# Obamacare: A Cost Analysis of the

# Patient Protection and Affordable Care Act, Relative to Recent Estimates

Senior Honors Thesis

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Abstract

The Patient Protection and Affordable Care Act, widely recognized as “Obamacare,” is one of the most polarizing pieces of legislation in modern America, and will likely be considered the centerpiece of Obama’s presidency in future generations. As of this writing, the GOP has attempted to repeal Obamacare over 30 times since its inception. However, the law remains in place today and seeks to dynamically alter the health care landscape in America. But at what cost? This paper tackles precisely that question. Specifically, the history of Obamacare will be introduced, followed by a summary of exactly what the law aims to accomplish. Then, a thorough cost analysis of the Obamacare Act will determine whether or not the Congressional Budget Office is accurate in its claims concerning the sources of funding for, and spending implications related to, the act.

Introduction to Obamacare

In the United States, the health care system and federal budget are two of the greatest points of concern and contention in the public eye. Health care costs are the fastest growing component of the federal budget today; in 2011 Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) accounted for 21 percent of the budget, with Medicare taking responsibility for about two-thirds of that accumulation.[1] At a time when the 65-plus population in America is rapidly expanding, health care costs show no signs of slowed growth, putting a huge strain on the entire system and creating numerous problems within. The over 15 percent of uninsured Americans can largely be explained by discrimination in the policy market. People who want to buy insurance with a pre-existing condition can, and often are, turned down at point of sale; this is common and understandable practice for insurance companies looking to maximize profits and minimize risk through the underwriting process. In addition, small businesses looking to insure their employees are met with a disadvantage when workers get sick; in many cases, they are asked to pay extra to account for ill employees, for similar reasons. These unfavorable outcomes for those seeking insurance are simply a natural byproduct of insurance companies protecting both themselves and those who are already insured.

Enter the Patient Protection and Affordable Care Act (PPACA), otherwise known as Obamacare, with the ultimate goal of major, nationwide health care reform, in the largest effort since Medicare and Medicaid were passed in 1965. President Obama signed PPACA into law on March 23rd, 2010. The bill is extensive, and it essentially proposes two phases. As of this writing, the first phase of the bill is nearing its conclusion, and the second, more radical phase is set to

[1] Policy Basics: Where Do Our Federal Tax Dollars Go? http://www.cbpp.org/cms/?fa=view&id=1258

begin on the 1st of January 2014. To understand just how expansive the bill really is and begin to determine the cost, each phase is best dissected separately.

Phase I is less a complete overhaul and more detail-oriented. It aims to fill the gaps that have been plaguing potential health insurance customers who may carry substandard risk; this term includes individuals that an insurance company determines are especially risky to insure, whether because of a pre-existing condition or other reasons. Policies purchased through an employer or privately purchased after Phase I began are no longer subject to lifetime limits, easing the strain on individuals and families looking for solutions to chronic condition bills. Children can no longer be turned down for a policy based on pre-existing conditions, and they can remain on their parents' policy until the age of 26, ensuring a smooth transition from dependency to self-support. In addition, many preventative care services like vaccinations and screenings are now free for all private insurance policies purchased after the start of Phase I, and small businesses have new tax breaks they can utilize to recoup some of the money spent on purchasing health insurance for employees. For example, small businesses can apply for tax breaks up to 35% of their employee premiums if they have fewer than 25 full-time employees.[2] But perhaps the biggest change Phase I made was the creation of a new high-risk pool, which enabled those adults who could not secure a policy because of their poor health to obtain one. The government chips in an additional amount of money to keep down costs for insurance companies who scout from this pool, but only until the pool is phased out at the end of 2013.

This is the time at which Obamacare begins to show its true colors. At the start of the 2014 calendar year, Medicaid will expand to cover every low income individual and family in

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[2] Explaining Obamacare's Baffling Tax Breaks for Small Business. http://www.businessweek.com/articles/2013-03-22/explaining-obamacares-baffling-tax-breaks-for-small-business

states that choose to allow it. This was originally planned to encompass all fifty states until a June 2012 Supreme Court decision ruled this aspect of Obamacare unconstitutional[3]; this is elaborated on in a later section. Obviously, still not everyone will qualify as low income; the group of everyone else from middle class to the wealthiest individuals will acquire health insurance through other available options. Many individuals will still elect to keep their employer's insurance provider, which is completely fine and unchanged for the most part. The system overhaul largely applies to those who do not have the option to purchase health insurance through their place of work. These individuals will now be able to participate in the new exchange system, which is most simply described as a mall of health insurance companies. Based on where individuals live, they will receive options from regional insurance companies that are now forced to compete under strict rules, ensuring that everyone is given a fair shake in the health insurance market. Additionally, in a continuation of the "hole filling" that constituted most of Phase I, insurance companies will no longer be able to turn anyone down or charge more for a pre-existing condition or illness.

This is a radical new plan, as well as a double edged sword for some individuals. Not only will health insurance companies be held to a higher standard under this new act; now, all individuals will be expected to either have insurance or pay a penalty tax, with very few exceptions. One can draw analogies to smaller state statutes that require either mandatory participation or large levies of fines; the Florida helmet laws for motorcycle operators comes to mind, which requires either the wearing of a helmet or possession of at least $10,000 of applicable insurance.[4] However, this and other similar state and local laws are not so expansive

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[3] Supreme Court Upholds Health Care Law, 5-4, in Victory for Obama. http://www.nytimes.com/2012/06/29/us/supreme-court-lets-health-law-largely-stand.html

