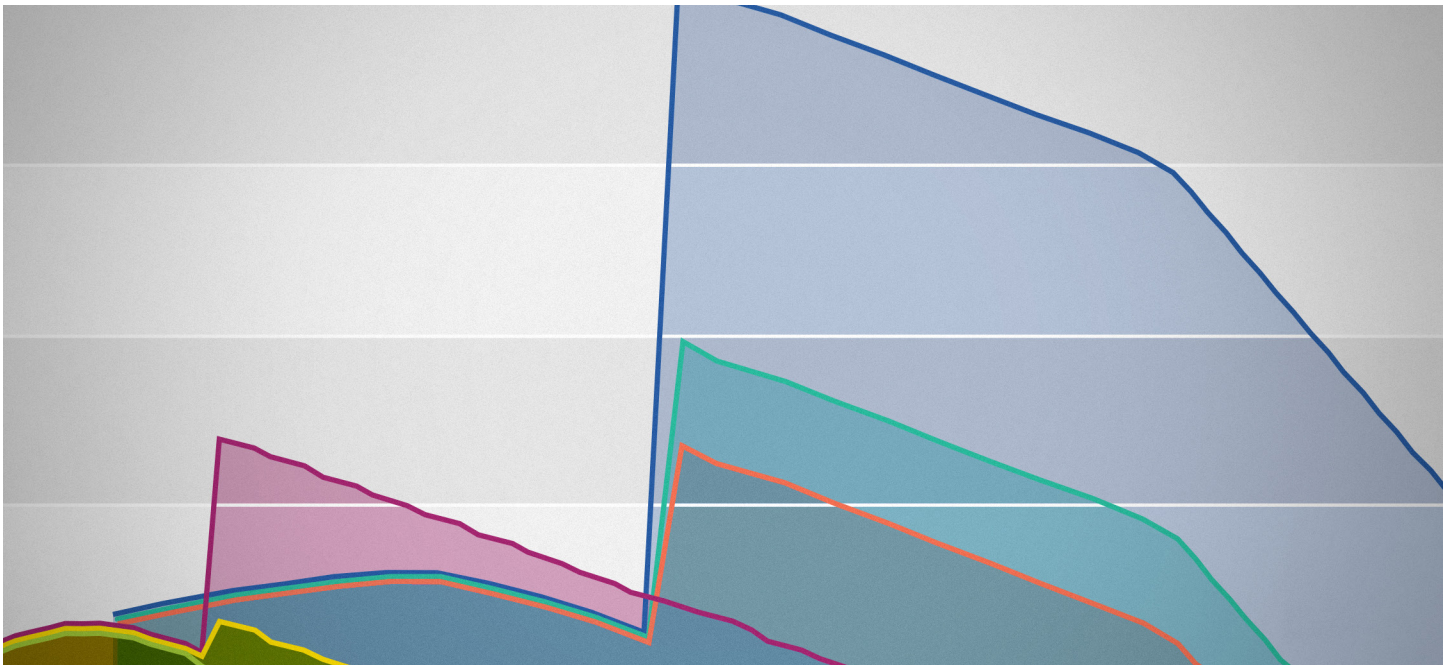
Expanded ACA Subsidies: Exacerbating Health Inflation and Income Inequality

By Brian Blase, PhD



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Expanded ACA Subsidies: Exacerbating Health Inflation and Income Inequality

By Brian Blase, PhD
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OVERVIEW

The legislation being proposed by congressional Democrats to boost spending on the Affordable Care Act (ACA) reveals that the law has severely underperformed expectations. Even worse, the proposed expansion recklessly boosts federal subsidies for health insurance in a way that exacerbates tax inequities, substantially replaces private spending with government spending, reduces incentives for work and productivity, and significantly adds to already unsustainable family and government health care expenditures.

The revised structure makes the premium tax credits (PTCs) much larger for older people and those with higher incomes. PTCs reduce enrollees' out-of-pocket payments for health insurance with the federal government sending funds to health insurers each month. Since the proposal would deliver tens of billions of more taxpayer subsidies to them annually, health insurance companies are lobbying strongly in support of it.[1]

Update: *This version was updated on June 11, 2021, and it reflects the legislation that Congress enacted to expand ACA subsidies in March 2021—a month after the original paper version was released. The original paper was an assessment of the legislative proposal. The differences pertain to the amount of premium tax credit (PTC). The original paper was based on analysis that the PTC indexing provisions would apply to the expanded tax credits in 2021 and 2022. However, for 2021 and 2022 the tax credit indexing provisions do not apply. This means that the PTCs for 2021 and 2022 are slightly higher than shown in the original analysis.*

The paper continues to refer to the expanded PTCs as proposed even though these expanded PTCs are now current law and are in place for 2021 and 2022.

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[1] In addition to the PTC expansion, there are other provisions that deliver taxpayer funds to health insurance companies, such as a large subsidy for COBRA continuation coverage.

By the Numbers

Under the proposal, a family of four with a 60-year-old head of household and income of 600 percent of the federal poverty level (FPL), or $159,000 a year, would qualify for an annual PTC of $16,845 under the proposal.[2] If that family made 1,000 percent of the FPL, or $265,000 a year, it would qualify for a PTC of $7,835.

If enacted, this PTC expansion is unlikely to significantly reduce the number of uninsured, as most of the benefit goes to people who are already insured. According to the Congressional Budget Office (CBO), nearly 75 percent of the new spending goes to people who have coverage and largely replaces private spending with government spending.[3] CBO estimates that the two-year cost would total about $34 billion—an amount equal to one-third of what the federal government is already spending on PTCs—and would increase the number of insured by only 800,000 in 2021 and 1.3 million in 2022. Therefore, on an annualized basis, this proposal boosts federal spending on the PTCs by about $17,000 for every person who is newly insured.

While the temporary PTC expansion is still being debated, there are already calls to make it permanent, calls that would certainly grow louder if the temporary expansion is enacted. There would be political pressure to make the temporary expansion permanent as well, as beneficiaries would not want to lose such a large benefit. If Congress does make them permanent, American businesses, particularly firms with fewer than 50 workers and those with older workforces, would have large financial incentives to stop offering group health coverage. Start-up firms would have disincentives to offer group insurance. As employers migrate their workers to the exchanges, federal costs, through higher taxes and debt, would significantly increase, as the PTCs have a much

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[2] Throughout this paper, I use illustrations of a 30-year-old, 45-year-old, and 60-year-old. Using the Kaiser Family Foundation Health Insurance Marketplace Calculator, I used the following as benchmark 2021 premiums: $400 for a 30-year-old single, $509 for a 45-year-old single, and $957 for a 60-year-old single. For a family of four headed by a 30-year-old couple with two young children, the benchmark premium is $1,340. For a family of four headed by a 45-year-old couple with two teenagers, the benchmark premium is $1,592. For a family of four headed by a 60-year-old couple with two teenagers, the benchmark premium is $2,530.

[3] According to CBO's estimates, $22.5 billion of $35.5 billion cost of the PTC expansion would go to existing exchange enrollees. CBO projects that 1.7 million people would enter the exchanges as a result of the expanded PTCs, with 400,000 replacing either employer coverage or other nongroup coverage. Apportioning the $13.0 billion evenly across the 400,000 already with coverage and the 1.3 million uninsured means that $4.0 billion is expended on the 400,000 who already have coverage. This means that $26.5 billion of the $35.5 billion is for people who already have coverage. See CBO, "At a Glance: Reconciliation Recommendations of the House Committee on Ways and Means," February 17, 2021, https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf.

greater budgetary cost than the tax exclusion for employer coverage does. Moreover, the increased subsidies would put upward pressure on health care prices and premiums, resulting in Americans spending more on health care than on other goods and services.

