CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

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July 24, 2012

Honorable John Boehner
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

As you requested, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have estimated the direct spending and revenue effects of H.R. 6079, the Repeal of Obamacare Act, as passed by the House of Representatives on July 11, 2012. This estimate reflects the spending and revenue projections in CBO's March 2012 baseline as adjusted to take into account the effects of the recent Supreme Court decision regarding the Affordable Care Act (ACA).[1] H.R. 6079 would repeal the ACA, with the exception of one subsection that has no budgetary effect.[2]

In repealing the ACA, H.R. 6079 would restore provisions of law modified by that legislation as if the ACA had never been enacted. Among other things, H.R. 6079 would:

- Eliminate the requirement that most legal residents of the United States obtain health insurance or pay a penalty tax;

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1. See Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* (July 2012). The ACA comprises the Patient Protection and Affordable Care Act (Public Law 111-148) and the provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) that are related to health care. In addition to repealing the ACA itself, H.R. 6079 would also affect certain subsequent changes in statute. As used in this letter, the term "repealing the ACA" encompasses all of the effects of H.R. 6079.

2. That subsection relates to procedures for Congressional consideration of a proposal that the Independent Payment Advisory Board (or the Secretary of Health and Human Services) submits to the Congress as required under section 1899A of the Social Security Act. That provision has no effect on CBO and JCT's estimate of the budgetary effects of the ACA or its repeal.

- Eliminate insurance exchanges through which certain individuals and families will receive federal subsidies to substantially reduce the cost of purchasing health insurance coverage;

- Significantly reduce eligibility for Medicaid for residents of states that will choose to expand their programs under the ACA;

- Increase the rate of growth of Medicare's payment rates for most services (relative to the growth rates projected under current law);

- Eliminate the excise tax on health insurance plans with relatively high premiums;

- Eliminate certain taxes on individuals and families with relatively high incomes; and

- Make various other changes to the federal tax code, Medicare, Medicaid, and other programs.

Table 1 summarizes CBO and JCT's assessment of the changes in federal budget deficits that would result from the effects of H.R. 6079 on direct spending and revenues. Table 2 (on pages 5 and 6) shows more detail on the federal budgetary cash flows for direct spending and revenues associated with the legislation. Tables 3 and 4 (on pages 11 and 12) provide estimates of H.R. 6079's effects related to health insurance coverage: Table 3 shows changes in the number of nonelderly people in the United States who will have health insurance, and Table 4 shows the primary budgetary effects of the legislation's major provisions related to insurance coverage.

Impact on the Federal Budget in the First Decade

Assuming that H.R. 6079 is enacted near the beginning of fiscal year 2013, CBO and JCT estimate that, on balance, the direct spending and revenue effects of enacting that legislation would cause a net increase in federal budget deficits of $109 billion over the 2013–2022 period (see Table 1). That net increase in deficits from enacting H.R. 6079 has three major components:

- The ACA contains a set of provisions designed to expand health insurance coverage, which, on net, are projected to cost the government money. The costs of those coverage expansions—which include the cost of the subsidies to be provided through the

exchanges, increased outlays for Medicaid and the Children's Health Insurance Program (CHIP), and tax credits for certain small employers—will be partially offset by penalty payments from employers and uninsured individuals, revenues from the excise tax on high-premium insurance plans, and net savings from other coverage-related effects. By repealing those coverage provisions of the ACA, over the 2013–2022 period, H.R. 6079 would yield gross savings of an estimated $1,677 billion and net savings (after accounting for the offsets just mentioned) of $1,171 billion.[3]

- The ACA also includes a number of other provisions related to health care that are estimated to reduce net federal outlays (primarily for Medicare). By repealing those provisions, H.R. 6079 would increase other direct spending in the next decade by an estimated $711 billion.

- The ACA includes a number of provisions that are estimated to increase federal revenues (apart from the effect of provisions related to insurance coverage), mostly by increasing the Hospital Insurance (HI) payroll tax and extending it to net investment income for high-income taxpayers, and imposing fees or excise taxes on certain manufacturers and insurers. Repealing those provisions would reduce revenues by an estimated $569 billion over the 2013–2022 period.

Deficits would be increased under H.R. 6079 because the net savings from eliminating the insurance coverage provisions would be more than offset by the combination of other spending increases and revenue reductions. In total, CBO and JCT estimate that H.R. 6079 would reduce direct spending by $890 billion and reduce revenues by $1 trillion over the 2013–2022 period, thus adding $109 billion to federal budget deficits over that period (see Table 2). For various reasons discussed elsewhere in this document, the estimated budgetary effects of repealing the ACA by enacting H.R. 6079 are not equivalent to an estimate of the budgetary effects of the ACA with the signs reversed.

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3. The estimated net effects of repealing the coverage provisions of the ACA differ slightly from CBO and JCT's current projections of the budgetary effects of those provisions (see Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, July 2012). Some of the effects of changes made under the ACA that are captured in those projections would be expected to continue even if H.R. 6079 was enacted. For example, if H.R. 6079 was enacted, CBO does not expect health insurers to universally or immediately discontinue the coverage of preventive health benefits without copayments that is required by the ACA.