[4] Florida's Motorcycle Helmet Law. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448295/

as to affect an entire nation of individuals, approximately 55 million nonelderly which were uninsured as of May 2013[5], making Obamacare an unprecedented change for a country that has shown to be dealing with roughly 50% overweight and obese rates[6], among other health issues. In addition to this penalty for individuals, larger businesses and corporations are also required to offer insurance to their employees, or pay fines as an alternative. The government estimates that over 25 million of these nonelderly individuals who do not currently have health insurance will be newly insured by the year 2017, which is a substantial improvement. This would leave just 30 million uninsured, which amounts to 11% of the total projected population or 8% of the eligible population, a figure that excludes undocumented immigrants who are not eligible for coverage under PPACA.[7]

It has been shown that Obamacare is both comprehensive and expansive, but of concern for this study is the cost of such a program. The law has already run into major difficulties during Phase I; for example, the high-risk pools, thought to be one of the greatest boons of the act, have already strained the $5 billion budget they were allocated. Ironically, at the end of May 2013 the Health and Human Services Department of the United States began blocking enrollment into this high-risk pool because of the financial strain it has put on the Obamacare program, and began shifting more of the healthcare costs onto the enrollees, which at first glance seems extremely counterproductive considering that Obamacare's very design is centered around shifting cost

[5] CBO's May 2013 Estimate. http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf

[6] Overweight and Obesity – 2013 Statistical Fact Sheets. http://www.heart.org/idc/groups/heart-public/@wcm/@sop/@smd/documents/downloadable/ucm_319588.pdf

[7] CBO's May 2013 Estimate. http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf

away from the individual.[8] In addition, on July 3rd, 2013, the U.S. Treasury Department pushed back the employer mandate until 2015, meaning that many small businesses have another year to get a health insurance plan together for their employees without penalty.[9] And with recent reports that federal and state health officials will not have the new health insurance exchanges set up in time for their debut in late 2013, there is a lot to sort through when trying to determine how much Obamacare will cost, and where the money will come from.

## The Cost of Obamacare

The first step in this analysis is determining how much the Obamacare bill will cost American citizens and the government, in order to better understand the rationale behind funding sources. This is a difficult number to pinpoint, simply because the bill continues to grow and evolve, month after month, with modifications and delays such as those described above. It is best to begin with the Congressional Budget Office's first attempt at estimating the scope of Obamacare, an attempt that was first made available to the public on December 19th, 2009 on the CBO website[10], and seeing how the numbers included in this report shifted as more recent estimates were made.

The time period concerned in this initial report was the ten-year period from the beginning of 2010 to the end of the year 2019 (a bit optimistic for its time, considering that the bill was not signed into law until March 23rd, 2010, almost three months into the period under consideration). Overall, according to the initial assessment made by the CBO and the Joint

[8] Funds run low for health insurance in state 'high-risk pools'. http://articles.washingtonpost.com/2013-02-15/national/37115717_1_high-risk-pools-insurance-oversight-health-insurance
[9] Delay in Obamacare – what you need to know. http://money.cnn.com/2013/07/03/smallbusiness/obamacare-employer-mandate/index.html?iid=EL
[10] Report to Senate Majority Leader Harry Reid on spending and revenue effects. http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/108xx/doc10868/12-19-reid_letter_managers_correction_noted.pdf

Committee on Taxation (JCT), the projected net cost of the proposed expansions in insurance coverage that Obamacare offers is $614 billion over the ten-year period being considered.[10] The report describes this net cost in two components: "a gross total of $871 billion in subsidies" to fund the new insurance exchanges as well as increased funding for both Medicaid and the Children's Health Insurance Program, all of which are offset by "$149 billion in revenues from the excise tax on high-premium insurance plans and $108 billion in net savings from other sources." It should be noted that this section of the report also claims that this net cost will be "more than offset" by various spending changes and other provisions; this will be further considered after analyzing the progression of the legislation's total cost.

The $871 billion in gross cost was broken down into the following categories, with mostly intuitive results. $395 billion was allocated to "Medicaid & CHIP Outlays" over the ten years, clearly a direct result of the Obama administration's desire to see Medicare expanded rather than limited. Another $436 billion was allocated to "Exchange Subsidies" and other spending related to the creation of this new healthcare marketplace of sorts. In a footnote, the report also mentions that $5 billion of this figure was allocated to funding the high-risk pools, which is already known to be a huge underinvestment that will be later reevaluated. Finally, $40 billion was allocated to small employer tax credits, the credits detailed earlier that will be awarded to small businesses paying at least half of their employee health insurance premiums.

Three months later, the final, reconciled version of the bill made its way through Congress with a number of significant changes, not all of which concerned health care. Changes were made to the Federal Family Education Loan program, eliminating private lenders in the middle and establishing new college loads funded directly by the U.S. Treasury and administered

by the Department of Education.[11] This change was estimated to save about $60 billion over the ten-year period from 2010-2019, and represents the largest non-healthcare amendment made between the initial cost analysis and this one.

The March 2010 report details the changes with the largest budgetary effects concerning the ten-year period, including:

- Increased funding for premiums and cost sharing through the new exchanges;
- Increased penalties for employers that do not offer health insurance;
- Increased federal spending for a portion of Medicaid beneficiaries;
- Increased Medicaid eligibility and expanded drug benefits for Medicaid;
- Increased taxes for a larger portion of higher-income households.

At first look, these initiatives appear to be oriented toward higher overall spending for the life of the bill, and this is indeed the case. The new estimates included in the report detail an increase of $39 billion to Medicaid & CHIP spending and an additional $28 billion in spending relative to the insurance exchanges, resulting in a new gross figure of $938 billion.