Disappointing Exchanges and the Proposal to Expand Subsidies

The ACA's early advocates, including then-President Barack Obama, emphasized that the new health insurance exchanges would substantially reduce the number of uninsured. The exchanges were supposed to usher in an improved individual health insurance market with numerous affordable choices. As we start the beginning of the law's eighth year of operation, it is clear this did not happen.

CBO expected that 25 million people would be enrolled in the exchanges by now.[4] Yet enrollment, on an annualized basis, has been stuck at only about 10 million people since 2015—60 percent below expectations. In fact, the size of the entire individual market, which also includes a few million people who purchase coverage off the exchanges, is only about 2 million people above pre-ACA levels. In 2017, the Department of Health and Human Services released a report showing that individual market premiums increased by 105 percent between 2013 (the year prior to the ACA's key changes taking effect) and 2017.[5] Deductibles are also high, and individual market plans typically cover far fewer providers than employer-sponsored insurance (ESI) plans.

Enrollment in ACA plans is concentrated among just two groups of people: (1) lower-income people who receive large subsidies that cover either the entire premium or most of it and (2) people who expect to incur significant medical expenses, regardless of income, and are therefore willing to pay the high premiums. The subsidies, or PTCs, are structured to limit the amount of income that households must pay for a benchmark plan, the second-lowest-cost silver plan in a rating area. The amount of the PTC declines as household income increases. People who qualify for a PTC can then use their

[4] CBO, "Effects of the Affordable Care Act on Health Insurance Coverage, May 2013," https://www.cbo.gov/sites/default/files/recurringdata/51298-2013-05-aca.pdf.

[5] U.S. Department of Health and Human Services, "Individual Market Premium Changes: 2013-2017," May 23, 2017, https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf.

subsidies toward the purchase of any plan. For the vast majority of enrollees, the PTC is advanced each month to the insurance company selected by the enrollee. In 2020, 86 percent of exchange enrollees received PTCs.[6] And in the median state, the PTC amount covered more than 80 percent of the total premium.[7] Exchange enrollees who select silver plans and who have income below 250 percent of the FPL also benefit from reduced cost-sharing as insurers are required to lower their deductibles, copayments, and out-of-pocket maximums.[8]

In terms of a simple cost-benefit analysis, taxpayers are now spending about $50 billion in PTCs. Since individual market enrollment is up by slightly under 2 million people from a 2011-2013 baseline,[9] this works out to more than $25,000 in annual tax and debt increases per newly insured person in the individual market, a low rate of return suggesting that government crowd-out of private spending was extremely high.[10]

Congressional Democrats are now proposing to substantially increase the subsidies—passing along to taxpayers the burdens of funding an even greater share of the cost. The American Rescue Plan Act of 2021, introduced by House Democrats on February 19, 2021, decreases the amount of income that people have to pay for a benchmark plan and removes the income cap on subsidy eligibility in 2021 and 2022. Right now, subsidies are available only to people with income below 400 percent of the FPL.

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[6] Kaiser Family Foundation, "Marketplace Effectuated Enrollment and Financial Assistance: 2020," https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[7] Kaiser Family Foundation, "Marketplace Average Premiums and Average Advanced Premium Tax Credit (APTC): Open Enrollment 2020," https://www.kff.org/health-reform/state-indicator/marketplace-average-premiums-and-average-advanced-premium-tax-credit-aptc/.

[8] For individuals with income between 100 percent and 150 percent of the FPL, the cost-sharing reductions increase the actuarial value of a silver plan from 70 percent to 94 percent. For individuals with income between 150 percent and 200 percent of the FPL, the actuarial value of a silver plan is increased to 87 percent. For individuals with income between 200 percent and 250 percent of the FPL, the actuarial value of a silver plan is increased to 73 percent.

[9] From 2011 to 2013, there were about 10.7 million enrollees in the individual health insurance market. See Larry Levitt, Cynthia Cox, and Gary Claxton, "Data Note: How Has the Individual Insurance Market Grown Under the Affordable Care Act," Kaiser Family Foundation, May 12, 2015, https://www.kff.org/health-reform/issue-brief/data-note-how-has-the-individual-insurance-market-grown-under-the-affordable-care-act/. There were 11.7 million enrollees in the individual market in 2019 on an annualized basis. See Centers for Medicare and Medicaid Services, "Trends in Subsidized and Unsubsidized Enrollment," October 9, 2020, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY18-19.pdf.

[10] This amount does not include state and federal administrative costs. Rather, it simply a metric for the per capita subsidy necessary for one additional individual market enrollee given all the other changes that the ACA made to individual market coverage.

Massive Increase in Subsidies, Especially for Older and Upper-Income People

Table 1 shows how the proposed PTC expansion changes the percentage of income that households, including singles and families, at certain levels of the FPL must pay for a benchmark health insurance plan. Table 2 shows levels of income for a single individual and a family of four that correspond to certain FPLs. The income amount associated with each FPL increases as household size increases.

The pending legislative proposal increases the PTC amount at every income level, but the distribution varies significantly depending on the

TABLE 1

Limits on Income for Benchmark Plan, 2021

FPL	Original	Expanded
150%	4.14%	0%
200%	6.52%	2%
250%	8.33%	4%
300%	9.83%	6%
350%	9.83%	7.25%
400%	9.83%	8.5%
>400%	No Subsidy	8.5%

TABLE 2

Annual Income Corresponding to FPL

FPL	Single	Family of Four
150%	$19,320	$39,750
200%	$25,760	$53,000
250%	$32,200	$66,250
300%	$38,640	$79,500
350%	$45,080	$92,750
400%	$51,520	$106,000
450%	$57,960	$119,250
500%	$64,400	$132,500
550%	$70,840	$145,750
600%	$77,280	$159,000
700%	$90,160	$185,500
800%	$103,040	$212,000
900%	$115,920	$238,500
1000%	$128,800	$265,000
1100%	$141,680	$291,500
1200%	$154,560	$318,000
1300%	$167,440	$344,500

SOURCE: Health and Human Services Department, "Annual Update of the HHS Poverty Guidelines," *U.S. Federal Register*, January 17, 2020, https://www.federalregister.gov/documents/2020/01/17/2020-00858/annual-update-of-the-hhs-poverty-guidelines.

age and income of the recipient. The PTC is already large for people at lower incomes, so the proposed PTC increases, while still significant, are much smaller in percentage terms for people below 400 percent of the FPL than for those with income above 400 percent of the FPL. The magnitude of the PTC increase is also much greater for older adults, so the main beneficiaries are older, upper-income adults.

Figure 1 shows the increase in the PTC amount that the six sets of households receive from this proposal. The most obvious feature from Figure 1 is how large the PTC increase is at 401 percent of the FPL—$51,649 for a single household and $106,265 for a household of four. Above this income amount, the PTCs gradually decline. A second prominent takeaway is that older people qualify for much greater assistance above 400 percent of the FPL than do younger people. A third key takeaway is that wealthy people receive a large gain from the proposed PTC expansion. For example, the following five households would receive about $1,400 in subsidies from this proposal—a single person of any age earning around $40,000, a family of four headed by a person of any age earning around $106,000, a family of four headed by a 30-year-old earning $173,000, a family of four headed by a 45-year-old earning $208,000, and a family of four headed by a 60-year-old earning $340,000.

