



COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET

Principles for Responsible “Obamacare” Repeal and Replace January 17, 2017

CHAIRMEN

MITCH DANIELS
LEON PANETTA
TIM PENNY

PRESIDENT

MAYA MACGUINEAS

DIRECTORS

BARRY ANDERSON
ERSKINE BOWLES
CHARLES BOWSHER
KENT CONRAD
DAN CRIPPEN
VIC FAZIO
WILLIS GRADISON
WILLIAM HOAGLAND
JIM JONES
LOU KERR
JIM KOLBE
DAVE MCCURDY
JAMES MCINTYRE, JR.
DAVID MINGE
JUNE O'NEILL
PAUL O'NEILL
MARNE OBERNAUER, JR.
BOB PACKWOOD
RUDOLPH PENNER
PETER PETERSON
ROBERT REISCHAUER
ALICE RIVLIN
CHARLES ROBB
ALAN K. SIMPSON
JOHN SPRATT
CHARLIE STENHOLM
GENE STEUERLE
DAVID STOCKMAN
JOHN TANNER
TOM TAUKE
PAUL VOLCKER
CAROL COX WAIT
DAVID M. WALKER
JOSEPH WRIGHT, JR.

Policymakers are expected to soon consider legislation to repeal and possibly replace large parts of the Affordable Care Act (“ACA” or “Obamacare”). Any significant changes to the ACA are likely to have substantial impacts on health care costs, insurance coverage, premiums, the distribution of benefits, economic growth, and the federal budget.

Because the ACA included a mix of spending increases, spending reductions, and tax hikes, the magnitude and direction of the budgetary impact of “repeal and replace” legislation is highly dependent on yet-undetermined details (see our estimates of some illustrative scenarios [here](#)).

With the national debt at post-WWII era record-high levels and growing unsustainably, it is important that changes to the ACA be fiscally responsible. We recommend that any repeal and replace legislation – whether enacted all at once or in pieces – follow these guiding principles:

- 1. Retain or replace, and build upon, the ACA’s cost-control measures.**
- 2. Reduce, rather than increase, the debt.**
- 3. Maintain or improve Medicare solvency.**

It appears some policymakers would prefer to enact ACA repeal and replacement in pieces, with the first part (“repeal and delay”) setting a future date for the ACA’s coverage provisions to expire. This approach is not optimal. But if it is pursued, repeal and delay should not only abide by the principles above but also the following additional principles:

- 4. Continue the ACA’s offsets as long as coverage provisions are retained.**
- 5. Generate sufficient repeal savings to finance any future replacement.**
- 6. Enact any replacement in a timely and fiscally responsible manner.**

Legislation that fails to meet these goals would likely lead to higher debt, a less secure Medicare program, and ultimately slower economic growth.



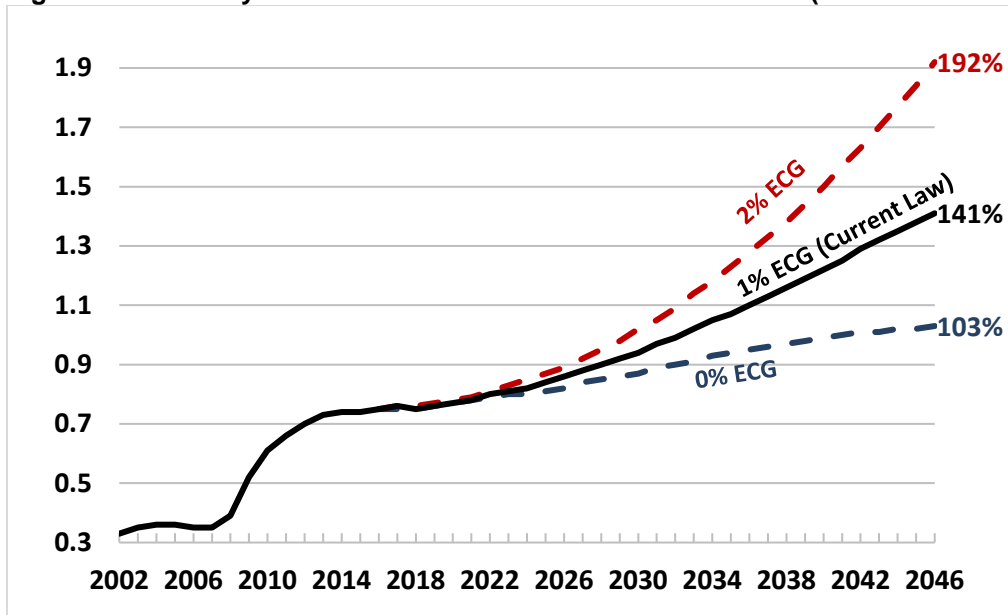
1) Retain or replace, and build upon, the ACA’s cost-control measures

