

**The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays
and Total National Health Care Expenditures**

Testimony before the
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by

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Chairman Ryan, Representative Van Hollen, distinguished Committee members, thank you for inviting me to testify today about the impact of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, on the Medicare and Medicaid programs and on total health expenditures in the U.S.

I would like to begin by saying a little about the role of the Office of the Actuary at the Centers for Medicare & Medicaid Services. We have the responsibility to provide actuarial, economic, and other technical assistance to policy makers in the Administration and Congress on an independent, objective, and nonpartisan basis. Our highest priority is to help ensure that policy makers have the most reliable technical information possible as they work to sustain and improve Medicare and Medicaid. The Office of the Actuary has performed this role on behalf of Congress and the Administration since the enactment of these programs over 45 years ago. We have also provided actuarial estimates for various past national health reform initiatives, including the proposed Health Security Act in 1993-1994 and the Affordable Care Act as it was developed and enacted in 2009-2010.

I am appearing before your Committee today in my role as an independent technical advisor to Congress. My statements, estimates, and other information provided in this testimony are my own and do not represent an official position of the Department of Health & Human Services or the Administration. Unless noted otherwise, the estimates used in this testimony are drawn from my memorandum of April 22, 2010, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended." This memorandum and the other documents to which I refer are available on the CMS website at <http://www.cms.gov/ActuarialStudies/>. We are in the process of updating many of these estimates for use in the President's 2012 Budget and in a forthcoming article on national health expenditure projections. Although some of the updates will be significant, they will not substantially change the overall outlook for the financial effects of the Affordable Care Act as described in this testimony.

Affordable Care Act

The March 2010 health care reform legislation, generally known as the Affordable Care Act, affects nearly every aspect of health care in the U.S. Among its many provisions expected to have a significant financial effect, the Act:

- Mandates coverage for health insurance in 2014 and later.
 - Establishes Health Insurance Exchanges.
 - Provides Federal subsidies for Exchange insurance premiums and cost-sharing requirements.
 - Provides temporary tax credits for small businesses that offer health coverage.
 - Imposes penalties on some individuals who forgo coverage.
 - Imposes penalties on large employers that do not offer health insurance to workers.
- Expands Medicaid eligibility and makes other changes to Medicaid and the Children’s Health Insurance Program (CHIP).
 - Increases income threshold from less than 100 percent of Federal Poverty Level (FPL) to 138 percent.
 - Extends coverage to those without specific non-income qualifying factors (e.g., disability).
 - Increases Medicaid prescription drug rebates.
 - Reduces Medicaid disproportionate share hospital (DSH) expenditures.
 - Introduces Medicaid “Community First Choice Option” and other changes to encourage home and community-based services.
 - Raises Federal matching rates for States with existing childless-adult coverage expansions.
 - Temporarily increases Medicaid payments to primary care physicians.
 - Extends CHIP funding for 2014 and 2015.
- Implements numerous Medicare changes.
 - Permanently reduces Medicare payment updates for most categories of providers by the increase in economy-wide multifactor productivity (approximately 1.1 percent per year).
 - Reduces Medicare Advantage payment benchmarks and permanently extends the authority to adjust for coding intensity.
 - Reduces Medicare DSH payments and refines imaging payments.
 - Creates an Independent Payment Advisory Board together with Medicare expenditure growth rate targets.
 - Increases the HI payroll tax rate by 0.9 percentage point for individuals with earnings above \$200,000 and families above \$250,000 and raises Part D premiums for single enrollees with incomes above \$85,000 or couples above \$170,000.
 - Phases out the Part D coverage gap (“donut hole”).
 - Initiates numerous quality- and coverage-related Medicare provisions, including reporting of physician quality measures, reducing payments in cases involving hospital-acquired infections, reducing readmissions, and implementing evidence-based coverage of preventive services.
 - Creates a Center for Medicare and Medicaid Innovation in CMS for testing alternative models of health care delivery systems, payment methods, etc. and establishes a Medicare Shared Savings Program for accountable care organizations (ACOs).

- Implements certain immediate insurance reforms.
 - Minimum coverage requirements.
 - Pre-existing Condition Insurance Plan for those uninsured for at least 6 months.
 - Federal reinsurance for employer-sponsored early retiree plans.
 - Expansion of dependent coverage to age 26.
- Creates Federal Community Living Assistance Services and Supports (CLASS) long-term care insurance program.
- Supports comparative effectiveness research.
- Adds new taxes and fees.
 - Excise tax on high-cost employer health plans.
 - Taxes or fees on insurance plans, prescription drug manufacturers, device makers.
 - Additional 0.9-percent HI payroll tax on high earners.
 - Additional 3.8-percent tax on high investment returns, other non-earnings income.

As described in more detail in my April 22, 2010 memorandum, the Affordable Care Act is estimated to reduce the number of uninsured persons in the U.S. by 34 million in 2019. Approximately 18 million would gain Medicaid coverage as a result of the expansion of eligibility criteria. (In addition, roughly 2 million people with employer-sponsored health insurance would enroll in Medicaid for supplemental coverage.) Another 16 million uninsured persons would receive individual insurance coverage through the newly created Exchanges, with the majority of these qualifying for Federal premium and cost-sharing subsidies. Finally, we estimate that the number of individuals with employer-sponsored health insurance would decrease slightly overall, reflecting both gains and losses in such coverage under the Affordable Care Act.

