CENTER FOR MEDICAL PROGRESS
AT THE MANHATTAN INSTITUTE

EMBARGOED AND NOT FOR DISTRIBUTION BEFORE FEBRUARY 9, 2011 AT 10AM

The Impact of the Affordable Care Act On the Economy, Employers, and the Workforce

Paul Howard, PhD
Senior Fellow and Director
Center for Medical Progress
Manhattan Institute for Policy Research

I'd like to thank Chairman Kline, Ranking Member Miller and members of the Committee for the opportunity to speak this morning on the effects of the Patient Protection and Affordable Care Act on the economy, employers and the workforce.

I'm speaking today from my experience studying health care policy; speaking with providers, patients, and employers from across the country; and from my own research on health care as director and senior fellow at the Manhattan Institute's Center for Medical Progress.

First of all, I'd like to state that there is a critical need for real health care reforms that improve access to affordable health insurance; protect individuals and families from the risk of catastrophic health care expenses; lower the unsustainable rate of health care cost growth for private and public payers; and create better incentives for health care providers to offer more cost effective care.

Creating truly portable individual health insurance would reduce the incidence of job-lock, encouraging entrepreneurship and allowing employees to changes jobs without fear of losing valuable health insurance. Slowing the rate of insurance premium growth for employer-based coverage would allow employers to shift scarce capital to other critical business operations (including job creation) and/or increase employee compensation in the form of higher take home pay.

Without significant health care reforms, rising employer health insurance premiums will continue to sap business capital and erode employee take home pay. More businesses (especially small employers) will drop coverage as insurance becomes unaffordable, leading to an ever growing number of uninsured. Entitlement spending for Medicare and Medicaid will swamp state and federal budgets, threatening economically crippling tax increases or devastating spending cuts.

Unfortunately, the Patient Protection and Affordable Care Act is not the solution to our health care woes. If anything, the Affordable Care Act "doubles down" on many of the worst aspects of our current system, while adding new cost pressures and problems that will serve as a drag on economic growth and job creation for years to come.

I believe that the negative economic impacts of the Affordable Care Act can be separated into three broad categories:

- PPACA will Increase the Deficit, Not Reduce It
- PPACA will Increase Insurance Costs and Reduce Employment
- Regulatory Uncertainty under PPACA will Hinder Job Creation

In turn, I will discuss why the Affordable Care Act is much more likely to increase the deficit than reduce it; explain how the mandates, taxes, and penalties that it imposes on insurers and employers will increase health care costs and decrease employment; and conclude by exploring the negative effects of regulatory uncertainty at a time when companies are "sitting" on trillions of dollars in cash that could be used for job creation.

PPACA will Increase the Deficit, Not Reduce It

From an economic perspective, reducing the federal deficit to sustainable levels would be an enormous boon for U.S. economic competitiveness and job creation. If we continue spending at current projected levels, the U.S. economy will be exposed to the risk of a sovereign debt crisis that would force economically crippling tax increases or sudden and severe cuts in government spending that would have long lasting negative consequences for U.S. economic growth and employment.

Slowing the rate of excess health care cost growth for government health care entitlement programs like Medicare and Medicaid would be a significant step towards addressing the U.S.'s long term structural deficit. However, the Affordable Care Act creates a new middle class entitlement for the purchase of heavily subsidized private health insurance, and approximately doubles the size of the Medicaid program. This is hardly the best way to "bend the curve" of health care spending, since it creates large new constituencies for increased health care spending and increased demand is likely to put significant upward pressure on the cost of health care goods and services.

The Affordable Care Act does contain what MIT economist Jonathan Gruber calls (approvingly) a "spaghetti approach to cost control"[i]. This includes a grab-bag of Medicare pilot projects and payment reforms including Accountable Care Organizations, bundled payment systems, and pay-for-performance initiatives. The strategy, insofar as it can be called a strategy, is to throw "a bunch of stuff at against the wall [to] see what sticks."

