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The Affordable Care Act's Mounting Budgetary Pressures

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Abstract

To obscure the huge deficit increases from the Affordable Care Act's coverage expansions, the legislation's authors packaged those expensive components together with a collection of dubious revenue and savings measures. Now, the Congressional Budget Office states that the total fiscal effects of the legislation can no longer be determined. Nonetheless, its major provisions are still in the early stages of being enforced, and their continued implementation can be expected to increase the costs of health insurance for millions of Americans, while destabilizing existing private employer-based insurance arrangements and reducing the level of accessible services in Medicare. Even worse, lawmakers' deficit fixation has distracted from the far more important focus on the health care law's massive spending. As the new health care entitlements approach full implementation over the next several years, the true costs of the law will become progressively clearer—and they will further threaten the federal government's deteriorating fiscal health.

It is paid for. It is fiscally responsible.
—President Barack Obama, about the national health care plan, March 23, 2010

Throughout the development of their ambitious national health insurance plan, President Barack Obama and his congressional allies vowed that the sprawling new entitlement program would not worsen the government's already disturbing fiscal outlook. "I will not sign a plan that adds one dime to our deficits," the President had declared, "either now or in the future."[1] It was a curious pledge consid-

Key Points

- Authors of the Affordable Care Act (ACA) pledged that this major new entitlement would not increase the federal deficit. So they disguised the law's massive spending increases with ostensibly offsetting spending cuts and tax hikes.
- The ACA's savings provisions are still in the early stages of enforcement, and some are subject to alteration as they take effect. Equally important, the deficit fixation that drove the law's development created distorted policies and distracted from the foremost budgetary concern: how much the law would spend.
- Once the alleged deficit-reducing provisions were enacted, their effects could no longer be tracked separately by Congress's conventional estimating practices: The actual deficit effects of the law will never be known.
- The history of the ACA's development reflects not only the reckless ideological zeal of its proponents—determined to drive through the legislation at any cost—but also the fundamental failings of the congressional budgeting process.

This paper, in its entirety, can be found at **http://report.heritage.org/bg2980**

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ering that annual deficits had already metastasized to more than $1 trillion, with debt swelling to near-record postwar levels.[2] Nevertheless, congressional leaders gave the law an illusion of fiscal responsibility by packaging its costly insurance expansions together with a collection of dubious offsetting Medicare savings and tax increases. The Congressional Budget Office (CBO)—Congress's official scorekeeper and a pivotal player in the debate—had no choice but to analyze the legislation as written, using assumptions in current law and its own well-established estimating conventions. In its final analysis before enactment, the CBO reported that the measure's combination of health care and tax provisions would yield a net deficit reduction of $124 billion from 2010 through 2019[3]—ostensibly fulfilling one of many bold promises of what became the Affordable Care Act (ACA).[4]

In the process, however, the deficit fixation distracted Congress from what should have been the foremost budgetary concern: How much the ACA would *spend*, and, thus, by how much it would expand government. "A focus on the net deficit impact of legislation is not ... a sufficient basis for evaluating reforms," argues Charles P. Blahous, a Public Trustee for Medicare and Social Security. "In theory, one could address federal deficits while leaving the skyrocketing path of federal health care spending uncorrected and perpetually raising taxes by a still greater amount."[5] Besides, once the law was enacted, the CBO could no longer track the deficit-reduction provisions (explained below under "The Vanishing Deficit Reduction").

Today, the facts are simple. While the spending components of the national health insurance law have largely remained intact, the major cost-saving measures are still in the early stages of enforcement, and their budgetary impact remains uncertain. Indeed, some are highly subject to alteration as their effects take hold. This should not be surprising: In an early and perceptive piece on the politics of the ACA, Jacob S. Hacker, a professor of political science at Yale University and an ardent supporter of the law, warned his fellow "progressives":

> Financing is the soft underbelly of health reform. The health care bill relies on a grab bag of revenue sources. Over the long term, if costs grow more quickly than these sources, federal deficits and the pressure to cut subsidies for coverage will grow. Both outcomes would undermine the ability of reform to achieve its promise and public confidence in the law.[6]

As the ACA's coverage expansions come into full implementation over the next several years, the law's true costs, and its dubious financing schemes, will become increasingly clear. The following review of those elements offers a chilling fiscal prognosis. More broadly, this latest expression of progressive ideology also demonstrates two major failings of congressional budgeting itself: how much lawmakers will contort policy choices to satisfy arcane and often abstract estimating rules, and the ineffectual fiscal standards that now govern those decisions.

Guaranteed Spending: The Latest Coverage Projections

While annual federal deficits have recently declined, principally because of higher revenue, they remain in the range of a half trillion dollars a

1. News release, "Remarks by the President to a Joint Session of Congress on Health Care," The White House, September 9, 2009, http://www.whitehouse.gov/the-press-office/remarks-president-a-joint-session-congress-health-care (accessed November 10, 2014).
2. U.S. Office of Management and Budget, *Budget of the U.S. Government, Fiscal Year 2015: Historical Tables*, Table 7.1, http://www.whitehouse.gov/sites/default/files/omb/budget/fy2015/assets/hist.pdf (accessed November 10, 2014).
3. Congressional Budget Office, analysis of the Patient Protection and Affordable Care Act (H.R. 3590) as passed by the Senate, and of the Reconciliation Act of 2010 (H.R. 4872), March 20, 2010, http://www.cbo.gov/sites/default/files/amendreconprop.pdf (accessed November 19. 2014). The legislation also contained student loan provisions that provided an additional $19 billion in savings over 10 years.
4. The final legislation actually consists of two measures: the Patient Protection and Affordable Care Act (PPACA) (H.R. 3590, Public Law 111–148), and the Reconciliation Act of 2010 (H.R. 4872, Public Law 111–152). The combination constitutes what is known as the Affordable Care Act, also commonly called Obamacare.
5. Charles P. Blahous, "The Fiscal Consequences of the Affordable Care Act," The Mercatus Center at George Mason University, April 2012, p. 10, http://mercatus.org/publication/fiscal-consequences-affordable-care-act (accessed November 10, 2014).
6. Jacob S. Hacker, "Health Reform 2.0," *The American Prospect*, July 29, 2010, http://prospect.org/article/health-reform-20-0 (accessed November 10, 2014).

year—hardly cause for celebration.[7] Moreover, the "relief," such as it is, is temporary. Federal spending, deficits, and debt are expected to climb rapidly, especially after 2018. The CBO projects that from 2015 through 2024, deficits will total $7.2 trillion, and that publicly held debt will continue to rise from today's historically high 74 percent of gross domestic product (GDP) to more than 77 percent of GDP by 2024.[8] Meanwhile, the national health insurance law is locking in enormous new federal spending. For the same 2015–2024 period, the CBO estimates the ACA will spend nearly $2 trillion.[9] Yet that huge number, so precariously balanced on a set of conservative assumptions and bedeviled by the inevitable unintended consequences, could very well turn out to underestimate the true cost of the law.