Estimated impact of Affordable Care Act on Federal expenditures

The table shown on the following page presents the estimated financial effects of selected provisions in the Affordable Care Act on the Federal Budget in fiscal years 2010-2019. For convenience of presentation, the provisions of the legislation are grouped into six major categories:

- (i) Coverage provisions, which include the mandated coverage for health insurance, the expansion of Medicaid eligibility, and the additional funding for CHIP;
- (ii) Medicare provisions;
- (iii) Medicaid and CHIP provisions other than the coverage expansion and CHIP funding;
- (iv) Provisions aimed in part at changing the trend in health spending growth;
- (v) The CLASS program; and
- (vi) Immediate health insurance reforms.

The estimated costs and savings shown in the table are based on the effective dates specified in the law as enacted. We assume that employers and individuals would take roughly 3 to 5 years to fully adapt to the new insurance coverage options and that the enrollment of additional individuals under the Medicaid coverage expansion would be completed by the third year of implementation. Because of these transition effects and the fact that most of the coverage provisions would be in effect for only 6 of the 10 years of the budget period, the cost estimates shown in this memorandum do not represent a full 10-year cost for the new legislation.

Estimated Federal costs or savings under selected provisions of the Affordable Care Act
[Costs (+) or savings (-) in billions]

Provisions	Fiscal Year										Total, 2010-19
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	
Total*	\$9.2	-\$0.7	-\$12.6	-\$22.3	\$16.8	\$57.9	\$63.1	\$54.2	\$47.2	\$38.5	\$251.3
Coverage†	3.3	4.6	4.9	5.2	82.9	119.2	138.2	146.6	157.6	165.8	828.2
Medicare	1.2	-4.7	-14.9	-26.3	-68.8	-60.3	-75.2	-92.1	-108.2	-125.7	-575.1
Medicaid/CHIP	-0.9	-0.9	0.8	4.5	8.6	5.1	4.6	3.4	1.3	1.7	28.3
Cost trend‡	—	—	—	—	-0.0	-0.1	-0.2	-0.4	-0.6	-0.9	-2.3
CLASS program	—	-2.8	-4.5	-5.6	-5.9	-6.0	-4.3	-3.4	-2.8	-2.4	-37.8
Immediate reforms	5.6	3.2	1.2	—	—	—	—	—	—	—	10.0

* Excludes Title IX revenue provisions except for sections 9008 and 9015, certain provisions with limited impacts, and Federal administrative costs.

† Includes expansion of Medicaid eligibility and additional funding for CHIP.

‡ Includes estimated non-Medicare Federal savings from provisions for comparative effectiveness research, prevention and wellness, fraud and abuse, and administrative simplification. Excludes impacts of other provisions that would affect cost growth rates, such as the productivity adjustments to Medicare payment rates (which are reflected in the Medicare line) and the section 9001 excise tax on high-cost employer plans.

As indicated, the provisions in support of expanding health insurance coverage (including the Medicaid eligibility changes and extended CHIP funding) are estimated to cost \$828 billion through fiscal year 2019, net of penalty receipts from nonparticipating individuals and employers. The Medicare, other Medicaid and CHIP, growth-trend, CLASS, and immediate reform provisions are estimated to result in net savings of about \$577 billion, leaving a net overall cost for this period of \$251 billion before consideration of additional Federal administrative expenses and the increase in Federal revenues that would result from the excise tax on high-cost employer-sponsored health insurance coverage and certain other revenue provisions. (The new Supplementary Medical Insurance revenues from fees on brand-name prescription drugs under section 9008 of the Affordable Care Act, and the higher Hospital Insurance payroll tax income under section 9015, are included in the estimated Medicare savings shown here.) The Congressional Budget Office and the Joint Committee on Taxation have estimated that the total net amount of Medicare savings and additional tax and other revenues would somewhat more than offset the cost of the national coverage provisions, resulting in an overall reduction in the Federal deficit through 2019.

Estimated impact of Affordable Care Act on Medicare expenditures and revenues

Net Medicare savings are estimated to total \$575 billion for fiscal years 2010-2019. Substantial savings are attributable to provisions that would, among other changes, reduce Part A and Part B payment levels and reduce future “market basket” payment updates by the increase in economy-wide multifactor productivity (\$233 billion); eliminate the Medicare Improvement Fund (\$27 billion); reduce DSH payments (\$50 billion); reduce Medicare Advantage payment benchmarks and permanently extend the authority to adjust for coding intensity (\$145 billion); freeze the income thresholds for the Part B income-related premium for 9 years (\$8 billion); implement an Independent Payment Advisory Board together with strict Medicare expenditure growth rate targets (\$24 billion); and increase the HI payroll tax rate by 0.9 percentage point for individuals with earnings above \$200,000 and families above \$250,000 (\$63 billion). Other provisions would generate relatively smaller amounts of savings, through such means as reporting physician quality measures, reducing payments in cases involving hospital-acquired infections, reducing readmissions, refining imaging payments, increasing Part D premiums for higher-income beneficiaries, and implementing evidence-based coverage of preventive services.