As a reminder, Figure 1 shows the national average. In areas of the country where the benchmark plans are above average, the PTC increases would be greater. In some parts of the country, households with more than $500,000 would now qualify for PTCs. For example, a 64-year-old couple with no dependents in Kay County, Oklahoma, earning $500,000 per year, which faces a benchmark premium of $49,897 a year, would qualify for a PTC of $7,397.[11]

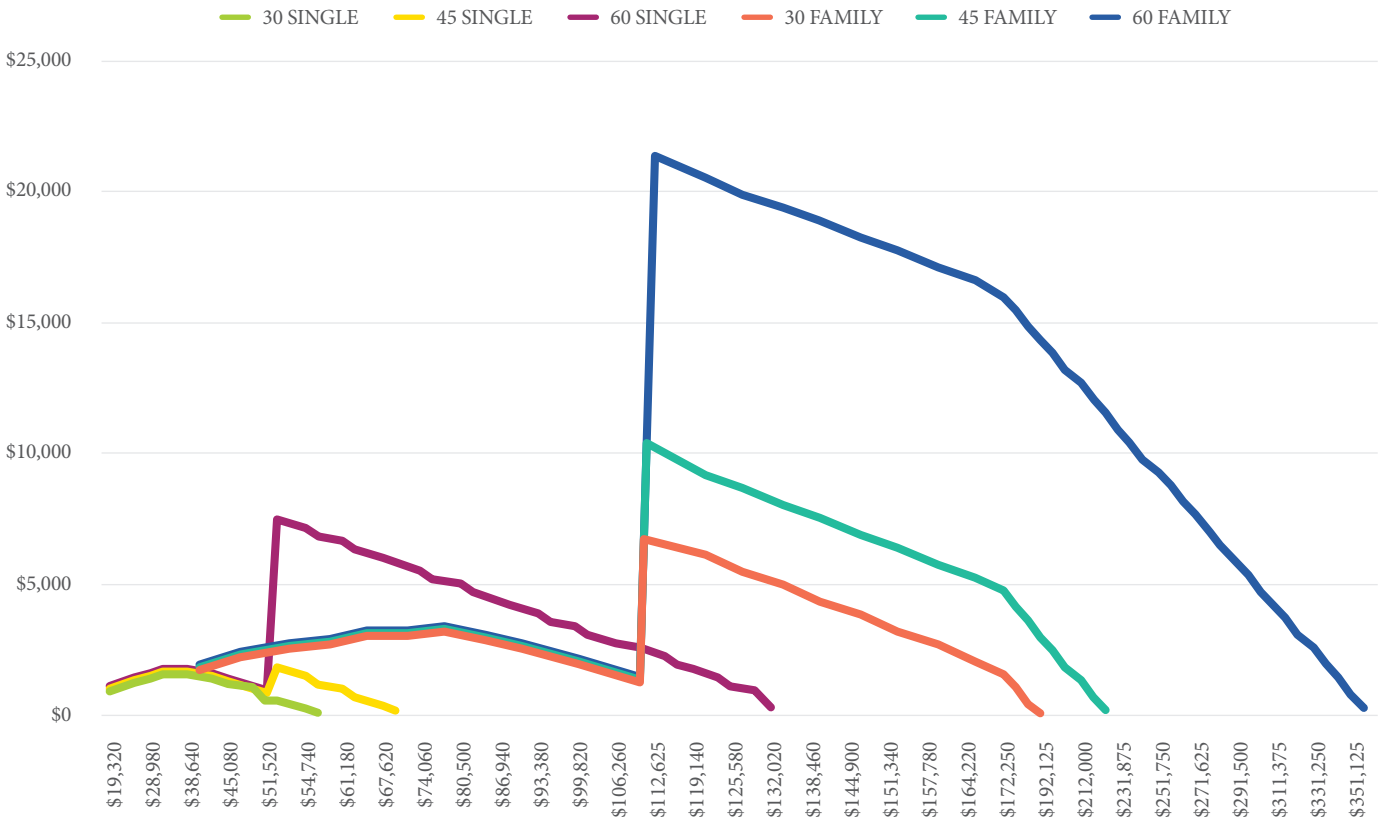
Because the proposal increases PTCs the most for people in households with incomes above 400 percent of the FPL, the proposed PTC expansion is regressive. In 2020, median worker income equaled $51,168.[12] In 2019, the median income of all households, which includes singles and families, was $68,703. The top two quintiles, or the wealthiest 40 percent of households, earn incomes above 400 percent of the FPL, and they would be newly eligible for subsidies

[11] See the Kaiser Family Foundation's Health Insurance Marketplace Calculator at https://www.kff.org/interactive/subsidy-calculator/. The zip code for this couple is 74601.

[12] The median weekly earnings for full-time wage and salary workers is $984. Multiplying $984 by 52 weeks yields $51,168 per year. See U.S. Bureau of Labor Statistics, "Labor Force Statistics from the Current Population Survey: Median Weekly Earnings of Full-Time and Salary Workers by Detailed Occupation and Sex," last modified January 22, 2021, https://www.bls.gov/cps/cpsaat39.htm.

FIGURE 1

Increase in PTC Amount for Households at Various Income Levels



SOURCE: Author's calculations based on the subsidy formula and using national averages for premiums.

NOTE: The figure scale changes at an income of $172,250 so the information can fit on the figure.

under the Democrats' proposal.[13] According to CBO's estimates, 40 percent of these new exchange enrollees will earn above 400 percent of the FPL, and the marginal subsidy to them from the PTC expansion proposal is greater, as they do not currently qualify for any PTC. Households with incomes just above 400 percent of the FPL receive the most substantial benefit.

[13] Kaiser Family Foundation, "Distribution of Total Population by Federal Poverty Level: 2019," accessed February 20, 2021, https://www.kff.org/other/state-indicator/distribution-by-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Tables 3-5 compare the size of the PTC under current law with the proposed PTC expansion. The tables show the substantial benefit that would accrue to households just above 400 percent of the FPL who do not receive an offer of affordable ESI. The tables use the average national benchmark premiums for 2021 as reported by the Kaiser Family Foundation. In areas of the country where ACA plans are more expensive, both the premiums and the PTCs would be higher. Conversely, in areas of the country where ACA plans are less expensive, both the premiums and the PTCs would be lower.

Since the proposed PTC structure is also more generous for older workers, it is particularly beneficial for older workers with upper-middle incomes. For example, consider a single individual with income at 500 percent of the FPL, which is $64,400. This person is currently not eligible for a PTC. Under the Democrats' proposal, a single 60-year-old at that income level would qualify for an annual PTC of $6,010, compared to just $634 for a 45-year-old and $0 for a 30-year-old. The key to understand this is that the PTC is structured to hold the percentage of income that a household spends on the benchmark health insurance plan constant, regardless of the size of the premium. Taxpayers pick up the difference. The ACA permits premiums for 64-year-olds to be three times more than the premiums for 21-year-olds. This means that the PTC is much larger for older enrollees, since the credits rise dollar-for-dollar with premiums. Holding income, household size, and geographic location constant, buying subsidized exchange plans is thus a much better deal for older workers relative to younger workers. The examples in this paper use a 60-year-old and 30-year-old, and their premium variation is 2.4 to 1, so they do not illustrate the full magnitude of how this PTC structure benefits older workers and disadvantages younger workers.

