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HOW THE AFFORDABLE CARE ACT CHANGES

THE DISTRIBUTION OF INCOME

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P R O C E E D I N G S

MR. AARON: (in progress) -- is going to affect the distribution of income that he and I will presently describe. We have some copies of the paper outside. There's a single sheet which is what you might call an executive summary, although it's an awfully long executive summary that summarizes the results. If any of you don't get a copy of the paper and would like one, please e-mail me or Gary, and we will be glad to send you an electronic version.

After Congress passed the Affordable Care Act, Gary and me and most observers thought that most observers were neglecting one important aspect of the bill. Obviously the law was intended to expand coverage. Some critics alleged that it didn't deal with cost control, although, in fact, virtually every idea for cost control is in the bill in at least embryonic form. And it also contains a variety of proposals for improving the quality of care. But Gary and I realized also that the ACA would redistribute income probably quite a lot, even more than any recent expenditure legislation, and we wanted to measure those effects.

We applied to the Rockefeller Foundation for support, they generously gave it, and this study is the result. In the course of this work, I have to say I learned a lot about, not just the Affordable Care Act, but the surprising and odd, even odd interaction between conventions for measuring income and standard economic theory. I was surprised, and I think many of you may be surprised, too, when you hear Gary's description. He's going to present the results.

We want to emphasize that what you're hearing are tentative results. We are going to hear criticisms and comments from three very knowledgeable people, and we are prepared to correct our ways if they tell us we have, persuade us we have done something incorrect. Here's the routine for today, Gary is going to describe our study, what we did. And after Gary is done, I'll spend a few minutes describing what we didn't do and point out why we left out some very important aspects of the legislation from our estimates. And then you're going to have a chance to hear from three superlative commentators, and we're going to have the opportunity to benefit from their comments.

The first is Doug Holtz-Eakin. He is a one-time professor of economics from Syracuse University, formerly director of the Congressional Budget Office, an advisor to presidential candidates, and now the head of a new think tank, the American Action Forum.

He's going to be followed by Marilyn Moon who is a former public trustee of the Social Security and Medicare trust funds. She was for years an economist at the Urban Institute. She is now institute fellow at the American Institutes for Research where she directs a staff of more than 100 at their Center for Aging.

Finally we're going to hear from Uwe Reinhardt who is a professor of economics at Princeton University, a regular contributor to the New York Times economics blog. He serves on a variety of boards including that of Duke University and some rather large companies and a whole string of Federal agencies. And if what I've heard is true, his most remarkable single

accomplishment may be that he has made a course in accounting the most popular course at Princeton University. (Laughing) As you might infer, he is a much sought after speaker.

After Doug, Marilyn, and Uwe have delivered their comments, we make talk a bit among ourselves up here, but we're going to try not to do it for too long because we would like to open the floor to comments and questions from you until noon when this event has to end. So in any event I want to stop at this point. It will be Gary's turn to present our results.

I want to add one thing before I do sit down, and that is today's ground rules. The Affordable Care Act is highly charged politically. All of us here up on the stage have and will again play in that game, but not necessarily on the same side. But there aren't going to be any political tussles here today. Gary and I are reporting on, and the three discussants, are going to be commenting on a pretty technical study. For this morning we're just economists tackling a difficult set of challenges. We checked our political hats at the door. And we trust that when it's your turn, you will have done so, too.

Gary, it's your turn

MR. BURTLESS: What I want to do, if we have a screen to present these results, is to describe very briefly what we were trying to learn, how we went about learning it, and what we found. As Henry pointed out -- uh-oh, this is not good. Audiovisual equipment is the Achilles tendon of academic presentations. The goal of the ACA was to expand health insurance coverage by making it more affordable. It was not to change the income distribution.

Most observers expect that reform will help make coverage more affordable and especially for people with lower incomes. And it's going to do this by ensuring that employer plans are available to full-time workers who are employed in large- and mid-sized firms by expanding Medicaid coverage and by providing tax credits to help people who are not offered an affordable insurance plan, so that they can obtain affordable coverage through a state insurance exchange.

Now even though the ACA is mainly about expanding health coverage and holding down the cost of insurance, it's going to affect the income distribution to some degree. Some people are going to get new government subsidies to help them pay for insurance. Some workers will gain access to or take up employer plans that are going to be available to them. And this may indirectly affect their wages.

Finally, the new public benefits provided through the ACA are paid for. Congress didn't pass a law that wasn't completely funded. They tried to come up with cost measures and cost-saving measures and also revenue increases that would pay for this. They changed Medicare premiums for high-income people covered by that program. They hiked taxes on high-income families. They trimmed insurance subsidies available under some Medicare plans. The law also raises revenues by imposing penalties on workers who don't, people who don't get coverage and on employers who don't offer affordable plans to their workers.

Now our analysis gives an initial assessment of the potential

effects of the new law on the income distribution. They're based on detailed assumptions which are described in the paper. We don't account for all of the effects of ACA as Hank will document later on, this includes most importantly the ACA affect on the trajectory of health costs and a bit less significantly its impact on competition in the private insurance market.

Our first conclusion is simple. The projected income distribution effects of the ACA favor Americans in the bottom quarter of the distribution, but the size of the gains are particularly sensitive to the way that we define family income, in particular by how we count, in that measure of family income, the value of the health insurance benefits that people receive. Under the standard income definition, the Census Bureau's money income measure, health insurance coverage is assigned absolutely no value, it does not count. This is the case even if insurance is provided for free by an employer or for free by the government through Medicaid or Medicare.

So how much health insurance benefits count in the money incomes of Americans is essentially just zero. I hope some of you can see these. They're pretty small. So this is how much money income counts, this is how much health insurance benefits count, this chart. And you can see that there's no value whatever when we rank people from lowest to highest. This is how much counts in a definition of income offered by the Census Bureau called the fungible value of health insurance benefits. This counts 100 percent of the value of employer contributions to a worker's health plan and it counts some prorated portion of the value of government health insurance benefits depending on

whether people have low or high incomes.

If they have low incomes below the amount needed to buy a basic food-and-shelter budget, they're assigned no value to these benefits whatsoever. People in comfort income ranges, 100 percent of the value of government health benefits are counted. So and if we include the total value of health insurance benefits, you see the light line there, that's the value of health insurance that doesn't get counted when you only do fungible. And the total value obviously rises quite considerably if you include the total value of health insurance benefits that go to the lowest income population.