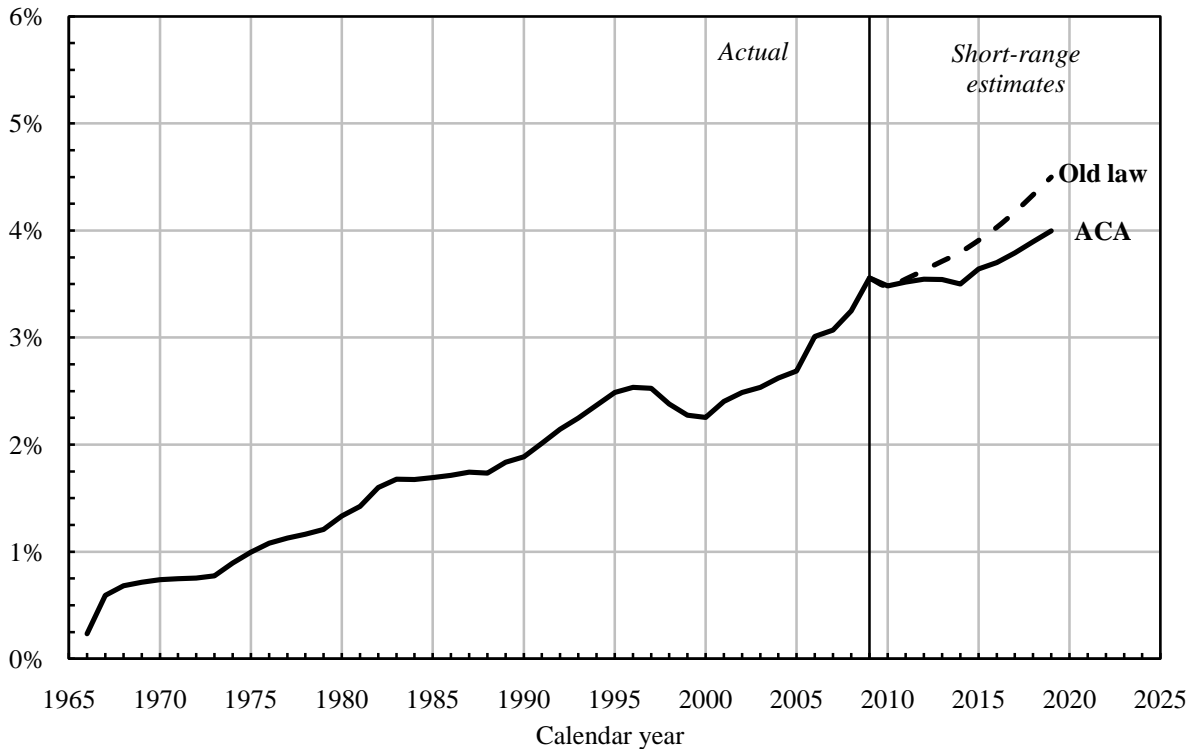
These savings are slightly offset by the estimated costs of closing the Part D coverage gap (\$12 billion); reducing the growth in the Part D out-of-pocket cost threshold (\$1 billion); extending a number of special payment provisions scheduled to expire, such as the postponement of therapy caps (\$5 billion); and improving preventive health services and access to primary care (\$6 billion).

As noted below, the Affordable Care Act authorizes a substantial program of research, development, and testing for innovative new health delivery systems and payment methods. This program has significant potential for improvements in the quality and cost efficiency of health care, but its effects on Medicare expenditures cannot be assessed until specific plans have been developed and tested.

The following chart shows actual past Medicare expenditures as a percentage of gross domestic product (GDP), together with estimated future amounts for 2010-2019 under the Affordable Care Act and under the prior law. Of the estimated net total Medicare savings of \$575 billion over this period, \$486 billion is attributable to a net reduction in Medicare expenditures (with the balance due to increased revenues from taxes and fees). The chart illustrates the expenditure impact only.

By 2019, the net reduction in Medicare expenditures is estimated to be 0.5 percent of GDP, which represents an 11-percent decrease from the level projected prior to the Affordable Care Act. This percentage reduction would grow larger over time as a result of the compounding effect of the slower annual updates in Medicare payment rates for most categories of health care providers.

Medicare expenditures before and after the Affordable Care Act
(as a percentage of GDP)