Combined federal health care spending is the largest part of the federal budget. It is also [the fastest growing part](#) aside from interest. Repeal and replace legislation should therefore focus on controlling health care cost growth; at minimum, it should retain the parts of the ACA designed to do just that.

As recently as 2000, federal health spending totaled 3.1 percent of Gross Domestic Product (GDP). Today, it costs 5.5 percent of GDP. And based on Congressional Budget Office (CBO) projections, we estimate it will grow to 6.7 percent of GDP within a decade and 9 percent within thirty years. Though this growth is in part due to the population aging, it is also due to per-capita health care costs continuing to grow faster than inflation or the economy, which impacts not only the federal government but also state and local governments, businesses, and households.

Health care cost control is hugely important. Over the next three decades, CBO projects per-capita health care spending to grow about 1 percentage point faster than the economy each year, on average. If policymakers successfully slowed its growth to the pace of the economy, debt in three decades would rise to slightly over 100 percent of GDP, rather than roughly 140 percent. On the other hand, if health costs grew 2 percentage points faster than GDP per capita, debt would rise to over 190 percent of GDP.

Fig. 1: Debt Held by the Public Under Different ECG* Scenarios (Percent of GDP)



Source: Congressional Budget Office.

*ECG refers to excess cost growth, or growth in per-capita health spending above the rate of per-capita potential GDP growth. Numbers in the graph above are average ECG over the period.

Although many parts of the ACA likely accelerated health care cost growth, many other parts – particularly those addressing Medicare – were designed to slow cost growth.



In particular, the ACA included:

- “Productivity adjustments,” which limit the growth of Medicare provider payments in order to encourage more cost-effective delivery of care.
- Payment reforms and experiments designed to reduce hospital readmissions, increase the use of comparative effectiveness research, encourage care coordination, and begin to replace fee-for-service with new models such as bundled payments and Accountable Care Organizations (ACOs).
- New government entities charged with developing and testing new payment reforms (the Center for Medicare & Medicaid Innovation) and limiting Medicare cost growth (the Independent Payment Advisory Board, or IPAB).
- Demonstration projects to test mechanisms for better coordination of Medicare and Medicaid enrollees who are eligible for both programs, including managed care for long-term services and supports, multi-payer arrangements, and behavioral health integration.
- A “Cadillac tax” on high-cost insurance plans designed to slow the growth of health spending resulting from employer-provided health insurance.

Many of these provisions are still in their infancy, though some are already proving effective in helping to stem health care cost growth. For the most part, they should be retained and built upon under any repeal and replace plan. For example, policymakers could [adopt recommendations](#) we made in 2015 to significantly expand ACOs and bundled payments.

Policymakers may wish to repeal some of the ACA’s unpopular cost-control measures. If repealed, these provisions should be replaced with others that are at least as effective. For example, if the Cadillac tax is repealed it could be replaced with a limit on the [tax exclusion for employer-sponsored health insurance](#). If IPAB were repealed, it could be replaced with a “Medicare trigger” that limits Medicare cost growth by encouraging congressional action and making automatic changes (for example, payment freezes) if action fails.

Repeal and replace proposals should be viewed as an opportunity to enact further cost controls on top of those in the ACA. These could include, for example, modernizing Medicare cost-sharing, limiting Medigap plans, reforming medical malpractice rules, reducing costs through more market competition, or encouraging the use of low-cost drugs.

While the debate over repeal and replacement is likely to revolve largely around coverage, it is important that policymakers remember cost control is the key to sustaining any reforms over the long run.