Now let's think about what the impact of reform would be that boost the extent and the value of government subsidies to people who obtain health insurance at the bottom end of the income distribution. Suppose almost all the increase is targeted on people with an income below four hundred percent of the poverty line, which is, in fact, the case; using money income, absolutely none of the increases in coverage get counted. Zero gets counted.

If we use the fungible value estimates, virtually none of the value of the increases in this insurance coverage for people at the very bottom counts. And an increasing share of the increase in health insurance benefits counts as we move up the income distribution. And finally, when the total value is counted, then clearly the parts of the population that derive the most increased spending under the reform will also see the biggest increases in their income.

The omission from the standard of -- health benefits from the standard definition of money income is especially problematical because the

proportion of money income represented by health care benefits is much higher at the bottom end of the income distribution than it is further up. At the top only 4 percent of money income, health benefits constitute 4 percent of the money income on average received in the top 10th of the income distribution, but they constitute 85 percent of the measured money income of people in the bottom.

Our projections of the income distribution impact of ACA are based on information from 60,000-plus people who were interviewed in the medical expenditure panel survey back in 2006 and 2008. All the numbers we adjusted to reflect expected inflation, income and wage gains, premium and subsidy values in 2016, which is the year we analyzed. And we picked that year because it's the first one when we think most of the main provisions of the Affordable Care Act will be in effect.

Our model identifies families that will be offered new insurance options as a result of the ACA, perhaps an employer-sponsored plan in some cases, perhaps Medicaid in others, and, you know, almost all cases for people who are not poor, they will be offered the option of purchasing insurance through a state health insurance exchange with a subsidy if they have a low enough income. We predict the insurance choices that family will make, typically, not always, this will be the cheapest one available to them. Finally, we project the implications of these choices for family income. And you won't be surprised to learn that we do that under four different definitions of family income.

First is the standard census money income definition. Second is the census's money income plus the fungible value of insurance benefits. Third

is money income plus the total value of insurance benefits. And finally we calculate income in a way that takes into account also the tax increases that were proposed in the Affordable Care Act. Now the ACA like the health insurance and health care system in general is really filled with moving parts. We don't pretend to have taken all of them into account. In fact, the time, trouble, and sheer pain of creating, testing, and revising our model to reflect first, the original law, second, the law as amended by the Supreme Court decision, and finally, the law as amended by the actual administration decisions about how to implement the law have sometimes made us wonder whether we would ever reach a conclusion.

Our difficulties in modeling and coding gave me a boatload of sympathy for the problems of getting healthcare.gov off the ground. I should point out; however, that the cost of this analysis was a heck of a lot lower than the budgets for the healthcare.gov contractors. So what do we find? Under our broadest income measure, one that includes the total value of health insurance benefits, we see a shift of the income distribution in favor of low-income people. We project a significant jump in health coverage rates, especially between the 10th and the 30th percentiles of the income distribution.

Much of the rise is driven by increases in Medicaid coverage and enrollments in exchange-provided insurance plans for which people receive a new Federal tax credit to help them pay for the cost of those plans. Our estimates show that when the total value of health coverage is counted as income, the average incomes of Americans in the bottom fifth of the income

distribution rise by six percent.

The income gain is much smaller and especially in the bottom 10th of the income distribution, it's practically nonexistent, when we only figure changes in family's money incomes. Folks in the bottom fifth see an average income gain of just 1.4 percent, not the 6 percent I mentioned before. And at the very bottom of the distribution, in the bottom 10th, there may even be small declines in money income. Now the ACA was paid for, as I mentioned, increased government spending on Medicaid and tax credits for insurance purchased through the state exchanges were offset by tax hikes, Medicare premium increases, penalty charges, cuts in the subsidies to some kinds of Medicare.

Even though the great majority of middle income and affluent families is unaffected by these changes, some families are going to see a loss in their net incomes, at least under some of the income definitions. This reduces the average incomes in higher deciles. Bear in mind the overwhelming majority of people currently covered by an employer plan by Medicare, by Medicaid, will see little direct effect of the ACA. Their insurance is going to continue as it was before with some changes in regulation.

Our protections attempt to identify the people who will be affected and to estimate the financial gains or losses that they will experience, but most people are not directly affected. Our estimates attach no value to the change in well being that will occur because non-poor families are now assured of access to an affordable health plan. If a MEPS family had adequate insurance and its

insurance arrangements are unaffected by reform, our estimates show no change in their financial position.

From an economist perspective, that's not quite right though. In 2008 a person covered by employer insurance who lost their job and lost their health insurance at the same time, would have no assurance that she would, that either there would be a plan available or that that plan would be affordable to her. In 2016 if ACA remains in effect, many more Americans will have a reasonable assurance that they can buy an affordable health plan even if they don't work for an employer that offers such a plan. We do not assign any value to this guarantee even though without a doubt it has some value to people.

Here are our estimates of the percentage of Americans who lack health coverage in 2016 with the noncoverage rates calculated each position in the income distribution, not surprisingly noncoverage is highest at the bottom of the income distribution and coverage improves as you move up the distribution. Here's what we expect the affect will be across the income distribution on noncoverage rates. And you see a very sharp drop in between the 10th and the 30th income percentiles.

This is another way of expressing the same numbers. It expresses a percentage change in health insurance coverage. It is striking how much bigger the gains are in the second and third deciles than they are in the very bottom of the distribution. Part of the explanation is the Supreme Court's ruling against Federal penalties on states that do not expand their Medicaid coverage. This is what our estimates are of the additional coverage that we

would have seen if the Supreme Court had ruled in favor of those Federal penalties rather than ruling against them.

So remember this chart when considering the income gains that we actually do find at the very bottom. Insurance and income gains at the bottoms would have been bigger under the originally passed law compared as with the law as essentially amended by the Supreme Court. Here are our projections of in enrollments in group health insurance plans obtained through the state exchanges.

The blue line shows enrollment in plans that are partly financed with new Federal tax credits. The red line shows enrollment in policies that are not subsidized through these credits. Virtually no one in the bottom 10 or 12 percent of the income distribution will purchase plans through the exchanges. Between the 10th and the 60th percentiles of the money income distribution, most of the plans purchased through the exchanges will come with some Federal tax credit subsidies. Above the 60th percentile, there will be no subsidy.