This March 2010 report was the last cost estimate released by the CBO before the bill was signed into law on March 23rd. The next analysis came in the form of a testimony by CBO Director Douglas Elmendorf before the Subcommittee on Health, Committee on Energy and Commerce, and the House of Representatives on March 30th, 2011. For this report, the ten-year period has shifted to concern 2012-2021, and the new figures dramatically reflect this. Because this report includes only two more years of Phase I Obamacare and eight years of Phase II, when

[11] Reconciliation Act of 2010 (Final Health Care Legislation). http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf

the majority of spending begins, the ten-year spending figure increases to about $1.45 trillion, a considerable sum, especially when compared with the previous ten-year figures. Elmendorf confirms that "the difference between the two estimates does not reflect any substantial change in the estimation of the overall effects of the two laws," and is simply a product of the passage of time.[12] However, it has been common during the entire life of Obamacare to see these figures skewed and used in such a way as to make the bill look foolish and improvident. The difference of about $500 billion in spending is wholly justified by the years 2020 and 2021, when PPACA will presumably be in full-swing.

The CBO's March 2012 analysis is a bit intriguing; while gross spending estimates increased to nearly $1.5 trillion from $1.45 trillion in the previous year, offsetting income increased even more, resulting in an overall reduction of the net spending estimates. Continuing with the focus on the gross spending figures, the March 2012 report provides that the major reason for the slight gross spending increase is based on a small change in the economic outlook. The January 2012 economic forecast predicted an increase in unemployment for the projected ten-year period 2012-2021, as well as a lower prediction for wage and salary levels in the same period.[13] This leads to two consequences: an increase in the number of people eligible for Medicaid and CHIP, and a reduction in those eligible for purchasing through the exchanges. One would expect these two shifts to counterbalance, but the reduction in exchange-eligible individuals is composed of two forces: those individuals at the low-end of the salary spectrum who move from exchange to Medicare, and those at the high-end that go from an ineligible to an eligible state. As one could expect, there is a much bigger population at the low-end, which

[12] CBO's Analysis of the Major Health Care Legislation Enacted in March 2010. http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf

[13] Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act. http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf

means that the cost of Medicare for these newly eligible citizens will greatly outweigh the savings from a reduction in subsidy-eligible individuals; this is the heart of the gross spending increase from 2011 to 2012 projections.

A major landmark in the brief but busy history of Obamacare took place on June 28th, 2012. After three days of heated arguments in the nation's capital, the Supreme Court of the United States delivered a ruling that left the Affordable Care Act "largely unscathed[14]," but made some changes that merited an updated cost analysis from the Congressional Budget Office, namely the partial restriction of Medicare's expansion.[15] The court ruled that it was unconstitutional for the law to require forced participation in commercial activities and the purchase of services that individuals do not want. In addition, the justices also determined that the Affordable Care Act cannot require states to make an "all-or-nothing" decision when considering whether or not they should participate in the healthcare expansion. Previously, states would have had to decide either to participate in the Affordable Care Act and receive additional government payments, or decline such participation at the expense of payments currently being received. The Supreme Court revised these two choices: states now have the option to participate in the Affordable Care Act and receive the additional payments, or decline participation as before, but now in the latter scenario the federal government cannot revoke existing payments being made to states. As a result of these rewritings, the CBO came to the conclusion that projected Medicaid and CHIP savings based on the Supreme Court's decision would outweigh additional exchange subsidy costs. Specifically, about six million fewer individuals are projected to participate in Medicaid, leading to roughly $36 billion in government savings in 2022,

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[14] Supreme Court Upholds Health Care Law, 5-4, in Victory for Obama. http://www.nytimes.com/2012/06/29/us/supreme-court-lets-health-law-largely-stand.html
[15] Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf

contrasted by a cost of about $9 billion in 2022 for the three million additional individuals projected to participate in the healthcare exchanges. The CBO report is very careful to note that "there are many questions about how the new state option for Medicaid will be administered," and this remains true to this day: on September 5th, 2013, "fewer than half of the states have decided to expand Medicaid within their borders" in 2014.[16]

Finally, at the beginning of May 2013, the Congressional Budget Office released their most recent cost estimate for PPACA, and the ten-year totals have now been shifted to the period from 2014 to 2023, entirely concerning Phase II.[17] The results of the preceding four years of cost analyses are summarized in Table 1. On a macro level, there is nothing particularly remarkable about any figures and reasons provided by the CBO reports discussed. They all appear to be rather realistic and grounded, and have been provided mostly to set the stage for the next section of this investigation, which revolves around identifying the sources of funding for Obamacare and ultimately determining whether or not the bill is realistically funded by the federal government.

Does America Have The Money Right Now?

To answer this question, it is best to start by first moving from the gross spending estimates provided by the CBO reports to the net spending estimates, and analyzing how this difference is justified. CBO's July 2012 estimate pegs the gross cost of coverage provisions at $1.68 trillion for the ten-year period from 2013-2022. Since the first CBO analysis in 2009, the

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[16] Many will not get Obamacare benefits in states resisting Medicaid push: study. http://www.washingtontimes.com/news/2013/sep/5/many-will-not-get-obamacare-benefits-states-resist/
[17] Direct spending and revenue effects of H.R. 6079. http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf

following four elements have been included when calculating the net cost of coverage for PPACA:

- Penalty payments by uninsured individuals;
- Penalty payments by employers failing to comply with Obamacare;
- An excise tax on high-premium insurance plans;
- Other effects on tax revenues and outlays (mostly revenues).

These elements have significant effects in the tens of billions, bringing the net cost of coverage provisions for the same ten-year period to $1.165 trillion. This number becomes the primary focus of this analysis, with a goal of determining whether the entire figure is appropriately funded or not. The Obama administration chose to pay for Obamacare with two broad categories of funding: government spending cuts and revenue increases. All of the following figures concern the same ten-year period from 2013 to 2022.