TABLE 1. ESTIMATE OF THE IMPACT ON THE DEFICIT THAT WOULD RESULT FROM THE DIRECT SPENDING AND REVENUE EFFECTS OF H.R. 6079, THE REPEAL OF OBAMACARE ACT

	By Fiscal Year, in Billions of Dollars											
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013-2017	2013-2022
NET CHANGES IN THE DEFICIT FROM INSURANCE COVERAGE PROVISIONS [a,b]												
Effects on the Deficit	-4	-45	-95	-130	-146	-146	-145	-146	-153	-160	-420	-1,171
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING [c]												
Effects on the Deficit of Changes in Outlays	1	37	50	51	59	74	90	103	117	129	199	711
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [d]												
Effects on the Deficit of Changes in Revenues	37	32	50	52	57	61	64	68	72	76	228	569
NET INCREASE OR DECREASE (-) IN THE DEFICIT [a]												
Effect on Deficits	**34**	**24**	**6**	**-26**	**-31**	**-12**	**9**	**25**	**36**	**44**	**7**	**109**
On-Budget	32	22	3	-32	-39	-23	-6	10	21	27	-14	14
Off-Budget [e]	2	2	3	6	8	12	14	15	16	17	21	95

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT).

Note: Numbers may not sum to totals because of rounding.

a. Does not include federal administrative costs that are subject to appropriation.

b. Includes excise tax on high-premium insurance plans.

c. These estimates reflect the effects of provisions affecting Medicare, Medicaid (other than the effects of provisions related to coverage), and other federal health programs, and include the effects of interactions between insurance coverage provisions and those programs.

d. The changes in revenues include effects on Social Security revenues, which are classified as off-budget. The 10-year total of $569 billion includes $565 billion in reduced revenues from tax provisions (estimated by JCT) apart from receipts from the excise tax on high premium insurance plans and $5 billion in reduced revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by CBO and JCT).

e. Off-budget effects include changes in Social Security spending and revenues as well as in spending by the U.S. Postal Service.

TABLE 2. ESTIMATED CHANGES IN DIRECT SPENDING AND REVENUES OF H.R. 6079, THE REPEAL OF OBAMACARE ACT

	By Fiscal Year, in Billions of Dollars											
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013-2017	2013-2022
CHANGES IN OUTLAYS FROM DIRECT SPENDING												
Health Insurance Exchanges												
Premium and Cost Sharing Subsidies	0	-23	-45	-74	-91	-101	-107	-111	-118	-123	-233	-793
Grants to States for the Establishment of Exchanges	*	-1	-1	*	*	0	0	0	0	0	-2	-2
Other Related Spending	-2	-1	*	*	*	*	*	*	*	*	-3	-3
Subtotal	-2	-24	-46	-75	-91	-101	-107	-111	-118	-123	-238	-798
Effects of Coverage Provisions on Medicaid and CHIP	-1	-26	-49	-62	-69	-77	-83	-86	-92	-99	-206	-643
Reinsurance and Risk Adjustment Payments [a]	0	-6	-17	-18	-20	-19	-21	-23	-25	-27	-61	-177
Medicare and Other Medicaid and CHIP Provisions												
Reductions in Annual Updates to FFS Payment Rates	4	14	21	25	32	42	53	64	75	86	96	415
Medicare Advantage Rates Based on FFS Rates	0	8	14	18	18	16	18	19	20	23	59	156
Medicare and Medicaid DSH Payments	0	*	3	4	6	8	10	9	9	6	14	56
Other Provisions	-1	18	15	7	6	10	13	14	16	18	44	114
Subtotal	3	41	54	54	61	77	94	105	121	133	213	741
Other Changes in Direct Spending												
Community Living Assistance Service and Supports [b]	0	0	0	0	0	0	0	0	0	0	0	0
Other Provisions [c]	-1	-3	-3	-1	*	-1	-1	*	-1	-2	-9	-14
Subtotal	-1	-3	-3	-1	*	-1	-1	*	-1	-2	-9	-14
Total Outlays	**-2**	**-18**	**-61**	**-102**	**-119**	**-121**	**-118**	**-115**	**-116**	**-119**	**-302**	**-890**
On-Budget	-2	-18	-61	-101	-118	-120	-117	-114	-115	-117	-299	-882
Off-Budget	0	*	-1	-1	-1	-1	-1	-1	-1	-1	-2	-8

Continued

TABLE 2. Continued

	By Fiscal Year, in Billions of Dollars											
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013-2017	2013-2022
CHANGES IN REVENUES												
Coverage-Related Provisions												
Exchange Premium Tax Credits	0	7	14	22	26	29	30	31	31	32	69	222
Small Employer Tax Credits	2	2	3	2	1	2	2	2	2	2	11	20
Penalty Payments by Uninsured Individuals	0	0	-3	-6	-7	-7	-7	-8	-9	-9	-15	-55
Penalty Payments by Employers	0	-4	-9	-10	-11	-12	-14	-15	-15	-16	-33	-106
Excise Tax on High-Premium Insurance Plans	0	0	0	0	0	-11	-18	-22	-27	-32	0	-111
Associated Effects of Coverage Provisions on Tax Revenues	-1	-3	-6	-14	-23	-29	-34	-36	-35	-37	-46	-216
Reinsurance and Risk Adjustment Collections [a]	0	-13	-16	-18	-18	-20	-22	-24	-26	-27	-65	-184
Other Provisions												
Fees on Certain Manufacturers and Insurers [d]	-10	-12	-15	-15	-18	-19	-18	-19	-20	-21	-69	-165
Additional Hospital Insurance Tax	-20	-10	-25	-29	-32	-35	-38	-41	-43	-46	-115	-318
Other Revenue Provisions	-7	-11	-10	-8	-7	-8	-8	-9	-9	-9	-44	-87
Total Revenues	**-36**	**-42**	**-67**	**-75**	**-88**	**-109**	**-127**	**-140**	**-152**	**-163**	**-308**	**-1,000**
On-Budget	-34	-40	-64	-69	-79	-97	-111	-124	-135	-145	-285	-896
Off-Budget	-2	-2	-3	-7	-9	-13	-16	-16	-17	-19	-23	-103
INCREASE OR DECREASE (-) IN THE DEFICIT [e]												
Net Effect on Deficits	**34**	**24**	**6**	**-26**	**-31**	**-12**	**9**	**25**	**36**	**44**	**7**	**109**
On-Budget	32	22	3	-32	-39	-23	-6	10	21	27	-14	14
Off-Budget	2	2	3	6	8	12	14	15	16	17	21	95

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: Does not include effects of spending subject to future appropriation. Numbers may not sum to totals because of rounding.