The ACA's spending projection for the next 10 years is roughly twice what the CBO estimated for the program's first decade. The difference is largely an artifact of the time periods measured, but is noteworthy nevertheless.

"Each time a year goes by, a less expensive early year is replaced by a more expensive later year," the CBO explains.[10] Major provisions of the ACA, such as enrollment in its insurance exchanges, did not start until 2014, and the CBO projected that coverage would build up gradually. So, obviously, the first 10 years' worth of CBO estimates predictably failed to capture the full range of spending required by the law.

This phenomenon of understated costs is a common occurrence for major government programs, but it demonstrates a fundamental limitation of Washington's conventional budget-estimating practices, which detail only the initial decade of any new initiative. "Legislation often allows several years to set up a program, and the program is phased in only after that period," writes former acting CBO Director Donald B. Marron. "With health care, costs can increase very rapidly from year to year, so the average cost of the first 10 years may be much lower than later annual costs."[11]

The CBO's projections show coverage through the government exchanges rising until 2017, then leveling off at about 25 million people, with roughly 13 million additional enrollees in Medicaid and the Children's Health Insurance Program (CHIP) reached the following year. Hence, the latest CBO estimates reflect something closer to a typical 10 years of the program, and those starting in 2018 will be even more representative. (Also in 2018, the CBO says, 12 million fewer people will have employer-based or other private health insurance, and the number of the uninsured will total 29 million, rising to 31 million in 2024.)[12]

The doubling of these cumulative costs compared with figures for the first decade holds true even though the CBO has also lowered its gross cost projection for 2015 through 2024 by $165 billion.[13]

During this period, the coverage expansions will consume $1.89 trillion in mandatory (entitlement) spending, the CBO says. The figure compares with the CBO's estimated $898 billion for the legislation's first decade, as projected in March 2010. (See Table 1.) These outlays consist of the refundable portion of the premium subsidy tax credits intended to help recipients purchase health coverage in the government exchanges,[14] cost-sharing assistance, the additional spending for Medicaid and CHIP, and federal payments for risk adjustment and reinsurance for

7. Congressional Budget Office, "Monthly Budget Review: Summary for Fiscal Year 2014," November 10, 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/49759-MBR.pdf (accessed November 18, 2014).
8. Congressional Budget Office, "An Update to the Budget and Economic Outlook: 2014 to 2024," August 27, 2014, http://www.cbo.gov/sites/default/files/45653-OutlookUpdate_2014_Aug.pdf (accessed November 10, 2014).
9. Congressional Budget Office, "Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act," April 14, 2014, Table 1, http://www.cbo.gov/publication/45231 (accessed November 10, 2014).
10. Congressional Budget Office, "Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act," p. 21.
11. Donald B. Marron, "Understanding CBO Health Cost Estimates," Heritage Foundation *Backgrounder* No. 2298, July 15, 2009, p. 8, http://www.heritage.org/research/reports/2009/07/understanding-cbo-health-cost-estimates.
12. Congressional Budget Office, "Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act," pp. 3–5.
13. Ibid., p. 21.
14. The premium subsidies are structured as "refundable tax credits." This means that conceptually they are administered as reductions in individuals' tax liabilities. The portion of the credit that exceeds an individual's income tax liability is delivered as a payment and classified as an outlay in the CBO's estimating conventions. This is the refundable portion of the tax credit, and constitutes the majority of the premium subsidies.

TABLE 1

Comparing 10-Year Coverage Costs of the Affordable Care Act

Positive numbers indicate an increase in the deficit effect, while negative numbers indicate a decrease.

IN BILLIONS OF DOLLARS	2010–2019	2015–2024
Spending Increase from Coverage Provisions*	$898	$1,885
Net Revenue Increase**	–$105	–$503
Net Change in Deficit Effect from Coverage Provisions	**$793**	**$1,382**

* Consists of outlays for the refundable portion of premium subsidy tax credits, cost-sharing subsidies, exchange grants to states, risk adjustment and reinsurance, and Medicaid and CHIP expansions.
** Net of revenue portion of insurance premiums subsidies, small employer tax credits, penalty payments by employers and uninsured individuals, excise taxes for high-premium plans, reinsurance and risk adjustment collections, and associated revenue effects. Does not include Medicare taxes that CBO no longer estimates separately.

Note: Figures may not sum due to rounding.
Source: Congressional Budget Office, letter to Rep. Nancy Pelosi, "Analysis of the Patient Protection and Affordable Care Act Combined with the Reconciliation Act of 2010," March 20, 2010, Table 2, http://www.cbo.gov/sites/default/files/amendreconprop.pdf (accessed November 25, 2014), and Congressional Budget Office, "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014," Tables 1 and 3, http://www.cbo.gov/publication/45231 (accessed November 25, 2014). Tax estimates are by the Joint Committee on Taxation.

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TABLE 2

Gross and Net Costs of the Affordable Health Choices Act, 2009

Positive numbers indicate an increase in the deficit, while negative numbers indicate a decrease.

IN BILLIONS OF DOLLARS	2010–2019
Gross Costs of Exchange and Employer Subsidies	$1,339
Payments by Uninsured Individuals	–$2
Medicaid/CHIP Outlays	–$38
Tax Revenue Effects of Coverage Changes	–$257
Total Deficit Increase	**$1,042**

Note: Figures may not sum due to rounding.
Source: Congressional Budget Office, letter to Sen. Edward M. Kennedy, "Analysis of the Affordable Health Choices Act as Released by the Senate Committee on Health, Education, Labor, and Pensions," June 15, 2009, http://www.cbo.gov/sites/default/files/06-15-healthchoicesact.pdf (accessed November 25, 2014). Tax estimates are by the Joint Committee on Taxation.