Cuts to government spending are relatively straightforward and account for $741 billion of the $1.165 trillion figure.[18] As the Washington Post notes, the government spending cuts are "mostly changes to how the government pays the doctors and hospitals who provide care to Medicaid and Medicare patients." The $741 billion is broken down into $415 billion of cuts in Medicare payment rates, $156 billion of cuts in Medicare Advantage payments, $56 billion to cuts to disproportionate share payments, and $114 billion in other cuts. At the same time, revenue increases come from a variety of sources. The CBO report breaks it down into six categories: $55 billion in tax penalties by those who choose not to carry health insurance, $117

[18] How Congress paid for Obamacare. http://www.washingtonpost.com/blogs/wonkblog/wp/2012/08/30/how-congress-paid-for-obamacare-in-two-charts/

billion in tax penalties paid by noncompliant employers, $111 billion in excise taxes on the highest premium health insurance plans, $216 billion saved from positive side effects of expanding insurance to more individuals (more preventative care and less emergency care, for example), $318 billion generated by a new 3.8% tax on investment income for those who make $200,000 or more annually, and another $165 billion from new fees placed on manufacturers and insurers.

Some of these figures are already included in the net spending estimates that CBO provides. Table 1 considers each component individually and establishes that Obamacare is about 102% funded according to numbers established in the CBO reports, resulting in Obamacare running a $43 billion surplus. This is actually a reasonable figure when compared with the nearly $17 trillion debt that America currently holds. However, rather than compare figures over the entire ten-year period, a more natural way to approach this problem is to take present values of figures in each future year of the timeframe being considered, and compare the sums of those present values instead.

Table 1: Funding components of Obamacare (in 2013 $B)[19]

| | **PV** | **% of Gross Estimate** |
|---|---|---|
| Gross Spending Estimate, 2013-2022 | -1,677 | -100% |
| Penalty Payments by Individuals | 55 | 3.3% |
| Penalty Payments by Employers | 117 | 7.0% |
| "Cadillac Plans" Excise Tax | 111 | 6.6% |
| Insurance Expansion Benefits | 216 | 12.9% |
| Investment Income Tax | 318 | 19.0% |
| Manufacturer/Insurer Fees | 165 | 9.8% |
| Medicare Cuts | 415 | 24.7% |
| Medicare Advantage Cuts[20] | 156 | 9.3% |
| Disproportionate Share Cuts[21] | 56 | 3.3% |
| Other Cuts | 114 | 6.8% |
| **Total Funding** | **1,723** | **102.7%** |
| **Difference** | **46** | **2.7%** |

Considering Multiple Scenarios with Present Values

For this phase of the analysis, three different interest rates will be utilized in the present value calculations. The CBO reports do not provide individual per-year cash flows for every category being considered; this is a problem that can be solved with reasonable estimation of these per-year cash flows depending on the funding source. To start, the cash flows that are explicitly provided in the CBO reports are considered first. Unless otherwise noted, the following figures and resulting calculations are all obtained from Footnote 17 and are discounted to the current year (2013). Total figures taken directly from the CBO reports (at 0% effective interest) may not equal the sum of individual years because of rounding, but calculated present value figures are summed precisely and rounded to the nearest billion dollars.

[19] Numbers in bold across all tables may not sum correctly to totals due to being rounded to the nearest billion dollars.

[20] Medicare Advantage plans are "a type of Medicare health plan offered by a private company that contracts with Medicare" to provide an individual with Medicare Part A and B benefits. http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html

[21] Disproportionate Share Hospitals provide care for insolvent patients using funding from the United States government. http://en.wikipedia.org/wiki/Disproportionate_share_hospital

Interest rate justification.

With the current state of American markets and the economy, an interest rate less than 1% might be the most realistic number to use when discounting cash flows. However, for the sake of reasonable analysis, 1.01 was chosen as the lowest of the three discount factors. The other two chosen rates were 5%, representing a moderate interest rate, and 10%, which is intended to represent an unusually high interest rate. This way, multiple conclusions about Obamacare's funding and future can be drawn, no matter which direction American interest rates travel in the next ten years and beyond.

Table 2: Gross Spending Estimates (in 2013 $B)[22]

| | **PV** | **i = 0.01** | **i = 0.05** | **i = 0.10** |
|---|---|---|---|---|
| 2013 | 5 | 5.000 | 5.000 | 5.000 |
| 2014 | 53 | 52.475 | 50.476 | 48.182 |
| 2015 | 113 | 110.773 | 102.494 | 93.388 |
| 2016 | 161 | 156.265 | 139.078 | 120.962 |
| 2017 | 189 | 181.625 | 155.491 | 129.090 |
| 2018 | 208 | 197.905 | 162.973 | 129.152 |
| 2019 | 221 | 208.192 | 164.914 | 124.749 |
| 2020 | 229 | 213.592 | 162.746 | 117.513 |
| 2021 | 242 | 223.483 | 163.795 | 112.895 |
| 2022 | 256 | 234.071 | 165.020 | 108.569 |
| **Total** | **1,677** | **1,583** | **1,272** | **989** |

These numbers are extracted directly from the July 2012 CBO analysis. Of note is the pattern at higher interest rates. At 5% valuation, the cash flows seem to level out at around $165 billion per year, indicating a decent amount of stability. At an exceptionally high interest rate of 10%, these flows actually begin decreasing in present value after 2018.

