from the health care industry, which receives offsetting revenue from the legislation's coverage expansion. Very few Americans are affected by the ACA's tax increase on high earners, and those who pay must contribute only a small percentage of income. Medicare cuts that fund the ACA apply mainly to providers and insurers, not seniors themselves, who receive increased benefits. By contrast, the vast majority of ACA resources are spent to help low and moderate income consumers, many of whom get substantial assistance, calculated as a percentage of total income. Analyzed carefully, many redistribution claims about the ACA turn out to be exaggerated.

Appendix: Additional Tables

Table A1. Federal Cost of ACA Insurance Affordability Programs Compared to GDP Projections: 2013 CBO and Joint Tax Estimates for Fiscal Year 2019 (Billions of Dollars)

		2019 Amounts
GDP as Projected by CBO in 2013		$21,890
CBO's 2013 Cost Estimates	Medicaid Expansion	$80
	Exchange Subsidies	$123
	Total (Dollars)	$203
	Total (Percentage of GDP)	0.9%

Source: CBO 2013.

Table A2. ACA Funding Sources Other Than Higher-Income Americans, Health Care Providers, and Insurers: CBO and Joint Tax Estimates for Fiscal Year 2019 (Billions of Dollars)

		2019 Amounts
Penalty Payments	Employers	$11.0
	Individuals	$4.0
Tax Changes	Limits on Tax Preferences for Health Care Costs and Accounts	$7.7
Other Sources		$1.1
	Total:	**$23.8**

Source: CBO 2010, Joint Tax 2010.
Note: Penalty payments include tax effects. Limits on tax-preferred health costs involve the deductibility of out-of-pocket health care costs as well as limits on tax-preferred health savings accounts, flexible spending accounts, cafeteria plans, and similar arrangements. Other sources are made up of revenue from codification of the economic substance doctrine and what CBO classified as “miscellaneous effects” on payroll tax revenues.

Notes

1 Wall Street Journal (editorial). "Who Pays for ObamaCare?" July 10, 2010. http://online.wsj.com/news/articles/SB10001424052748704075604575356930951157948.

2 Betsy McCaughey, "Obamacare's Redistribution of Health." September 26, 2010, http://betsymccaughey.com/obamacares-redistribution-of-health/

3 Merrill Goozner, "Spare us the complaints about healthcare 'redistribution,'" Modern Healthcare, November 30, 2013, http://www.modernhealthcare.com/article/20131130/MAGAZINE/311309987/spare-us-the-complaints-about-healthcare-redistribution.

4 Robert Reich, "The three large truths about the Affordable Care Act," Baltimore Sun, November 27, 2013, http://articles.baltimoresun.com/2013-11-27/news/bal-the-three-large-truths-about-the-affordable-care-act-20131126_1_health-care-system-pre-existing-conditions-insurers.

5 CBO. H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation). March 20, 2010 (letter to the Honorable Nancy Pelosi). http://cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf. Joint Committee on Taxation. Estimated revenue effects of the amendment in the nature of a substitute to H.R. 4872, the "Reconciliation Act of 2010," as amended, in combination with the revenue effects of H.R. 3590, The "Patient Protection and Affordable Care Act ('PPACA')," as passed by the Senate, and scheduled for consideration by the House Committee on Rules. March 20, 2010. https://www.jct.gov/publications.html?func=download&id=3672&chk=3672&no_html=1.

6 After calendar year 2019, the percentage of Medicaid costs for newly eligible adults paid by the federal government falls to 90 percent.

7 For example, by the time CBO estimated the effects of ACA repeal legislation, the ACA's reduced payments to Medicare Advantage plans were embodied in federal contracts with insurers that CBO did not believe could be quickly reversed; and the ACA's savings from accelerating competitive bidding for Medicare's purchases of durable medical equipment could not be undone, in CBO's view. CBO. Letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act. July 24, 2012. http://cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf.