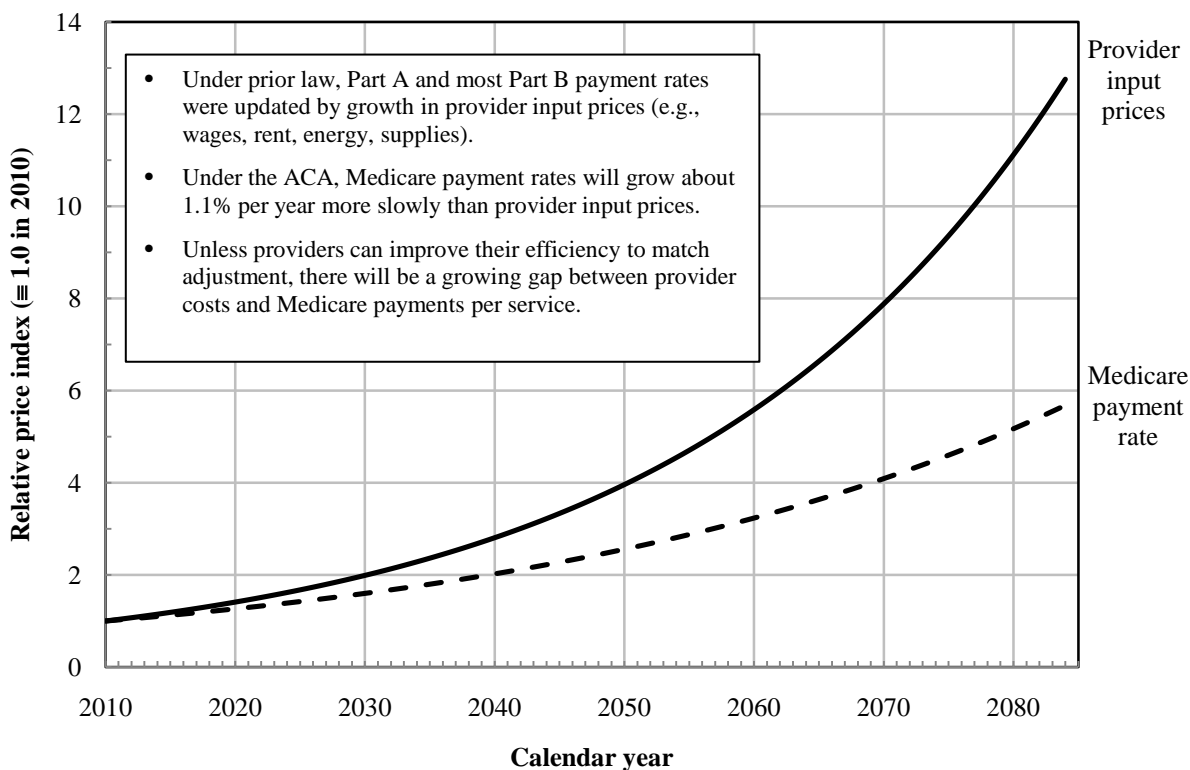
Based on the estimated savings for Part A of Medicare, the assets of the Hospital Insurance trust fund would be exhausted in 2029 compared to 2017 under the prior law—an extension of 12 years. The combination of lower Part A costs and higher tax revenues results in a lower Federal deficit based on budget accounting rules. However, trust fund accounting considers the same lower expenditures and additional revenues as extending the exhaustion date of the HI trust fund. 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. Conversely, expenditure reductions under Part B translate directly to lower financing requirements from general revenues and beneficiary premiums, since financing is re-established annually to match program costs. Thus, in the case of Part B, the savings under the Affordable Care Act are not needed to help pay for future benefit costs, and the full reduction in Federal general revenues attributable to such savings can be used to offset other Federal costs, such as those arising under the health reform coverage expansions. (Part D expenditures will increase under the Affordable Care Act, requiring additional Federal general revenue financing.) More detailed information on the financial status of the Medicare trust funds is available in the 2010 Medicare Trustees Report.

It is important to note that the estimated savings for one category of Medicare provisions may be unrealistic. The Affordable Care Act requires permanent annual productivity adjustments to price updates for most providers (such as hospitals, skilled nursing facilities, and home health agencies), using a 10-year moving average of economy-wide private, non-farm productivity

gains. While such payment update reductions will create a strong incentive for providers to maximize efficiency, it is doubtful that many will be able to improve their own productivity to the degree achieved by the economy at large.¹

The following chart illustrates the very large differential that would accumulate over long periods between the prices that health care providers have to pay to obtain the inputs they need to provide health care services and the corresponding Medicare payment rates. In practice, providers have few alternatives to paying market-based increases in wages and fringe-benefit costs for their employees. Similarly, price increases for office space, energy, utilities, and medical equipment and supplies are generally outside of providers' control.

Cumulative increase in provider input price vs. Medicare payment rate
(for providers subject to productivity adjustments under current law)



Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the providers' costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to

¹ The provision of most health services tends to be very labor-intensive. Economy-wide productivity gains reflect relatively modest improvements in the service sector together with much larger improvements in manufacturing. Except in the case of physician services, I am not aware of any empirical evidence demonstrating the medical community's ability to achieve productivity improvements equal to those of the overall economy. The Office of the Actuary's most recent analysis of hospital productivity highlights the difficulties in measurement but suggests that such productivity has been small or negligible during 1981 to 2005. (See <http://www.cms.hhs.gov/HealthCareFinancingReview/downloads/07-08Winterpg49.pdf>.)

remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries). Simulations by the Office of the Actuary suggest that roughly 15 percent of Part A providers would become unprofitable within the 10-year projection period as a result of the productivity adjustments.² Although this policy could be monitored over time to avoid such an outcome, changes would likely result in smaller actual savings than described here for these provisions.

In their 2010 report to Congress on the financial status of the program, the Medicare Board of Trustees cautioned:

The Affordable Care Act improves the financial outlook for Medicare substantially. However, the effects of some of the new law's provisions on Medicare are not known at this time, with the result that the projections are much more uncertain than normal, especially in the longer-range future. For example, the ACA initiative for aggressive research and development has the potential to reduce Medicare costs in the future; however, as specific reforms have not yet been designed, tested, or evaluated, their ability to reduce costs cannot be estimated at this time, and thus no specific savings have been reflected in this report for the initiative.

Another important example involves lower payment rate updates to most categories of Medicare providers in 2011 and later. These updates will be adjusted downward by the increase in productivity experienced in the economy overall. Since the provision of health services tends to be labor-intensive and is often customized to match individuals' specific needs, most categories of health providers have not been able to improve their productivity to the same extent as the economy at large. Over time, the productivity adjustments mean that the prices paid for health services by Medicare will grow about 1.1 percent per year more slowly than the increase in prices that providers must pay to purchase the goods and services they use to provide health care services. Unless providers could reduce their cost per service correspondingly, through productivity improvements or other steps, they would eventually become unwilling or unable to treat Medicare beneficiaries.