Unfortunately, these programs are underpowered, and are likely to be cut short whenever they work too effectively, and threaten the interests of one or another powerful health care interest group. The Affordable Care Act's focus on top-down planning also ignores the myriad unintended consequences that follow when bureaucracies with limited information attempt to control the behavior of hundreds of thousands of physicians, and thousands of hospitals, who have powerful financial incentives to find ways to maximize revenue from administratively favored activities and procedures and avoid painful cuts to disfavored ones.

Even if we take the Affordable Care Act at face value, it has not done nearly enough to address current and projected entitlement spending. Just two months after the Affordable Care Act passed, the director of the Congressional Budget Office (CBO) noted that:

> Rising health care costs will put tremendous pressure on the federal budget during the next few decades and beyond. In CBO's judgment, the health legislation enacted earlier this year does not substantially diminish that pressure.[ii]

Nonetheless, it has been endlessly repeated that the Affordable Care Act will actually reduce the deficit by a small amount in its first ten years and by trillions of dollars thereafter. How is this circle squared? The federal government is clearly committed to spending hundreds of billions more on Medicaid, the State Children's Health Insurance Plan (or SCHIP), and new subsidies for middle- and upper income-uninsured to buy health insurance on newly created state health insurance exchanges beginning in 2014.

Still, the CBO does score the Affordable Care Act as reducing the deficit by about $143 billion in its first decade (including $19 billion from its education related provisions). However, the CBO also notes that the federal government will spend about $401 billion more on health care programs in the Affordable Care Act's first decade, while increasing federal revenues, through taxes and fees, by an even greater amount, $525 billion.[iii]

Consequently, half-a-trillion dollars will be shifted out of the private economy and directed largely towards new health care spending. Not only will this reduce funds available for private sector job growth and innovation, but the funds are also lost for any future deficit reduction efforts. Estimates that the Affordable Care Act reduces the deficit by $143 billion seem reassuring, but only if we ignore the fact that we are shifting substantial new revenues from non-health care sources to meet new health care obligations – hardly "bending the curve" by any plausible definition.

The passage of the Affordable Care Act also set a new low in Washington's perennial fiscal shell games. First of all, the legislation double-counts $53 billion in Social Security payments and $70 billion in premium payments for a new long term care insurance program (CLASS) as revenues. It also ignores up to $115 billion in discretionary costs associated with the Affordable Care Act, including $10-20 billion in direct implementation costs[iv], including:

- $5-10 billion for the IRS associated with "the eligibility determination, documentation, and verification processes for premium and cost-sharing credits"

- $5-10 billion in costs for a variety of federal agencies including CMS, the Office of Personnel Management, Medicaid and CHIP

Many more costs loom just over the horizon. The infamous "doc fix" for the sustainable growth rate (SGR) formula under Medicare threatens large cuts to physicians fees every year. Congress passed the latest SGR patch in December and deferred cuts for 2011, without offering any permanent resolution. Ultimately the SGR has to be addressed, but the fiscal cost is staggering: estimated at $276 billion over 10 years. The CBO also estimates that costs for the new insurance subsidies and Medicaid expansion under the Affordable Care Act will grow by approximately 8% annually beginning in 2019.

Defenders of the Affordable Care Act may concede that the near term prospects for the bill to control costs are poor. Instead, they point to the increased savings in the second decade of the legislation, and to the 2010 Medicare Trustees report, which estimates that the Affordable Care Act will extend Medicare's hospital insurance trust fund an additional 12 years (from 2017 to 2029), and cut trillions from Medicare's long-term expenditures.

The problem is that these figures assume that Congress will tolerate large cuts to payments for Medicare providers or that such cuts will have no effect on services for Medicare beneficiaries. The office of the Medicare Actuary has published what amounts to a dissent from the 2010 Trustees report, noting that:

> [T]he financial projections shown in this report for Medicare do not represent a reasonable expectation for actual program operations… the statutory reductions in price updates for most categories of Medicare provider services will not be viable.[v]

Medicare actuaries estimate that by 2019, Medicare payment rates would be lower than those currently paid for Medicaid (which already pays providers much less than private insurance). In the long run, Medicare payments would dip to "one-third of the relative current private health insurance prices and half of those for Medicaid," according to the actuaries' memorandum. Under these projections, a full 15% of Medicare providers would be unprofitable by 2019, 25% by 2030, and 40% by 2050.[vi] Needless to say, it is unlikely that Congress would actually allow these cuts to go into effect, since they would have dire consequences for Medicare beneficiaries.