8 For example, in 2012, Congress passed a law that increased the amount of money that recipients of advance payment of premium tax credits could be forced to repay the Internal Revenue Service at tax reconciliation. This lowered the estimated federal cost of HIM subsidies. We compare CBO's July 2012 estimated impact of this law to the most recent prior CBO baseline projection of HIM subsidy costs, which was published in January 2012. Using these two estimates, we calculate the law's reduction in HIM subsidy costs as a percentage of total HIM subsidy costs. This has the effect of eliminating from consideration all changes to CBO's economic forecasts between 2010, when the ACA passed, and 2012, when this particular legislative modification was enacted.

9 These changes raised the caps on advance premium tax credit reconciliation for taxpayers with incomes below 400 percent FPL; added tax-exempt Social Security income to modified adjusted gross income; and modified federal income and payroll tax rates, which CBO estimated would affect overall employer coverage and generate spill-over effects on subsidy costs.

10 CBO also adjusted several assumptions involving the likely pace of enrollment and the average risk level of adults newly eligible for Medicaid.

11 We modified CBO's estimates to reflect changes in policy and estimation methodology, while attempting to screen out revised macroeconomic assumptions, as follows. The first post-enactment change to ACA, made in December 2010, increased the amount that households with incomes at or below 400 percent FPL could be required to pay at reconciliation if their premium tax credit, calculated based on income shown on federal income tax returns, exceeds amounts advanced during the year. Based on a comparison between CBO's original ACA estimates and those produced for H.R. 4994, the legislation making this change, the resulting reduction in HIM subsidies lowered 2019 subsidy amounts by 0.6 percent. Compare CBO. Estimate of Effects on Direct Spending and Revenues for H.R. 4994, an Act to Extend Certain Expiring Provisions of the Medicare and Medicaid Programs, and for Other Purposes. December 10, 2010; and CBO. CBO's August 2010 Baseline: Health Insurance Exchanges. August 25, 2010. The next legislative change added tax-exempt Social Security payments to modified adjusted gross income, for purposes of determining eligibility for insurance affordability programs. This legislation lowered 2019 Medicaid/CHIP cost increases, attributable to ACA, by 3.2 percent and increased 2019 HIM subsidy costs by 0.9 percent, based on a comparison of (a) CBO's February 2011 estimate of the impact of repealing ACA and (b) CBO's score of the effects of those two legislative changes. CBO. Cost estimate for H.R. 2, Repealing the Job-Killing Health Care Law Act, February 18, 2011; CBO. Budgetary Effects of H.R. 674, as placed on the Calendar in the Senate on October 31, 2011, with Senate Amendment 927, proposed on November 8, 2011. November 9, 2011. We did not adjust the estimates to reflect the elimination of employer free choice vouchers, since CBO estimated that this provision would reduce the net cost of HIM subsidies by only $0.4 billion during 2012–2021. CBO. Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act. March 2012. A second increase in the amount of tax reconciliation liability was enacted in 2012, reducing HIM subsidies by another 5.4 percent. Compare CBO. Recapture of Overpayments Resulting From Certain Federally Subsidized Health Insurance. April 24, 2012; and CBO. The Budget and Economic Outlook: Fiscal Years 2012 to 2022. January 2012. In its original response to the U.S. Supreme Court decision permitting states to opt out of the Medicaid expansion, CBO estimated that the decision would reduce the ACA's increase in Medicaid/CHIP spending by 31 percent and increase subsidy spending by 25.9 percent; this estimate applied to the 2012-22 time period, without any year-by-year breakout allowing us to isolate the impact on 2019 costs. CBO. Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. July 2012. By February 2013, CBO made further changes unrelated to changed economic conditions, taking into account the effect of newly issued CMS regulations, new assumptions about the speed of likely enrollment into insurance affordability programs, the likely cost of newly eligible Medicaid adults, and changes to federal tax law that increased the attractiveness of HIM coverage, relative to ESI. These changes lowered ACA's increase to 2019 Medicaid costs by 13.3 percent and increased HIM subsidy costs by 4.4 percent. Compare CBO. CBO's February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage. February 2013; and CBO. Cost Estimate for H.R. 6079, the Repeal of Obamacare Act, as passed by the House of Representatives on July 11, 2012. July 24, 2012. Finally, in May 2013, CBO further revised its estimates to reflect CBO's changed judgment about the number of states likely to expand Medicaid, anticipating, for 2019, an 11.1 percent increase in ACA-related Medicaid cost growth and an 14.0 percent reduction in HIM subsidies, relative to CBO's February 2013 baseline. CBO. Updated Budget Projections: Fiscal Years 2013 to 2023. May 2013; CBO. CBO's May 2013 Estimate of the Budgetary Effects of the Insurance Coverage Provisions Contained in the Affordable Care Act. May 2013.