CHIP = Children's Health Insurance Program; FFS = fee-for-service; DSH = disproportionate share hospital.

* = between $0.5 billion and -$0.5 billion.

a. Reductions to risk-adjustment payments lag revenues shown later in the table by one quarter. The reduction in payments for reinsurance totals $20 billion over the 10-year period.

b. On October 14, 2011, the Secretary of the Department of Health and Human Services announced that she did not "see a viable path forward for CLASS implementation at this time." CBO considers that announcement to be definitive new information and as a result, CBO assumes that CLASS will not be implemented unless there are changes in law or other actions by the Administration that would supersede the Secretary's announcement. Legislation to repeal the provisions of law establishing the CLASS program are therefore estimated to have no budgetary effect relative to current law.

c. The 10-year total includes $30 billion in reduced outlays from non-coverage provisions that are not related to Medicare, Medicaid, or CHIP. This amount is partially offset by $16 billion in net increased outlays, which represents the outlay portion of several coverage-related provisions including small employer tax credits, penalty payments by employers, and associated effects of coverage provisions on tax revenues and outlays for Social Security benefits.

d. Amounts include repeal of fees on manufacturers and importers of branded drugs and on health insurance providers, and repeal of an excise tax on manufacturers and importers of certain medical devices.

e. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

In addition to those effects on direct spending and revenues, by CBO's estimates, repeal of the ACA would reduce the need for appropriations to the Internal Revenue Service by between $5 billion and $10 billion over 10 years. Repealing the ACA would also reduce the need for appropriations to the Department of Health and Human Services by between $5 billion and $10 billion over 10 years, CBO estimates. Such savings might be reflected in reductions in total discretionary spending, or they might free up room for additional spending for other purposes under the caps on discretionary appropriations that were established by the Budget Control Act of 2011.

Projections of the budgetary impact of H.R. 6079 are quite uncertain because they are based, in large part, on projections of the effects of the ACA, which are themselves highly uncertain. Assessing the effects of making broad changes in the nation's health care and health insurance systems requires estimates of a broad array of technical, behavioral, and economic factors. Separating the incremental effects of the provisions in the ACA that affect spending for ongoing programs and revenue streams becomes more uncertain as the time since enactment grows. The recent Supreme Court decision that essentially made the expansion of the Medicaid program a state option has also increased the uncertainty of the estimates. However, CBO and JCT, in consultation with outside experts, have devoted a great deal of care and effort to the analysis of health care legislation in the past few years, and the agencies have strived to develop estimates that are in the middle of the distribution of possible outcomes.

Implementing Repeal of the Affordable Care Act

If H.R. 6079 was enacted near the start of fiscal year 2013, a number of final rules and other administrative actions to implement the ACA (and some modifications to it that were subsequently enacted) will have taken effect or been finalized during the 2½ years since that law was enacted. H.R. 6079 does not specify how to implement the requirement that the provisions of law modified by the ACA be restored as if the ACA had never been enacted—for example, with regard to Medicare's payment rules and certain changes to the Internal Revenue Code that are already in operation. Because of that ambiguity, H.R. 6079 would cede considerable discretion to the executive branch to implement its provisions.

CBO and JCT cannot anticipate with certainty the choices that the executive branch agencies would make—particularly as they pertain to the retroactive changes in law. CBO and JCT expect that retroactive adjustments to spending programs and tax provisions would tend to be applied in ways that would, on net, cost the government money:

- For provisions related to the Medicare program, for example, CBO assumes that the Department of Health and Human Services would implement retroactive changes in payment rules that would increase spending (because there would be pressure from, or legal actions by, providers and other potential recipients), and would probably not be able to fully implement changes that would require recoupment of payments already made. CBO projects that the retroactive payments would be disbursed over the 2013–2015 period.

- Similarly, for some provisions that provided new tax benefits or increased existing tax benefits and have already been in effect, JCT and CBO expect that the Internal Revenue Service would not be able to recover the forgone revenues retroactively. For other provisions that are already in effect that created new or increased taxpayer liabilities, JCT and CBO expect that taxpayers would be able to file for a refund.

In addition, some provisions cannot be retroactively adjusted. For example, payment rates and subsidized benefits in the Medicare Advantage program and the Part D prescription drug program since the ACA was enacted were established in negotiated contracts. The benefits provided under those contracts cannot be adjusted retroactively. Therefore, CBO assumes that the payments made under those contracts would not be adjusted if H.R. 6079 was enacted.

CBO and JCT also anticipate that some of the changes induced by the ACA in how public and private health insurance and health care programs are administered would be sustained under H.R. 6079. In some cases, the ACA established deadlines that accelerated certain activities, such as expansion of the competitive bidding program for durable medical equipment in Medicare. CBO expects that expansion of that program would not revert to the slower schedule anticipated under prior law. Likewise, entities that pay for or provide health care have changed processes to comply with standards established pursuant to the administrative simplification provisions of the ACA, and long-term care facilities have changed prescribing processes to comply with a provision of the ACA that required those facilities to reduce certain wasteful practices. CBO expects that those already-implemented changes in processes will have a lasting impact even if the ACA is repealed.