Other analysts, after discounting the double-counting of revenues and cuts that are likely to be unsustainable, put the true deficit costs of the Affordable Care Act during its first 10 years at over $562 billion and second decade at over $1.5 trillion.[vii] Meeting these obligations will require significant new tax increases or spending cuts, draining funds from the private sector or reducing investment for other critical priorities like public education and infrastructure.

We should also not ignore the serious impact that the Affordable Care Act will have on already strained state budgets. The new law would bring 16 million Americans—one-half of the estimated 32 million who will receive new insurance coverage—into Medicaid, covering Americans making up to 133 percent of the federal poverty level.

Medicaid spending currently consumes about 20 percent of state budgets, crowding out spending on everything from education to infrastructure. The federal government will pick up 100 percent of new Medicaid costs for the first several years after 2014, when the law goes into effect, paring back to 90 percent in 2020. Still, states will face $21 billion in new Medicaid costs from 2014-2019[viii], not including up to $12 billion in new administrative costs.[ix] While this pales besides the $443 billion in new Medicaid costs for the federal government, many state budgets are in such poor condition that they can't afford *any* new outlays; they need, in fact, to cut spending.

States will also be responsible for the approximately 11 million uninsured Americans who are currently eligible for Medicaid but have never bothered to enroll. In 2014, once the Affordable Care Act takes effect, many of these eligible but not enrolled people will presumably sign up for Medicaid coverage. Unfortunately for the states, these enrollees would be covered not under the higher federal matching rate that the Affordable Care Act establishes but under the pre-PPACA rate, which varies by state but is much more onerous. These trends will only increase Medicaid pressures on state budgets, leading to more economically damaging tax increases, budget cuts, or state employee layoffs.

PPACA will Increase Insurance Costs and Reduce Employment

While the full deficit effects of the Affordable Care Act are not likely to be felt for several years after full implementation begins in 2014, the Act also contains a number of other provisions including new insurance mandates, taxes, and employer penalties that will have a direct and more immediate effect on the cost of health insurance coverage and employer decisions to hire (or not hire) additional employees.

The Affordable Care Act imposes a number of new requirements on insurers, including

extending dependent coverage for adult children until they are 26; eliminating the lifetime cap on health insurance coverage and gradually increasing and then eliminating annual coverage limits; forbidding companies from excluding children with pre-existing conditions from child-only coverage policies; and eliminating cost-sharing for preventive services in Medicare and private plans. These provisions may result in what is perceived to be a "richer" benefit package, but at the cost of higher insurance premiums that employers will have to offset through reduced employee wages or job creation.

New taxes on insurance companies, pharmaceutical companies, and medical device companies are all likely to be passed through directly onto employers and employees in the form of higher insurance premiums. (Some of these new costs can, of course, also be passed along to consumers in the form of higher prices for goods and services.)

The administration has also repeatedly promised that "if you like your plan, you can keep it, and thus that "grandfathered" plans would not be subject to new insurance regulations, and new costs. However, the government has since revealed that up to 69 percent all employers (and up to 80 percent of small employers) will lose their grandfathered status over the next several years and be subject to new regulatory requirements and costs.[x]

Massachusetts' experience with health insurance reform, the template for the Affordable Care Act, suggests that health insurance costs will rise for employers and for small firms in particular. A July 2010 study by health economists John Cogan, Glenn Hubbard, and Daniel Kessler found that premium trends for employer-provided health insurance rose faster in the Bay State after reforms were implemented, particularly for individual coverage and for small businesses.