There are two kinds of new health coverage that will receive generous government subsidies. The first is Medicaid expansions. That's indicated by the light blue. And the second is the tax credits that people will obtain when they get insurance through an exchange. That is indicated by the bold red. The biggest jump in enrollment in government-subsidized plans occurs around the 20th percentile, but the enrollment gains are proportionately smaller at the bottom, in spite of the fact that that's where noncoverage is a bigger problem. And the reason is the Supreme Court decision.

Our projections of the distributional gains or losses in money income are shown in this chart, that is the change in people's pretax cash income. You might ask why health reform has any affect at all on money income, because after all money income doesn't count the value of health insurance benefits. The main reason is that some workers will give up their employer health insurance to obtain a cheaper plan elsewhere, while other workers will take up an employer-sponsored plan possibly to avoid paying a penalty because they don't have adequate coverage or possibly because a plan will be offered to them by their employer for the first time.

We assume that employers who no longer pay for their workers' health coverage are going to realize some cost savings on the health compensation part of the package, so they'll give money wage increases to those workers. But employers who have to start contributing to an employer-employee health plan will have less money available to pay money wages, so money wages would decline. Most workers in employer provided plans will keep the plan they already have and they will be unaffected.

But the ones most likely to gain higher money wages are those who have high premium employer plans who are now offered subsidized enrollment either in Medicaid or through a state exchange. The money wage gains for those workers are especially concentrated in the second income decile and also at the very top of the distribution where there are very minor gains. In between we see modest declines in people's money pages.

The gains to the folks obtaining new government subsidies are

even more impressive when we count the fungible value, but notice, even counting fungible value, those people at the very bottom of the distribution appear to gain nothing from reform even though they got fairly sizable increases in their health coverage.

When we count the full value of health insurance coverage in people's incomes, as I do in this chart, you can see that the gains at the bottom are more impressive still. The poorest Americans now see the biggest proportionate gains in their incomes. People in the top four-fifths of the distribution, on average, are projected to experience small losses. And here when we make a further adjustment to people's incomes, subtracting payroll taxes that they pay including the new higher payroll tax to fund the Affordable Care Act, the losses are larger at the top and the gains are proportionately bigger at the very bottom.

So this summarizes what happens in the bottom 10th and the bottom one-fifth of the income distribution in response to the ACA. The black bars there are the changes in money incomes. The pink line, the pink bars there are the change in fungible income including the fungible value of health insurance benefits. The green bar is just to include the total value of health insurance benefits. And the purple bars there reflect the effects of the payroll tax changes, too.

So summarizing our findings, the ACA is going to significantly boost incomes at the bottom end if all the value of government insurance is counted in people's income. If most or all the value of benefits is excluded as it is

in the black bars there, the effects of reform will appear negligible or modest. The impact of the ACA at the very bottom of the income distribution is substantially smaller than would have been the case if the Supreme Court had ruled differently on the Federal penalties on states failing to expand their Medicaid plans.

The tax increases, penalty payments, and Medicare subsidy reductions embodied in the Affordable Care Act will help pay for the cost of government subsidies and Medicaid expansions, but on balance they will modestly reduce the net incomes of people in the top three quarters of the income distribution at least when we use a comprehensive income definition that includes the subsidies embedded in people's health insurance.

Our assessment of the distributional impact, as Hank will document further, ignores some important effects, but it notably ignores the value to the working age population of having an assured source of health insurance even if they work for or are unemployed -- if they work for an employer who does not offer an affordable plan, the law will change that, and that certainly has some value to working age people.

MR. AARON: I'll wait until the buzzing stops. Gary has told you what we did or that we tried to do. I'm going to describe much more briefly what we didn't do. And I'll also explain why those omissions are mostly inescapable. First, as Gary made clear, the results we report refer to percentage changes in income of all people within an income decile and within the paper. We also look at age groupings as well. Only, in fact, only a minority will, in fact, become newly

eligible for Medicaid, qualify for refundable tax credits, pay new taxes imposed by the ACA, or see their incomes change under any income definition.

If incomes of most people in each income bracket or age category don't change, then the percentage changes in incomes that we show significantly understate the impacts on those whose incomes are affected by the ACA. The millions who will gain access to Medicaid, for example, particularly at the very bottom of the income distribution are going to see their incomes rise at least under our broad definition of income by 20 percent, 30 percent, and in some cases even more.

The income reductions, which are much smaller, in the upper tail of the portion of the income distribution, will also be larger than the percentages that we show here. Second, we did not or could not include in our calculations many provisions of the ACA that are extremely important and that are at least as important as the provisions that we did measure.

Gary referred to the possible inherently unmeasurable potential impact of the ACA on the price of medical care services. We don't know how that's going to play out. We also didn't do some things that we might have done. And the most notable example perhaps is the donut hole closing for Medicare, that range of income over which people are exposed to all or substantially all of the cost of prescription drug benefits. It's to be closed gradually, but it isn't going to be closed entirely until 2020 which happens to be well after the 2016 date we used as the point for our estimates.

It's comparatively small. We left it out. Simply put, the effects on

incomes of some of the other provisions, some very important provisions were simply beyond our capacity to estimate. Let me give you some examples. The ACA promises and probably will transform the market for individual health insurance, and it may do so also for insurance for small groups. For example, the ACA prohibits premium variations based on medical history and on sex. Age based variations that existed pre-ACA ran to 6 to 1 in some places, as much as 10 to 1 and maybe even a bit more. The ACA limits those variations to 3 to 1.

Insurance companies can no longer deny coverage to those deemed too risky to insure. And they can't cancel policies for people who seem likely in the future to generate very high claims. Some insurance companies in the past, out of their premium income, paid out only 60 or 70 percent in benefits, sometimes even a bit less than that. Now they are required by law to pay out 85 percent of benefits for large groups and 80 percent for small groups.

In the year 2012, under the ACA, they were forced to return to policy holders, 12.8 million of them, in fact, a bit for than a billion dollars. The, presumably the law will render those return payments unnecessary in the future. In addition state exchanges have the, and the Federal exchanges as well, have the capacity to require rates for all insurance sold to small groups and to individuals to be calculated within a single pool.

Now all of those provisions are going to cause income to be redistributed. Most of that redistribution will be within income classes and not between them. The effects can be large. We wish we could have measured them. We didn't think we could.