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[22] Direct spending and revenue effects of H.R. 6079.
http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf

Table 3: Individual Penalty Payments (in 2013 $B)

| | **PV** | **i = 0.01** | **i = 0.05** | **i = 0.10** |
|---|---|---|---|---|
| 2013 | 0 | 0.000 | 0.000 | 0.000 |
| 2014 | 0 | 0.000 | 0.000 | 0.000 |
| 2015 | 3 | 2.941 | 2.721 | 2.479 |
| 2016 | 6 | 5.824 | 5.183 | 4.508 |
| 2017 | 7 | 6.727 | 5.759 | 4.781 |
| 2018 | 7 | 6.660 | 5.485 | 4.346 |
| 2019 | 7 | 6.594 | 5.224 | 3.951 |
| 2020 | 8 | 7.462 | 5.685 | 4.105 |
| 2021 | 9 | 8.311 | 6.092 | 4.199 |
| 2022 | 9 | 8.229 | 5.801 | 3.817 |
| **Total** | **55** | **53** | **42** | **32** |

The individual penalty has encountered the most stress in the form of public perception, when in reality it is perhaps the least vital component of Obamacare's budget. A favorite argument for critics of the Affordable Care Act involves collection enforcement for the individual penalty tax (for those individuals who decide not to purchase health insurance); already there exists plenty of commentary and opinion on government powers and the Internal Revenue Service's ability to actually collect this penalty.[23] Essentially, the only way they could legally enforce such a measure is by withholding the money from a tax refund due to an individual, but the entire ordeal seems to be largely semantics according to the tables above. Not only is the individual penalty tax the smallest source of sustenance for the bill, but even in the worst-case scenario for the administration (where the government receives zero dollars in the form of individual penalty taxes), Obamacare would remain at least 99% funded, all else equal. A reasonable alternative suggested by some critics involves a one year delay of the individual mandate, similar to the delay that has been imposed on the employer mandate, based on the fact that the individual penalty in the year 2014 will be negligible at best. For example, PPACA

[23] Obamacare's Unenforceable Linchpin. http://reason.com/archives/2012/07/18/obamacares-uneforceable-linchpin

section 1501 currently calls for a penalty which is "$95 or 1% of family income in excess of filing threshold," whichever is greater.[24] United Liberty makes the point that for individuals under 35, this is a roughly $200 individual penalty, which is typically less than one month's premium for a low-level Bronze plan on the Obamacare exchange. This reinforces the weakness of the individual mandate as a meaningful component of the ACA budget. Of far greater concern for proponents of the bill is the volatility that the other riskier categories carry with them

Table 4: Employer Penalty Payments (in 2013 $B)

| | **PV** | **i = 0.01** | **i = 0.05** | **i = 0.10** |
|---|---|---|---|---|
| 2013 | 0 | 0.000 | 0.000 | 0.000 |
| 2014 | 4 | 3.960 | 3.810 | 3.636 |
| 2015 | 9 | 8.823 | 8.163 | 7.438 |
| 2016 | 11 | 10.676 | 9.502 | 8.264 |
| 2017 | 12 | 11.532 | 9.872 | 8.196 |
| 2018 | 14 | 13.321 | 10.969 | 8.693 |
| 2019 | 15 | 14.131 | 11.193 | 8.467 |
| 2020 | 16 | 14.923 | 11.371 | 8.211 |
| 2021 | 17 | 15.699 | 11.506 | 7.931 |
| 2022 | 18 | 16.458 | 11.603 | 7.634 |
| **Total** | **115** | **110** | **88** | **68** |

As mentioned earlier, the employer mandate was delayed and will no longer take effect until the year 2015, sparing employers the potential $3,000 per employee penalty for not offering some form of health insurance. However, many misconceptions have also persisted regarding the consequences of the employer mandate. 94% of companies with more than 50 workers were already offering health insurance before the delay was even implemented, meaning that it will have only the slightest negative effect on employees trying to obtain jobs with health insurance

[24] One-Year Individual Mandate Delay Wouldn't Cripple ObamaCare. http://www.unitedliberty.org/articles/15430-one-year-individual-mandate-delay-wouldn-t-cripple-obamacare

benefits in the year 2014.[25] This corroborates well with the relatively small-sized $4 billion figure in the table above.

Table 5: Excise Tax Payments (in 2013 $B)

| | **PV** | **i = 0.01** | **i = 0.05** | **i = 0.10** |
|---|---|---|---|---|
| 2013 | 0 | 0.000 | 0.000 | 0.000 |
| 2014 | 0 | 0.000 | 0.000 | 0.000 |
| 2015 | 0 | 0.000 | 0.000 | 0.000 |
| 2016 | 0 | 0.000 | 0.000 | 0.000 |
| 2017 | 0 | 0.000 | 0.000 | 0.000 |
| 2018 | 11 | 10.466 | 8.619 | 6.830 |
| 2019 | 18 | 16.957 | 13.432 | 10.161 |
| 2020 | 22 | 20.520 | 15.635 | 11.289 |
| 2021 | 27 | 24.934 | 18.275 | 12.596 |
| 2022 | 32 | 29.259 | 20.627 | 13.571 |
| **Total** | **111** | **102** | **77** | **54** |

Pages 1,941 to 1,956 of PPACA detail the 40% excise tax that begins to take effect in January 2018.[26] Overall, this is still one of the smaller components of the Obamacare budget, especially considering present values and the fact that the government will not see the effects of this for another four years after Phase II begins.

[25] Obamacare Employer Mandate Delayed For One Year. http://www.huffingtonpost.com/2013/07/02/obamacare-employer-mandate_n_3536695.html

[26] Full List of Obamacare Tax Hikes: Listed by Size of Tax Hike. http://atr.org/full-list-obamacare-tax-hikes-listed-a7010#ixzz2k0uw1IAn

Table 6: Expansion Benefits (in 2013 $B)

| | **PV** | **i = 0.01** | **i = 0.05** | **i = 0.10** |
|---|---|---|---|---|
| 2013 | 1 | 1.000 | 1.000 | 1.000 |
| 2014 | 3 | 2.970 | 2.857 | 2.727 |
| 2015 | 6 | 5.882 | 5.442 | 4.959 |
| 2016 | 14 | 13.588 | 12.094 | 10.518 |
| 2017 | 23 | 22.103 | 18.922 | 15.709 |
| 2018 | 29 | 27.593 | 22.722 | 18.007 |
| 2019 | 34 | 32.030 | 25.371 | 19.192 |
| 2020 | 36 | 33.578 | 25.585 | 18.474 |
| 2021 | 35 | 32.322 | 23.689 | 16.328 |
| 2022 | 37 | 33.831 | 23.851 | 15.692 |
| **Total** | **216** | **205** | **162** | **123** |

Of all the projections that CBO makes with regard to future cash flows, this could be considered one of the toughest to estimate. Obamacare is still in its early stages, and while estimates of how many new adopters of Medicaid there will be are relatively stable, it is nearly impossible to estimate both how people will utilize preventative care and whether or not all of these people will still encounter major health problems that would cut into these "preventative care profits," so to speak. The success of this component of the budget and the accuracy of this estimate is almost entirely dependent on recipients taking advantage of the benefits as early as possible.