Effects on Insurance Coverage and Their Budgetary Impact

H.R. 6079 would repeal all of the provisions of the ACA that are designed to expand insurance coverage as well as related provisions. Most of those provisions are scheduled to go into effect in January 2014. Under H.R. 6079, about 30 million fewer nonelderly people would have health insurance in 2022 than under current law, leaving a total of about 60 million nonelderly people uninsured (see Table 3). About 81 percent of legal nonelderly residents would have insurance coverage in 2022, compared with 92 percent projected under current law (and 82 percent currently).

That difference of 30 million in the number of uninsured people in 2022 reflects a number of changes relative to what will occur under current law. If H.R. 6079 was enacted, approximately 25 million people who will otherwise purchase their own coverage through insurance exchanges would not do so, and Medicaid and CHIP would have roughly 11 million fewer enrollees. Partly offsetting those reductions would be net increases, relative to the number projected under current law, of about 3 million people purchasing individual coverage directly from insurers and about 4 million people obtaining coverage through their employer.

CBO and JCT estimate that the repeal of the provisions of the ACA affecting health insurance coverage would result in a *net* decrease in federal deficits of $1,171 billion over fiscal years 2013 through 2022 (see Table 4).

That figure includes a $643 billion reduction in net federal outlays for Medicaid and CHIP and $1,013 billion in savings resulting from eliminating the exchange subsidies (and related spending). In addition, the repeal of the tax credit for certain small employers who offer health insurance is estimated to save $22 billion over 10 years.

Those *gross* savings of $1,677 billion through 2022 would be partly offset by lower revenues or higher costs, totaling $506 billion over the 10-year budget window, from four sources related to insurance coverage:

- Eliminating the penalty payments by uninsured individuals, which would reduce revenues by $55 billion over 10 years;
- Eliminating penalty payments by employers whose workers would receive subsidies via the exchanges, which would increase deficits by $117 billion over 10 years;

- Eliminating the excise tax on high-premium insurance plans, resulting in a decline in revenues of $111 billion over 10 years; and

- Other budgetary effects, mostly on tax revenues, associated with shifts in the mix of taxable and nontaxable compensation resulting from changes in employment-based health insurance coverage, which would increase deficits by $223 billion over 10 years.[4]

In addition to the federal budgetary effects, repealing the coverage provisions of the ACA would reduce states' spending for Medicaid and CHIP. Those provisions of the ACA will increase states' spending because states are required to pay a share of outlays for Medicaid and CHIP; consequently, under H.R. 6079, states' spending on Medicaid and CHIP would be less than under current law.[5] CBO estimates that enacting H.R. 6079 would reduce state governments' spending for Medicaid and CHIP for provisions related to coverage by $41 billion over the 2013–2022 period.

4. Changes in the extent of employment-based health insurance affect federal revenues because most payments for that coverage are tax-preferred. If employers increase or decrease the amount of compensation they provide in the form of health insurance (relative to current-law projections), CBO and JCT assume that offsetting changes will occur in wages and other forms of compensation—which are generally taxable—to hold total compensation roughly the same. Such effects also arise with respect to specific elements of the proposal (such as the tax credits for small employers), and those effects are included in the estimates for those elements.

5. Costs for Medicaid and CHIP are shared by the federal government and the states. The average federal share of spending typically has been 57 percent for Medicaid and 70 percent for CHIP. Under the ACA, the federal government will pay all of the costs for people made newly eligible for the Medicaid program through 2016, between 90 percent and 95 percent of their costs for 2017 through 2019, and 90 percent in 2020 and thereafter. Similarly, for CHIP the ACA increased the federal share of all costs for 2016 through 2019 from an average of 70 percent to an average of about 93 percent. Under H.R. 6079, the federal share of spending would remain, on average, 57 percent for Medicaid and 70 percent for CHIP.

TABLE 3. ESTIMATE OF THE EFFECTS OF H.R. 6079, THE REPEAL OF OBAMACARE ACT, ON HEALTH INSURANCE COVERAGE

	Millions of Nonelderly People, by Calendar Year									
Effects on Insurance Coverage [a]	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Current-Law Coverage [b]										
Medicaid and CHIP	35	41	44	42	42	42	42	43	43	43
Employer	158	156	155	154	155	155	156	157	156	157
Nongroup and Other [c]	25	24	25	26	26	28	28	28	28	28
Exchanges	0	9	14	23	25	26	26	25	25	25
Uninsured [d]	53	41	36	30	29	29	29	29	30	30
Total	271	272	274	275	277	280	280	282	283	284
Change										
Medicaid and CHIP	-1	-7	-9	-10	-10	-11	-11	-11	-11	-11
Employer	-1	2	3	5	5	6	6	5	4	4
Nongroup and Other [c]	*	1	1	2	2	3	2	2	3	3
Exchanges	0	-9	-14	-23	-25	-26	-26	-25	-25	-25
Uninsured [d]	2	14	20	26	28	28	28	29	30	30
Uninsured Population Under H.R. 6079										
Number of Uninsured Nonelderly People [d]	55	55	55	56	57	57	57	58	60	60
Insured Share of the Nonelderly Population [a]										
Including All Residents	80%	80%	80%	80%	80%	80%	80%	79%	79%	79%
Excluding Unauthorized Immigrants	81%	81%	82%	82%	81%	81%	82%	81%	81%	81%

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: CHIP = Children's Health Insurance Program; * = between 0.5 million and -0.5 million.

a. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia who are younger than 65.

b. Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source. To illustrate the effects of enacting H.R. 6079, changes are shown compared with coverage projections under current law.

c. Other includes Medicare; the effects of enacting H.R. 6079 are almost entirely on nongroup coverage.

d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.