It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. Similarly, the implementation of payment and delivery system reforms, facilitated by the ACA research and development program, could help constrain cost growth to a level consistent with the lower Medicare payments. These outcomes are far from certain, however. Many experts doubt the feasibility of such sustained improvements and anticipate that over time the Medicare price constraints would become unworkable and that Congress would likely override them, much as they have done to prevent the reductions in physician payment rates otherwise required by the sustainable growth rate formula in current law.

The annual report to Congress on the financial status of Medicare must be based on current law. In this report, the productivity adjustments are assumed to occur in all future years, as required by the Affordable Care Act. In addition, reductions in Medicare payment rates for physician services, totaling 30 percent over the next 3 years, are assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override these latter reductions.

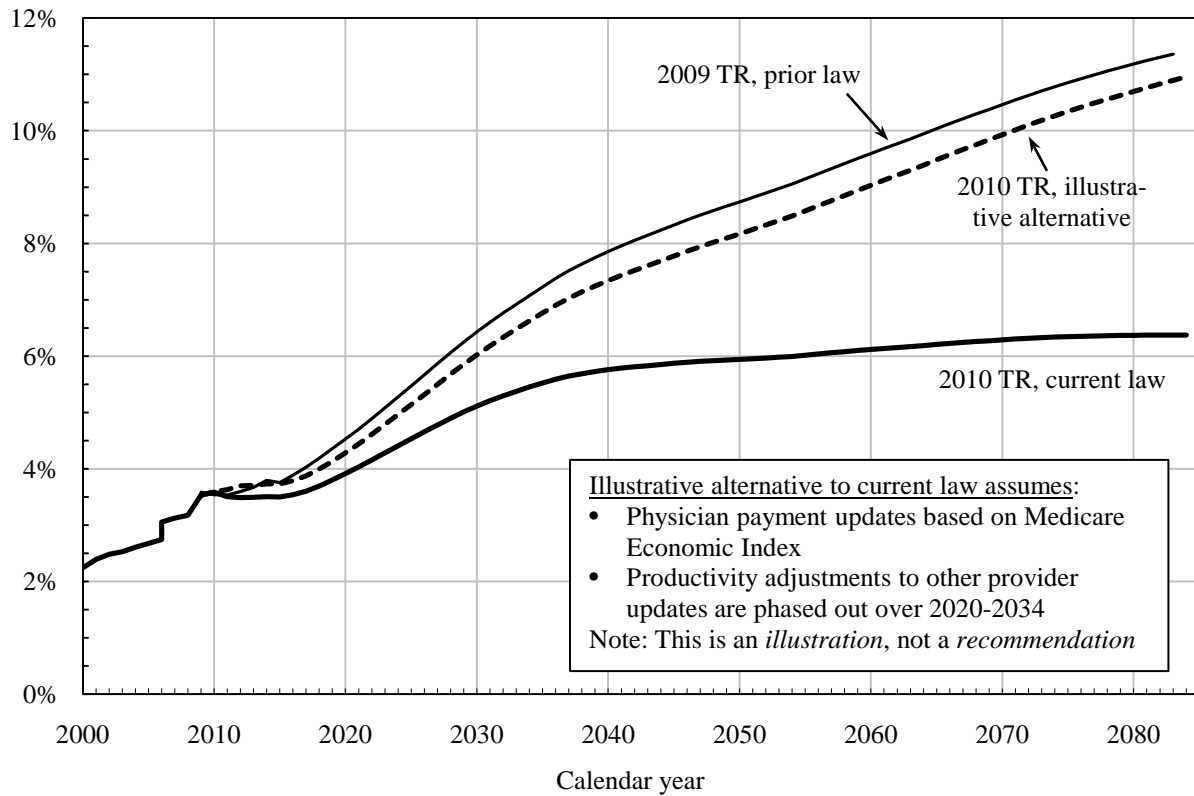
In view of the factors described above, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections in this report. We recommend that the projections be interpreted as an illustration of the very favorable financial outcomes that would be experienced if the productivity adjustments can be sustained in the long range—and we caution readers to

² The simulations were based on actual fiscal year 2007 Medicare and total facility margin distributions for hospitals, skilled nursing facilities, and home health agencies. Provider revenues and expenditures were projected using representative growth rates and the Office of the Actuary's best estimates of achievable productivity gains for each provider type, and holding all other factors constant.

recognize the great uncertainty associated with achieving this outcome. Where possible, we illustrate the potential understatement of Medicare costs and projection results by reference to an alternative projection that assumes—for purposes of illustration only—that the physician fee reductions are overridden and that the productivity adjustments are gradually phased out over the 15 years starting in 2020.

The following chart shows long-range projections of total Medicare expenditures, as a percentage of GDP, under three scenarios. The substantial impact of the Affordable Care Act on expenditures is apparent by comparing the current-law projections from the 2010 Trustees Report (which includes the effect of all ACA provisions) to the corresponding projections from the 2009 Trustees Report (pre-ACA). Medicare expenditures in 2030 are currently projected to be about 20 percent lower than shown in the 2009 report, primarily as a result of the Affordable Care Act provisions. By 2050 and 2080, the projected difference increases to 32 and 43 percent, respectively.