The authors found that "health reform in Massachusetts increased single coverage employer-sponsored insurance premiums by about 6 percent in aggregate and by about 7 percent for firms with fewer than 50 employees. . . . For small employers, the differential Massachusetts/US growth in small group [family] premiums from 2006-2008, over and above the growth from 2004-2006, was 14.4 percent."[xi]

The Affordable Care Act also contains a play or pay mandate that penalizes companies with more than 50 employees who do not offer coverage, or offers "unaffordable" coverage if one or more employees at the firm purchases subsidized coverage on a state health insurance exchange beginning in 2014.

The consulting firm Mercer predicts that "more than a third of the nation's employers – 38% - have at least some employees for whom coverage would be considered 'unaffordable' under [PPACA]." The penalty is equal to $3,000 per full-time employee receiving subsidized coverage, or $2,000 per FTE excluding the first 30, whichever is less. (Although Mercer found that more small companies would be affected by the penalty, 31% of employers with 500 or more employees would be at risk, along with 20% of employers with 20,000 or more employees.)

The "play or pay" mandate is apt to have a variety of effects on coverage and employment decisions. For employers with 50 or fewer employees who do not offer coverage, it will be a disincentive to grow beyond the "cap" and incur the penalty – reducing employment. One labor economist notes that the $2,000 penalty will amount to 15% of average wages in the restaurant industry and nearly 10% of wages in the retail sector – providing an incentive for firms to hire fewer lower-wage workers or become more automated. (In general, firms will also prefer to hire full-time workers

as the cost of benefits per-hour of labor is lower.)[xii]

For employers who do not offer "affordable" coverage, they can avoid the penalty by increasing spending on health care benefits to reduce the employees' share of health insurance costs below the 9.5% threshold of household income. However, these expenditures would compete with total employee compensation or other employment decisions. (How, exactly, firms will go about learning their employees' household income for purposes of determining if their coverage is "affordable" – household income may fluctuate throughout the year – is another question entirely, with potentially troubling privacy implications.)

Of course, many companies may rationally decide that the "price" of dropping coverage (along with any increase in an employees' salary or other compensation) is more than offset by the savings recouped from ending an employee insurance policy that costs $11,000 or more annually.[xiii]

The decision to end employer-based coverage will also be encouraged by the fact that the Affordable Care Act effectively creates a "most favored subsidy" group, insofar as individuals and families in the exact same income bracket may qualify for very different tax subsidies based on whether or not they are offered employer-based insurance coverage.

The subsidies and cost sharing support available on the state health insurance exchanges are significantly more generous than the current insurance tax exemption for employer provided health insurance – at least for households earning less than 200-250 percent of the federal poverty level – providing an additional incentive for low-wage employees to migrate into the exchange. (Higher-wage employees who do not qualify for subsidies on the exchanges, or who would still face substantial out of pocket costs, will want to "stay put" in employer-based coverage.)

The Affordable Care Act does contain a tax credit to offset the costs of insurance coverage for small firms. The credit, however, phases out for firms with between 10-25 employees and as average wages approach $50,000. Proprietors and their family members are also excluded from claiming the credit, even though many small firms are family-run. Given these limitations, the National Federation of Independent Businesses estimates that only 35 percent of firms with fewer than 25 employees will be able to qualify for the credit. In any case, the premium is only available for a total of six years (2010-13, plus a two year credit beginning in 2014).

Although it is difficult to predict the exact magnitude of the Act's effect on employment-based coverage, CBO does expect that as many as 3 million people would lose employer based coverage, noting that "firms that would choose not to offer coverage as a result of the proposal would tend to be smaller employers and employers that predominantly employ lower wage workers."[xiv] Other sources estimate that far more lower-wage employees may be "dropped" into the state exchanges than has been previously estimated – perhaps as many as 43 million, substantially increasing taxpayer obligations and driving up the cost of the program.[xv]

Firms are therefore most likely to end coverage for lower wage employees, and/or outsource or automate their functions to both avoid paying a fine and to shed health insurance costs. In sum, the tax

advantage on the exchanges for many households is likely, over the long term, to undermine coverage in the employer-based market, increase taxpayers' exposure to subsidy costs, and reduce demand for low-wage labor.

(Many low-income employees may also find themselves enrolled in Medicaid, a joint-federal state program that offers comprehensive insurance coverage on paper, but which has serious access problems due to low and slow reimbursements for physicians' services. Medicaid also seems to have worse outcomes for serious illnesses like cancer and heart disease.)