TABLE 4. ESTIMATED EFFECTS ON DIRECT SPENDING AND REVENUES RELATED TO INSURANCE COVERAGE PROVISIONS FROM ENACTING H.R. 6079, THE REPEAL OF OBAMACARE ACT

	By Fiscal Year, in Billions of Dollars										
Effects on the Federal Deficit [a,b]	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013-2022
Medicaid and CHIP Outlays [c]	-1	-26	-49	-62	-69	-77	-83	-86	-92	-99	-643
Exchange Subsidies and Related Spending [d]	-2	-24	-61	-97	-119	-129	-137	-141	-148	-155	-1,013
Small Employer Tax Credits [e]	-2	-3	-4	-2	-1	-2	-2	-2	-2	-2	-22
Gross Impact of Coverage Provisions	-5	-53	-113	-161	-189	-208	-221	-229	-242	-256	-1,677
Penalty Payments by Uninsured Individuals	0	0	3	6	7	7	7	8	9	9	55
Penalty Payments by Employers [e]	0	4	9	11	12	14	15	16	17	18	117
Excise Tax on High-Premium Insurance Plans [e]	0	0	0	0	0	11	18	22	27	32	111
Other Effects on Tax Revenues and Outlays [f]	1	3	6	15	24	30	35	37	36	36	223
Net Impact of Coverage Provisions [a, b]	**-4**	**-45**	**-95**	**-130**	**-146**	**-146**	**-145**	**-146**	**-153**	**-160**	**-1,171**

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: Numbers may not sum to totals because of rounding.

CHIP = Children's Health Insurance Program.

a. Does not include federal administrative costs that are subject to appropriation.

b. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

c. States have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that H.R. 6079 would reduce state spending on Medicaid and CHIP in the 2013-2022 period by about $41 billion as a result of repealing the coverage provisions.

d. Includes spending for high-risk pools, premium review activities, loans to co-op plans, grants to states for the establishment of exchanges, and the net budgetary effects of proposed collections and payments for risk adjustment and transitional reinsurance.

e. The effects on the deficit of H.R.6079 include the associated effects on tax revenues of changes in taxable compensation.

f. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would decrease by about $7 billion over the 2013-2022 period.

Effects on Health Insurance Premiums

CBO has not analyzed the effect of H.R. 6079 on health insurance premiums; however, it expects that the effects on premiums of repealing the ACA would be similar to reversing the effects estimated in November 2009.[6] In particular, that analysis suggests that if H.R. 6079 was enacted, premiums for health insurance in the individual market would be somewhat lower than under current law, mostly because the average insurance policy in that market would cover a smaller share of enrollees' costs for health care and a slightly narrower range of benefits. Nevertheless, many people would end up paying more for health insurance—because under current law, the majority of enrollees purchasing coverage in that market would receive subsidies via the insurance exchanges, and H.R. 6079 would eliminate those subsidies.

That prior analysis of premiums also suggests that premiums for employment-based coverage obtained through large employers would be slightly higher under H.R. 6079 than under current law, reflecting the net impact of many relatively small changes. Premiums for employment-based coverage obtained through small employers might be slightly higher or slightly lower (owing to uncertainty about the impact of the enacted legislation on premiums in that market).

Effects on Spending for Medicare, Medicaid, and Other Programs

Many of the other provisions that would be repealed by enacting H.R. 6079 affect spending for Medicare, Medicaid, and other federal programs. The ACA made numerous changes to payment rates and payment rules in those programs, established a voluntary federal program for long-term care insurance through the Community Living Assistance Services and Supports (CLASS) provisions, and made certain other changes to federal health programs. In total, CBO estimates that repealing those provisions would increase net federal spending by $711 billion over the 2013–2022 period. (Those budgetary effects are summarized in Table 1.)

Spending for Medicare would increase by an estimated $716 billion over that 2013–2022 period. Federal spending for Medicaid and CHIP would increase by about $25 billion from repealing the noncoverage provisions of the ACA, and direct spending for other programs would decrease by about $30 billion, CBO estimates.

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6. See Congressional Budget Office, letter to the Honorable Evan Bayh providing an analysis of health insurance premiums under the Patient Protection and Affordable Care Act (November 30, 2009).

Within Medicare, net increases in spending for the services covered by Part A (Hospital Insurance) and Part B (Medical Insurance) would total $517 billion and $247 billion, respectively. Those increases would be partially offset by a $48 billion reduction in net spending for Part D.

The provisions whose repeal would result in the largest increases in federal deficits include the following (all estimates are for the 2013–2022 period):

- Repeal of the reductions in the annual updates to Medicare's payment rates for most services in the fee-for-service sector (other than physicians' services) would increase Medicare outlays by $415 billion. (That figure excludes interactions between those provisions and others—namely, the effects of those changes on payments to Medicare Advantage plans and collections of Part B premiums.) Of that amount, higher payments for hospital services account for $260 billion; for skilled nursing services, $39 billion; for hospice services, $17 billion; for home health services, $66 billion; and for all other services, $33 billion.

- Repeal of the new mechanism for setting payment rates in the Medicare Advantage program would increase Medicare outlays by $156 billion (before considering interactions with other provisions).

- Repeal of the reductions in Medicaid and Medicare payments to hospitals that serve a large number of low-income patients, known as disproportionate share hospitals (DSH), would increase federal spending by $56 billion.

- Repeal of other provisions pertaining to Medicare, Medicaid, and CHIP (other than the coverage-related provisions discussed earlier) would increase federal spending by $114 billion.[7] That figure includes a $3 billion increase in spending from eliminating the Independent Payment Advisory Board (IPAB).[8] Under current law, the IPAB will be required, under certain circumstances, to recommend changes to the Medicare program to reduce that program's spending; such changes will go into effect automatically.

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7. That figure incorporates the effect on federal spending for prescription drugs and biologics of Public Law 112-144, the Food and Drug Administration Safety and Innovation Act, which was enacted earlier this year.