For a family of four at 500 percent of the FPL, the annual PTC amount is $4,818 for a family headed by a 30-year-old couple, $7,842 for a family headed by a 45-year-old couple, and $19,098 for a family headed by a 60-year-old couple. To emphasize, a family that is earning $132,500 a year would qualify for a $19,098 health insurance tax credit. A 60-year-old-led family of four earning 1,000 percent of the FPL, or $265,000 a year, would qualify for an annual PTC of $7,835 under the proposal.

The high premiums for exchange plans, coupled with the PTC design, has caused the exchange risk pools to disproportionately consist of older and lower-income people. The economics of the proposed PTC expansion would likely disproportionately add older, higher-income people to the risk pool. If so, insurance companies would increase premiums to cover the risk of an older and less healthy risk pool, and subsidies would consequently increase as well.

TABLE 3

Current PTC vs Proposed PTC for a 30-Year-Old, Annual Amounts

	Single Coverage				Family of Four			
FPL	Income	Current PTC	Proposed PTC	PTC Increase	Income	Current PTC	Proposed PTC	PTC Increase
150%	$19,320	$4,000	$4,800	$800	$39,750	$14,434	$16,080	$1,646
200%	$25,760	$3,120	$4,285	$1,164	$53,000	$12,624	$15,020	$2,396
250%	$32,200	$2,118	$3,512	$1,394	$66,250	$10,561	$13,430	$2,869
300%	$38,640	$1,002	$2,482	$1,480	$79,500	$8,265	$11,310	$3,045
350%	$45,080	$369	$1,532	$1,163	$92,750	$6,963	$9,356	$2,393
400%	$51,520	$0	$421	$421	$106,000	$5,660	$7,070	$1,410
401%	$51,649	$0	$410	$410	$106,265	$0	$7,047	$7,047
450%	$57,960	$0	$0	$0	$119,250	$0	$5,944	$5,944
500%	$64,400	$0	$0	$0	$132,500	$0	$4,818	$4,818
550%	$70,840	$0	$0	$0	$145,750	$0	$3,691	$3,691
600%	$77,280	$0	$0	$0	$159,000	$0	$2,565	$2,565
650%	$83,720	$0	$0	$0	$172,250	$0	$1,439	$1,439
700%	$90,160	$0	$0	$0	$185,500	$0	$312	$312

SOURCE: Author's calculations based on the subsidy formula and using national averages for premiums.

The proposed PTC expansion would also benefit men more than women, as the U.S. median income was about $10,000 higher for men than for women ($56,264 versus $46,332) in 2020.[14] Since men tend to make more than women do, and this proposal provides greater benefits as incomes increase, it almost certainly benefits men more than women overall. Some might consider this particularly unfair for older women, because they have suffered the highest premium and cost-sharing increases of any group because of the ACA.[15]

[14] The median weekly earnings for full-time wage and salary male workers is $1,082 and for full-time wage and salary female workers is $891. Multiplying these amounts by 52 weeks yields $56,264 and $46,332 per year, respectively. See "Labor Force Statistics from the Current Population Survey."

[15] Joann Weiner, "Older Women Bear the Brunt of Higher Insurance Costs Under Obamacare," *The Washington Post*, June 24, 2014, https://www.washingtonpost.com/blogs/she-the-people/wp/2014/06/24/older-women-bear-the-brunt-of-higher-insurance-costs-under-obamacare/.

TABLE 4

Current PTC vs Proposed PTC for a 45-Year-Old, Annual Amounts

	Single Coverage				Family of Four			
FPL	Income	Current PTC	Proposed PTC	PTC Increase	Income	Current PTC	Proposed PTC	PTC Increase
150%	$19,320	$5,308	$6,108	$800	$39,750	$17,458	$19,104	$1,646
200%	$25,760	$4,428	$5,593	$1,164	$53,000	$15,648	$18,044	$2,396
250%	$32,200	$3,426	$4,820	$1,394	$66,250	$13,585	$16,454	$2,869
300%	$38,640	$2,310	$3,790	$1,480	$79,500	$11,289	$14,334	$3,045
350%	$45,080	$1,677	$2,840	$1,163	$92,750	$9,987	$12,380	$2,393
400%	$51,520	$1,044	$1,729	$685	$106,000	$8,684	$10,094	$1,410
401%	$51,649	$0	$1,718	$1,718	$106,265	$0	$10,071	$10,071
450%	$57,960	$0	$1,181	$1,181	$119,250	$0	$8,968	$8,968
500%	$64,400	$0	$634	$634	$132,500	$0	$7,842	$7,842
550%	$70,840	$0	$0	$0	$145,750	$0	$6,715	$6,715
600%	$77,280	$0	$0	$0	$159,000	$0	$5,589	$5,589
650%	$83,720	$0	$0	$0	$172,250	$0	$4,463	$4,463
700%	$90,160	$0	$0	$0	$185,500	$0	$3,337	$3,337
750%	$96,600	$0	$0	$0	$198,750	$0	$2,210	$2,210
800%	$103,040	$0	$0	$0	$212,000	$0	$1,084	$1,084

SOURCE: Author's calculations based on the subsidy formula and using national averages for premiums.

In essence, the ACA hiked premiums and cost-sharing most significantly for older women, and this proposal delivers the greatest benefits to older, upper-income men.

TABLE 5

Current PTC vs Proposed PTC for a 60-Year-Old, Annual Amounts

	Single Coverage				Family of Four			
FPL	Income	Current PTC	Proposed PTC	PTC Increase	Income	Current PTC	Proposed PTC	PTC Increase
150%	$19,320	$10,684	$11,484	$800	$39,750	$28,714	$30,360	$1,646
200%	$25,760	$9,804	$10,969	$1,164	$53,000	$26,904	$29,300	$2,396
250%	$32,200	$8,802	$10,196	$1,394	$66,250	$24,841	$27,710	$2,869
300%	$38,640	$7,686	$9,166	$1,480	$79,500	$22,545	$25,590	$3,045
350%	$45,080	$7,053	$8,216	$1,163	$92,750	$21,243	$23,636	$2,393
400%	$51,520	$6,420	$7,105	$685	$106,000	$19,940	$21,350	$1,410
401%	$51,649	$0	$7,094	$7,094	$106,265	$0	$21,327	$21,327
450%	$57,960	$0	$6,557	$6,557	$119,250	$0	$20,224	$20,224
500%	$64,400	$0	$6,010	$6,010	$132,500	$0	$19,098	$19,098
550%	$70,840	$0	$5,463	$5,463	$145,750	$0	$17,971	$17,971
600%	$77,280	$0	$4,915	$4,915	$159,000	$0	$16,845	$16,845
700%	$90,160	$0	$3,820	$3,820	$185,500	$0	$14,593	$14,593
800%	$103,040	$0	$2,726	$2,726	$212,000	$0	$12,340	$12,340
900%	$115,920	$0	$1,631	$1,631	$238,500	$0	$10,088	$10,088
1000%	$128,800	$0	$536	$536	$265,000	$0	$7,835	$7,835
1100%	$141,680	$0	$0	$0	$291,500	$0	$5,583	$5,583
1200%	$154,560	$0	$0	$0	$318,000	$0	$3,330	$3,330
1300%	$167,440	$0	$0	$0	$344,500	$0	$1,078	$1,078

SOURCE: Author's calculations based on the subsidy formula and using national averages for premiums.