Finally, the ACA slows the growth of reimbursements to a variety of providers under Medicare. Big time money up, estimated $430 billion over ten years. We didn't know whether those spending cuts would lower payments to physicians and other health care personnel, cut into the profits of hospitals and other organizations, lower investments by those organizations in ways that curtail benefits for patients, reduce the quantity of services rendered to patients, shift cost to payers other than Medicare or in other ways, or more likely what the mix of all of those effects would be. We could not and did not measure that effect.

I want to close with a plea that I fear will be disregarded by many. Some very large benefits will accrue to the millions of people who will become newly eligible for Medicaid and refundable tax credits, but the President and Congress went to great lengths to prevent the ACA from adding to the Federal budget deficit. Someone has to pay for those benefits. That means that income gains and income losses will roughly balance. So my plea is please don't cherry pick our results.

And now you're going to have a chance to hear from the commentators. No further introductions are necessary. And if they were, I'm going to fail because I'm not giving them.

Doug.

MR. HOLTZ-EAKIN: Well, I first and foremost want to thank the authors for the chance to be here today and to congratulate them on the paper. It's really a wonderful piece of work and something that I'm delighted to have a chance to talk about. This is, in the end, a very technical question, how does a change in

public policy affect the real distribution of income? And that differs from who receives checks or who sends in tax payments only in circumstances where behavioral responses shift the burden.

And the most simple example of this is a real live one. A couple of years back the U.S. elected to tax luxury yachts. The result was no one bought luxury yachts, the shipyards closed, and the workers got laid off and lost income. In that case, the ostensible burden which was to be on rich people buying yachts got shifted to lower income workers in the boating industry. The tax has since been repealed for precisely that reason.

So in this case what we want to do is look at the ACA, trace through all the impacts, and try to identify whose real income went up and went down as a result of the passage of the law. Now if you think back to its passage, in ballpark terms, basically the ACA provided a trillion dollars over 10 years in new subsidies to Medicaid, those under 138 percent of poverty and to insurance subsidies, those up to 400 percent of the Federal poverty line, phased out as you went higher.

And so you have a trillion dollars in receipt of cash at the low end of the income distribution. It's going to be pretty hard not to find out that this is a highly progressive policy change that redistributes income to the bottom unless you can find something exceedingly striking in the way it was financed, about $500 billion worth of taxes, that would have to be comparably borne by low-income individuals or the $500 billion in, roughly in Medicare and other spending cuts would have to be borne by low-income people. Unless you've got

that, you're not going to be able to overturn the basic finding, that's pretty clear; the real work that's left is to measure this correctly.

And that's the job that the authors have taken and done very well. The other job is to see if you can cleverly tell a story that overturns the basic finding. That's my job, and I'm going to try and fail. So what have we got? First of all, if you look at the taxes that are in here. We've got some high income surtaxes on payroll and on investment earnings by high-income individuals. Very unlikely to see those shifted down in the distribution.

There is a tax on medical devices that you've heard a lot about. Here it's really embedded into basically every medical device, probably into the prices, at least in part, of those medical devices. There is some concern about employment losses in the medical device industry. If the combination of those higher taxes showed up as prices in medical devices that are purchased by lower income individuals, that moves against the basic finding in the paper. And if it results in wage losses for individuals who tend to be lower income, that goes against the basic finding in the paper.

But again, I doubt that even if all of the medical device tax was shifted, you can change the basic result very much. It's the kind of thing you want to just check on as you go through. I have more concerns about the incidents of the health insurance tax, something I've looked at very carefully. This is a very peculiarly constructed tax on health insurers. It will almost certainly be shifted forward into higher premiums that will be borne at least in part by middle income individuals and lower income individuals. It will also lead to a lot

of churning in the nature of policies. It's got a very strange design.

I want to point out that that churning is probably a bad effect, but it wouldn't show up in the change in the income distribution, because you would just change from one cash policy to another. You might have liked the first one more, but you would see that the income would show up in the same place. So we won't find that. But again, I think this, leaving that out overstates to some extent the progressiveness of this.

Then there is the famous Cadillac tax which is going to kick in later and be a tax on high income or on high-dollar value plans. Those high-dollar value plans are not exclusively located in the upper end of the income distribution. They are also going to be, for example, union health insurance plans and the like. And there's a serious question about what the response will be to that tax, whether it will show up as constraining the size of the plans and thus would show up as less in the way of the total value or fungible value of these plans that would show up in their estimates or it would show up in premiums for these plans and where will that show up in income distribution.

The same kind of logic prevails. This is something that they acknowledge in the paper. It's not something that they don't know about it, but yet it's not built into the estimates. It's very hard to get right. And I'm not going to talk about the tanning tax. Who knows who that hurt really badly? (Laughing) So but those are the basic kinds of taxes, and then there's the Medicare cuts as well.

Here some work that I've seen by Jim Capretta and Robert Book

and others does suggest that, to the extent the Medicare Advantage cuts lead to plans being dropped, that will disproportionately affect low income and minority Americans, but I don't think it will show up in their estimates because the impact would be to move those Medicare beneficiaries from Medicare Advantage into traditional Medicare. Again, you're going to see them having the health insurance in their incomes, and so that's the kind of churn that might occur, but won't affect the basic results. So those are sort of the basic mechanics of this thing.

It's pretty hard to imagine the incidents of those things changing very much, particularly on a static matter. Then there are a couple of other issues just to flag, technical issues. When you do an incidence analysis, you have to make three basic decisions, and there's no right or wrong here, but it affects the nature of your results. The first thing you have to do is pick a measure of income, and Gary walked through the issues associated with picking the measure of income in this case. I, for the record, would be happy to see them simply leave out the census money income, something which I view as indefensible for purposes of serious policy analysis. It's in the paper, but -- it's for completeness, I think, it doesn't really make a lot of sense. But you do have to make a decision about how you're going to measure the income, and they've done a thorough job of that.

The second thing you have to do is pick your unit of observation. In this case it's a household. You could pick individuals, you could have picked families. I think it's households in this case. That won't matter too much here

except in two instances, which I don't think are dramatic, but are going on. And the first is the ACA had this provision that allows you to cover children up to age 26. The question is, does that change household formation in any way for young Americans and thus change the number of households that you're going to have out there and thus the incomes in them?