8. See Congressional Budget Office, cost estimate for H.R. 452, the Medicare Decisions Accountability Act of 2011 (March 6, 2012).

Repeal of the Community Living Assistance Services and Supports (CLASS) provisions would have no impact on projected federal deficits. The ACA established the CLASS program as a national, voluntary long-term care insurance program for providing community living assistance services and supports financed through insurance premiums. On October 14, 2011, the Secretary of Health and Human Services announced that she did not "see a viable path forward for CLASS implementation at this time."[9] Therefore, CBO's baseline incorporates no spending or premium collections for the CLASS program. Consequently, legislation to repeal the CLASS program is estimated to have no budgetary effect relative to current law.[10]

Effects on Discretionary Spending

The figures discussed elsewhere in this estimate generally do not include any savings associated with lower discretionary spending under H.R. 6079. CBO's original cost estimate for the ACA, issued in March 2010, focused on direct spending and revenues because those effects are relevant for pay-as-you-go purposes and occur without any additional legislative action (in contrast with discretionary spending, which is subject to future appropriation action). However, that earlier estimate noted that additional funding would be necessary for agencies to carry out the responsibilities required of them by the legislation and that the legislation also included explicit authorizations for a variety of grants and other programs.[11]

Although enacting H.R. 6079 would reduce the amounts of future appropriations that might be needed or are specifically authorized, its impact on total discretionary appropriations over the next several years would depend on future legislative actions. Moreover, the potential impact of H.R. 6079 or any other legislation on future appropriations is affected by the caps on annual appropriations that were established by the Budget Control Act of 2011 through fiscal year 2021. Eliminating the need to implement the ACA might lead to reductions in total discretionary spending

9. See letter from Kathleen Sebelius, Secretary of the Department of Health and Human Services, to John A. Boehner, Speaker, House of Representatives, October 14, 2011.

10. For more information, see CBO's October 31, 2011, letter to Senator John Thune providing an explanation of CBO's treatment of the CLASS program in its baseline projections.

11. For more information, see Congressional Budget Office, letter to the Honorable Nancy Pelosi about the budgetary effects of H.R. 4872, the Reconciliation Act of 2010 (March 20, 2010), pp. 10-11; letter to the Honorable Jerry Lewis about potential effects of the Patient Protection and Affordable Care Act on discretionary spending (May 11, 2010); and "Additional Information About the Potential Discretionary Costs of Implementing PPACA" (May 12, 2010).

or might free up some room under those caps for additional spending for other discretionary programs.

By CBO's estimates, repeal of the health care legislation would reduce the need for appropriations to the Internal Revenue Service by between $5 billion and $10 billion over 10 years. In addition, repealing the ACA would reduce the need for appropriations to the Department of Health and Human Services by between $5 billion and $10 billion over 10 years, CBO estimates.

H.R. 6079 would also repeal a number of authorizations for appropriations, which, if left in place, might or might not result in additional appropriations. In 2011, CBO estimated that such provisions authorizing specific amounts or extending existing authorizations with a specified level, if fully funded, would result in appropriations of around $100 billion over the 2012–2021 period.[12] Enacting H.R. 6079 would have the effect of reversing some but not all of those authorizations. For example, H.R. 6079 would have no impact on provisions of the ACA that authorized spending only for 2012 because appropriations for that year have already been made.

Enacting H.R. 6079 would probably not significantly affect appropriations for spending for programs and activities that existed prior to the ACA. Many of the authorizations in the ACA were for activities that were already being carried out under prior law or that were previously authorized and that the ACA authorized for future years. For example, the ACA reauthorized the Indian Health Service (IHS); CBO estimated in March 2012 that the ongoing activities of the IHS would cost $53 billion from 2012 through 2022. Consequently, just as the authorizations in the ACA of an estimated $100 billion over the 2012–2021 period will not necessarily lead to an increase of that amount in total discretionary spending, the repeal of those authorizations would not necessarily result in discretionary savings of that amount.

Effects on Revenues Not Related to Coverage

A number of changes to the Internal Revenue Code not directly related to the coverage provisions were enacted as part of the ACA. In addition, some of the changes made by provisions affecting spending that were not related to the coverage provisions generated indirect effects on revenues. For example, one of the ACA's tax provisions, a requirement for additional information reporting by small businesses of sales to corporations, has

12. See Congressional Budget Office, cost estimate for H.R. 2, the Repealing the Job-Killing Health Care Law Act (February 18, 2011).

already been repealed by the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (P.L. 112-9). In total, repeal of the remaining provisions not directly related to the coverage provisions is projected to reduce revenues by $569 billion over the 2013–2022 period.

The largest of those revenue effects include the following (all estimates are for the 2013–2022 period):

- The ACA increased the employee's share of the HI payroll tax rate for certain high-income taxpayers and broadened the HI tax base for those taxpayers to include net investment income. Repeal of this provision is projected to reduce revenues by $318 billion.

- Repeal of an annual fee on health insurance providers is estimated to reduce revenues by $102 billion.

- Repeal of an annual fee on manufacturers and importers of branded drugs is projected to reduce revenues by $34 billion.

- Repeal of an excise tax on manufacturers and importers of certain medical devices is expected to reduce revenues by $29 billion.

- Repeal of a $2,500 limitation on the amount individuals may set aside on a pre-tax basis in flexible spending arrangements is estimated to reduce revenues by $24 billion.

Comparison with Previous Estimate

The estimated 10-year increase in deficits from repealing the ACA under H.R. 6079 differs from what CBO and JCT estimated for H.R. 2 in February 2011, although the legislative language of the two acts is essentially the same.[13] In that prior estimate, CBO and JCT projected that changes in direct spending and revenues from enacting H.R. 2 would increase deficits by $210 billion over the period from 2012 through 2021 (for 2013 through 2021, the cost was projected to be $185 billion); the current estimate shows that changes in direct spending and revenues from enacting H.R. 6079 would increase deficits by $65 billion from 2013 through 2021 (and by $109 billion including the effects in 2022).