Long-range projections of Medicare expenditures under current law, prior law, and an illustrative alternative to current law
(as a percentage of GDP)



The growing difference between the current-law and prior-law projections in the long range is primarily attributable to the compounding effect of the slower Medicare price updates. To help assess the potential understatement of Medicare costs under current law, the Board of Trustees asked the Office of the Actuary to make projections under an illustrative alternative to current law. The alternative assumes that (i) Medicare payment updates for physicians would be based on the Medicare Economic Index, rather than the sustainable growth rate (SGR) formula, and

(ii) the productivity adjustments to most other categories of providers would be gradually phased out after 2019. As indicated in the chart above, Medicare costs under the illustrative alternative to current law would be substantially greater than the current-law projections. It is important to note that the illustration represents only a means by which to consider the potential understatement of costs under current law. No endorsement of the illustrative payment changes by the Trustees, CMS, or the Office of the Actuary should be inferred.

Estimated impact of Affordable Care Act on Medicaid and CHIP

The Affordable Care Act is estimated to add a total of \$455 billion to aggregate Medicaid expenditures during fiscal years 2010-2019, an increase of about 8 percent. Federal expenditures represent the great majority (\$434 billion) of this projected increase, equivalent to a 13-percent increase compared to prior law. State expenditures are projected to expand only \$21 billion (or about 1 percent). The Federal government participation is relatively larger than for current Medicaid expenditures because the Affordable Care Act specifies a much higher Federal matching rate for newly eligible beneficiaries, ranging from 100 percent in fiscal years 2014, 2015, and 2016 to 90 percent by 2020 and beyond.

The most significant provision, measured by its impact on expenditures and enrollment, is the expansion of Medicaid eligibility to all persons under age 65 living in families with incomes below 138 percent of FPL beginning in 2014. This expansion is projected to add more than 20 million Medicaid enrollees by 2019, an increase of about one-third compared to the prior law (including an estimated 2 million individuals with employer-sponsored health insurance who would enroll for supplementary coverage through Medicaid). About three-quarters of the additional enrollees are expected to be adults and the remaining one-quarter to be children.³ The percentage increase in Medicaid expenditures will be considerably lower than the increase in enrollment, since adults and children have much lower average health care costs than aged and disabled enrollees.

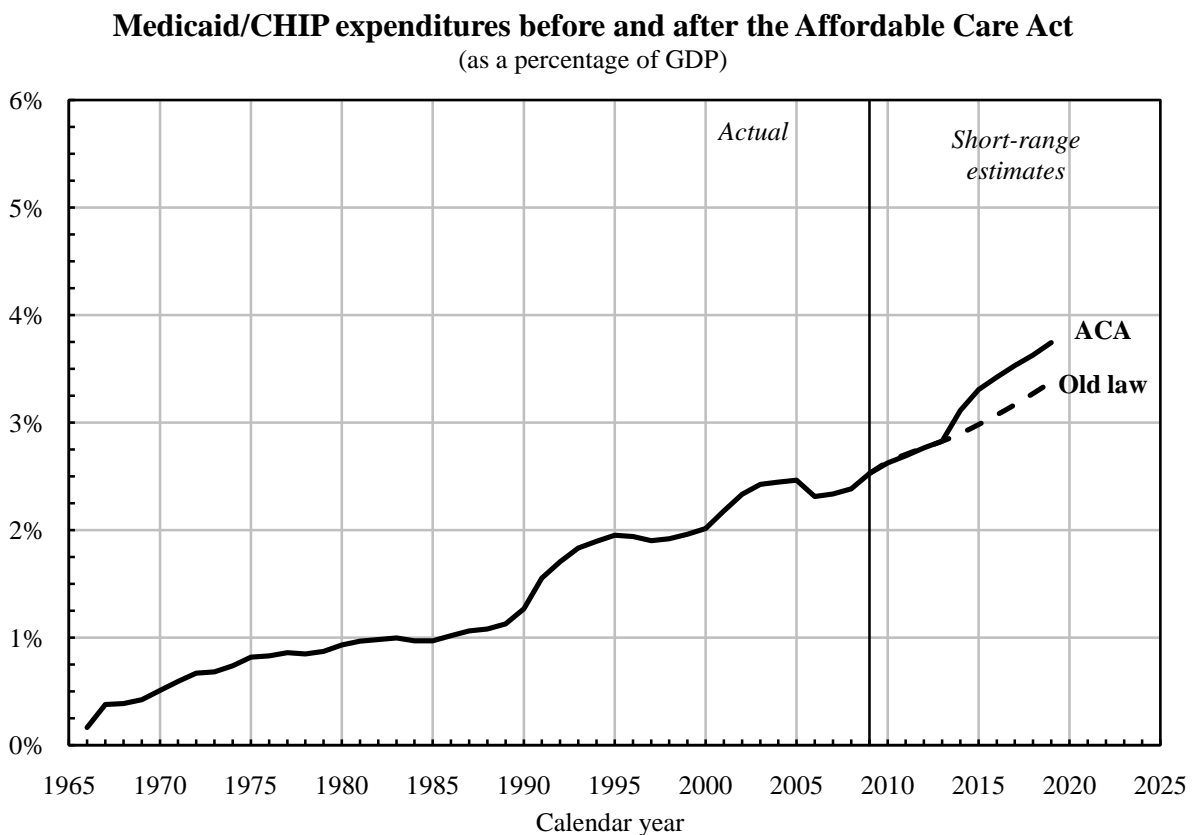
The Affordable Care Act also provides for additional funding for the CHIP program, for 2014 and 2015, which would increase such expenditures by an estimated \$29 billion.