Table 7: Investment Income Taxes (in 2013 $B)

| | **PV** | **i = 0.01** | **i = 0.05** | **i = 0.10** |
|---|---|---|---|---|
| 2013 | 20 | 20.000 | 20.000 | 20.000 |
| 2014 | 10 | 9.901 | 9.524 | 9.091 |
| 2015 | 25 | 24.507 | 22.676 | 20.661 |
| 2016 | 29 | 28.147 | 25.051 | 21.788 |
| 2017 | 32 | 30.751 | 26.326 | 21.856 |
| 2018 | 35 | 33.301 | 27.423 | 21.732 |
| 2019 | 38 | 35.798 | 28.356 | 21.450 |
| 2020 | 41 | 38.241 | 29.138 | 21.039 |
| 2021 | 43 | 39.710 | 29.104 | 20.060 |
| 2022 | 46 | 42.060 | 29.652 | 19.508 |
| **Total** | **318** | **302** | **247** | **197** |

This comprises perhaps the most volatile component of the budget for Obamacare. Weights for the different interest rates range from 19% to 20% of the overall ACA budget; in the event of a large shock to national and worldwide markets, this funding source would likely decline and perhaps bring the budget a decent amount into the red.

Table 8: Manufacturer and Insurer Fees (in 2013 $B)

| | **PV** | **i = 0.01** | **i = 0.05** | **i = 0.10** |
|---|---|---|---|---|
| 2013 | 10 | 10.000 | 10.000 | 10.000 |
| 2014 | 12 | 11.881 | 11.429 | 10.909 |
| 2015 | 15 | 14.704 | 13.605 | 12.397 |
| 2016 | 15 | 14.559 | 12.958 | 11.270 |
| 2017 | 18 | 17.298 | 14.809 | 12.294 |
| 2018 | 19 | 18.078 | 14.887 | 11.798 |
| 2019 | 18 | 16.957 | 13.432 | 10.161 |
| 2020 | 19 | 17.722 | 13.503 | 9.750 |
| 2021 | 20 | 18.470 | 13.537 | 9.330 |
| 2022 | 21 | 19.201 | 13.537 | 8.906 |
| **Total** | **165** | **159** | **132** | **107** |

In a similar vein as investment income taxes, manufacturer and insurer fees are relatively volatile between interest rates, ranging almost 100 basis points across different hypothetical interest rates.

Table 9: Medicare Cuts (in 2013 $B)

| | **PV** | **i = 0.01** | **i = 0.05** | **i = 0.10** |
|---|---|---|---|---|
| 2013 | 4 | 4.000 | 4.000 | 4.000 |
| 2014 | 14 | 13.861 | 13.333 | 12.727 |
| 2015 | 21 | 20.586 | 19.048 | 17.355 |
| 2016 | 25 | 24.265 | 21.596 | 18.783 |
| 2017 | 32 | 30.751 | 26.326 | 21.856 |
| 2018 | 42 | 39.962 | 32.908 | 26.079 |
| 2019 | 53 | 49.928 | 39.549 | 29.917 |
| 2020 | 64 | 59.694 | 45.484 | 32.842 |
| 2021 | 75 | 69.261 | 50.763 | 34.988 |
| 2022 | 86 | 78.633 | 55.436 | 36.472 |
| **Total** | **415** | **391** | **308** | **235** |

Table 10: Medicare Advantage Cuts (in 2013 $B)

| | **PV** | **i = 0.01** | **i = 0.05** | **i = 0.10** |
|---|---|---|---|---|
| 2013 | 0 | 0.000 | 0.000 | 0.000 |
| 2014 | 8 | 7.921 | 7.619 | 7.273 |
| 2015 | 14 | 13.724 | 12.698 | 11.570 |
| 2016 | 18 | 17.471 | 15.549 | 13.524 |
| 2017 | 18 | 17.298 | 14.809 | 12.294 |
| 2018 | 16 | 15.223 | 12.536 | 9.935 |
| 2019 | 18 | 16.957 | 13.432 | 10.161 |
| 2020 | 19 | 17.722 | 13.503 | 9.750 |
| 2021 | 20 | 18.470 | 13.537 | 9.330 |
| 2022 | 23 | 21.030 | 14.826 | 9.754 |
| **Total** | **156** | **146** | **119** | **94** |

These two aspects of Obamacare's budget have encountered the most criticism and controversy since its inception, mainly from those who believe that these cuts dramatically hurt senior citizens. Despite reports that Medicare Advantage enrollment has actually increased as much as

30% since cuts were announced[27], there are mounting reports that the administration has "quietly started to cancel the contracts of providers" in order to save the $156 billion outlined above.[28]

Table 11: Disproportionate Share Cuts (in 2013 $B)

| | **PV** | **i = 0.01** | **i = 0.05** | **i = 0.10** |
|---|---|---|---|---|
| 2013 | 0 | 0.000 | 0.000 | 0.000 |
| 2014 | 0 | 0.000 | 0.000 | 0.000 |
| 2015 | 3 | 2.941 | 2.721 | 2.479 |
| 2016 | 4 | 3.882 | 3.455 | 3.005 |
| 2017 | 6 | 5.766 | 4.936 | 4.098 |
| 2018 | 8 | 7.612 | 6.268 | 4.967 |
| 2019 | 10 | 9.420 | 7.462 | 5.645 |
| 2020 | 9 | 8.394 | 6.396 | 4.618 |
| 2021 | 9 | 8.311 | 6.092 | 4.199 |
| 2022 | 6 | 5.486 | 3.868 | 2.545 |
| **Total** | **56** | **52** | **41** | **32** |