12 Medicaid and CHIP, together, are projected to spend $446.7 billion in FY 2019. CBO, Medicaid Spending and Enrollment Detail for CBO's May 2013 Baseline, May 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204_Medicaid.pdf; CBO, Children's Health Insurance Program Spending and Enrollment Detail for CBO's May 2013 Baseline, May 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44189-CHIP.pdf. In May 2013, CBO estimated that the ACA would increase Medicaid and CHIP costs by $80 billion in FY 2019. CBO. CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage. May 2013. Subtracting the latter from the former total results in estimated non-ACA spending on Medicaid and CHIP of $366.7 billion. The latter figure equals 1.6 percent of the $22.7 trillion in 2019 GDP estimated by CBO in September 2013. CBO. "Supplemental Data," The 2013 Long-Term Budget Outlook. Sept. 17, 2013. http://cbo.gov/sites/default/files/cbofiles/attachments/44521-LTBOSupplementalData2013_0.xlsx.

13 According to the Office of Management and Budget, revenue losses from the income tax and payroll tax are estimated to equal $407.5 billion in FY 2018, the final year of OMB's projection. OMB. FY 2014 Analytical Perspectives: Budget of the U.S. Government. April 2013. http://www.gpo.gov/fdsys/pkg/BUDGET-2014-PER/pdf/BUDGET-2014-PER.pdf. On the assumption that the 5.3 percent increase in such losses from FY 2017 to FY 2018 would also apply to changes from FY 2018 to 2019, the tax exclusion for employer-sponsored insurance will cost $429.1 billion in 2019. That represents 1.9 percent of 2019 GDP, calculated using either CBO's above-cited $22.7 trillion estimate or OMB's $22.247 trillion estimate. We did not use estimates of tax exclusion costs from CBO or Joint Tax, since the former did not provide annual estimates beyond 2013 and the latter was limited to federal income tax effects, without considering payroll tax losses.

14 CBO projects Medicare costs to equal $803 billion in 2019. CBO. CBO's May 2013 Medicare Baseline. May 2013. http://www.cbo.gov/sites/

default/files/cbofiles/attachments/44205_Medicare_0.pdf. This represents 3.5 percent of 2019 GDP, as forecast by CBO in September 2013.

15 CBO. "Exhibit 1." The 2013 Long-Term Projections for Social Security: Additional Information. December 2013. http://www.cbo.gov/sites/default/files/cbofiles/attachments/2013%20Social%20Security%20Supplemental%20Data.xlsx.

16 Matthew Buettgens, Bowen Garrett, and John Holahan. America Under the ACA. Prepared by the Urban Institute for the Robert Wood Johnson Foundation. 2010. http://www.urban.org/publications/412267.html.

17 The share going to the lower income group may be somewhat higher than estimated here since it will include enrollment from those with incomes from 100-133 percent of the FPL in states that do not expand Medicaid, which was not accounted for in the distributional estimates, which preceded the Supreme Court ruling that essentially made the Medicaid expansion optional for states.

18 Premium costs are estimated based on the U.C. Berkeley Labor Center National Subsidy Calculator, http://laborcenter.berkeley.edu/healthpolicy/calculator/, updated October 2013.

19 CMS. "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015." Federal Register.Dec. 2, 2013. 78(231): 72322-72392, http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28610.pdf

20 Cost sharing subsidy and out-of-pocket spending amounts are based on averages within age and income group, under CMS, HHS Notice of Benefit and Payment Parameters for 2015, op cit. Because health care spending is highly skewed, a typical (median) consumer may have much lower out-of-pocket spending than the average consumer.