And the second and the more serious one that I can't quite figure out how it would play out, the ACA mandates that employers provide affordable insurance; but to surprise of many, it turned out that's not affordable family coverage for those employees who have families, it's affordable individual coverage. So there is the possibility that you could have people with a family plan currently who would end up with an individual plan for the employee. The spouse and any children would then have to find coverage elsewhere. And I'm not sure what that does to the household's income measure.

They may go get, they'll get some more cash wages because they don't have the offset of a family plan, so the employer can pay them more, but they'll also probably get subsidies out there in the exchanges for the spouse and the kids. That's the one instance where I think the choice of the household might matter, and I can't figure out exactly what it does to the results. But again, as a matter of magnitudes, my suspicion is it's not very big.

The last decision you have to make is a decision about time periods. This is an annual income measure. And there's not anything wrong with that, but you could look over lifetimes. And over lifetimes some of the low-income folks getting subsidies may migrate to be high-income folks paying

the taxes. You get a very different answer there. Or you could look at cohorts and where whether the old who might get windfalls here and never pay taxes make out at the expense of younger who will pay higher premiums in many cases and some of the taxes later in life. But these results don't answer all of the questions. They answer only the questions associated with the time period annual income. And those can be different people at different points in their life.

Then the last thing I want to list is just some remaining quibbles on the kinds of things that might go on and just emphasize how the analysis is being done. The first and most important assumption which they are clear about in the paper and which you really have to understand how much it drives results is that employers care about the total compensation to their employees, and as a result if the mandate of benefits go up for insurance and that costs the employer more, they will cut wages to offset exactly, total compensation is unchanged.

That means that the mandate does nothing to the income distribution. It can't, per se. I mean, because you just swap the way you pay your workers. You give them more or less health insurance, more or less cash. And that's a key part of what goes on. I agree with that. I think that's exactly the right way to do the analysis, but for those who haven't been through this before, that's an important part of it.

Second thing that I think is an important behavioral response that we might want to think about it is the degree to which the CBO estimates of employer dropped which the authors adopt are right. I am among those who is worried that the employer drop may be bigger than is estimated in this paper.

Essentially if you do the math, up to about 300 percent of the Federal poverty line, it is possible for employers to stop offering insurance, pay the penalty, give their workers a raise, allow that raise after tax plus subsidies to purchase insurance in the exchanges which is as good or better as the employer was offering.

So the financial incentives on both sides, employee-employer to get out of the health insurance business are pretty big. Now what keeps them in is the fact that high-income people get no direct subsidies under the Affordable Care Act. They instead get a tax study, the non-taxation of their employer sponsored insurance. They want that and they want the insurance through their employer for that reason. And the rules are nondiscrimination means if you offer it to high-wage employees, then you have to offer it to everybody. And that's the hook that's keeping employers in the business of offering low earning employees their health insurance.

I'm not convinced given the cleverness of the U.S. business and legal community that hook is going to be strong enough and that over time we will see an erosion of the employer-sponsored market even more so than we've seen already. If so, we get, again, employers dropping. They'll pay the workers more. So we'll see their employee-based compensation unchanged, but now we would be picking up subsidies out in the exchanges. That's going to look like bigger transfers to low end would exacerbate the effects that you have in the paper, they would be even bigger yet.

There's an open question how this increase above and beyond the

estimates of the CBO would be financed, and then where that shoe drops affects the rest of the incidents. But I think the employer drop issue remains an important issue. I'm also just curious about their thoughts, if we have a discussion afterwards, on the impact of the age bands on their results. I mean, my reading of it is that, you know, we know pretty clearly that the age bands mean that premiums are going to be relatively high for young and healthy, relatively low for the older and sicker. That was the intention of the policy.

The paper essentially assumes that the income distributions are the same in those two groups, so when this goes up and this goes down, they offset. I don't -- that doesn't feel right to me and I think it would be worth thinking harder about that, but that's an issue. And then there are the labor market impacts of the ACA which will affect labor earnings and thus the income distribution. There is a lot of speculation, no evidence yet about movement of people from just a little bit over 30 hours to under 30 hours to avoid the mandate and thus move to part-time work, replace two -- one full-time worker with two part-time workers, a lot of things like that. That would change these results dramatically because they're changing the incomes that people get before their subsidies.

And then there's concerns about the growth impacts for small firms and the mandate hitting at going over 50 workers. Will you see those firms, the growing firms, which is where job creation and labor market vitality has come from traditionally in the United States, get hampered somewhat by this. If so, again, you're shifting some of this burden onto the workers in those firms. They

tend to be lower wage workers in smaller firms. You change the impacts as well.

And then the last one which they mentioned, and I don't know how to do any better than theirs, is, you know, we're going to spend a trillion dollars in subsidies and we're going to have a bunch of Medicare cuts; what's going to be impact on prices of providers? You're going to have a big demand push from the folks who now have insurance and previously didn't buy as much health services. They're going to have an offsetting cut somewhere else in the system. What's that impact on the actual prices paid and that's the value of these dollars? We don't know, but again, it's not in the paper, and it's something that's going to play out over the next 10 years.

So the bottom line is that I think it's pretty hard to punch a big hole in the basic findings. You can tweak the numbers one way or another if you take into consideration some of these effects, but it's not going to change the basic distributional picture that you get out of the Affordable Care Act. And I just want to thank the authors for taking the time and energy and computer coding to dig out how big these numbers really are. Thanks.

MS. MOON: Thanks. I want to add my note of thanks for this. This is an interesting paper and I commend you all to read it. It brings me back to the old days of being a poverty warrior and worrying about how to measure the value of medical benefits in poverty estimates. That they're struggling with many of the same things, and they've used some of the same conventions that have been used there. So if that's something that you're interested in, you might look back into that.

I think I'm going to have a little bit more of a glass half full set of comments as opposed to the glass half empty in terms of how these results might vary a little bit, if you could do some of the things that aren't possible to do and how you want to think about and look at this. I agree very much with Henry Aaron that we have to be very careful about cherry picking from these results, because it will be easy for someone who pants to play got ya on either side to grab a number of and say, see, ah-hah, it works this way. But this is a very complicated issue, and these results are better thought of as a story that's woven together that says if you look at it this way, you get one idea; if you look at it that way, you get a bit of another idea.

