

BEA BRIEFING

Affordable Care Act Transactions in the National Income and Product Accounts

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THE PATIENT Protection and Affordable Care Act, often called the Affordable Care Act (ACA), was signed into law on March 23, 2010. The stated purpose of the ACA was to ensure health insurance coverage for most U.S. citizens. The law includes a large number of provisions that have taken, or that will take, effect at various times between 2010 and 2020. In order to use the national income and product accounts (NIPAs) to analyze the impact of the ACA on the economy, it is important to understand the major provisions of the ACA and how the related transactions are classified and measured in the NIPAs.

The ACA mandates that beginning in 2014, most Americans are required to obtain health insurance through their employer, through public programs such as Medicaid or Medicare, or through newly established health insurance exchanges. Effective in 2010, health insurers were prohibited from excluding from coverage children with preexisting health conditions, and beginning in 2014, this prohibition was extended to adults. Subsidies, tax credits, and the expansion of existing programs, such as Medicaid and the Children's Health Insurance Program, provide help to those who cannot afford health insurance. To finance these assistance provisions, the ACA includes a mix of increases to existing taxes, reductions to certain tax credits, and the establishment of new excise taxes, penalty payments, and fees.¹

1. For the details, see "Where can I read the Affordable Care Act?" on www.healthcare.gov.

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These ACA provisions and funding mechanism affect numerous transactions and several sectors of the NIPAs. Due to the size and scope of the ACA, it is difficult to analyze every provision and related transaction; therefore this article includes a discussion of only the major, direct transactions of the ACA.

Federal Government Sector

Health premium assistance

Beginning in 2014, the unemployed, the self-employed, and people who work for businesses that do not offer insurance can shop for coverage in newly established government-run health exchanges and may be eligible for federal subsidies based on income. The federal subsidy is administered as a prepaid refundable tax credit, which in most cases will be paid directly to the insurer, not to the individual.² To the policy holder, the subsidy will appear as a discount on the policy. To receive a subsidy, an eligible individual enrolls in a plan offered through an exchange and reports his or her income to the exchange. Based on the information provided to the exchange, the individual receives a subsidy based on income, and the Internal Revenue Service pays the subsidy to the insurance provider chosen by the individual. The individual is responsible for paying the insurer the difference between the premium assistance credit from the government and the total premium charged for the plan. Although paid to the insurer, the subsidy for premium assistance is classified in the NIPAs as a social benefit, which is a transfer to persons. The total purchase cost of the exchange insurance plan is captured in personal consumption expenditures (PCE) for health insurance. For more information, please see the box "Accounting for Health

2. The term "subsidy" is not used here as it is in the NIPAs (as a current transfer payment from the government to the business sector). Because these transactions are administered as refundable tax credits on an individual's tax return, they are classified in the NIPAs as social benefits rather than as subsidies.

Care Spending in Gross Domestic Product.”

A person’s eligibility for the subsidy as well as the amount of the subsidy is determined before or during (due to enrollment extensions) the year of insurance coverage. The subsidy amount is based on household income and family size in the prior 2 years as well as the monthly premiums for qualified health plans in the individual market in which the taxpayer, spouse, and any dependents are enrolled. The subsidy is paid during the year for which coverage is provided by the exchange. In the subsequent year, the subsidy is reconciled with the allowable refundable credit for the

year of coverage. Generally, this reconciliation will be handled on the tax return filed for the year of coverage, based on that year’s actual household income, family size, and premiums.

Differences between the amount of the advance premium assistance that was provided and the calculation of the final refundable tax credit result in an adjustment to taxes. If the subsidy received through an advance payment exceeds the amount of credit to which the taxpayer is entitled, the excess is treated as an increase in tax liability. For those whose household income is below 400 percent of the federal poverty

Accounting for Health Care Spending in Gross Domestic Product

Why is some government spending on health captured in personal consumption expenditures?

When using the national income and product accounts (NIPAs) to analyze health care spending, it is important to understand the classification of government health programs, such as Medicare and Medicaid.

People covered by government health programs, such as Medicare and Medicaid, receive health care goods and services through health care providers and then pay expenses, such as copayments and other costs. The portion of the costs of the health goods and services that are covered by the government programs are paid by the applicable government program directly to the health care provider or insurers (chart 1).