The total net Federal cost of the other Medicaid and CHIP provisions is estimated to be \$28 billion in fiscal years 2010-2019 and reflects numerous cost increases and decreases under the individual provisions. Those with significant Federal savings include various provisions increasing the level of Medicaid prescription drug rebates (\$24 billion) and reductions in Medicaid DSH expenditures (\$14 billion). Interactions between the different sections of the Affordable Care Act, such as the lower Medicare Part B premiums, contribute an additional \$9 billion in reduced Medicaid outlays.

³ In addition to the higher level of allowable income, the Affordable Care Act expands eligibility to people under age 65 who have no other qualifying factors that would have made them eligible for Medicaid under prior law, such as being under age 18, disabled, pregnant, or parents of eligible children. The estimated increase in Medicaid enrollment is based on an assumption that Social Security benefits would continue to be included in the definition of income for determining Medicaid eligibility. If a strict application of the modified adjusted gross income definition is instead applied, as may be intended by the Act, then an additional 5 million or more Social Security early retirees would be potentially eligible for Medicaid coverage.

The key provisions that would increase Federal Medicaid and CHIP costs are the Medicaid “Community First Choice Option” and other changes to encourage home and community-based services (\$29 billion), higher Federal matching rates for States with existing childless-adult coverage expansions (\$24 billion), a temporary increase in payments to primary care physicians (\$11 billion), and increased payments to the Territories (\$7 billion). The net impact of the Medicaid and CHIP provisions on State Medicaid costs is a reduction totaling \$33 billion through fiscal year 2019. These savings result in part because certain of the provisions reallocate costs from States to the Federal government.

The following chart shows past Medicaid and CHIP expenditures (Federal plus State) as a percentage of GDP, together with 10-year projections under the Affordable Care Act and prior law.

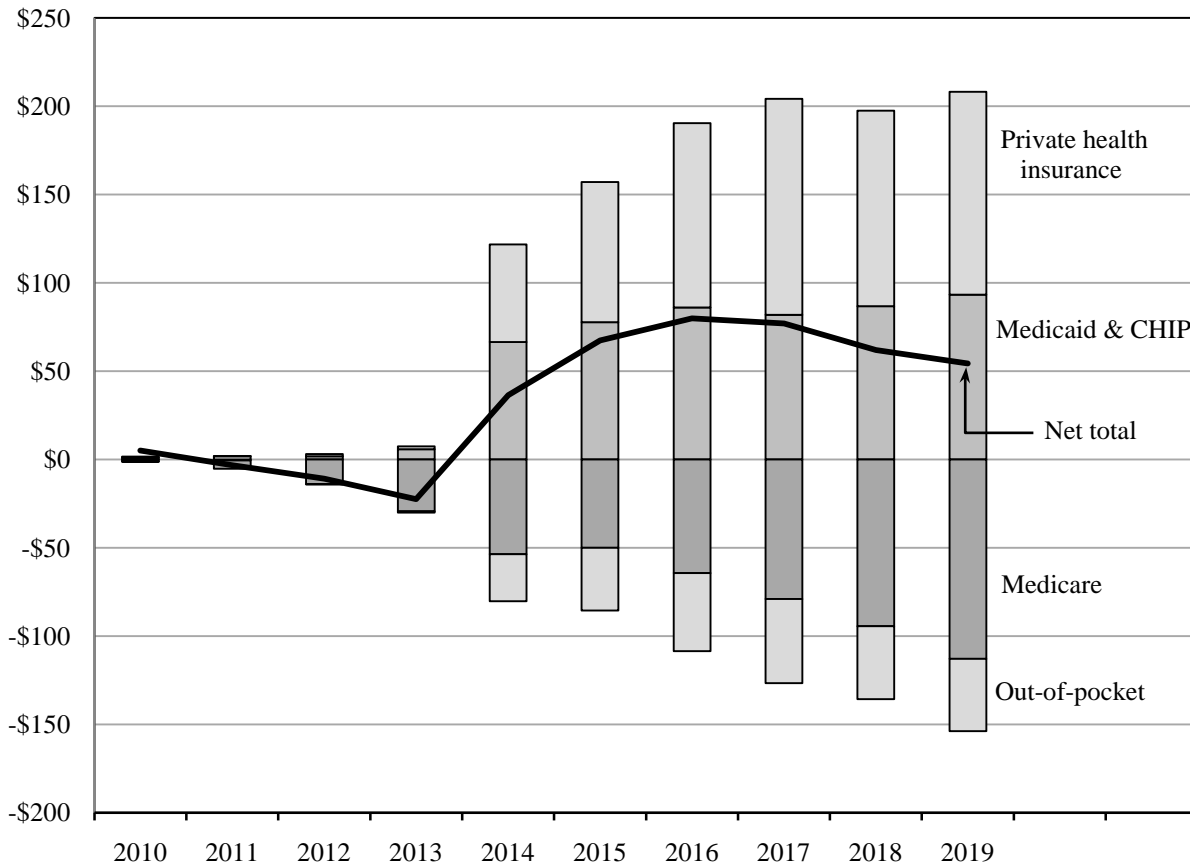


Estimated impact of Affordable Care Act on total national health expenditures

The estimated effects of the Affordable Care Act on overall national health expenditures (NHE) are shown by the “net total” curve in the following chart. In aggregate, we estimate that for calendar years 2010 through 2019, NHE would increase by \$311 billion, or 0.9 percent, compared to prior law. Year by year, the relative increases are largest in 2016, when the coverage expansions would be fully phased in (2.0 percent), and gradually decline thereafter to 1.0 percent in 2019.