The somewhat linear reduction in disproportionate share hospital funding starting in 2015 will certainly affect the capacity of such facilities; the official Medicaid website explains that "because the number of uninsured is expected to drop due to the eligibility changes in the Affordable Care Act, the law reduces DSH funding over time."[29]

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[27] Obamacare's Reviled Medicare Cuts Have Turned Out Better Than Expected. http://nation.time.com/2013/10/14/obamacares-reviled-medicare-cuts-have-turned-out-better-than-expected/

[28] The seniors getting hurt by Obamacare. http://www.nydailynews.com/opinion/seniors-hurt-obamacare-article-1.1504414

[29] Provider Payments. http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html

Table 12: Other Cuts (in 2013 $B)

| | **PV** | **i = 0.01** | **i = 0.05** | **i = 0.10** |
|---|---|---|---|---|
| 2013 | -1 | -1.000 | -1.000 | -1.000 |
| 2014 | 18 | 17.822 | 17.143 | 16.364 |
| 2015 | 15 | 14.704 | 13.605 | 12.397 |
| 2016 | 7 | 6.794 | 6.047 | 5.259 |
| 2017 | 6 | 5.766 | 4.936 | 4.098 |
| 2018 | 10 | 9.515 | 7.835 | 6.209 |
| 2019 | 13 | 12.247 | 9.701 | 7.338 |
| 2020 | 14 | 13.058 | 9.950 | 7.184 |
| 2021 | 16 | 14.776 | 10.829 | 7.464 |
| 2022 | 18 | 16.458 | 11.603 | 7.634 |
| **Total** | **114** | **110** | **91** | **73** |

Table 13: Sum of Explicit Components, compared with Gross Spending Estimates (in 2013 $B)

| | **PV** | **i = 0.01** | **i = 0.05** | **i = 0.10** |
|---|---|---|---|---|
| Gross Spending | -1,677 | -1,583 | -1,272 | -989 |
| Individual Penalties | 55 | 53 | 42 | 32 |
| Employer Penalties | 115 | 110 | 88 | 68 |
| Excise Tax Payments | 111 | 102 | 77 | 54 |
| Expansion Benefits | 216 | 205 | 162 | 123 |
| Investment Income Tax | 318 | 302 | 247 | 197 |
| Manufacturer and Insurer Fees | 165 | 159 | 132 | 107 |
| Medicare Cuts | 415 | 391 | 308 | 235 |
| Medicare Advantage Cuts | 156 | 146 | 119 | 94 |
| Disproportionate Share Cuts | 56 | 52 | 41 | 32 |
| Other Cuts | 114 | 110 | 91 | 73 |
| **Total** | **1,723** | **1,629** | **1,306** | **1,015** |
| **Surplus (deficit)** | **46** | **46** | **34** | **26** |

Table 14: Percentage of Explicit Components (in 2013 $B)

| | **% of PV** | **i = 0.01** | **i = 0.05** | **i = 0.10** |
|---|---|---|---|---|
| Gross Spending | -100% | -100% | -100% | -100% |
| Individual Penalties | 3.3% | 3.3% | 3.3% | 3.2% |
| Employer Penalties | 6.9% | 6.9% | 6.9% | 6.9% |
| Excise Tax Payments | 6.6% | 6.4% | 6.1% | 5.8% |
| Expansion Benefits | 12.9% | 13.0% | 12.7% | 12.4% |
| Investment Income Tax | 19.0% | 19.1% | 19.4% | 19.9% |
| Manufacturer and Insurer Fees | 9.8% | 10.0% | 10.4% | 10.8% |
| Medicare Cuts | 24.7% | 24.7% | 24.2% | 23.8% |
| Medicare Advantage Cuts | 9.3% | 9.2% | 9.4% | 9.5% |
| Disproportionate Share Cuts | 3.3% | 3.3% | 3.2% | 3.2% |
| Other Cuts | 6.8% | 6.9% | 7.2% | 7.4% |
| **Total** | **102.7%** | **102.9%** | **102.7%** | **102.6%** |
| **Surplus (deficit)** | **2.7%** | **2.9%** | **2.7%** | **2.6%** |

Analysis of tables.

Just to clarify, the above table illustrates how much extra funding there is for Obamacare at the different hypothesized interest rates. For example, after considering the three funding components explicitly provided in the CBO report to Rep. John Boehner, at 0% interest, $46 billion is excess funding. Similarly, when the separate cash flows are valued at 10% interest, $26 billion is excess funding.

The overall feeling one can take away from this present value analysis is how balanced the cash flows appear to be. Despite a spectrum of varying interest rates, the Affordable Care Act appears to be extremely viable no matter how volatile interest rates become in the next ten years. The largest component of Obamacare's budget, cuts to the existing Medicare program, still makes up an enormous 23% of the expected funding for the bill even in a fictional 10% interest rate scenario, but cuts can be considered relatively stable cash flows. These three components can fairly be assessed as the "riskiest" funding sources for the bill.