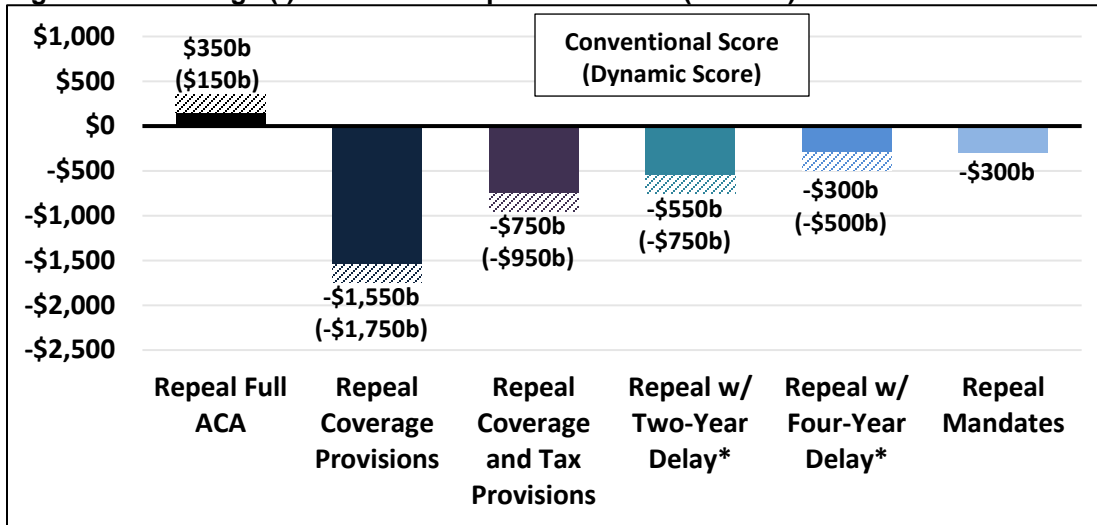


2) Reduce, rather than increase, the debt

Repeal and replace legislation – whether enacted in a single bill or across multiple bills – should aim to reduce the near- and long-term projected debt. Certainly, health reform should not be *adding* to the national debt, which is already higher as a share of GDP than at any time other than just after World War II.

Repealing the ACA in its entirety would cost \$350 billion (\$150 billion on a dynamic basis) over ten years, but even retaining all of the ACA’s Medicare savings would only generate \$750 billion (\$950 billion, dynamic) of savings. \$750 billion may prove insufficient to pay for replacement legislation, considering that the ACA’s coverage provisions cost \$1.55 trillion on net (\$1.75 trillion, dynamic) and close to \$2 trillion when removing savings from the individual and employer mandates. See our full paper "[The Cost of Full Repeal of the Affordable Care Act](#)" for more discussion of these scenarios.

Fig. 2: Cost/Savings (-) of Different Repeal Scenarios (Billions)



Source: CRFB calculations based on Congressional Budget Office data.
*Assumes revenue and mandate provisions are repealed immediately, Medicaid expansion and exchange subsidies are repealed on a delay, and most other provisions are retained.

Ensuring repeal and replace legislation reduces the deficit will likely require policymakers to retain most health and revenue offsets from the ACA, or else replace them with alternative savings measures, while ensuring any replacement is cost-effective and affordable.

Policymakers should especially focus on ensuring legislation reduces the long-term debt over the next few decades, as the baby boom generation retires. By our estimates, repealing the coverage and revenue provisions would save roughly \$1.5 trillion over two decades, while repealing only the coverage provisions would save about \$3.5 trillion. And repealing the entire ACA would *cost* nearly \$4 trillion over two decades.

Over the long term, savings from repeal should be larger than the cost of replacement.



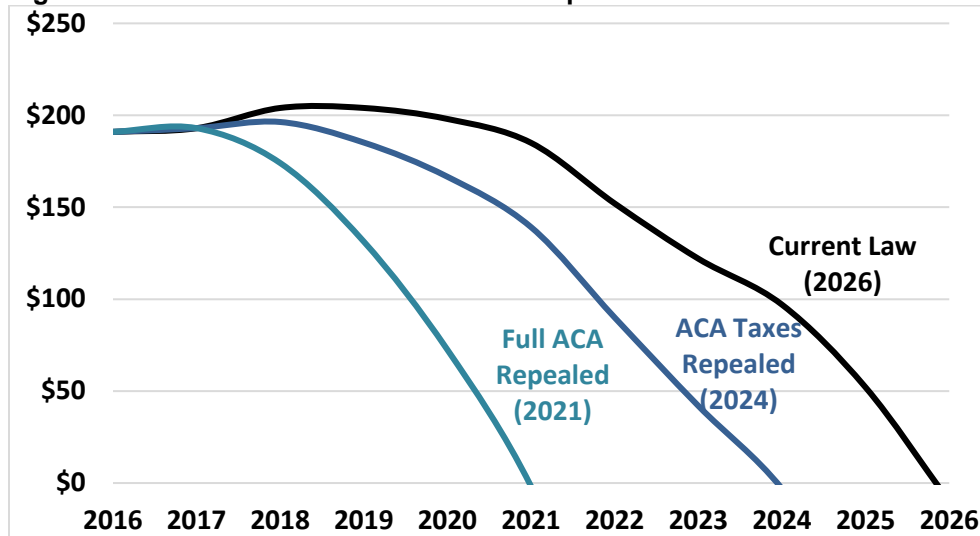
3) Maintain or improve Medicare solvency