Estimated effect of the Affordable Care Act on total national health spending

[Estimated increase (+) or decrease (-) in annual spending, in billions)



The net total increase in NHE reflects several large—and largely offsetting—effects on expenditures by private health insurance, Medicare, Medicaid, and individuals’ own out-of-pocket costs, as shown by the columns in the chart above. Health expenditures are expected to increase by about \$200 billion annually due to the substantial expansions of coverage under the Affordable Care Act. Numerous studies have demonstrated that individuals and families with health insurance use more health services than otherwise-similar persons without insurance. Under the health reform legislation, by 2019 an estimated 34 million currently uninsured people would gain comprehensive coverage through the health insurance Exchanges, their employers, or Medicaid. The availability of coverage would typically result in a fairly substantial increase in the utilization of health care services, with a corresponding impact on total health expenditures. These higher costs would be partially offset by the sizable discounts imposed on providers by State Medicaid payment rules and by the significant discounts negotiated by private health insurance plans. We estimate that the net effect of the utilization increases and price reductions arising from the coverage provisions of the Affordable Care Act would increase NHE in 2019 by about 3.4 percent.

The Affordable Care Act will also affect aggregate NHE through the Medicare savings provisions. We estimate that these impacts would reduce NHE by roughly 2.4 percent in 2019, assuming that the productivity adjustments to Medicare payment updates can be sustained through this period. The legislation would have only a slight impact on the utilization of health care services by Medicare beneficiaries (subject to the caveat mentioned previously regarding possible access issues if Medicare payment rates become inadequate). As shown in the chart, the Medicare savings accumulate rapidly, principally due to the compounding effect of the slower payment updates for most categories of providers.

As indicated in the chart, out-of-pocket spending would be reduced significantly by the Affordable Care Act (an estimated net total decline of \$237 billion in calendar years 2010-2019). This reduction reflects the net impact of (i) the substantial coverage expansions through Medicaid and the health insurance Exchanges, (ii) the significant cost-sharing subsidies for low-to-middle-income persons with Exchange coverage, (iii) the maximum out-of-pocket limitations associated with the qualified health benefit, (iv) lower cost-sharing payments by beneficiaries in fee-for-service Medicare, (v) higher cost-sharing payments by Medicare Advantage enrollees, and (vi) the increases in workers' cost-sharing obligations in plans affected by the excise tax on high-cost employer-sponsored health insurance coverage.

A number of the other provisions in the Affordable Care Act would also affect national health expenditures during 2010-2019, although the magnitude of these effects would be much smaller than the financial effects of the coverage expansions and Medicare savings provisions. These other provisions include the immediate insurance reforms in Title I; comparative effectiveness research; the excise tax on high-cost employer health plans; fees on health insurance plans and on manufacturers and importers of brand-name prescription drugs; and an excise tax on non-personal-use retail sales by manufacturers and importers of medical devices. The effects of these provisions are included in the respective categories of national health expenditures shown in preceding chart.

Compared to prior law, the *level* of total national health expenditures is estimated to be higher through 2019 under the Affordable Care Act, but two particular provisions of the legislation would help reduce NHE *growth rates* after 2016. Specifically, the productivity adjustments to most Medicare payment updates would reduce NHE growth by about 0.10 to 0.15 percent per year. In addition, the excise tax on high-cost employer health plans would exert a further decrease in NHE growth rates of an estimated 0.05 percent in 2019 and slightly more than that for some years thereafter. Although these growth rate differentials are not large, over time they would have a noticeable downward effect on the level of national health expenditures. Such an outcome, however, would depend critically on the sustainability of both provisions. As discussed previously, the Medicare productivity adjustments could become unsustainable even within the next 10 years, and over time the reductions in the scope of employer-sponsored health insurance could also become an issue. For these reasons, the estimated reductions in NHE growth rates after 2016 may not be fully achievable.

Conclusions

The Affordable Care Act makes far-reaching changes to most aspects of health care in the U.S., including mandated coverage for most people, required payments by large employers not offering insurance, expanded eligibility for Medicaid, Federal premium and cost-sharing subsidies for many individuals and families, a new system of health benefits Exchanges for facilitating coverage, and a new Federal insurance program in support of long-term care. Additional provisions will reduce Medicare outlays, make other Medicaid modifications, provide more funding for the CHIP program, add certain benefit enhancements for these programs, and combat fraud and abuse. Federal revenues will be increased through an excise tax on high-cost insurance plans; fees or excise taxes on drugs, devices, and health plans; higher Hospital Insurance payroll taxes for high-income taxpayers; a new tax on investment revenues and other unearned income; and other provisions.

In our independent capacity as technical advisors to the Administration and Congress, the Office of the Actuary at CMS has estimated the effects of the non-tax provisions of the Affordable Care Act on Federal outlays, overall national health expenditures, and health insurance coverage in the U.S. Our estimates are based on available data sources and what we believe are reasonable assumptions regarding individual, employer, and health plan responses to the legislation, together with analyses of the likely changes in the cost and use of health care services. In view of the complexity and scope of these changes, estimates of their financial and other effects are necessarily very uncertain. As the Affordable Care Act provisions are finalized through regulations, and as providers, employers, and individuals respond to the requirements and opportunities in the legislation, we will continue to monitor developments and to update our estimates for Medicare, Medicaid, CHIP, and total national health expenditures as necessary.

I hope that the information presented here is of value to policy makers, and I pledge the Office of the Actuary's continuing assistance to the joint effort by the Administration and Congress to determine optimal solutions to the financial challenges associated with health care in the U.S. I would be happy to answer any questions you might have.