One small business owner (an IHOP franchisee in New Jersey) anticipates that Affordable Care Act penalties for his 140 uninsured workers (up to $220,000) will force him to raise prices or possibly lay workers off. "We are still figuring out how to deal with this," he told the *Cleveland Plain Dealer* in July. "Ultimately, either businesses will close or consumers will pay more."

Regulatory Uncertainty under PPACA Will Hinder Job Creation

The Patient Protection and Affordable Care Act is likely to increase insurance premiums for employers by mandating richer benefit packages; penalize firms that do not offer insurance or do not offer "affordable" insurance; and increase incentives for employers to find ways to reduce insurance coverage for, or reliance on, low-wage labor. Overtime, the Affordable Care Act will significantly undermine the employer-based insurance coverage and leave millions more Americans in insurance markets that are government controlled.

Still, much of the regulation that will affect insurance costs and firms' allocation of wages and employment will be written over the next several years. As a result, employers face tremendous uncertainty as they try to understand their exposure to costs associated with federal and state insurance requirements; calculate potential penalties for going without coverage or exceeding maximum allowable household costs; and prepare to navigate the thicket of regulations that will emerge piecemeal from the Department of Health and Human Services, state departments of insurance, and state health insurance exchanges.

Employers are already struggling with unintended consequences of the legislation. To date, the Department of Health and Human Services has had to issue 733 waivers from minimum insurance requirements under the Affordable Care Act, including 182 issued to plans provided under union collective bargaining agreements.

While HHS should be commended for acting to minimize the loss of coverage or large premium increases for millions of enrollees in these plans, it does underscore the potential for political pressures to be brought to bear that will make the transparent implementation of the Affordable Care Act extraordinarily difficult. Indeed, we have already seen how union pressures on Congress and the White House pushed back the "Cadillac Tax" in the Affordable Care Act to 2018 (and substantially raised the threshold at which the tax takes effect), raising the question of how many other provisions may be selectively enforced or not enforced at all.

At least until 2014, firms will proceed very cautiously before committing themselves to new investment or employment decisions. Given persistently high unemployment, and a fragile recovery from the worst financial crisis since the Great Depression, the Affordable Care Act will remain a drag on the economy until many of these questions are resolved – and beyond. The Congressional Budget Office currently estimates that the Affordable Care Act will reduce labor in the U.S. by approximately

.5 percent, primarily because it will "affect some individuals' decisions about whether and how much to work, and some employers' decisions about hiring workers."[xvi]

This may seem to be a modest amount (although it may represent hundreds of thousands of lost jobs). And private firms can and do adapt themselves to a variety of regulatory environments. But a glance at our European competitors shows that universal health insurance is not, in itself, a boost to employment or global competitiveness. Many European countries have persistently higher overall unemployment than the U.S. The French economist Guy Sorman puts it as follows:

> France's costly national health insurance is mostly financed by taxes on labor. A Frenchman making a monthly salary of 3,000 euros will pay approximately 350 of them (deducted by his employer) for health insurance. Then the employer will add approximately 1,200 euros, making the total monthly cost to the employer of this individual's services not 3,000 euros but 4,200.
>
> High labor costs in France affect not only consumer prices but also unemployment rates, since employers are reluctant to pay so much for low-skill workers. Economists agree that unemployment rates and the cost of national health insurance are directly related everywhere, which partly explains why even in periods of economic growth, the average French unemployment rate hovers around 10 percent.[xvii]

A different, and better approach for the U.S., would've relied on incremental reforms to expand coverage to those with the greatest medical and financial need; implemented tax reforms to equalize the tax treatment of insurance purchased on the individual market or through employers; and instituted health care and insurance reforms that utilize competition and consumer choice to drive health care costs down.

Instead, we've created a new open-ended federal entitlement, mandated even more expensive, comprehensive insurance coverage, and instituted a massive new regulatory process that will generate unintended consequences for years to come.

Members of the Committee, thank you for the opportunity to be here today. I look forward to answering your questions.