In the NIPAs, government payments to cover health care costs on behalf of households are treated as social benefits just as if they were paid directly to households.

These benefits are recorded in personal income as a transfer receipt by persons. To properly account for the consumption of health care, personal consumption expenditures (PCE) includes all purchases of health care by persons, regardless of whether the care was paid directly by the consumer (through copayments and out-of-pocket payments, for example), by health insurance providers, or by the government. This treatment aligns household income with household consumption in the NIPAs (chart 2).¹

1. Total payments in chart 2 equals government payments in chart 1 plus household out-of-pocket expenses in chart 1 plus net insurance premiums plus private insurance benefits paid on behalf of households. Total payments in chart 2 also equals goods and services in chart 1. Social benefits in chart 2 equals government payments in chart 1.

Chart 1. Observed Economic Activity

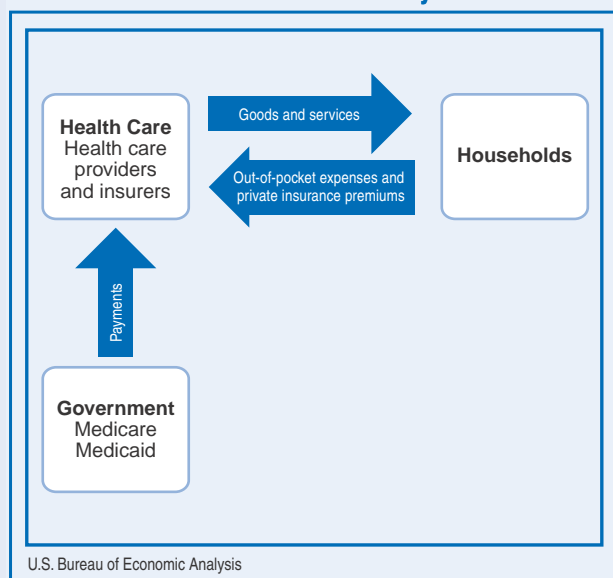
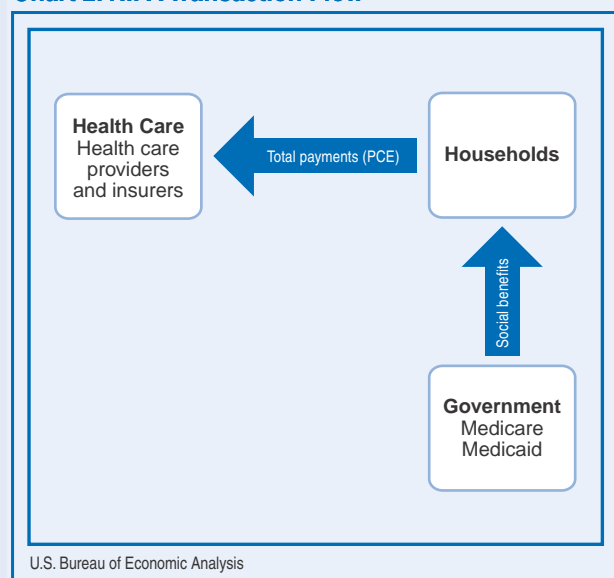


Chart 2. NIPA Transaction Flow



level, the amount of the increase in tax is limited to \$400. If the subsidy received through an advance payment is less than the amount of the credit to which the taxpayer is entitled, the shortfall is treated as a reduction in taxes. The reductions or increases in tax liability will be reflected in the estimates of personal current taxes in the NIPAs. If the amount of the reconciled credit exceeds the tax filer's liability, a social benefit is recorded for the difference between the additional credit and the tax liability.

Annual estimates for this refundable tax credit will ultimately be based on data from the *Budget of the United States*. Initial monthly and quarterly estimates are based on enrollment data from Health and Human Services and estimates of average subsidy amounts from the Congressional Budget Office.

Medicaid expansion and Children's Health Insurance Program (CHIP).