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the health insurance companies participating in the public exchanges.[15] From a budgetary standpoint, these spending provisions are the essence of the ACA; without them, the program could not exist.[16]

This total spending also provides one of the best measures of how much the initiative will expand the reach of the federal government, no matter how it is financed. Citing an early version of the health care legislation sponsored in 2009 by the late Senator Edward M. Kennedy (D–MA),[17] Marron noted that the CBO's analysis reported a net "cost"—meaning its deficit increase—of $1 trillion over 10 years. (See Table 2.) Total spending, however, would be $1.3 trillion, partly offset by about $257 billion in higher tax revenues. "In that case," Marron wrote, "the gross figures—which show the impact on spending and on revenues separately—provide a much richer description of the policy change than is provided by the net figures alone."[18]

On the opposite side of the ledger, the ACA imposes roughly $643 billion in coverage-related taxes and other collections over the next 10 years, according to

15. Congressional Budget Office, "Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act," Tables 1 and 3, and Table 2, analysis of the PPACA (H.R. 3590) as passed by the Senate, and the Reconciliation Act of 2010 (H.R. 4872), March 20, 2010, http://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf (accessed November 10, 2014).
16. This concept lies at the heart of the *King v. Burwell* case, which the Supreme Court is expected to hear next spring. Plaintiffs challenged the Internal Revenue Service (IRS) ruling that insurance subsidies would be available in the federal exchanges, even though the plain language of the statute confines them to state exchanges. Participants in the case agree that without the subsidies, the ACA cannot work.
17. The Affordable Health Choices Act of 2009 as released by the Senate Committee on Health, Education, Labor, and Pensions on June 9, 2009.
18. Marron, "Understanding CBO Health Cost Estimates," p. 7.

updated estimates. The figure includes the "mandate" taxes imposed on employers and individuals for failing to buy insurance, excise taxes for high-premium plans, reinsurance and risk-adjustment collections, and associated revenue effects.[19] Toward the end of the bitter congressional debate in 2010, the comparable gross revenue increase estimated in March 2010 was just $249 billion for the first 10 years.[20]

Subtracting the revenue effects of the insurance subsidies in the exchange and small business tax credits, and accounting for rounding and other adjustments, yields a rise in net revenue of $503 billion over 10 years. That leaves a net "cost" for the insurance expansions—its addition to budget deficits estimated by the CBO's conventional scoring—of $1.38 trillion over the next 10 years. That, too, approaches twice the increase estimated for the first 10 years at the time of enactment.[21]

The CBO's most recent estimates could be altered by other factors that are difficult to predict. The most important is how the law's complex combination of mandates, penalties, and subsidies will affect the behavior of employers and employees and their existing health insurance coverage. Of the 25 million persons who will obtain coverage in the government exchanges by 2024, the vast majority will be eligible for insurance subsidies. The law's combination of employer tax penalties and generous premium subsidies for low-income persons could encourage more companies to cut back or discontinue their health coverage, resulting in larger than anticipated jumps in enrollment in the government exchanges.

The CBO says that 7 million to 8 million fewer persons will have employment-based coverage by 2016.[22] Independent analysts, however, looking solely at the competing incentives of cheap tax penalties for employers who do not offer coverage and more expensive insurance costs for maintaining it, have been more pessimistic about the numbers of those able to retain their job-based health coverage. If the CBO's conservative estimates are wrong, and millions more enter the exchanges who were previously insured at their place of work, the costs of the premium subsidies would skyrocket, fueling significantly larger deficits.

All these seemingly dry figures have huge implications for both the government's troubled fiscal policy and the immense health care sector.

First, according to the CBO's latest figures, over the next 25 years *all* the growth in the government's future noninterest spending as a share of the economy will come from just a few major programs—Social Security, Medicare, Medicaid, and the ACA. A full two-thirds of that spending will flow from the giant health care entitlements. Of that increase in health spending, 62 percent will result from the ACA's government exchange insurance subsidies and Medicaid expansions.[23] Federal government spending was already projected to continue outgrowing the economy over the long term, inviting permanent deficits and stifling debt.[24] The Affordable Care Act recklessly accelerates this trend.

Second, nearly half of the nation's roughly $3 trillion in total health care spending comes from federal, state, or local governments—and their share is

19. Congressional Budget Office, "Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act," April 2014, Table 1 and Table 3. Other revenue effects include, for example, changes in taxable income due to employment disincentives resulting from the legislation's benefit structure.
20. Congressional Budget Office, analysis of the Patient Protection and Affordable Care Act (H.R. 3590) as passed by the Senate, and the Reconciliation Act of 2010 (H.R. 4872), March 20, 2010, Table 2.
21. Congressional Budget Office, "Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act," April 2014, Table 1 and Table 3; and, analysis of the Patient Protection and Affordable Care Act (H.R. 3590) as passed by the Senate, and the Reconciliation Act of 2010 (H.R. 4872), March 20, 2010, Table 2.
22. Congressional Budget Office, "Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act," p. 4. The CBO has also varied its estimates about the number of people who would be transitioned out of employment-based health insurance.
23. Congressional Budget Office, *The 2014 Long-Term Budget Outlook*, July 2014, Box 1-1, pp. 22–23, http://www.cbo.gov/sites/default/files/45471-Long-TermBudgetOutlook_7-29.pdf (accessed November 12, 2014). See also Alyene Senger, "Government Spending on Health Care Projected to Rapidly Increase," The Daily Signal, July 16, 2014, http://dailysignal.com/2014/07/16/government-spending-healthcare-projected-rapidly-increase/.
24. Congressional Budget Office, *The Long-Term Budget Outlook*, June 2009, Table 1-2, http://www.cbo.gov/sites/default/files/06-25-ltbo.pdf (accessed November 12, 2014).

growing. Medicare and the federal portion of Medicaid account for nearly one-third.[25]

The rapid growth in government health care spending reflects an extension of government's reach and control over Americans' lives. This has major economic, as well as political, costs. Government spending is reliably less efficient than the private sector's, in part because with government, the market disciplines—intense plan or provider competition, consumer choice, profit motivation, and rational pricing reflecting the conditions of supply and demand—are muted or nonexistent. Consequently, the federal government's latest venture in nationalizing health care will surely worsen the widely acknowledged economic inefficiencies that already plague the health care sector. The result will be higher health insurance premiums, higher direct medical costs, higher taxes, or a combination of all three.

This is a principal reason why the ACA's outlays—not its deficits—are the crucial measure of the legislation's fiscal impact. In fundamental ways, the ACA, like government in general, *is* what it *spends*.[26]

Uncertain Savings and Revenues

"It is hard to remember it now," wrote the distinguished political scientist James Q. Wilson two decades ago, "but there once was a time, lasting from 1789 to well into the 1950s, when the debate over almost any new proposal was about whether it was *legitimate* for the government to do this at all."[27] The once-honored balanced budget norm offered a simple and straightforward test of legitimacy: Government should be limited to taxpayers' willingness and ability to finance it. The ACA's massive spending, however, was justified by today's sterile, judgment-free standard of "deficit neutrality."

This is the modern version of "pay-as-you-go," which no longer renounces deficit spending, but instead *ratifies* existing imbalances, however great, as the measure of budget "discipline." Thus, the congressional practice, codified a month before the ACA's enactment,[28] actually rationalizes today's chronic borrowing and debt, and justifies any expansion of government under its pretense of fiscal "responsibility."[29]

To satisfy this budgetary relativism, the ACA's authors wrapped its expensive coverage components in a collection of highly doubtful spending reductions and tax hikes, and also exploited out-and-out estimating gimmicks. This discussion covers only a sampling of these maneuvers. Because most are still unfolding, their full effects remain to be seen—and the budgetary projections may well prove as unreliable and unrealistic as critics have warned.