Exacerbate Unfairness in the Tax Code Based on How People Obtain Coverage

Premiums for ESI—both the employer share and employee share—are not subject to federal income or payroll taxes. By protecting ESI premiums from taxation, the government has historically encouraged employers to offer health plans to their workers. According to CBO, the average tax benefit that a recipient of ESI receives is about $2,000 in 2021.[16] The ACA left the tax advantage for ESI in place but added the PTC. The PTC was designed to help people who did not have access to affordable ESI or qualify for Medicare or Medicaid.

Because of the progressivity of the tax code, the value of the ESI tax exclusion is greater for higher-income households as well as for people who receive more expensive health coverage. The current design of the PTC is much more valuable to people with lower incomes than is the value of the tax exclusion. The exclusion is more valuable to higher-income people, because the amount of PTC phases out as income increases.

For simplicity purposes, assume that the per-person tax benefit for ESI regardless of income is $2,000 a year. The proposed PTC structure means that the credit will be more valuable than the ESI tax exclusion for a much larger set of people, particularly upper-income and older households. For example, a 60-year-old worker at 200 percent of the FPL would, under the Democrats' proposal, qualify for a PTC of $10,969—more than five times the average value of the ESI tax exclusion. For a 45-year-old worker, the proposed PTC at 200 percent of the FPL is $5,593—or nearly three times the average value of the ESI exclusion. For a 30-year-old worker, the proposed PTC at 200 percent of the FPL is $4,285—more than twice the average value of the exclusion.

For a 30-year-old worker, the break-even point between the value of the PTC and the tax benefit from the exclusion is around 325 percent of the FPL. For workers who earn incomes below this threshold, the PTC exceeds the tax benefit from the exclusion. For workers who earn more than this threshold, the tax exclusion is larger than the PTC. For 45-year-old workers and 60-year-old workers, the break-even points are around 385 percent of the FPL and 870

[16] CBO, "Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2035," September 2020, https://www.cbo.gov/system/files/2020-09/56571-federal-health-subsidies.pdf.

percent of the FPL, respectively. These examples should show that firms that employ a large share of workers for whom the PTC is a much better deal than the exclusion—lower-income workers and older workers all else equal—would be incentivized to not offer a group health plan.

Replace Private Spending with Government Spending

What Has Already Happened?

Roughly 13 million people gained health insurance on net because of the ACA between 2013 and 2019.[17] While people purchase health insurance for many reasons, and trends such as the strength of the economy determine whether people have coverage and the source of that coverage, the ACA's new spending is the central reason that the number of uninsured declined after 2013. However, the net reduction in the uninsured was entirely or almost entirely the result of the ACA's expansion of Medicaid to lower-income, working-age adults without disabilities.

In the ACA's greatest failure, only 2 million more people had individual market coverage in 2019 than 2013.[18] Annualized exchange enrollment in 2019 was 10 million—15 million people below CBO's projections of 25 million exchange enrollees in 2019.[19] The increase in individual market enrollment is offset by a decrease of about 2 million in the number of people with ESI.[20]

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[17] As discussed in the paper, nearly an equivalent number of people likely gained individual market plans as lost employer coverage because of the ACA. The U.S. Census reported a reduction of 13.3 million uninsured people between 2013 and 2017. See Edward R. Berchick, Emily Hood, and Jessica C. Barnett, "Health Insurance Coverage in the United States: 2017," U.S. Census Bureau, September 2018, https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf.

[18] From 2010 to 2013, individual market enrollment in the fourth quarter of the year averaged about 11.8 million people. In 2019, individual market enrollment in the fourth quarter was 13.7 million people. Data for private market enrollment by market segment is derived from insurer regulatory filings compiled by the National Association of Insurance Commissioners, as well as filings by companies regulated by the California Department of Managed Care, and was accessed through Mark Farrah Associates.

[19] CBO, "CBO'S May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," https://www.cbo.gov/sites/default/files/recurringdata/51298-2013-05-aca.pdf.

[20] From 2010 to 2013, ESI enrollment in the fourth quarter of the calendar year averaged 160.0 million covered lives. From 2014 through 2017, the fourth quarter average was 157.8 million. A variety of other factors, including the strength of the economy, contributed to employers' decision to offer ESI, so the immediate period after ACA enactment is most appropriate to determine the law's effect on ESI offerings. Data for private market enrollment by market segment is derived from insurer regulatory filings compiled by the National Association of Insurance Commissioners, as well as filings by companies regulated by the California Department of Managed Care, and was accessed through Mark Farrah Associates.

Since the cost of PTCs is about $50 billion annually, the spending for the 2 million more people with coverage in the individual market is a hefty $25,000 per person. Accounting for the fact that about 2 million people lost employer coverage, which reduces federal budget deficits by about $4 billion, the ACA resulted in about a $46 billion increase in federal subsidies for no net change in the number of people with private insurance.

What This Proposal Would Do

The proposed PTC expansion would benefit four main categories of individuals. The first two categories represent pure crowd-out of private spending with government spending. First, they would be used by people who are already enrolled in exchange plans or ACA-compliant coverage purchased off the exchange. Second, some people who are insured through their employers or through coverage other than ACA-compliant plans would replace that coverage with exchange plans because of the expanded PTC. Third, some people who are uninsured would purchase exchange plans because of the expanded PTC. A fourth group of people benefit from the overall proposal, which makes exchange plans free for people on unemployment insurance, but my analysis does not consider this because of the added complexities and because, unlike the enhanced PTC proposals, it is unlikely that Congress permanently enacts that proposal.

Roughly 9 million people, on an annualized basis, receive PTCs.[21] The proposed PTC expansion makes the subsidies more generous for everyone who is currently receiving one. For example, as Table 4 shows, the PTC would increase by about 26 percent for a 45-year-old at 200 percent of the FPL who is purchasing single coverage and by about 64 percent for that same person earning 300 percent of the FPL. In addition, there are about 2 million people enrolled in ACA-compliant individual market plans—either purchased through the exchange or off-the-exchange—who do not currently receive PTCs. Almost all of them are in households with income above 400 percent of the FPL. Many of them would gain a significant benefit from the expanded PTC, particularly the older people in this group.[22] Additional tax credit expenditures on these 11 million people would not lead to an increase in the number of people with coverage.

[21] CBO, "At a Glance."

[22] Some members of this group, particularly younger ones, would still not quality for PTCs after the expansion.

According to CBO's analysis, $22.5 billion of the $35.5 billion in the cost of the proposal is for individuals who were already enrolled in exchange plans.[23] While these individuals benefit from the expanded subsidies, taxpayers lose by an equal amount. Moreover, given the excess burden of taxation, there is a significant societal loss from replacing private spending with government spending.[24] So, for these 11 million people, the total societal impact from the expanded PTCs is negative.

By limiting the PTC expansion to two years, the decline in ESI is likely to be small. CBO estimates that only about 100,000 people would lose ESI as a result of the temporary PTC expansion.[25] Employers, even those for whom dropping coverage makes economic sense for their workers, may be reluctant to do so if they think the expanded subsidies will expire after 2022. If the PTC expansions are made permanent, however, there would be much greater loss of employer-sponsored coverage, and the crowd-out of private spending from this group would likely exceed that of the first group.