21 These estimates do not include several original revenue sources that were repealed following ACA's enactment: namely, premium payments for the ACA's long-term care program and revenue gains from new reporting requirements that were applicable to small business.

22 We reach the same result using CBO's most recent estimates, produced in 2013, on the assumption that, in Cost Estimate for H.R. 6079, the Repeal of Obamacare Act, as passed by the House of Representatives on July 11, 2012., op cit., the reference to "Other Provisions" under "Medicare and Other Medicaid and CHIP Provisions" in Table 2 estimates the increased costs that would result from repealing the ACA provisions that raised Part B and Part D premiums for higher-income Medicare beneficiaries.

23 Joint Committee on Taxation. 2010.

24 The ACA changed the income thresholds for means-tested Part B premiums and froze them at 2010 levels until 2020. It also imposed a new, means-tested premium for Part D on the same beneficiaries whose incomes subject them to increased Part B premiums. By 2019, these changes were projected to impose premiums on 6 percent of Part B recipients and 9 percent of Part D recipients. Juliette Cubanski, Tricia Neuman, Jennifer Huang, Jim Mays and Monica Brenner. Income-Relating Medicare Part B and Part D Premiums: How Many Medicare Beneficiaries Will Be Affected? Kaiser Family Foundation and Actuarial Research Corporation. December 2010.

25 For example, a single worker with $220,000 in MAGI of which $10,000 is net investment income would pay the new tax only on the investment income, resulting in a $380 tax liability, since the $10,000 net investment income is less than the $20,000 difference between total MAGI and the applicable $200,000 threshold. Likewise, an individual who does not work but receives $210,000 of MAGI entirely through investment income consisting of interest and dividends would also pay a tax of $380, since the $10,000 difference between total MAGI and the $200,000 threshold is less than the person's $210,000 in investment income.

26 Urban-Brookings Tax Policy Center Microsimulation Model (version 0411-3). Table T12-0091. http://www.taxpolicycenter.org/numbers/displayatab.cfm?Docid=3349&DocTypeID=2.

27 See, e.g., Associated Press, "White House, hospitals reach deal on health care," July 8, 2009, http://www.accessnorthga.com/detail.php?n=221664.

28 Linda J. Blumberg, Matthew Buettgens. Why the ACA's Limits on Age-Rating Will Not Cause "Rate Shock": Distributional Implications of Limited Age Bands in Nongroup Health Insurance. Prepared by the Urban Institute for the Robert Wood Johnson Foundation. March 2013. http://www.urban.org/UploadedPDF/412757-Why-the-ACAs-Limits-on-Age-Rating-Will-Not-Cause-Rate-Shock.pdf.

29 Blumberg and Buettgens, op cit.

30 CBO has estimated that state Medicaid costs related to the ACA's eligibility expansion will equal $41 billion over 2012–2022. CBO. Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. July 2012. However, such increased spending will be offset, to some degree, by state savings on both Medicaid and non-Medicaid health costs. Stan Dorn, John Holahan, Caitlin Carroll, and Megan McGrath. Medicaid Expansion Under the ACA: How States Analyze the Fiscal and Economic Trade-Offs. Prepared by the Urban Institute for the Robert Wood Johnson Foundation. June 2013. http://www.urban.org/UploadedPDF/412840-Medicaid-Expansion-Under-the-ACA.pdf. It is not clear whether, on balance, state health care spending will rise or fall under the ACA.

31 We note that providers were already expected to spend an estimated $62.1 billion on uncompensated health care for the uninsured in 2009, which was projected to reach between $107 and $141 billion by 2019, in the absence of reform. John Holahan and Bowen Garrett. The Cost of Uncompensated Care with and without Health Reform. Urban Institute. March 2010. http://www.urban.org/UploadedPDF/412045_cost_of_uncompensated.pdf.