Medicare Provider Cuts. The ACA contains 165 Medicare provisions[30] that on net aim to offset some of the hefty costs of the law's insurance expansions. From a budgetary standpoint, the most important of these provisions are those that modify, reduce, or cut Medicare provider payments. The largest set of these reductions affect Medicare Part A: payments for hospitalization, nursing homes, home health agencies, and hospice care organizations. The next largest set falls in Medicare Part C: the reductions,

25. Centers for Medicare and Medicaid Services, "National Health Expenditure Data: 2012–2022," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html (accessed November 12, 2014). These figures do not include the hundreds of billions of dollars of tax breaks to employers who sponsor group health plans for their employees.
26. Allen Schick, *The Federal Budget: Politics, Policy, and Process*, 3rd Edition (Washington, DC: Brookings Institution Press, 2007), p. 2.
27. James Q. Wilson, "The Rediscovery of Character: Private Virtue and Public Policy," in Wilson, *On Character* (Washington, D.C.: The AEI Press, 1995), p. 19.
28. The Statutory Pay-As-You-Go (PAYGO) Act of 2010, Public Law 111–139.
29. Essentially, pay-as-you-go requires that any legislation that would increase deficits relative to current projections—whether due to higher spending or tax reductions—must "pay for" the effect with commensurate spending cuts or tax increases elsewhere, so that the legislation remains "deficit neutral." As explained by the January 2012 Congressional Budget Office Glossary: "The procedure was first created in the Deficit Control Act [the Balanced Budget and Emergency Deficit Control Act of 1985], which expired at the end of 2006; a similar procedure was resurrected in the Statutory Pay-As-You-Go Act of 2010. PAYGO may also refer to the Senate rule (first established in 1993) or the House rule (first established in 2007) that prohibits the consideration of direct spending or revenue legislation that is not deficit neutral within certain time periods."
30. *2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, p. 1 and Appendix A, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2010.pdf (accessed November 12, 2014).

over time, of payments to health plans in the Medicare Advantage program.

In Part A, the key modification was the adjustment of payments based on higher productivity targets—standards borrowed from private manufacturing. Independent analysts called attention to some inherent weaknesses with applying these standards to the delivery of health care services. The main problem is that health care is inherently labor intensive, with far less latitude for providers to secure increased productivity through the application of technological innovation that obtains in the much more heavily automated manufacturing sector. Hence, the Medicare Actuary judged the Part A cuts to be simply unrealistic:

> It is possible that health care providers could improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long-range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.[31]

Shortly after the ACA's enactment, the actuaries at the Centers for Medicare and Medicaid Services (CMS) projected that by 2019, 15 percent of these providers would be running in the red. If the payment reductions remained in place, 25 percent of Medicare providers would have "negative" profit margins by 2030, and 40 percent by 2050; Medicare providers would not be able to sustain such losses, the actuaries said, and would either have to withdraw from the program or shift even more costs to the private sector.[32] Thus, instead of reducing the general level of health care costs—a stated goal of the ACA—the law would increase health care costs in the private sector.

A more recent analysis indicates that the outlook has worsened. In July of this year, the actuaries wrote that under their calculations, "[b]y 2040, approximately half of hospitals, two-thirds of skilled nursing facilities (SNFs), and 90 percent of home health agencies (HHAs) would have negative facility margins"—or in plain English, would be operating at a loss. "Over the long range," the actuaries concluded, "the simulations suggest that, absent other modifications, significant financial pressure will arise for providers, increasing the possibility of access and quality of care issues for Medicare beneficiaries."[33]

The Medicare provider payment cuts in general were intended to slow the growth in Medicare spending, a goal broadly shared across partisan and ideological lines. In 2010, the Chief Actuary at CMS estimated that the initial 10-year savings for all the ACA's Medicare payment reductions would amount to $575 billion by 2019. In a July 2012 analysis of a potential repeal of the ACA, the CBO indicated that those provisions would yield net savings of about $716 billion for the later period of 2013 to 2022.[34]

Taken together, all the Medicare payment provisions were projected to slow the Medicare spending growth per beneficiary to well below the rate of the prior two decades. Medicare's growth rate has, in fact, slowed down, particularly in Parts A and D, but the specific reasons are a matter of ongoing dispute among economists and health policy analysts.[35]

31. *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, "Appendix C. Illustrative Alternative Projections," pp. 205–210, http://downloads.cms.gov/files/TR2013.pdf (accessed November 12, 2014).
32. John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures Under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," Centers for Medicare and Medicaid Services, August 5, 2010, p. 6, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/2010TRAlternativeScenario.pdf (accessed November 12, 2014).
33. Office of the Actuary, Centers for Medicare and Medicaid Services, "Simulations of Affordable Care Act Medicare Payment Update Provisions on Part A Provider Financial Margins," July 8, 2014, http://cms.hhs.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ACAmarginsimulations2014.pdf (accessed November 12, 2014).
34. Congressional Budget Office estimate of the Repeal Obamacare Act (H.R. 6079), July 24, 2012, p. 14, http://www.cbo.gov/sites/default/files/43471-hr6079.pdf (accessed November 12, 2014).
35. While analysts often suggest that the recent sluggishness in the general economy has dampened health care spending generally, the Medicare changes may also reflect changes in provider or patient behavior. In any case, as a matter of historical record, Medicare's price controls, tightened up with the ACA, will probably not have a permanent impact on Medicare spending any more than previous congressional attempts, such as the ill-fated reimbursement cuts in the Balanced Budget Act of 1997.

The larger question, in terms of the ACA's budgetary impact, is whether the law's scheduled payment reductions can be sustained. In December 2009, analyzing an early version of the legislation, the CBO expressed skepticism on that very point:

> It is unclear whether such a reduction in the growth rate could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or would reduce access to care or diminish the quality of care.[36]

Although the CBO did not use the term, the latter would, in effect, constitute *rationing* Medicare beneficiaries' services. One cannot receive more medical services of the same or higher quality by paying progressively less for them. The CBO repeated the warning in its final estimate before the ACA's enactment.[37]

The CBO and the Medicare Trustees also questioned savings to be achieved by the new Independent Payment Advisory Board (IPAB). IPAB is charged with recommending, if necessary, changes in certain Medicare payment categories to hold costs per beneficiary below the average of rising medical prices and the consumer price index—an ambition the CMS Chief Actuary promptly questioned:

> [L]imiting cost growth to a level below medical price inflation alone would present an exceedingly difficult challenge. Actual Medicare cost growth per beneficiary was below the target level in only 4 of the last 25 years, with 3 of those years immediately following the Balanced Budget Act [BBA] of 1997; the impact of the BBA prompted Congress to pass legislation in 1999 and 2000 moderating many of the BBA provisions.[38]

Most of the ACA's vaunted Medicare savings, it should be noted, would result not from reforming the program's fundamentally flawed administrative payment system, but by wrenching further reductions through its anachronistic, top-down, price-fixing mechanisms.