While much of the focus around the ACA is on the exchange subsidies and Medicaid expansion, the law also made significant changes to extend the solvency of Medicare Part A's Hospital Insurance (HI) trust fund. Though these initial improvements were made in part by "[double counting](#)" some savings, policymakers should nonetheless avoid backtracking and thus worsening the state of the HI trust fund.

The ACA strengthened the HI trust fund in two ways. First, it increased the revenue going into the trust fund through a 0.9 percent HI payroll surtax on high earners. At the same time, it reduced the growth of Medicare spending by reducing reimbursements to Medicare Advantage plans, slowing the growth of provider payments, and enacting other reforms.

By our [estimates](#), full repeal of the ACA – including the Medicare cuts – would advance the HI insolvency date from 2026 to 2021 and triple its 10-year shortfall. Repealing the coverage and revenue provisions while retaining the Medicare cuts would advance the HI insolvency from 2026 to 2024 and increase the 10-year shortfall by about half.

Fig. 3: HI Trust Fund Balance Under ACA Repeal Scenarios and Exhaustion Dates (Billions)



Source: CRFB calculations based on Congressional Budget Office data.

Policymakers should preserve and build upon the Medicare solvency improvements. This could be accomplished most easily by maintaining all of the Medicare reductions and the HI surtax in the ACA. But even if policymakers decide to repeal the ACA in full, these provisions should be replaced with alternative improvements.

Repeal and replace legislation should also maintain or improve the financial sustainability of Medicare Part B and Part D, though those programs do not rely on trust fund financing in the same way Medicare Part A does.¹

¹ Although Part B and D are technically funded from the Supplemental Medical Insurance (SMI) trust fund, that fund is mostly financed from general revenue based on program costs, and is a trust fund in name only.



Repeal and delay must meet additional standards

While [many health experts](#) believe ACA repeal and replacement should be enacted concurrently, some policymakers argue they should be enacted in parts. The “repeal and delay” strategy would repeal large parts of the ACA at some point in the future – perhaps after two or four years – with the intention of enacting an ACA replacement before that time frame passes.

Separating “repeal” from “replace” legislation introduces a number of challenges, many beyond the scope of this paper. From a fiscal perspective, timing issues might be used to obscure the costs or savings; repeal and delay legislation might make it more difficult to pass fiscally responsible replacement legislation.

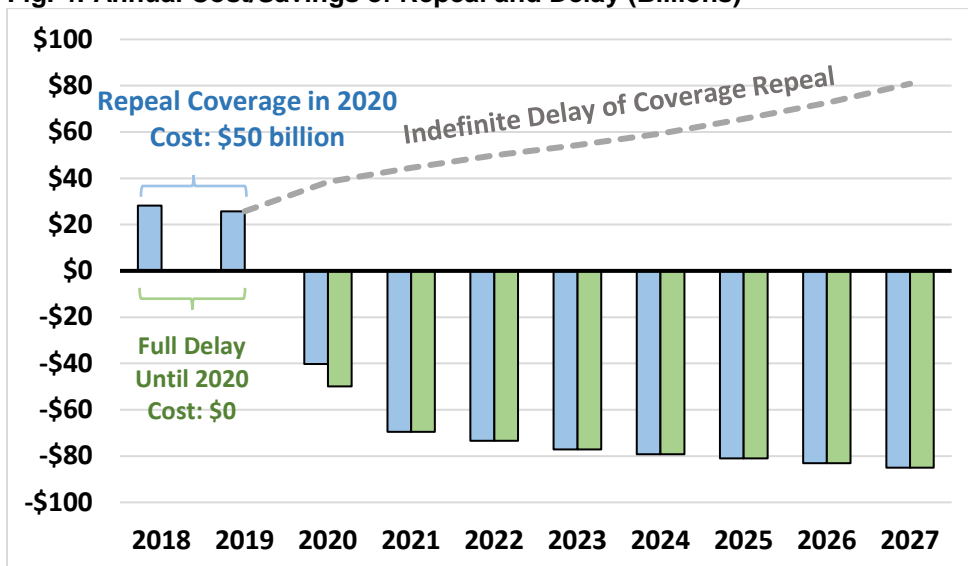
To ensure health reform is fiscally responsible, repeal and delay would need to conform with the three principles above as well as the additional principles below:

4. Continue the ACA’s offsets as long as coverage provisions are retained

The [previous version of repeal and delay](#), vetoed by President Obama in January 2016, would have repealed the ACA’s mandates and revenue provisions immediately while delaying repeal of its insurance subsidies and Medicaid expansion for two years. Such an approach would add to near-term deficits and would likely reduce long-term deficits in name only.

We estimate under an approach like this that a two-year delay would cost roughly \$50 billion over two years, while a four-year delay would cost \$135 billion over those four years. In this case, the \$450 to \$600 billion of gross savings in subsequent years would not only have to pay for a replacement, but also cover the cost of repeal in the early years. Adding to near-term deficits for this purpose would be unjustified and unwise. (See [“Repeal and Delay Shouldn't Increase Near-Term Deficits”](#) for more detail.)

Fig. 4: Annual Cost/Savings of Repeal and Delay (Billions)



Source: CRFB calculations based on CBO data.



Delayed repeal should mean delay for *all* parts of repeal, not just the coverage provisions. Retaining the ACA's giveaways while repealing its offsets – even on a temporary basis – represents irresponsible budgeting that could prove costly in the future. So long as policymakers continue to offer costly coverage provisions, they must keep all the measures paying for that coverage. Better yet, policymakers should retain all of the offsetting provisions until a replacement is put in place.

5. Generate sufficient repeal savings to finance any future replacement

If policymakers retain the ACA's Medicare savings, repeal and delay legislation by itself is likely to reduce budget deficits. By our estimates, repealing all mandate and revenue provisions immediately and coverage provisions after two years would save \$550 billion over a decade; repealing coverage provisions after four years would save \$300 billion.

However, if replacement legislation is expected to follow repeal, simply reducing the deficit in repeal is not enough. Instead, repeal legislation needs to reduce the deficit by enough to fully finance the net cost of any future replacement legislation. Since consensus replacement legislation has not yet been written, it is impossible to know the cost of any new coverage provisions nor the savings from new offsets and thus what is needed to pay for the difference. Given this reality, it is best to follow the guideline that “more is better” and generate as much savings as possible in the repeal and delay legislation. If a replacement bill ends up being less expensive than the savings from repeal, leftover funds could be dedicated to deficit reduction.

6. Enact any replacement in a timely and fiscally responsible manner

The longer policymakers wait between repealing the ACA and replacing it, the more disruptions and uncertainties will be created for individuals seeking coverage, companies, and providers – not to mention the additional cost and fiscal implications. Maintaining coverage with no individual mandate and a set of exchanges slated to disappear will likely require spending more on insurance companies so they continue to offer coverage and more on individuals who will be facing higher premiums and thus larger subsidies. Yet replacing the ACA with an even costlier plan would worsen an already unsustainable fiscal situation.

Upon repeal, policymakers should act quickly to develop, agree to, and pass any replacement legislation in a way that – in combination with the repeal legislation – reduces rather than adds to the overall debt now and in the future.

Conclusion

The new Congress and president have made clear that Obamacare repeal and replacement is a top priority. Any legislation to significantly modify or replace the ACA will have numerous implications, including many fiscal in nature.



Certainly, repeal and replacement legislation should be designed and evaluated based on its impact on coverage, premiums, and economic growth. But it is especially important that policymakers focus on the impact of repeal and replacement on health care cost growth and the overall federal budget.

As we [argued](#) around the passage of the ACA eight years ago, health reform is an iterative process that requires time and vigilance to ensure that long-term goals are being met.

The national debt continues to rise unsustainably, and that is in part a direct result of the unsustainable nature of U.S. health care costs. If policymakers want to repeal the ACA, they need to do so in a way that would improve the debt's trajectory, shore up Medicare, and spur further economic growth.