Starting in 2014, states began to have the option to expand Medicaid to most nonelderly people with income below 133 percent of the federal poverty level. The federal government will pay 100 percent of the costs of covering newly eligible enrollees of expanded Medicaid through 2016; in subsequent years, the share of federal spending will vary from year to year but is ultimately expected to average about 90 percent.³ (Currently, the federal government usually pays about 57 percent, on average, of the costs of the nonexpanded Medicaid benefits.⁴) Also beginning in 2014, states receive higher federal reimbursement for CHIP beneficiaries, increasing from an average of 70 percent to 93 percent.⁵ The federal costs of Medicaid and CHIP are classified as grants-in-aid to state and local governments in the NIPAs, which are based on outlays data from the Department of Treasury's *Monthly Treasury Statement (MTS)*. Spending by state and local governments on Medicaid and CHIP benefits, including the use of federal funds, is classified as social benefits. The total purchases of health care through Medicaid are captured in PCE for health care related goods or services. Please see the box "Accounting for Health Care Spending in Gross Domestic Product" for more information.

Medicare and Medicaid reductions

Reductions of federal spending for Medicare and Medicaid programs will affect the accounts as follows: Re-

ductions in annual updates to Medicare fee-for-service payments will reduce NIPA estimates of federal social benefits, and disproportionate share hospital payments (DSH) to hospitals will reduce NIPA estimates of grants-in-aid to state and local governments.⁶ Annual estimates of Medicare social benefits payments are ultimately based on data from the Centers for Medicare and Medicaid Services (CMS).

Reinsurance and risk adjustment

The ACA includes provisions to reduce risks to insurers as coverage provisions are initiated. Three risk adjustment programs will pay insurers who cover higher risk individuals using funds collected from insurers with lower risk profiles. Federal receipts for these programs will be recorded in the NIPAs as current transfer receipts from business, and payments under these programs will be recorded as negative current transfer receipts from business. Annual estimates for these programs will be based on data from the federal *Budget*.

Administrative costs

Costs incurred by the federal government to directly administer the ACA, such as setting up and running federal ACA exchanges and funding research and development, are classified in the NIPAs as federal consumption expenditures and gross investment. Funds transferred to states to defray the start-up costs of state run exchanges are classified as grants-in-aid to state and local governments. Annual estimates for these costs are based on data from the federal *Budget*.

Medicare taxes

In 2013, two new Medicare surtaxes were imposed on certain individuals based on their income. Individuals making more than \$200,000 a year and married couples making more than \$250,000 a year are subject to increased Medicare Part A (hospital insurance) tax rates; the surtax increases the Medicare tax by 0.9 percentage point to 2.35 percent. This surtax is classified in the NIPAs as a contribution to social insurance. Estimates of contributions for social insurance generally are based on data from the Social Security Administration.

The second surtax is a tax of 3.8 percent on unearned income (such as dividends and interest) for taxpayers with an adjusted gross income in excess of \$200,000 or \$250,000 for married couples (unin-

3. *The Budget and Economic Outlook: 2014 to 2024*, (Washington, DC: Congressional Budget Office, February 2014): 58

4. See Financing and Reimbursement on www.Medicaid.gov.

5. See Children's Health Insurance Program Financing on www.Medicaid.gov.

6. The federal disproportionate share hospital program provides funding to hospitals to partially cover the costs of treating indigent patients.

dexed). This surtax is collected as part of income taxes and is therefore included in the NIPA estimates of personal current taxes. Estimates of personal taxes generally are based on data from the Office of Tax Analysis of the Department of the Treasury.

Penalty payments

As part of the individual mandate provisions of the ACA, individuals that do not obtain essential coverage (with exceptions) are subject to an individual shared responsibility fee, starting in 2014. This fee is collected through tax filings, so for most people, the fee won't be paid until 2015. This fee is classified in the NIPAs as a federal current transfer receipt from persons to the federal government and will be recorded in the year in which it is paid.

Similarly, certain businesses that do not provide health insurance will be subject to an employer shared responsibility payment. This requirement applies to businesses that have 50 or more employees, that do not offer health insurance as a benefit, and that have at least one full-time employee that receives a federal health insurance premium subsidy for insurance purchased by that individual. Originally scheduled to take effect in 2014, the payment requirement will begin in 2015 for businesses with 100 or more full-time employees and in 2016 for business with 50–99 full-time employees. The employer shared responsibility payment is classified in the NIPAs as a federal current transfer receipt from business to the federal government and will also be recorded in the year in which it is paid.

Annual estimates for these programs are based on data from the federal *Budget*.