The third group of individuals to benefit from the expanded PTC are otherwise-uninsured individuals who choose to purchase exchange plans because of the increased subsidies. As Tables 3-5 make clear, the proposed subsidy increases are largest for households earning just above 400 percent of the FPL who do not now qualify for PTCs. Moreover, these proposed PTCs are more generous for older people in upper-income categories. To get a sense for the uninsured who stand to benefit from the proposed PTC expansion, Table 6 shows the composition of the uninsured population as reported by CBO.

According to CBO, there are an estimated 31.5 million uninsured in 2021. Most of the uninsured are not eligible to receive PTCs to buy exchange plans. This includes people eligible for Medicaid but not enrolled (6.2 million), people who are not lawfully present (4.4 million), and people with income below the FPL in states where they are not eligible for Medicaid (3.8 million). It also includes people eligible for ESI, as most of them are turning down "affordable" offers of coverage. Assuming three-quarters of people who are uninsured and who have received offers of ESI received affordable offers, 21.3 million of the 31.5 million uninsured are not eligible for the expanded PTC.

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[23] CBO, "At a Glance."

[24] In simple terms, the excess burden of taxation or the deadweight loss is the cost from foregone economic activity as people take actions—such as working less—to avoid the tax.

[25] CBO, "At a Glance."

TABLE 6

Composition of the Uninsured Population, 2021

Eligible but not enrolled in Medicaid	6.2 million
Eligible but not enrolled in Exchange Subsidies	5.1 million
Eligible but not enrolled in Employer Coverage	9.2 million
Not Lawfully Present	4.4 million
Income Below FPL & Not Eligible for Medicaid	3.8 million
Income Too High for Exchange Subsidies	2.9 million
Total Uninsured	**31.5 million**

SOURCE: "Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2035."

There are roughly 10 million people who are currently uninsured and may benefit from an expanded PTC to purchase exchange plans. They fall into three groups—people currently eligible for exchange subsidies but not enrolled, people with income too high for exchange subsidies, and people who receive employer offers that are unaffordable. Some of these people, particularly younger ones, will continue to earn too much income to qualify for expanded PTCs, so their calculus regarding enrollment would remain unchanged.

CBO estimates that 1.7 million more people would be enrolled in the exchanges in 2022 as a result of the expanded PTCs.[26] Of the 1.7 million, 300,000 would replace nongroup coverage outside the exchanges, 100,000 people would replace ESI, and 1.3 million would be from those previously uninsured.[27] CBO expects that about 40 percent of the people who would newly enroll in the exchanges because of the proposed expanded PTCs are now ineligible for the PTCs under current law because their income exceeds 400 percent of the FPL.[28]

[26] Ibid.

[27] Ibid.

[28] Ibid.

Reduced Work and Economic Output

People are incentivized to accept jobs or to work longer hours if they receive a higher rate of return from doing so. The rate of return to work can be diminished both by explicit taxes, such as income and payroll taxes, and implicit taxes—that is, the loss of a government-provided benefit as income increases. The ACA's subsidies are structured as a sliding scale so that the size of the PTC declines as household income increases. Under current law, people between 150 percent and 300 percent of the FPL face an implicit marginal tax rate of about 15.5 percent from the PTC phase-out. This means that for every $100 their income increases, they lose about $15.50 in PTC. For lower-income households, the marginal tax rate they face from earning additional income, after including explicit taxes plus the loss of benefits in means-tested programs, can be 50 percent or more—significantly discouraging work.[29]

For people between 300 percent and 400 percent of the FPL, the implicit tax rate from the PTC phase-out is about 9.8 percent. At 400 percent of the FPL, there is currently a massive implicit marginal tax rate, as earning income above that level results in the complete loss of PTC. This is likely in the thousands of dollars for older workers and those with family plans. The implicit marginal tax rate is currently zero for people who have income above 400 percent of the FPL, as PTCs are not available to them. In the aggregate, CBO projects that the ACA provisions that reduce or eliminate coverage benefits as income rises would reduce work by about 2 million full-time workers[30] and reduce gross domestic product by about 0.7 percent.[31]

Table 7 displays how the PTC proposed expansion affects the implicit marginal tax rate—the loss of PTC as income increases—for a 45-year-old worker. The marginal tax rate changes for workers of other ages are about the same. The enhanced subsidy proposal reduces the implicit marginal rate by about 3.5 percentage points for households between 150 percent and 300 percent of the FPL, increases it by about 6.2 percentage points for households between 300 and 400 percent of the FPL, and increases it by 8.5 percentage points for

[29] David Altig et al., "Marginal Net Taxation of Americans' Labor Supply," *National Bureau of Economic Research* working paper 27164, May 2020, https://www.nber.org/papers/w27164.

[30] Edward Harris and Shannon Mok, "How CBO Estimates the Effects of the Affordable Care Act on the Labor Market," Congressional Budget Office, December 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/workingpaper/51065-acalabormarketeffectswp.pdf.

[31] CBO, "Budgetary and Economic Effects of Repealing the Affordable Care Act," June 19, 2015, https://www.cbo.gov/publication/50252.

TABLE 7

Average Marginal Tax Rates for 45-Year-Old Worker at Income Levels

	150%-300% FPL	300%-400% FPL	400%+ FPL
Current Law	15.5%	9.8%	0%
Proposed Law	12.0%	16.0%	8.5%
Difference	-3.5%	+6.2%	+8.5%

SOURCE: Author's calculations based on the subsidy formula and using national averages for premiums.

households above 400 percent of the FPL. In addition, the proposed PTC expansion substantially lowers the implicit marginal tax rate for households earning near 400 percent of the FPL. It is unclear how these changes would affect overall work and economic output. However, in the aggregate, the effect is likely to be negative, because the higher implicit tax rates would be borne by older workers with middle or upper-middle incomes—workers with generally high productivity. One of the clearest effects would likely be incentivizing workers close to retirement age to transition from full-time to part-time work. While the economic effect would be limited if the expanded subsidies expire after two years, a permanent expansion would likely lead to less work and economic output.

Making the PTCs more generous exacerbates other problems caused by the PTC. Because PTCs are conditioned on having a job without affordable ESI, it encourages workers to have no full-time job or to choose jobs where they are not offered coverage. As the federal government assumes more responsibility for worker health care costs, this increases federal health commitments. Moreover, it encourages workers to underreport income, which is easier for self-employed individuals. By underreporting income, people benefit from higher PTCs as well as lower explicit tax payments.

With respect to the current legislation, there are several components proposed in the Democrats' bill, particularly the expanded unemployment benefit, that would reduce the incentives to work in the short term. In addition, workers who are unemployed at all during the year would qualify for a PTC that covers 100 percent of the cost of a benchmark plan. This study does not analyze the magnitude of the impact of these proposals, but they would lead to less work and economic output in the short term.

Substantial Decline in Employer Coverage

What Has Already Happened?