13. See Congressional Budget Office, cost estimate for H.R. 2, the Repealing the Job-Killing Health Care Law Act (February 18, 2011).

The differences between the two sets of estimates result primarily from changes in projections of direct spending and revenues under the ACA since CBO prepared the January 2011 baseline. The differences in projections also reflect legislation that has been enacted, changes in CBO's economic forecast, other updates to the estimates (including the effects of the Supreme Court's recent decision regarding the ACA), and a shift in the time period covered. The most significant changes in the estimates include the following:

- CBO and JCT's July 2012 projections of the net costs of the ACA's coverage provisions over the 2013-2021 period are somewhat lower than those projections were in January 2011. That downward revision reflects the effects of subsequent statutory modifications, changes in the economic outlook, updated estimates of the growth in private health insurance premiums, the Supreme Court's recent decision regarding the ACA, and a number of technical changes in CBO and JCT's estimating procedures. Altogether, the estimated savings over the 2013–2021 period from repealing the coverage provisions are now $25 billion lower than was the case for H.R. 2.

- The Administration's decision not to implement the CLASS program eliminated the budgetary effects of repealing those provisions. Last year, CBO estimated that repealing the CLASS program would increase deficits by about $80 billion over the 2013–2021 period. Thus, the Administration's decision effectively reduces the cost of repealing the ACA by $80 billion over that period, relative to CBO's estimate prior to that decision.

- CBO's current projections of Medicare spending are lower than those in the January 2011 baseline.[14] In aggregate, therefore, the projected increase in spending from repealing the Medicare provisions of the ACA is also smaller. Since January 2011, however, CBO has increased the number of Medicare beneficiaries who are projected to be enrolled in the Medicare Advantage program (and reduced the number of beneficiaries estimated to be enrolled in the fee-for-service component of Medicare). The estimates presented here reflect that change in the projected distribution of enrollment.

14. See Congressional Budget Office, *Updated Budget Projections: Fiscal Years 2012 to 2022* (March 2012).

- More of the funding provided by the ACA has now been obligated or spent than was the case when the estimate of H.R. 2 was completed. As a result, larger amounts would not be recovered by enacting H.R. 6079 compared to the amounts estimated for H.R. 2. In addition, more regulations implementing aspects of that legislation have been promulgated, and more provisions of the ACA have been partially or fully implemented. The current estimate of the budgetary impact of repealing the ACA reflects those actions.

- The time periods covered by the two estimates differ. The February 2011 estimate for H.R. 2 covered the years from 2012 through 2021, the period used for Congressional budget enforcement procedures when that legislation was being considered (in calendar year 2011); the current estimate of the effects of H.R. 6079 covers the period from 2013 through 2022.

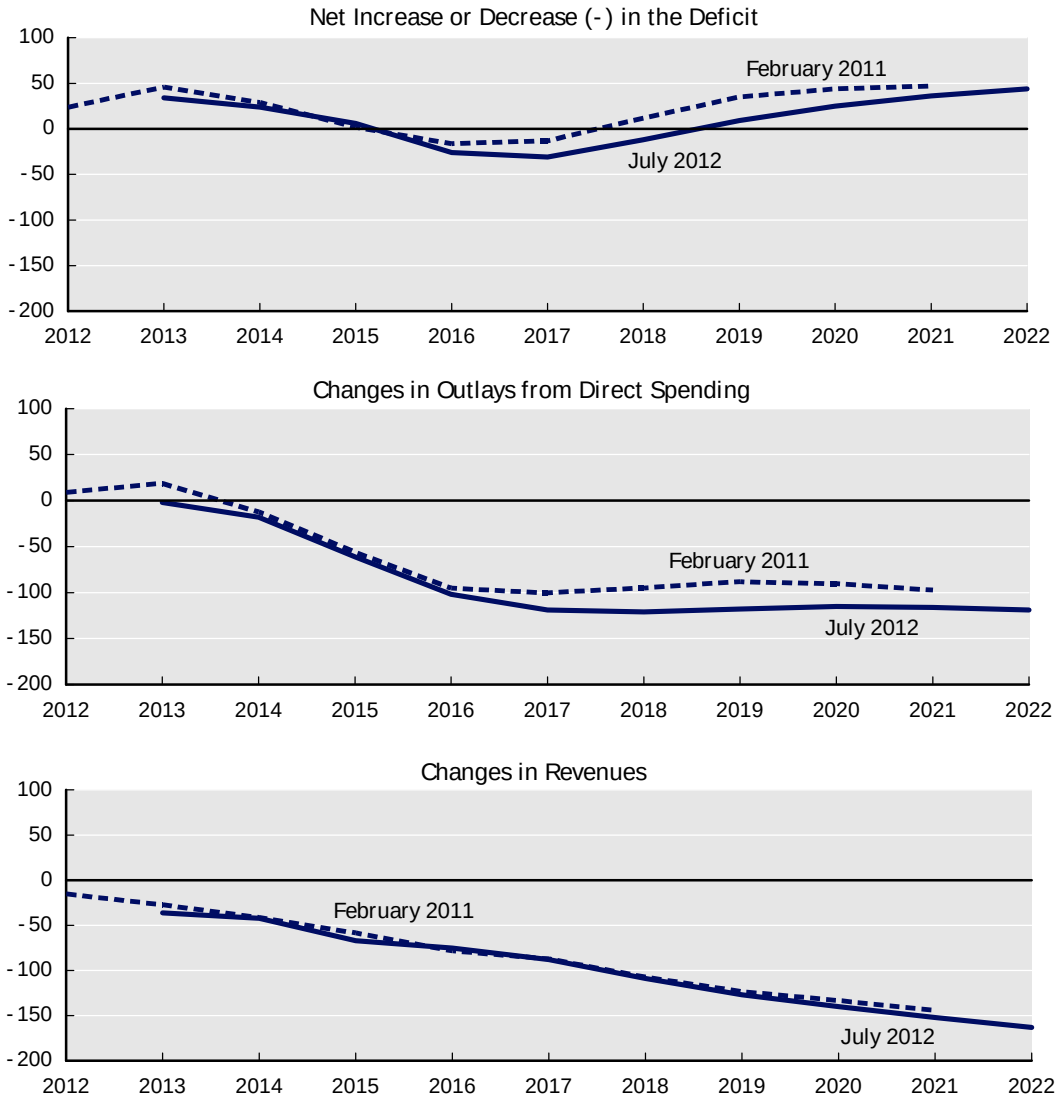
With the effects of those and other changes since February 2011 taken into account, repealing the ACA will lead to an increase in budget deficits over the coming decade, though a smaller one than previously projected, according to CBO and JCT's estimates. Figure 1 shows a comparison of the estimated effects of H.R. 2 and H.R. 6079 on direct spending, revenues, and deficits. From 2013 through 2016 and in 2021, the current estimates of those effects are very similar. For 2017 through 2020, the current estimates of the effects on revenues of repealing the ACA are quite close to the estimates for H.R. 2, and the estimated effects on direct spending show greater savings; thus the estimated increases in deficits are smaller.