32 See also Thomas B. Edsall, "The Obamacare Crisis," The New York Times, Nov. 19, 2013.

33 Juliette Cubanski, Tricia Neuman, Gretchen Jacobson, and Karen E. Smith. Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries? Kaiser Family Foundation and the Urban Institute. Feb. 2012.

34 Data are not available from which one could estimate the impact of ACA on total payments for hospice providers, the other provider category disproportionately affected by Medicare cuts for which CBO provides a separate estimate in Cost Estimate for H.R. 6079, op cit. Neither CBO nor the CMS Office of the Actuary provides differentiated projections of baseline spending on hospice care.

35 The effect of ACA on Medicare payments for both home care and skilled nursing care is estimated based on Cost Estimate for H.R. 6079, op cit. Medicare payments for these provider groups under current law are estimated based on CBO's May 2013 Medicare Baseline, op cit. Because CBO does not provide sufficiently specific projections to estimate baseline Medicaid costs, we rely on projections from the CMS Office of the Actuary. CMS Office of the Actuary. National Health Expenditure Projections 2012-2022. 2013. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2012.pdf. We also use the latter projections to estimate out-of-pocket spending, private insurance payments, and payments from other sources. Payments from such other sources include programs operated by the Department of Defense, the Department of Veterans' Affairs, the Indian Health Service, the Substance Abuse and Mental Health Services Administration, workers' compensation, worksite health care, general assistance, vocational rehabilitation, other federal programs, other state and local programs, and other private revenues. The percentage estimates in the text are based on a comparison of ACA's Medicare savings with the total reimbursement projected from all sources if the ACA had not passed, including the amounts cut by ACA.

36 Even at this early juncture, according to MedPAC's most recent report, despite a 5 percent cut in Medicare payments in 2012, the supply of providers increased and quality of care slightly improved. MedPAC. "Home health care services: Assessing payment adequacy and updating payments." Report to the Congress: Medicare Payment Policy, March 2013.

37 Crossroads GPS. "Obamacare Cuts Benefits for Seniors." April 22, 2010 (date provided by Google search results; web page itself undated). http://www.crossroadsgps.org/obamacare-cuts-benefits-for-seniors/.

38 MedPAC, "The Medicare Advantage program: Status report," Report to the Congress: Medicare Payment Policy, March 2013. See also MedPAC, "The Medicare Advantage program: Status report," Report to the Congress: Medicare Payment Policy, March 2012.

39 Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman. Medicare Advantage 2013 Spotlight: Enrollment Market Update. Kaiser Family Foundation and Mathematica Policy Research. June 2013.

40 Cuts estimated by CBO will rise from 4.0 percent in 2013 to 4.9 percent in 2014, 8.5 percent in 2015, 9.7 percent in 2016, finally reaching their maximum level of 9.9 percent in 2017, after which they will gradually fall to 8.3 percent in 2022. Over the entire 2013-22 period, they will average an 8.5 percent reduction, compared to total Medicare reimbursement; this is different from the earlier estimates, which were compared to all sources of reimbursement provided to the affected industries, rather than, in the case, as compared to Medicare alone. For 2014-2022, these estimates for MA plans compare ACA savings on Medicare Advantage plans, as estimated in Cost Estimate for H.R. 6079, op cit., with the sum of those amounts restored plus projected Medicare spending on group health

plans as projected in CBO's May 2013 Medicare Baseline, op cit. CBO does not separately itemize MA costs within other Medicare group health plan spending, but 97 percent of Medicare group health plan enrollment is in MA plans, according to CBO. CBO. CBO's March 2013 Medicare Baseline. March 13, 2012. For 2013, which is not included in Cost Estimate for H.R. 6079, op cit., we base our savings estimate on CBO, Cost estimate for H.R. 2, op cit.

[41] Henry J. Aaron and Gary Burtless. Potential Effects of the Affordable Care Act on Income Inequality. The Brookings Institution. January 24, 2014. http://www.brookings.edu/~/media/research/files/papers/2014/01/potential-effects-affordable-care-act-income-inequality-aaron-burtless/potential-effects-affordable-care-act-income-inequality-aaron-burtless.pdf.

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