The "Doc Fix" Shell Game. One of the cost-reduction measures in the 1997 Balanced Budget Act was a new payment update formula for Medicare physicians called the sustainable growth rate (SGR). Under the formula, if Medicare physicians' payments in any given year increase by more than the economy's growth, an automatic and proportionate reduction in their reimbursements is imposed the following year. By 2003, the mechanism had begun to bite deeply, and so Congress began to routinely circumvent its own handiwork by adopting a series of temporary adjustments preventing the SGR's reductions from taking effect. This practice, known as the "doc fix," is now a fixture of Washington policymaking and a monument to the absurdity of Medicare's administrative pricing. During the 2009 congressional debate on the ACA, the enforcement of the SGR threatened Medicare physicians with a 21 percent reduction in their reimbursements.

Early versions of the national health legislation included a full repeal of the SGR. At the time, however, that repeal would have added about $210 billion in Medicare spending over 10 years compared with the levels projected under then-current law. So, lawmakers simply shuffled off this additional cost to a stand-alone bill. "But passing a permanent doc fix separately does not change the fact that it increases federal spending," observed James C. Capretta, formerly a senior official at the Office of Management and Budget (OMB) during the Bush Administration.[39] It did, however, obscure the real cost of the congressional action and ensured a more favorable budget score for the President's signature legislative achievement.

The deception continues today. Congress never did pass a permanent doc fix—a repeal of the SGR—

36. Congressional Budget Office analysis of the Patient Protection and Affordable Care Act, Senate Amendment 2786 in the nature of a substitute to H.R. 3590, December 19, 2009, http://www.cbo.gov/sites/default/files/12-19-reid_letter_managers_correction_noted.pdf (accessed November 12, 2014).
37. Congressional Budget Office, analysis of the Patient Protection and Affordable Care Act (H.R. 3590) as passed by the Senate, and the Reconciliation Act of 2010 (H.R. 4872).
38. Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Centers for Medicare and Medicaid Services, April 22, 2010, p. 10, http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf (accessed November 12, 2014).
39. James C. Capretta, "The Real Budgetary Impact of the House and Senate Health Bills," Heritage Foundation *WebMemo* No. 2756, January 14, 2010, http://thf_media.s3.amazonaws.com/2010/pdf/wm_2756.pdf.

but instead has continued resorting to temporary extensions of existing physician payment rates. The most recent, under the Protecting Access to Medicare Act of 2014 (Public Law 113–93), maintains the current rates through March 31, 2015; after that date, the CBO's Medicare spending projections once again assume a major reduction in physicians' reimbursements—again estimated at 21 percent—required by the SGR.[40] As a result, the CBO's "current law" estimates project lower overall Medicare spending, and smaller budget deficits, than are likely to occur based on Congress's past actions. It is noteworthy that the Medicare trustees, in a concession to political reality, have abandoned this assumption.[41]

Double-Counting Medicare Reductions. Beyond the implausibility of their Medicare savings, the ACA's proponents had the audacity to claim them twice: first to help offset the cost of the law's insurance expansions (using the pay-as-you-go procedure), and second to extend the solvency of the Medicare hospital insurance (HI) trust fund (under trust fund accounting methods). When asked whether this flagrant double-count was legitimate, the CBO replied simply: "Our answer is basically no."[42]

Contrary to claims of the Administration's allies in Congress and elsewhere, the ACA's Medicare savings would be received by the government only *once*; they could not be set aside to finance future Medicare benefits and *also* pay for other government spending.[43] As Medicare's Chief Actuary Richard S. Foster stated: "In practice, the improved HI financing cannot be simultaneously used to finance 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."[44]

Yet this duplicity, too, persists. The Medicare savings in the total ACA package did help the legislation obtain a favorable cost estimate before enactment, aiding its passage. Today both the Medicare trustees and the CBO still assume those constraints in their projections of Medicare's fiscal outlook, which now suggest a modest improvement in the HI trust fund's solvency. Thus, the savings are still counted twice. As Blahous and Capretta have warned, this double-counting is paving the way for a future fiscal collision: "The government now has on its books two large, expensive and permanent entitlement commitments—the health law's premium subsidies and the Medicare hospital insurance program—yet Congress has only identified enough resources to pay for one of them."[45]

The CLASS Act Scheme. The ACA also relies on a number of tax increases and other receipts to offset the high cost of the coverage expansions. Many of these provisions are uncertain or unpopular, which casts doubt on their projected revenue gains.

One major subterfuge has already been discarded, but it illustrates the policy contortions used to disguise the ACA's true costs. It was the Community Living Assistance Services and Support (CLASS) Act, a provision of the law intended to finance long-term care. Lawmakers conjured the arrangement to front-load premium payments into a trust fund long before participants would begin receiving benefits, resulting in $70.2 billion in "savings" for 2010 through 2019. These premiums, however, were not considered payments to the government; under one of Congress's Orwellian estimating conventions, they are classified as "offsetting receipts," and counted as negative outlays.[46] Thus, the practice gives the impression that the government is spending less when, in fact, it is merely collecting more.[47]

40. Congressional Budget Office, *The 2014 Long-Term Budget Outlook*, p. 16.
41. *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, p. 2.
42. Congressional Budget Office, "Effects of the Patient Protection and Affordable Care Act on the Federal Budget and the Balance in the Hospital Insurance Trust Fund," December 23, 2009, http://www.cbo.gov/publication/25017 (accessed November 12, 2014).
43. Ibid.
44. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," p. 9.
45. Charles P. Blahous and James C. Capretta, "Exposing the Medicare Double Count," *The Wall Street Journal*, May 1, 2012, http://online.wsj.com/articles/SB10001424052702304299304577346332422834276 (accessed November 12, 2014).
46. Congressional Budget Office letter to Representative George Miller, Chairman of the House Committee on Education and Labor, November 25, 2009, http://www.cbo.gov/sites/default/files/class_additional_information_miller_letter.pdf (accessed November 12, 2014), and CBO letter to Senator Thomas R. Harkin, Chairman of the Senate Committee on Health, Education, Labor, and Pensions, November 25, 2009, http://www.cbo.gov/sites/default/files/class_additional_information_harkin_letter.pdf (accessed November 12, 2014).
47. Committee for a Responsible Federal Budget, "The Budget Act at 40: Time for a Tune Up?" July 14, 2014, p. 4, http://crfb.org/sites/default/files/crfb_budget_act_at_40_-_time_for_a_tune_up.pdf (accessed November 12, 2014).

The CLASS Act revenues never materialized. The program was so badly designed and fiscally unstable that even Health and Human Services officials determined they simply could not make it work. Overlooked in the Administration's insistence that the law would reduce deficits was a contrary assessment by the CMS Office of the Actuary that the new long-term care program would become an engine for adverse selection and explosive costs. In 2013, Congress, following the Department of Health and Human Services finding that it was unworkable, repealed the program. Hence, the CLASS Act revenues must be subtracted from the ACA balance sheets.