Employers design the best compensation packages to attract qualified employees. For most employers, particularly large employers, this compensation package includes a group health plan for their employees and generally their employees' dependents. After the ACA was enacted, several surveys showed that many employers would consider dropping coverage because of the new health insurance rules, as their employees would be guaranteed access to individual market plans along with PTCs available for lower and middle-income workers.[32] But if employees are offered affordable ESI, both they and their families are prohibited from receiving PTCs.[33] Employers could exit the health insurance benefits business and use the savings to increase wages. For employers with at least 50 full-time equivalent (FTE) workers, there are penalties for failing to offer "affordable" coverage, although there are no such penalties for smaller employers.[34]

Table 8 shows how the percentage of employers offering coverage, based on employer size, has changed in the period right before and after 2014—the year the exchanges opened. There has been virtually no change among employers with at least 200 workers, as nearly all of them offered ESI before the ACA's key provisions took effect and continued to do so in the years after. Firms with

[32] In early 2011, McKinsey and Company conducted a survey of employers on how the ACA would affect their decision to offer coverage. Overall, 30 percent of employers responded that they would definitely or probably stop offering ESI after 2014. Among employers with a high awareness of reform, this proportion increases to more than 50 percent, and upward of 60 percent would pursue some alternative to traditional ESI. See Shubham Singhal, Jeris Stueland, and Drew Ungerman, "How US Health Care Reform Will Affect Employee Benefits," McKinsey and Company, June 1, 2011, https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/how-us-health-care-reform-will-affect-employee-benefits.

[33] While many Democrats, including President Biden, have proposed to change this so that a worker's family would not be precluded from a PTC if the worker is offered affordable coverage for just themselves, this change is not part of the legislation currently under consideration.

[34] The ACA added Section 4980H, "Shared Responsibility for Employers Regarding Health Coverage," to the Internal Revenue Code. Section 4980H contains two penalties for employers with at least 50 FTEs. First, if an employer fails to offer coverage, it faces a penalty equal to $2,000 for every FTE beyond the first 30 FTEs at the company. Second, employers that offer coverage deemed "unaffordable" pay a $3,000 penalty per employee who receives a PTC. "Unaffordable" coverage is defined as coverage amounting to less than 60 percent of the costs of benefits or the employee's share of the premium exceeding 9.5 percent of his or her income.

TABLE 8

Percentage of Employers Offering ESI, by Employer Size

Employer Size	2010-2013 Average	2014-2017 Average	Percentage Point Drop	Percent Decline
3-9	50.5%	44.3%	6.3%	12.4%
10-24	72.0%	63.5%	8.5%	11.8%
25-49	87.3%	80.8%	6.5%	7.4%
50-199	93.3%	91.5%	1.8%	1.9%
200+	98.8%	98.3%	0.5%	0.5%

SOURCE: Figure 2.2, "2020 Employer Health Benefits Survey."

NOTE: The 2010-2012 column is the average of the offer rates in those three years and the 2017-2019 column is the average of the offer rates in those three years. 2020 was excluded to remove any potential effects of the pandemic.

50-199 workers had a small 1.9 percent decline. The decline in ESI offer rates was larger at firms with between 25 and 49 workers (a 7.4 percent decline) and largest for the firms with fewer than 24 workers (about a 12 percent decline).

Although the ACA caused some employers to stop offering coverage, only about a quarter as many employees are no longer covered with ESI because of the ACA than was originally expected. In their last estimate of the ACA prior to the key provisions taking effect, CBO estimated that about 7 million people would lose ESI because of the ACA,[35] but it is likely that closer to 2 million did.[36]

Table 9 shows the change in the percentage of employees covered by ESI in the four-year period immediately preceding and following when the ACA's key changes took effect. Similar to the decline in firm offerings of ESI, the noticeable decline in employee coverage rates with ESI is concentrated at firms with fewer than 50 employees. There was both a 5.5 percentage point decline in the percentage of employees covered by ESI at firms with 3-24 workers and firms with 25-49 workers. These percentage point declines correspond to a

[35] CBO, "CBO'S May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage."

[36] From 2010 to 2013, ESI enrollment in the fourth quarter of the calendar year averaged 160.0 million covered lives. From 2014 through 2017, the fourth quarter average was 157.8 million. A variety of other factors, including the strength of the economy, contributed to employers' decisions to offer ESI, so the immediate period after ACA enactment is most appropriate to determine the law's effect on ESI offerings.

TABLE 9

Percentage of Employees Covered by ESI, by Employer Size

Employer Size	2010-2013 Average	2014-2017 Average	Percentage Point Drop	Percent Decline
3-24	38.5%	33.0%	5.5%	14.3%
25-49	53.8%	48.3%	5.5%	10.2%
50-199	58.5%	55.3%	3.3%	5.6%
200+	62.5%	62.0%	0.5%	0.8%

SOURCE: Figure 3.11, "2020 Employer Health Benefits Survey."

NOTE: This includes firms that do and do not offer health coverage. It does not include information about dependents covered by a firm's health plan. The 2010-2012 column is the average of the coverage rates in those three years and the 2017-2019 column is the average of the coverage rates in those three years. 2020 was excluded to remove any potential effects of the pandemic.

14.3 percent decline and 10.2 percent decline, respectively. While the change in ESI offering and coverage rates is concentrated at small firms, most people are employed by larger firms. Roughly 73 percent of workers are employed by firms with at least 50 employees, with 65 percent of employers having more than 100 employees and 55 percent having more than 250 employees.[37] Therefore, while the percentage decline in ESI coverage has been significant at firms with fewer than 50 employees, only about one-quarter of U.S. workers are employed by such firms, and less than half of employees at small firms were covered by ESI prior to 2014.

While a few million fewer people have employer coverage because of the ACA, the decline has been less than expected. Initially, employers were probably in a wait-and-see mode, evaluating how the new exchanges would work. The significant initial technical problems along with reports of adverse selection, insurers' exit from the market, escalating premiums and deductibles, narrow network plans, and political uncertainty over the ACA's future likely discouraged many employers from ceasing their group plans in the first few years. Perhaps most importantly, the 2016-2019 period was characterized by an exceptionally strong labor market. Employers believed they needed to maintain coverage to compete for talent.

[37] U.S. Bureau of Labor Statistics, "Distribution of Private Sector Employment by Firm Size Class: 1993/Q1 through 2020/Q1, Not Seasonally Adjusted," https://www.bls.gov/web/cewbd/table_f.txt.

What the Democrats' Proposal Would Do

CBO estimates that only about 100,000 people would lose ESI because of the proposed PTC expansion. As noted earlier, the reason is that the proposed PTC expansion expires after 2022 and employers have already made their coverage decisions about 2021. While some firms, particularly firms with fewer than 50 FTEs, would decide not to offer coverage in 2022 because of the expanded PTCs, most firms, even for those for whom dropping coverage makes sense, would likely not disrupt their employees' coverage if they believe the enhanced subsidies will end after 2022. If they believe that the enhanced PTCs will be made permanent or extended beyond 2022, then there will likely be far more loss in employer coverage in 2022 than CBO projects. The enhanced PTCs would make it much less likely that firms that start operations in 2021 or 2022 would offer a group health plan.

As a result of the pandemic, the factors that lead to relatively small loss of ESI in the post-2013 period are potentially different now, with some employers less likely to think they need to offer coverage to attract workers given the weaker economy and with more insurers participating in the exchanges than did just a few years ago. More importantly, the proposed PTC expansion, if made permanent, provides a powerful incentive for existing employers, particularly those with fewer than 50 FTEs, to drop ESI if they currently offer it and for new employers not to offer coverage.

Assume a firm has 40 workers, with the median worker receiving an annual income of about $40,000. Assuming everyone enrolls in single coverage, the collective tax benefit these workers receive if their employer offers a group plan is about $80,000. The tax benefit from the expanded PTCs is likely to be about twice that much—with the tax benefit somewhat lower if the average age of the workers is below 45 and higher if the average age of the workers is above 45.