Excise taxes

The ACA established several new excise taxes effective beginning in 2010–2018. The new taxes are as follows:

- In 2010, a 10 percent excise tax on indoor ultra-violet tanning services.
- In 2011, an annual fee on manufacturers or importers of branded prescription drugs based on sales.
- In 2012, an annual Patient-Centered Outcomes Research Institute fee, which is paid by issuers of certain health insurance policies and sponsors of certain self-insured health plans.⁷
- In 2013, a 2.3 percent excise tax on importers and manufacturers of certain medical devices.

7. This excise tax applies to specified health insurance policies with policy years ending after September 30, 2012, and before October 1, 2019, and it is applicable for self-insured health plans with plan years ending after September 30, 2012, and before October 1, 2019.

- In 2014, an annual fee on health insurance providers that is divided among insurers according to a formula based on each insurer's net premiums. The tax is a set amount from 2014 to 2018.⁸ After 2018, the tax rises according to an index based on net premium growth.
- In 2018, a 40 percent excise tax on high-cost health insurance plans (or so-called Cadillac plans). High-cost plans are generally defined as plans having an annual cost above \$10,200 for individual coverage and \$27,500 for family coverage (indexed to inflation).

Annual NIPA estimates of these excise taxes are based on data from the Office of Tax Analysis and the federal *Budget*.

State and Local Government Sector

Medicaid expansion and Children's Health Insurance Program (CHIP)

As discussed earlier, increased federal payments to states that have expanded Medicaid and have increased CHIP matching rates result in increased receipts of grants-in-aid to state and local governments. These grants-in-aid are recorded as current receipts by state and local governments, while benefit payments of these programs are then classified as social benefits to persons. Ultimately, the purchase of the health care is recorded in PCE for health care goods or services.

Medicaid social benefits are based on data from CMS when available. When CMS data are not available, outlays for federal Medicaid grants are used to extrapolate benefits.

Administrative costs

Costs incurred by state and local governments to administer the ACA or support services, such as setting up and running state ACA exchanges, are classified as government consumption expenditures and gross investment. Estimates of these costs are ultimately based on data from Census Bureau surveys of government finances.

Household Sector

Purchases of health care

Purchases of health care goods and services are recorded in NIPA PCE. As indicated in the box "Accounting for Health Care Spending in Gross Domestic Product," health care purchases are recorded in PCE

8. The annual fee is scheduled to be as follows: \$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017, and \$14.3 billion in 2018.

for direct expenditures from persons (“out-of-pocket”), for benefit payments from insurance providers, and for payments by government on behalf of persons. PCE for health care services is ultimately based on Census Bureau data from the quarterly services survey (QSS) and the services annual survey (SAS). Before Census Bureau QSS data are available, the initial estimates of PCE health care services spending are based on judgmental trends and Bureau of Labor Statistics employment, hours, and earnings data. PCE health care goods spending is ultimately based on the Census Bureau retail trade survey and prescription drug retail sales from IMS Health.

Purchases of health insurance

Within PCE, purchases of health insurance are recorded as net premiums; net premiums are calculated as premiums less benefits paid. Therefore, increased purchases of health insurance as a result of the ACA individual mandate, either through ACA exchanges or purchased directly from insurance carriers, will be reflected within net premiums. The premiums used in the calculation will include both direct spending by persons and subsidized premiums paid by the federal government. Data that underlie these estimates are primarily from the Department of Health and Human

Services medical expenditure panel survey, the Bureau of Labor Statistics Consumer Expenditure Survey, and the *Monthly Treasury Statement*.

Summary of Impacts on NIPA Personal Income and Outlays

Many of the transactions that are impacted by the ACA affect BEA’s estimates of personal income and outlays as well as related measures. Personal income includes government social benefits to persons, which will reflect the changes to Medicaid and Medicare. It is reduced by contributions for government social insurance, which is increased by the ACA Medicare surtax on incomes over \$200,000 (individuals)/\$250,000 (married). Disposable personal income (personal income minus personal current taxes), reflects both the ACA impacts on personal income and the changes to personal current taxes, which include both the ACA Medicare surtax on unearned income of certain taxpayers and the reconciliation of the health insurance premium subsidy.

Personal outlays reflect the ACA impacts on PCE, which include effects on expenditures for goods and services. Personal outlays also include personal current transfer payments to government, which includes the individual shared responsibility fee.