Other Unreliable Revenues. Several other major taxes needed to sustain the health care law are, to put it simply, political poison. The so-called medical device tax, effective since 2013, is one example. It is a 2.3 percent excise tax on the revenues of manufacturers and importers of medical devices, and it is profoundly unpopular within the health care industry. In its initial 2010 assessment, the CBO estimated that the tax would generate approximately $20 billion in revenues by 2019. In the first year of its implementation, it raised only $913.4 million, as opposed to a projected $1.2 billion, IRS officials reported; that was a shortfall of roughly 25 percent.[48] This initial failure is rooted in various compliance problems, typical of the ACA, including flawed IRS collection methods. Not surprisingly, the medical device tax attracts broad, bipartisan opposition. During the 2013 Senate budget debate, for example, 79 Senators voted for a non-binding resolution to repeal it.[49]

Another example is the ACA's tax on so-called Cadillac health plans. This 40 percent excise tax on "high value" health coverage is scheduled to take effect in 2018, and is projected to generate $120 billion in revenues by 2024.[50] Whether the tax is ever levied, however, is open to serious question. It is, in effect, a middle-class tax hike highly unpopular with organized labor and many large corporations. More than eight of 10 affected taxpayers would be those who earn less than $200,000 annually. Further, because of the way the tax is indexed, its impact on the working population would spread rapidly over time.

Medicare Taxes. Then there are the ACA's two new Medicare taxes, effective since 2013. Those affected are individuals with annual incomes greater than $200,000 and married couples with incomes exceeding $250,000. The CBO estimates that these two measures would secure $318 billion in revenues by 2022, the largest revenue sources in the ACA.[51]

The first is a 3.8 percent tax on the "unearned income" of wealthy citizens. The new tax is to be applied to dividends or income from stocks, bonds, securities, rental income, and, in certain cases, even the sale of a home. Such a new tax on investment income is unprecedented and bound to be controversial. Remarkably, the revenues are not even exclusively earmarked for financing the Medicare program.

The second levy is a 0.9 percent increase in the Medicare payroll tax for upper-income persons; for them, the tax would rise from the standard 2.9 percent to 3.8 percent.

While packaged as a classic "tax on the rich," the Medicare payroll tax will relentlessly work its way deep into the middle class, because it is *not* indexed for inflation. In their 2013 *Annual Report*, the Medicare trustees say:

> Since current law does not index these income thresholds, over time an increasing proportion of workers and their earnings will become subject to the additional HI tax rate. Thus HI payroll tax revenues will increase steadily as a percentage of taxable payroll. (By the end of the long-range projection period, an estimated 80 percent of workers would pay the higher tax rate.)[52]

Almost by definition, a downward creeping Medicare payroll tax is politically vulnerable. It is more than likely that lawmakers will replicate the political dynamics of the equally unpopular "alternative

48. Peter Schroeder, "Report: Medical Device Tax Missing Revenue Mark," *The Hill*, August 19, 2014, http://thehill.com/policy/finance/215522-report-medical-device-tax-missing-revenue-mark (accessed November 12, 2014).
49. Ibid.
50. Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—April 2014 Baseline," Table 1, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-04-ACAtables2.pdf (accessed November 12, 2014).
51. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to Speaker John Boehner, U.S. House of Representatives, July 24, 2012.
52. *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, p. 30.

minimum tax" (AMT). Though originally focused on upper-income individuals, the AMT was structured to invade the precincts of middle-income taxpayers. Because Congress has periodically blocked the AMT from ensnaring middle-income tax filers, it is hard to imagine a future Congress not protecting these constituents from the new ACA Medicare tax.

Mandate Taxes. The ACA imposes two direct taxes aimed at compelling the purchase of government-approved health insurance. One of these levies—commonly referred to as a "mandate"[53]—applies to individuals who do not have coverage, and the other, to "large" employers (those with 50 or more full-time employees) who fail to provide such coverage for their workers. The Administration broadened the "hardship" exemption for the individual tax for the next two years, while delaying compliance with the employer tax for one year.

Revenue projections for both over the next three years are already below the original CBO estimates. The individual tax, the CBO says, would generate $46 billion in revenues between 2015 and 2024.[54] Compared to their 2012 forecast, CBO analysts now project that in 2016 individual levies would be $3 billion less, and the majority of the estimated 30 million uninsured persons would be exempt. Curiously, most of these revenues would come from low-income and lower-middle-income persons.[55]

In its 2014 update of the ACA's finances, the CBO says that the employer mandate tax would generate $139 billion by 2024.[56] While the Administration delayed compliance for one year (from 2014 to 2015), some prominent supporters of the law, such as Timothy S. Jost, professor of law at Washington and Lee University, as well as senior analysts at the Urban Institute, are calling for its repeal.[57] In that case, of course, Congress would somehow have to recover the $139 billion in lost revenue over 10 years, or let deficits expand by that amount.

Dueling Deficit Estimates. Apart from the dubious nature of these savings provisions, Medicare trustee Blahous has identified a more fundamental problem related to the way in which they are measured. Specifically, in an extensive report published by the Mercatus Center at George Mason University,[58] he has argued that the ACA's projected Medicare savings were overstated because they were predicated on an overestimate of Medicare's future spending growth: The figures were derived from a budgetary convention, not from actual law.

By law, Blahous explained, the HI program (Medicare Part A) can pay benefits only up to the limits of resources in its trust fund. Before the ACA's enactment, that fund was expected to become insolvent in 2017. Consequently, Medicare benefits and spending would be sharply reduced starting at that point. The CBO estimates for the ACA, however, disregarded