And I think that that's really important to do. It is important because there is so much emphasis right now on the issue of inequality. Everybody is interested in inequality. What does that mean? What's going to happen? How can you deal with that? I think that this paper fairly clearly demonstrates, and as it should, that it does help to redirect resources to those who are less well off overall. That is an inescapable finding because of the way it was set up and intended and indeed the findings indicate that, but that it also illustrates that there are going to be losers out of necessity.

When you try to pay for something, you have to create losers in the system as well. And that's also something that's important to take from this, but you need to look at them both and not just one versus another.

When you add new benefits to a system that already has subsidies, you also come up with a set of results that look a little bit lopsided in

some ways. I would suggest that one of the things that indicates why the bottom decile doesn't do better under the Affordable Care Act is that we've already taken care of much of the bottom decile. The really poorest of the poor already have Medicaid; they're already taken care of. What we're doing is filling in, to again, not over use the word complicated, to a complicated health care system extra benefits to people in various places who don't have it.

And as a result you're not going to get a nice smooth distribution of beneficiaries of who benefits from this. And again, that's appropriate in a world in which we are not trying to start from scratch. It would be easier if we were trying to start from scratch, both to do this and to estimate the impacts of these things. I also think that that means that when you think about what are the total subsidies we're providing for health care, it might be a useful additional piece of this paper to talk about of how many people get what kinds of subsidies right now and how do those work.

That raises the issue, though, that's always a tough one when we're dealing with this question and we're trying to be good economists and talking about adding a mandate, for example, to employers and saying, you must add these additional benefits and appropriately they use the convention that says, then you have to assume that wages will be cut. But I want to suggest that one of the things that when we look at empirically at what happens out there is that may not always be the case of what happens either.

Just as there's very good literature now that indicates that if you raise the minimum wage, it does not necessarily have the very pure economic

notion that it drives lots of people out of jobs and it does all of the easy things that people can talk about, the problems that can happen; but rather that what happens is that there are some forces that conspire not to have that occur. And I think that there are going to be some forces that conspire not to have a full offset of these wages in the case of individuals who are now facing a mandate.

Presumably in many ways we are leveling the playing field. And employers, who in the past have failed to offer these benefits, are now going to be required to offer them and that puts them in a bit of a more level playing field with other employers who are offering them. And the question is, will then there be compensating wage differentials? And it's a difficult question to answer, but I think it's something that deserves to be thought about, again, as one of these things that complements what you would like to study from this but you recognize you really can't.

I'd like to talk for a couple of minutes also about the notion of how we think about what you're trying to get from an income measure. And one of the difficulties of trying to measure the impact on income of an in-kind benefit is that it doesn't fit, it's a round peg in a square hole. Because an in-kind benefit certainly adds to the resources and ability to consume goods and services that people have, but it doesn't do so on a one-for-one basis.

You can, as many of my colleagues used to say, talk about the value of the Medicaid long-term benefit to older Americans and the fact that they can have that, but they can't take that to the bank. They borrow it against it and say, one of these days I'm going to spend all my resources, I'll have Medicaid,

and so give me a loan right now. You can't eat those benefits. You can't live in those benefits except for the long-term care perhaps.

In the case of medical care, you certainly can't stay in the hospital that long. So as a consequence we have to deal with them differently. That does not mean that they are of less value necessarily. It means that in terms of thinking about them as income they are different. And that's a distinction that I think it really important for people to make when they think about the implications of a paper like this. And that is there are benefits that you might want to look at of how they vary by income level however you decide to measure income.

And then there are the changes in income that will only show changes if you put those things into the measure. So one thing you could do is you could talk about the value of the benefits received by a standard income measure like the traditional census income and not try to put the benefits in but simply say that people in the bottom decile get $10,000 of extra benefits on average or $2,000 or whatever the case may be. And that's a different way of thinking about it and looking at it and it gets you away from a little bit the problem of the notion that it looks almost, when you're talking about the non-fungible value or the fungible value, whether you're talking about something that's worth less and maybe we shouldn't be giving it in kind.

One of the reasons that we provide in-kind benefits is that we believe they are of value that don't just get attached to giving somebody a dollar and saying, go out and buy health care, but rather we are inducing people to get health care coverage that has other extraneous benefits for the rest of us, and

that's the reason we do it. Otherwise we'd be foolish, and we should just simply give people money. If we didn't value having everyone have health insurance, then we should simply give people a check.

Why then do we value having people have health insurance? Well, for me, as someone who already has good health care coverage and is not eligible for a subsidy, it means that I am less likely to walk down the street and contract resistant tuberculosis from someone who is untreated, for example. It means that as a society, I don't have to worry about the resources of hospitals and other people being strained and not being able to meet my needs.

I'm going to be very -- what am I going to say -- non-altruistic about it. That there are a lot of things that I get as direct benefits. There are also benefits to society of having a healthier workforce that will work longer, have higher productivity, and so forth. None of those things get captured, particularly when you begin to then try to wedge this into the income notion and reduce the value of these benefits so that they don't overstate the income that people have. It's a legitimate problem, and it's a dilemma. You're damned one way or the other way. You have to sort of pick your poison here.

Now finally I'd like to say that I think that there is also an interesting thing in terms of thinking about the whole issue of what is going to happen and all the other offsetting changes that will come, sort of second-order effects when people have to pay for higher health insurance, will they lay off workers? Will they reduce hours and so forth? My thing that I'm always shouting at the television when I'm hearing pundits who aren't very smart who are making

various claims is the counterfactual, the counterfactual.

So I'm going to leave you with that notion. Economists worry a lot about it, and it's a really valuable thing to think about. What would have happened if the ACA did not occur? And I would argue that employers that don't want to provide health insurance would not be providing health insurance. That employers who decided that they did not want to have workers work as many hours so that they didn't have to put them on their health insurance policy that many of them have voluntarily done, would do that anyway.

And so in some ways it's a perfect excuse, it's a wonderful excuse to say the ACA made me do it. And anytime anyone tells you the ACA made them do it, I would simply say, we need to look a little further and ask the question of, did the ACA make that happen, or was that something that was going to happen anyway? And perhaps it accelerated the trend. So you'll see in one year an incredible movement down, but you go back to the same old trend over time anyway.

So as these results are being digested and as the authors think about how to portray them so that people don't cherry pick them, I would say there are a lot of things to keep in mind. It's a great document that a lot of people will use, but also a lot of people will misuse I'm afraid. So thank you very much.