Repeal of the ACA would reduce direct spending more than previously estimated primarily for two reasons: Eliminating the CLASS program would have no effect (rather than resulting in a net loss of income in the first decade), and the estimated costs of repealing other noncoverage provisions of the ACA are lower. Those differences are offset in part by the slightly lower estimated savings from repealing the coverage provisions.

Figure 1.

Estimated Budgetary Effects of Repealing the Affordable Care Act

(Billions of dollars, by fiscal year)



Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: The Affordable Care Act (ACA) comprises the Patient Protection and Affordable Care Act (Public Law 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). In addition to repealing the ACA itself, H.R. 6079 would also affect certain subsequent changes in statute. As used in this letter, the term "repealing the ACA" encompasses all of the effects of H.R. 6079.

The February 2011 estimates come from CBO's cost estimate for H.R. 2, the Job-Killing Health Care Law Act (February 18, 2011).

Impact on the Federal Budget Beyond the First 10 Years

Relative to current law, enacting H.R. 6079 would, CBO estimates, increase federal budget deficits in the decade following 2022. CBO does not generally provide cost estimates beyond the 10-year projection period. Over a longer time span, a wide range of changes could occur—in people's health, in the sources and extent of their insurance coverage, and in the delivery of medical care—that are very difficult to predict but that could have a significant effect on federal health care spending. Nonetheless, certain Congressional rules require some information about the budgetary impact of legislation in subsequent decades, and many Members have requested analyses of the long-term budgetary impact of proposed broad changes in the health care and health insurance systems.

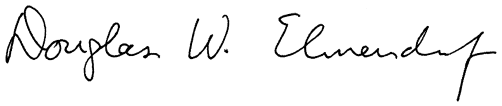
Using methodology developed during consideration of the ACA, CBO (with input from JCT) assessed the budgetary effects of H.R. 6079 in the decade following the 10-year projection period by grouping the elements of that legislation into broad categories and assessing the rate at which the budgetary impact of each of those broad categories would increase over time.

On that basis, CBO estimates that the total increase in deficits during the 2023–2032 period from enacting H.R. 6079 would lie in a broad range around one-half percent of GDP. CBO has not extrapolated that estimate further into the future. However, in view of the projected budgetary effects between 2023 and 2032, CBO anticipates that enacting H.R. 6079 would probably continue to increase budget deficits relative to those under current law in subsequent decades. The imprecision of that estimate reflects the greater degree of uncertainty that attends to it, compared with CBO's 10-year estimates.

Those calculations incorporate an assumption that the provisions of current law would otherwise remain unchanged throughout the next two decades. However, current law includes a number of policies that might be difficult to sustain over a long period of time. For example, the ACA reduced payments to many Medicare providers relative to what the government would have paid under prior law. On the basis of those cuts in payment rates and the existing "sustainable growth rate" mechanism that governs Medicare's payments to physicians, CBO projects that Medicare spending (per beneficiary, adjusted for overall inflation) will increase significantly more slowly during the next two decades than it has increased during the past two decades. If those provisions would subsequently be modified or implemented incompletely even in the absence of H.R. 6079, then the budgetary effects of H.R. 6079 could be quite different—but CBO cannot forecast future changes in law or assume such changes in its estimates.

If you wish further details on this estimate, please contact me or CBO staff. The primary staff contacts are Holly Harvey, Tom Bradley, Jean Hearne, and Jessica Banthin. Many others at CBO, along with staff of the Joint Committee on Taxation, contributed to this analysis, including Sarah Anders, Linda Bilheimer, Stephanie Cameron, Julia Christensen, Anna Cook, Peter Fontaine, Mark Hadley, Stuart Hagen, Lori Housman, Paul Jacobs, Paul Masi, T.J. McGrath, Jamease Miles, Alexandra Minicozzi, Julia Mitchell, Kirstin Nelson, Andrea Noda, Allison Percy, Lisa Ramirez-Branum, Lara Robillard, Robert Stewart, Robert Sunshine, Ellen Werble, Rebecca Yip, and Darren Young.

Sincerely,



Douglas W. Elmendorf
Director

cc: Honorable Nancy Pelosi
Democratic Leader