53. In its June 2012 ruling on the individual mandate, the Supreme Court concluded that this provision (26 U.S. Code §5000A) could stand as a tax upon individuals who do not hold a government-determined minimum level of health coverage, but not as a requirement to purchase such insurance, as proponents had sought. The latter, the Court said, would have vastly expanded Congress's power to regulate commerce. As Chief Justice John G. Roberts wrote for the Court: "The Federal Government does not have the power to order people to buy health insurance. Section 5000A would therefore be unconstitutional if read as a command. The Federal Government does have the power to impose a tax on those without health insurance. Section 5000A is therefore constitutional because it can reasonably be read as a tax." The application remains the same either way, but the decision might have other constitutional and legal implications. As the Congressional Research Service has written: "[T]he Court's decision creates a new limitation on Congress's authority to act under the Commerce Clause—that Congress can only regulate commercial activity, not compel an individual to engage in it." See the Supreme Court's ruling in *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services et al.*, June 28, 2012, and Congressional Research Service, "NFIB v. Sebelius: Constitutionality of the Individual Mandate," September 3, 2012.
54. Congressional Budget Office, "Payments of Penalties for Being Uninsured Under the Affordable Care Act: 2014 Update," June 2014, p. 1, http://www.cbo.gov/publication/45397 (accessed November 12, 2014).
55. The CBO projects that in 2016, 50 percent of the individual mandate tax penalty payers will be in the range of under 100 percent to 299 percent of the federal poverty level. Ibid., p. 2.
56. Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's April 2014 Baseline," Table 1, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-04-ACAtables2.pdf (accessed November 12, 2014).
57. Timothy S. Jost, "Repeal, and Replace, The Employer Mandate," *Health Affairs* Blog, June 4, 2014, http://healthaffairs.org/blog/2014/06/04/repeal-and-replace-the-employer-mandate/ (accessed November 12, 2014); and Linda J. Blumberg, John Holahan, and Matthew Buettgens, "Why Not Just Eliminate the Employer Mandate?" Urban Institute *In Brief*, May 2014, http://www.urban.org/UploadedPDF/413117-Why-Not-Just-Eliminate-the-Employer-Mandate.pdf (accessed November 12, 2014).
58. Blahous, "The Fiscal Consequences of the Affordable Care Act."

this premise and instead assumed that future Medicare benefits would be paid as scheduled, regardless of the trust fund's status—which the CBO formally defends as an estimating requirement.[59]

Blahous acknowledged the suitability of this method in many circumstances. "Among other things," he wrote, "it quantifies the gaps between scheduled benefits and scheduled revenues for policymakers."[60] Still, had the CBO based its projections on actual law, it would have estimated much lower future spending for Medicare, and hence smaller savings from the ACA reductions. "Perhaps the best and most accurate way to think through the issue," Blahous wrote, "is to appreciate that were it not for the Medicare savings in the ACA, other Medicare savings measures would have been necessary under prior law to avert HI Trust Fund insolvency."[61] The Medicare trustees' annual report confirms Blahous's point.[62]

Blahous also explains that by extending the solvency of the HI Trust Fund, the ACA made the overall fiscal outlook *worse*:

> The savings envisioned within Medicare under the ACA would not only be used to finance a new health entitlement, but would also result in an expansion of the spending authority of the Medicare Part A (HI) Trust Fund. The combination of these two effects exceeds the cost-saving measures in the legislation. This results in a worsening of federal deficits relative to previous law.[63]

Blahous thus estimated that the ACA would swell deficits by $340 billion to $530 billion between 2012 and 2021.[64]

A more recent estimate, by Republican staff analysts of the Senate Budget Committee, concluded that the total package of ACA components would end up increasing deficits by $131 billion over the next 10 years. The committee staff arrived at the figure through several steps, fully described in the Senate Budget Committee report. First, the committee analysts extrapolated from the CBO's July 2012 estimate for repealing the ACA—the last comprehensive assessment of the ACA's total package of provisions—to reach the current budget window, 2015 through 2024. They then accounted for numerous changes and adjustments by the CBO since 2012. These included Administration changes in the law, technical adjustments in the CBO's projections of health care spending, updated economic forecasts, and the depressing labor effects of the ACA's subsidies and taxes, which would reduce tax revenue.[65]

These contrasting estimates expose a fundamental flaw in using mere deficit management as a principal measure of fiscal responsibility. Even if all the ACA's savings and tax provisions were sound and sustainable, estimating their effects depends on the methodologies employed, and on a puzzle of complex and variable assumptions that are themselves no more than estimates. At the end of this Kafkaesque endeavor, the only certainty is that the results will change with the next projection. The one sure way to control the budget is to control spending—a principle clearly ignored by the sponsors of the utterly misnamed Affordable Care Act. As Blahous observes: "A more complete analysis of the likely fiscal effects of the ACA must recognize that the legislation employs comparatively uncertain cost-saving measures as budgetary offsets for comparatively certain cost-increasing provisions."[66]

59. Congressional Budget Office, *The 2012 Long-Term Budget Outlook*, June 2012, p. 62. The CBO reiterated the point in its *2014 Long-Term Budget Outlook*, published in July.
60. Blahous, "The Fiscal Consequences of the Affordable Care Act," p. 15.
61. Ibid., pp. 15–17.
62. *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, p. 2.
63. Blahous, "The Fiscal Consequences of the Affordable Care Act," p. 16.
64. Ibid., pp. 16 and 45.
65. U.S. Senate Committee on the Budget, Republicans, "Analysis of CBO Data Shows that Obamacare Will Increase Deficit Over Next Decade," October 14, 2014, http://www.budget.senate.gov/republican/public/index.cfm/budget-background?ID=e2e8ae56-17b9-4898-98ea-ca118a755468 (accessed November 12, 2014).
66. Blahous, "The Fiscal Consequences of the Affordable Care Act," p. 11.

The Vanishing Deficit Reduction

Confirming the uncertainty of these strenuously devised offsets, their fiscal effects have since slipped out of sight and can no longer be tracked separately. As *Roll Call* reported on June 4:

> Four years after enactment of what is widely viewed as President Barack Obama's key legislative achievement, it's unclear whether the health care law is still on track to reduce the deficit or whether it may actually end up adding to the federal debt. In fact, the answer to that question has become something of a mystery.[67]

Several other news outlets and commentators followed up on this startling discovery—but in fact it was not news at all, and it had nothing to do with the President's numerous changes in the law's coverage components.

As early as August 2010, in its first *Budget and Economic Outlook* after the ACA's enactment, the CBO wrote:

> In cases where the new laws affected an existing flow of spending or revenues—such as Medicare outlays or income tax receipts—their effects will not be separately identifiable. Therefore, comparing all elements of the laws' ultimate impact with the amounts estimated at the time of their enactment will not be possible.[68]

Put more simply, the moment President Obama signed his national health care legislation, the various policies extraneous to the coverage components dissolved into the vast sea of overall federal spending and revenues. As the CBO more recently explained: "[T]he problem is common to all legislation that changes existing federal programs or tax provisions with results that cannot be clearly distinguished from what would have occurred under previous law."[69]

Measuring the incremental effects of changes to programs such as Medicare and Medicaid, wrote the CBO, would require constructing a "counterfactual" baseline for comparison—one that would estimate how those programs would have unfolded absent the ACA. The budget agency itself described that as "a challenging undertaking that is beyond the scope of the CBO's usual analyses." It would require, for instance, numerous assumptions about what Medicare payment rates would have been, and how they would have affected the behavior of providers and enrollees.[70]

Nevertheless, the CBO can still track the coverage components of the law, as it did from the very beginning:

> In cases where PPACA and the Reconciliation Act created a new flow of spending or revenues that is tracked separately—such as outlays for the subsidies provided through the insurance exchanges or collections of new excise taxes—the direct effects will be observable and can be compared with the original estimates.[71]

That is what the CBO's projections since enactment demonstrate.