It would make little economic sense for firms with fewer than 50 FTEs to offer ESI if their employees earn below median wages. There is simply too much money that the federal government is providing in PTCs. The break-even points above show that smaller firms that employ lower-income and older-than-average workers would be especially likely to drop coverage.[38] Because the PTCs are so much larger than the ESI exclusion for these workers, the cost to the federal government would grow significantly as enrollment in ESI declines.

[38] This would be somewhat tempered, because older workers tend to have established networks of providers that they prefer. Because employer plans tend to cover a larger number of providers, they would tend to prefer employer coverage to individual market coverage.

Total employee premiums now exceed $7,000 for single coverage and $21,000 for family coverage, with the average employer contribution to the plans exceeding $6,000 for single coverage and $15,000 for family coverage.[39] Employers would boost wages with what they would otherwise use on premium contributions. Firms would likely have to boost wages more for higher-income workers who may not qualify for PTCs or whose PTCs would be relatively small. Or some firms could consider offering individual coverage health reimbursement arrangements (HRA) that are affordable only for higher-income workers. Doing so would permit lower-income workers to turn down the individual coverage HRAs and still obtain PTCs to purchase exchange plans. Meanwhile, upper-income workers could use the individual coverage HRAs to purchase individual market plans.

The economics for employers with at least 50 FTEs is more complicated because of the employer mandate. The optimal compensation package for many of these employers would be to offer ESI that is unaffordable to their lower-income workers. Employees offered unaffordable coverage are eligible to receive PTCs. While the firm would be subject to a tax penalty for failing to offer affordable coverage, it would apply only for individual workers who also received PTCs to buy exchange plans.[40] Employers in this scenario would likely save substantial funds, as their premium payment would decline by more than the amount of the mandate penalty they would owe. So they would be able to boost wages, particularly for their higher-income workers, and make their employees better off overall. This would help them hire and retain the most qualified workers that other firms are competing to hire. Of course, the downside of these actions would be profound—adding to the nation's growing health care costs by shifting and expanding costs to the government and taxpayers and with larger subsidies fueling higher health care prices and health insurance premiums.

[39] Average employer contributions for ESI in 2020 were $6,227 for single coverage and $15,754 for family coverage. For small firms, these amounts were $6,297 and $13,618, respectively. Figure 6.7. See Kaiser Family Foundation, "2020 Employer Health Benefits Survey," October 8, 2020, https://www.kff.org/report-section/ehbs-2020-section-6-worker-and-employer-contributions-for-premiums/.

[40] See footnote 33. The size of the penalty for failing to offer affordable coverage is about $4,060 for every worker who utilizes a PTC to purchase a product in the exchange.

PTC Structure Is Inflationary and Adds to Health Care Cost Pressure

Federal fiscal policy already contributes to high and growing health care costs in several ways, principally through Medicare, Medicaid, and the tax exclusion for employer coverage. The design of the PTCs also contributes to health care price inflation, as premium increases are borne by taxpayers and not enrollees. This is because the PTCs limit the percentage of income that households at specified income thresholds must pay for the benchmark plan. This creates inflationary pressure, because the enrollee is not sensitive to premium increases and because the insurer knows the enrollee is not sensitive to premium increases. In areas of the country where only a single insurer offers exchange coverage, the PTC design permits insurers to hike premiums without losing enrollees as they set the benchmark premium. Even where there is more than one insurer, the structure of the PTCs reduces price competition.

The aggregate PTC spending has been smaller than expected, as exchange enrollment is 60 percent below expectations. The proposed PTC expansion, however, would accelerate enrollment and increase the inflationary pressure caused by the PTC's design. By making the PTCs more generous up to 400 percent of the FPL, it would bring more people into the market who are insensitive to premium increases. Eliminating the cap at 400 percent of the FPL would also bring more people into the market who are insensitive to premium increases over time. As health care spending continues to crowd out other components of both family and government budgets, policymakers should be limiting the ways that tax and spending provisions create inflationary health cost pressures, not making them worse.

Policymakers should consider the interests of younger Americans and Americans not yet born who would suffer lower standards of living because of the burden of paying the country's large and growing federal debt—debt largely driven by our already unsustainable health spending policies. They should heed to the words of then-President Obama who assured the American people before a joint session of Congress in 2009 that the ACA would not add a dime to the deficit at any point in time.[41] While that promise has already been reneged on, Congress should at least not make the problem worse.

[41] "I will not sign a [health care] plan that adds one dime to our deficits—either now or in the future. I will not sign it if it adds one dime to the deficit, now or in the future, period. And to prove that I'm serious, there will be a provision in this plan that requires us to come forward with more spending cuts if the savings we promised don't materialize." President Barack Obama, "Transcript: Obama's Health Care Speech," CBS News, September 9, 2009, https://www.cbsnews.com/news/transcript-obamas-health-care-speech/.

The ACA recognized the problem that the uncapped ESI exclusion had on health care cost inflation, adding a 40 percent excise tax on high-cost plans to limit them. This "Cadillac" tax never had a natural political constituency, and Congress repealed it in 2019. The PTC structure is much worse than the ESI exclusion, because it is a credit that grows dollar-for-dollar as the premium for the benchmark plan increases. As such, the proposed PTC expansion puts the federal budget at further risk from increased spending on health care subsidies, which would add to the already massive federal budget deficits and add pressure for tax increases and spending cuts in other parts of the budget.

Conclusion

The ACA failed to usher in an improved individual market for health insurance. In fact, despite $50 billion a year in subsidies for exchange plans, the number of Americans with private coverage is unchanged. Government spending on exchange subsidies largely crowded out private spending on health insurance.

In an effort to boost the ACA-compliant individual market, congressional Democrats are proposing to increase subsidies for everyone who is already eligible for them and make them available to Americans in the top two income quintiles. They are proposing to insert these provisions in legislation intended to deal with the coronavirus pandemic fallout, but these provisions are not targeted to pandemic relief. Rather, they represent a significant increase of federal health spending, with a large part of the benefit going to upper-income Americans. Roughly 75 percent of the spending would represent pure crowd-out, going to individuals who already have health insurance.[42]

If Congress enacts the two-year proposed enhancement in the PTCs, pressure would build for it to be made permanent. Doing so would cause millions of employees to lose employer coverage given that the size of the PTCs is much larger for most workers than the tax benefit of the exclusion of ESI premiums from federal taxation. This, combined with the feature of the PTC that puts taxpayers at nearly full risk to shoulder premium increases, would fuel already unsustainable federal health care commitments, putting increasing strain on both family and government budgets.

Better approaches are available for Congress for both the short term and the long term. In the short term—and particularly since household income grew

[42] See footnote 2.

substantially in 2020 given the magnitude of the assistance provided by Congress—subsidies for health insurance should be limited to people who lost coverage because of the pandemic. In the long term, Congress needs to reform the way the federal government subsidizes health care and coverage to better utilize taxpayer dollars and create better incentives so that consumers and providers improve health care value. Congress should look to build on the individual coverage HRA, which equalized the tax benefit between traditional ESI and employer contributions that workers can use to purchase individual market coverage. A more comprehensive reform is contained in the Health Care Choices Proposal.[43]

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[43] Health Policy Consensus Group, "Health Care Choices 2020: A Vision for the Future," October 20, 2020, https://www.healthcarechoices2020.org/wp-content/uploads/2020/10/HEALTH-CARE-CHOICES-2020_A-Vision-for-the-Future_FINAL-002-1.pdf.

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