---

[i] Cost Questions Could Lead to Further Debate on Health Care Reform. California Healthline, April 26, 2010. http://www.californiahealthline.org/articles/2010/4/26/cost-questions-could-lead-to-further-debate-on-health-care-reform.aspx

[ii] Douglas Elmendorf, Director, Congressional Budget Office, Presentation to the Institute of Medicine, Health Costs and the Federal Budget, May, 26 2010. Slide 2. http://www.cbo.gov/ftpdocs/115xx/doc11544/Presentation5-26-10.pdf

[iii] Congressional Budget Office, The Budget and Economic Outlook: An Update. August 2010 (p. 6). http://www.cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf

[iv] Letter from Congressional Budget Office Director Douglas W. Elmendorf to the Hon. Jerry Lewis, ranking member of the House Committee on Appropriations. May 11, 2010 (p. 2). http://www.cbo.gov/ftpdocs/114xx/doc11490/LewisLtr_HR3590.pdf

[v] 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. "Statement of Actuarial Opinion", p. 282. https://www.cms.gov/ReportsTrustFunds/downloads/tr2010.pdf.

[vi] Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers. Centers for Medicare and Medicaid Services, Office of the Actuary, August 10, 2010 (p. 6). http://www.cms.gov/ActuarialStudies/Downloads/2010TRAlternativeScenario.pdf.

[vii] Douglas Holtz-Eakin and Michael J. Ramlet, Health Care Reform is Likely to Widen Budget Deficits, Not Decrease Them. *Health Affairs*, June 2010:1136-41. http://www.ncpa.org/pdfs/health-care-reform-likely-to-add-billions-to-deficit.pdf

[viii] Health Reform Issues: Key Issues About State Financing and Medicaid. Kaiser Family Foundation, May 2010 (p. 2). http://www.kff.org/healthreform/8005.cfm

[ix] Obamacare: Impact on States. Edmund F. Haislmaier and Brian C. Blasé, Heritage Foundation. July 2010 (p. 5). http://thf_media.s3.amazonaws.com/2010/pdf/bg2433.pdf

[x] HHS Urged to Ease Requirements for Maintaining 'Grandfathered' Status. Commonwealth Fund, August 17, 2010. http://www.commonwealthfund.org/Content/Newsletters/Washington-Health-Policy-in-Review/2010/Aug/August-23-2010/HHS-Urged-to-Ease-Requirements-for-Maintaining-Grandfathered-Statu.aspx

[xi] John F. Cogan, R. Glenn Hubbard, and Daniel Kessler (2010) "The Effect of Massachusetts' Health Reform on Employer-Sponsored Insurance Premiums," Forum for Health Economics & Policy: Vol. 13: Iss. 2 (Health Care Reform), Article 5. http://www.bepress.com/fhep/13/2/5

[xii] Health Care's Impact on the Low-Skilled Worker. Diana Furchtgott-Roth, RealClearMarkets.com, May, 6, 2010. http://www.realclearmarkets.com/articles/2010/05/06/healthcare_and_low-skilled_workers_98451.html

[xiii] Documents reveal that AT&T, Verizon, others, thought about dropping employer sponsored benefits. Shawn Tully, CNN Money, May 6, 2010. http://money.cnn.com/2010/05/05/news/companies/dropping_benefits.fortune/

[xiv] Cost estimate for the amendment in the nature of a substitute for H.R. 4872, incorporating a proposed manager's amendment made public on March 20, 2010 (p. 10). http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf

[xv] The Patient Protection and Affordable Care Act: Labor Market Incentives, Economic Growth, and Budgetary Impacts, Douglas Holtz-Eakin, January 26, 2011 (p. 14). http://waysandmeans.house.gov/UploadedFiles/HoltzEakin_Testimony_1_5.pdf

[xvi] See Congressional Budget Office, Director's Blog, October 22, 2010. http://cboblog.cbo.gov/?p=1478

[xvii] Paying for Le Treatment, Guy Sorman, City Journal, August 24, 2009. http://www.city-journal.org/2009/eon0824gs.html