The CBO was able to construct two more analyses that implied the updated costs of the overall legislation. These were estimates of repealing all the provisions enacted under the ACA. The most recent calculation, assembled in July 2012, indicated that eliminating the law's coverage components would save a net of $1.171 trillion between 2013 and 2022; repealing its non-coverage spending cuts and tax hikes would increase deficits by a total of $1.28 trillion. The net result, the CBO concluded, would be a 10-year deficit increase of $109 billion.[72] Obvious-

67. Paul M. Krawzak, "Fiscal Diagnosis Only Gets Tougher for Health Care Law," *Roll Call*, June 4, 2014.
68. Congressional Budget Office, "The Budget and Economic Outlook: An Update," August 2010, Box 1-1, http://www.cbo.gov/sites/default/files/08-18-update.pdf (accessed November 13, 2014).
69. Congressional Budget Office, "Answers to Questions for the Record Following a Hearing on the Budget and Economic Outlook for 2014 to 2024 Conducted by the Senate Committee on the Budget," June 10, 2014, http://www.cbo.gov/sites/default/files/45396-QFR-SBC.pdf (accessed November 13, 2014).
70. Ibid.
71. Congressional Budget Office, "The Budget and Economic Outlook: An Update." August 2010.
72. Congressional Budget Office analysis of the Repeal Obamacare Act (H.R. 6079), July 24, 2012, https://www.cbo.gov/sites/default/files/43471-hr6079.pdf (accessed November 18, 2014).

ly, the figures are not directly comparable to earlier or more recent estimates, due to the different time periods.

This does not necessarily suggest, however, that the cost of the national health law would simply be the reverse of these figures. Estimators would have to make assumptions about how the repeal would be implemented and, more important, how consumers and the health care sector would respond.[73]

In short, a CBO score on repeal would be imperfect and the true fiscal impact of the sweeping ACA legislation will never be known.

Time to Focus on Spending

The many budgetary failings of the Affordable Care Act reflect far more than technical or procedural flaws in the practice of congressional budgeting. The law's authors manipulated budget practices and conventions in any way necessary—and largely divorced from fiscal reality—to conjure the necessary illusion of fiscal responsibility in their massive new entitlement program. Their actions demonstrated a deliberate disregard for serious fiscal policymaking that will surely aggravate the government's malignant spending and deficits. It is noteworthy that 2010, when the ACA was enacted, was the last fiscal year for which the House and Senate agreed on a budget resolution, the essential instrument for setting congressional fiscal policy. Thus it culminated a long-developing breakdown of budgeting from which Congress has not yet recovered. Absent a regular and assertive practice of budgeting, lawmakers will ensure their own ultimate irrelevance, and give rise to a permanent, imperial executive.

The incoming 114th Congress faces the imperative of restoring the practice of budgeting. This is necessary both to begin reining in runaway spending—which, under current trends, will produce crushing and uncontrollable deficits and debt—and to recover Congress's viability as a governing institution. To reclaim its constitutional power of the purse, the new Congress should take guidance from two principal lessons of the ACA.

First, Congress must establish sound fiscal norms of the kind that the balanced budget principle once provided. Since that broadly accepted commitment dissolved after the 1950s, no other standard has truly filled the void. Various Congresses and Administrations have instituted myriad rationalistic techniques intended to manage the government's sprawling revenue and spending accounts, backed by extensive technical and economic justifications. They have manufactured "disciplines" such as "pay-as-you-go," which aims not to reduce deficits but merely to maintain them—and does so through the alchemy of highly complex and conditional calculations. Some earnest observers have focused on alternative, economically significant measures, such as the ratio of government debt to gross domestic product—though economists cannot agree on what a sustainable maximum level might be. Nothing has commanded a political consensus, embraced by the American public and their representatives, the way the balanced budget did. Without such a conviction, fiscal policy will remain adrift.

Second, Congress must recognize *spending* as its principal budgetary concern. Deficits and debt are clearly important, and are sufficient criteria for policy neutral institutions such as the CBO. The job of Congress, however, is to *make* policy—which includes deciding the proper size and scope of government. In the budgetary context, this is measured by spending, the root cause of all other fiscal consequences. Therefore, in restoring or reforming the budget process—and in considering any future legislation—Congress should focus on limiting what government spends. That is the most reliable approach for gaining control of fiscal policy, and determining the limits of government itself.

The ACA's Path to Budgetary Collapse

The Affordable Care Act epitomizes modern progressives' model of governance: faith in bureaucratic expertise and a commitment to centralized planning. Massive government expansions spawned by this ideology typically share two common features. "In almost every instance," wrote Professor Wilson, "leaders proposing a new policy erred in the direction of understating rather than overstating future costs; in almost every instance, evidence of a good inten-

73. The CBO has noted, for example, that estimating the effects of repeal would entail numerous assumptions concerning the ACA's effects on the health care sector and government medical programs—which would be imperfect. Consequently, the budget effects of the ACA are not simply the reverse of repealing it. Congressional Budget Office, "Answers to Questions for the Record Following a Hearing on the Budget and Economic Outlook for 2014 to 2024 Conducted by the Senate Committee on the Budget."

tion was taken to be government action rather than inaction."[74] The predictable result has been chronic borrowing to finance excessive levels of government; "pay-as-you-go" has been redefined from a commitment to balancing budgets to a rationale for permanent deficit spending and debt.

To satisfy this relativistic standard of fiscal discipline, the congressional sponsors of the ACA combined its insurance expansions with a collection of questionable savings policies that threaten to destabilize the health sector, particularly the Medicare program. The exercise reflected the many limits and contortions that result from Congress's arcane budgeting practices. Yet after all the tricks and policy maneuvers, and the dubious claims of deficit reduction, Congress's official budget estimators now say that they have no way of determining what the overall measure's true costs and deficit effects will be—even if all the policies are maintained as written.

Consequently, the law's supporters must embrace an almost mystical faith in its capacity for deficit reduction. This entails an entire subset of complementary beliefs: that Medicare providers will be able to improve productivity at unprecedented rates; that the Independent Payment Advisory Board will make enforceable recommendations to keep Medicare spending growth at targeted levels; that the law's numerous new taxes will go into effect as scheduled; and above all, that Congress will maintain these policies despite certain and widespread resistance. That drama is still playing out.

What can be known is what was clear from the start: The essence of the national health law—its insurance subsidies and entitlement expansions—vastly extend government authority and government health care spending. The certainty of the ACA's massive spending combined with the uncertainty, or absence, of serious cost savings is a virtual guarantee of deficit increases. As the law advances, its reckless overreach threatens to hasten the deterioration of Washington's increasingly unstable fiscal condition.

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74. Wilson, "The Rediscovery of Character: Private Virtue and Public Policy.".