MR. REINHARDT: Well, it's extremely difficult for me to think of points that my two colleagues haven't already mentioned. Let me say at the outset, I'm obviously a little puzzled when people bemourn the shrinking of the employment-based health insurance in the United States. There was a time

certainly in the '90s when a lot of friends at Heritage Foundation and other places -- and I belong to that cabal actually -- saying, you know, it would actually be desirable to get rid of the employment-based health insurance system all together.

It creates enormous illusions in the employer -- employees that somebody else pays for the health care when economists were convinced, and you heard it again from Doug, that most of the costs that the employer ostensibly pay is actually shifted back into the take-home pay of the workers. So it's an illusion that workers think they're getting something for nothing when, in fact, they're paying for it.

I always tell my students that employee benefit managers are basically pickpockets. They, if you think of a garden party where somebody steals your wallet and buys you chocolate and you say thank you, but it was your money. And this is of course what employer benefit managers do, they take it out of your paycheck, take-home pay, and then they buy you health insurance, and you genuflect. And the other problem of course is that it's not portable. You lose it when you lose your job which is a propitious time to lose your health insurance.

So to have a track with more portable permanent insurance seems to be better. There was just a study done recently comparing Canada and the U.S. And health care cost increases in Canada have almost no employment effect, while in the U.S. they actually do. So I would not bemourn the dumping of employees from the employment-based system into the

exchanges, as long as of course we're willing to fund the subsidies for the exchanges.

Now as my two colleagues, I want to at the outset, thank Henry and Gary for tackling this daunting task. I mean, you have to project a counterfactual into 2016 and then project what is likely to happen with the ACA and look at the difference. And for some things you can do it, and for others, as Henry Aaron pointed out, it's just pure speculation because we don't how the incident actually goes. So to actually tackle this job and devote so much of their life to it, I really congratulate you and thank you for that.

And as both my colleagues say, you can nitpick here and there and find something, for example, the medical device tax, we don't know, I think it will mainly be shifted back into the prices these people get, because the whole market for devices is changing, but who knows. But at stake 20 billion or so, right? It's in some way peanuts. I mean, its one and a half Princetons, but nevertheless peanuts in the sweep of things. (Laughing)

Now the, what is being distributed, the target of the analysis, that is of course tricky. Ideally, you know, we, economists, would like something like well being or we call it utility or happiness in the vernacular, that's what you really like. Then we, economists, invented something called welfare which I think is, well, I'll use the Chinese word “muelfin” because Princeton professors are not allowed to talk about this substance so bluntly, but I think most of welfare economics is hocus-pocus.

So I'm glad you did not engage in that and focused on income.

And there you have it. You know, who would have thought income is so difficult to define until you actually think about what all goes into income. And the problem always is these benefits-in-kind, what are they really worth? As Marilyn pointed out, it's just that you have liquid assets and non-liquid assets you can sell, certainly not very easily and here you have income that's really very fungible, you can buy anything with it and then you have other things of value that you cannot tap and get a loan against.

Ideally one might say what I'd really like to do is say, I'm giving a poor family a benefit-in-kind and say, what is that worth to you? Well, it's the maximum they would have bid for that benefit, but I think that's self defeating on its face because they have very little income, therefore their bid price would be very, very low for this benefit. And so then we use various ways, the fungible method, which is some attempt to come to grips with it, that if a family is near starvation, giving them a benefit like that is probably worthless to them because they wouldn't bid anything for it. And the fungible approach that Gary explained so well takes care of that.

If you take the full value, that certainly is likely to overstate the value to the family of this benefit-in-kind, which is of course what moves so many economists so say, why don't we just give them the cash equivalent, you get more happiness out of that. I think that misses an important point. But that's what we teach freshman. The reason we do it is because you can do that with graphs that will completely confuse them in the first lecture. I do it all the time. (Laughing) And then they think, whoa, this guy really knows stuff. Actually it's

just a banality dressed up in different skirts. You know, you've seen that.

I've actually written a piece on benefits-in-kinds and why economists are lousy lovers. (Laughter) I'm happy to share that with you. We don't give gifts, for example. Instead of dating, we just wire some money to our dates -- (Laughing) -- and say, by some Manolos and then meet me on a park bench, it's free. That's how we date -- (laughing) -- we economists.

Now the problem is with the, if you impute the full benefit as what taxpayers pay for a benefit and say now that I add to the income, you can just see, imagine a situation where for some reason, Congress maybe had a little too much to drink or whatever, but they raised the fees for pediatricians, supposing they did that. And then all of a sudden the pediatrician in a new Beemer goes into the neighborhood of the poor and he can tell the poor, you know, I bought this Beemer from the income increase you poor people got. Because we would add that fee increase to the income of the poor under this approach, right, that's where it would go.

And the poor not even realizing that the income went up, paid for the Beemer of the pediatrician. So there are some absurdities in it. But we really don't know how to cope with it any better than these two authors have done. And the best thing to do when there are alternatives is, in fact, to show all of them and then let people ruminate which measure tells them, different measures tell different stories, which they want to work with.

The same incidentally is true about value. You go to any health care conference, you'll hear value purchasing, value this, value insurance. I'm

going to have a conference on value valuing. I think it's a great concept. But we actually do not know the value of health care. We know -- we can guess that something is more valuable than something else, a treatment. So we can ordinarily talk about values, but we can't currently measure values in health care at all.

For example, what is a quality adjusted life here worth in America? Does anyone here know that? Do you know that?

MR. HOLTZ-EAKIN: What its worth?

MR. REINHARDT: Yeah. And he would know because he used to run the CBO. So this, they did as well as they could with the benefits-in-kind, but it is a can of worms that bedevils any incident analysis if it involves benefits-in-kind. Now the other problem is the employer-paid health insurance premiums. It is a natural and we always say that on talk shows on PBS. Doug and I would say, well, you know, we believe that when an employer spends more on health care, ultimately that's taken out of the wage, take-home wage of the workers. And we assume a one for one.

I'm actually not -- this is okay because that's, we each have, every discipline has their religion. Some people believe in the virgin birth. We believe in this. But it's not necessarily true. When you actually model it, I actually did, and I had some slides, but I think they would have, they would be counterproductive. If you write just a little two equation model of a competitive labor market, it has to do crucially with what value the workers attach to a dollar spent by their employer on health insurance.