An International Perspective: Greece

Policy issues and politics aside, Obamacare seems to be a reasonably-funded piece of legislation; however, it could be useful to look at healthcare spending patterns in other industrialized countries in comparison to obtain a broader, less internalized analysis of Obamacare. Much of the existing literature and analysis with respect to America's place in a healthcare world has some sort of political agenda behind it, leaving plenty of room for a cold take on just the healthcare systems, their numbers, what they mean, and how they compare. The Kaiser Family Foundation has compiled a table that details the percentage of health spending that the government takes on relative to total health expenditures per country; using this, it is possible to choose countries with governments that proportionately spend more, less, or a relatively equal amount on their healthcare system. In 2010 the United States government accounted for 48.2% of the country's healthcare spending.[30] This actually falls short of the 58.9% global average. A country with a figure similar to this global average and a good starting point for this comparison is Greece, whose government accounted for 61.5% of the country's healthcare spending in 2010. Analyzing Greece's healthcare expenditures could give insight into how effective America's healthcare reform is on the world scale, and how it could possibly be improved.

In Greece, just about all health care financing and provision decisions are controlled by the Ministry of Health and Social Solidarity.[31] In contrast with the recent United States trend of centralizing healthcare through PPACA, Greece has actually made some attempts to decentralize health care, but today most power still remains with the central government. The basic structure of Greece's healthcare revolves around social insurance funds that are supported by a payroll tax

[30] General Government Expenditure on Health (as Percent of Total Expenditure on Health). http://kff.org/global-indicator/government-health-expenditure-as-percent-of-total-health/
[31] The Grass Is Not Always Greener A Look at National Health Care Systems Around the World. http://object.cato.org/sites/cato.org/files/pubs/pdf/pa-613.pdf

and general tax revenues. Depending on which industry sector a citizen works in, they have access to a different, specific fund with differing benefits and contribution rates, all of which are determined by the Ministry of Health.[32] In addition to this structure, Greece has a similar counterpart to Medicare called the National Health Service that provides health care for the uninsured and elderly. The NHS also employs its own physicians and operates its own hospitals, although these facilities and services are often considered substandard. Despite this structure resulting in an 83% primary care coverage rate, similar to figures in the United States, Greece is plagued by waiting lists ranging from a month for a simple blood test to as much as a six-month wait for surgery; this is mostly caused by a combination of rationing and disproportionate funding by the government and a 2005 reform that requires general practitioners to write a referral before free treatment is received at an NHS hospital. To meet Greece's demand, it is estimated that over 5,000 general practitioners would be necessary, but in reality Greece only carried about 600 in 2008.[32]

What is really interesting about Greece's healthcare structure is the way patients and physicians have taken it into their own hands whenever possible. Patients will frequently pay out-of-pocket when possible to circumvent the system and receive faster and better care from physicians, who also actively try to recruit patients to switch from insurance to out-of-pocket for similar reasons. These similar interests between patients and doctors led informal, out-of-pocket payments to account for 42% of total health expenditures in 2002, a whole 4.5% of Greece's GDP that year and a figure with no American counterpart because of Greece's exceptional lack of nursing help.[33] Unfortunately, the debt crisis in Greece and other parts of Europe in the past

[32] The Grass Is Not Always Greener A Look at National Health Care Systems Around the World. http://object.cato.org/sites/cato.org/files/pubs/pdf/pa-613.pdf
[33] The Grass Is Not Always Greener A Look at National Health Care Systems Around the World. http://object.cato.org/sites/cato.org/files/pubs/pdf/pa-613.pdf

few years has led the government to make cuts to healthcare spending that the system was apparently not ready for. From 2009 to 2011, Greece cut its spending on health care from $19.5 billion to $17 billion, while public health facilities took on about 25% more patients on average.[34] Considering that supply of nurses and physicians was short before these cuts, one can assume that problems will only get worse as these cuts compound year over year. It seems that in Greece's case, austerity has had more drawbacks than benefits, at least as far as the country's health is concerned. Despite a vision of centralized healthcare, Greece may be better off with less restrictions on practitioners and citizens and more focus on essential services to offset the growing trends of HIV and malaria.[35]

Obamacare has already exhibited early signs of infrastructure inadequacies through the publicized failures of the healthcare.gov website[36], albeit not nearly as vital as Greece's problems as far as nursing and general physician supply. However, it is a fair reminder that Obamacare's policies limit new customers that previously had no legitimate healthcare to those choices offered by a marketplace that the government controls, whether these customers live in a state that adopts the Medicaid expansion or not. Should future budget cuts be necessitated for whatever reason or a budget component detailed earlier be more volatile than expected, these contracts and services could potentially be impacted. In Greece's case, a tremendous amount of money was removed from healthcare and transferred to managing the debt crisis, a move that has proven disastrous in recent months. On the other hand, Obamacare has budgeted within itself by

[34] Fiscal Crisis Takes Toll on Health of Greeks. http://www.nytimes.com/2011/12/27/world/europe/greeks-reeling-from-health-care-cutbacks.html
[35] Malaria and HIV Spike as Greece Cuts Healthcare Spending. http://www.theatlantic.com/international/archive/2013/05/malaria-and-hiv-spike-as-greece-cuts-healthcare-spending/275836/
[36] White House says 'Obamacare' website will be fixed by end of November. http://news.yahoo.com/white-house-says-obamacare-website-fixed-end-november-171107188--sector.html

imposing new taxes and penalties, as well as cutting from older, outdated health programs rather than other, completely separate components of the government.

Closing Notes

America approaches 2014, when the first policies offered through the Obamacare exchanges take effect as early as January 1st, and the average American should expect to learn a lot about how beneficial or harmful this new legislation will be for different classes and groups. For some, this will be the first time an affordable option for health care is a reality, and for others there will be policy changes. No one can be 100% certain on whether or not Obamacare will lead to an overall better quality of life for Americans, but it is reasonable to conclude that Obamacare does have realistic budget expectations. When individual cash flows are considered at multiple interest rates, Obamacare is still a feasible entity. And although centralization can have adverse and costly effects, these usually arrive in times of dramatic change or crisis. Only time will tell if the centralization of America's healthcare will play out as the administration intended.

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