That's the crucial variable because that drives which way the curve shifts when health care costs go up. The assumption we normally make passively is that the employer, the employee values the employer-paid insurance premiums one for one, you know, that they view it as a dollar cash equivalent adjusted for taxes. Of course if you don't assume that, then, in fact, the wage is backwards, is not one for one. It could be for every dollar health care spending increased by the employer, wages go down $0.50 and unemployment picks up the rest, that there is, in fact, an employment effect.

And recently there has been literature that I've seen in 2009, 2006, Assud, Gosh, and Escars, they found faster growth in health care costs had greater adverse effects on economic outcomes. You know, we found a 10 percent increase in excess growth in health care costs resulted in 120,000 fewer jobs, et cetera. And there was a paper by Baker and Chandler that also showed that. So therefore the offset may not be one to one, and that would affect some of your graphs, in particular in connection with a mandate.

If you mandate an employer to provide insurance, that may not all come out of the wage base of the workers. Again, this would be like Doug's, an effect that would change those bars a little bit. But it's something that I would recommend maybe you have a little section discussing the labor market and that, the case you use is one of many possible cases. It would enrich your analysis. I'm very glad to what length they go at the end to show what they couldn't estimate.

For one, you learned a lot about the Affordable Care Act, all those

wrinkles in it. It is an amazing thing. Part of it is unavoidable. Part of it was probably political. You had many, many sources funding this thing so that no source would get hit too hard, you just hit a lot of them each a little bit, but that makes for an extremely messy analysis.

I had some question. In the paper you said that people over 65, if you take their health spending to people who are in their 20s, it's 6 to 1. I think I've seen numbers like that, too. But what we'd really like to know, is the group from 55 to 65, on average, that's not 6 times the 20, that's maybe more like 5-ish, 4-1/2-ish, so that, in fact, a 3 to 1 may not be quite so shocking.

So maybe you can look at what that is. I think those numbers from MEPS must be easily available, what those ratios actually are. There is some age compression that surely is in the law that 3 to 1 is probably less than it really is.

Do you know what it is, either of you? I don't.

MS. MOON: I think it's like four and a half.

MR. REINHARDT: Four and a half.

MS. MOON: Four and a half.

MR. REINHARDT: You know, this kind of thing would occur to me on a train. That would be my number as well. And so again, I conclude, I mean, obviously the 40 percent excise tax for the Cadillac tax, I think that will be like the boats. I think those products will probably disappear just like those boats disappeared. And I therefore don't blame the authors at all not tackling those because you really don't know the behavioral response to this Cadillac. And it starts only in

2018.

MR. AARON: Right.

MR. REINHARDT: And who knows, I mean, we may not even be counting in dollars anymore. So --

MR. AARON: It may be in Chinese Yuan.

MR. REINHARDT: -- it is extremely -- one could from this, and I'm glad you mentioned this, cherry pick and tell all kinds of stories, and stories will be told; but I think if one wants to be honest about it, if you take it in totality, it's a very plausible, sensible forecast. I'm very grateful that you did it and that we now have it and that we can use it in teaching among other things, which I will. It will make a great preset. And let me leave it at that.

MR. AARON: Well, we've now heard three excellent overviews and reviews of what we've said with interesting additional thoughts about how we should think about the measuring income and assessing how income distribution might change. And so now we want to hear reactions from the audience or questions. If you have questions, if you want to spark a discussion up here, stand up and identify yourself.

Yes.

MR. MINARIK: Joe Minarik.

MR. AARON: Joe Minarik.

MR. CHEKO: Thank you. Larry Cheko. We've heard the word value quite a bit. And I would think that it's a loaded question because the value of health care really depends on your personal situation. If you have a chronic

disease, I think you value it more than if you're healthy. But I think it's more than an individual thing. I think we have to look at it from a cultural point of view. What value do we place on health care as a culture? To Ms. Moon's point of view.

I guess my basic question is, is the ACA, was it worth passing? Whether it distributes income or not, culturally was it a benefit or a negative for America? And it seems to me that it would be the first steps towards a universal health care system, you know, given the fact that, you know, some people want to see the Medicaid thing expanded. But anyway, that's my question, was it a positive or a negative?

MR. BURTLESS: Speaking as one of the two authors, I'm perhaps too bluntly going to say, we didn't make -- we really didn't address that question. That was not our goal. Our goal was to measure using the conventions of income measurement and standard economic theory what the impact is on income. You can make a lot of arguments one way or another regarding the desirability of the Affordable Care Act including the dimensions you have described. We stayed away from that.

MR. AARON: Joe Minarik.

MR. MINARIK: Thanks to the authors for the paper. Very helpful.

MR. AARON: Pardon me. Let me say by way of introduction, and in the future each person should please introduce themselves. Joe is a chief economist at the Committee for Economic Development.

MR. MINARIK: Thank you, sir. A narrow factual question for Hank. You

mentioned that your distributional numbers represented the affect on an income group, that a comparatively small number of people in any given income group are actually affected and therefore the impact on those who are affected would be proportionately larger than the numbers you mentioned. And I believe you explicitly said that that was true up and down the income scale. I would have thought that at the upper end of the income scale, the effects you're measuring are primarily paid-fors --

MR. AARON: Yes.

MR. MINARIK: -- which are more universally --

MR. AARON: Mostly, but not entirely.

MR. MINARIK: Yeah. And therefore that at the upper end of the income scale, more people are affected. The effects on individuals are more uniform at the lower end of the income scale. They would be more concentrated on particular individuals. Just interested in your reaction.

MR. AARON: I'm going to punt this to Gary because he worked with the data much more closely.

MR. BURTLESS: Well, if you're a family above, with income above $200,000 as an individual person and 250,000 I think --

MR. AARON: Uh-huh, yeah.

MR. BURTLESS: -- as a married couple, 100 percent of you will be affected if you derive income from earnings or from investment income. And that pretty much exhausts where you can derive taxable income, I think. So yes, but that's only a small portion of the top 10 percent really.

MR. MINARIK: But the top 10 percent has a lot of people below $200,000, too.

MR. BURTLESS: That's my point. So even when you see these fairly sizable gains under some measures of income, comprehensive measures of income at the bottom end of the distribution, the charts that we tried to show you in which we show the number of people taking up Medicaid in addition to the current numbers with Medicaid and the number taking up health plans for which they are receiving tax credits, in no part of the income distribution do those people constitute more than, you know, 15 percent or so of the total people.

So they're just, most people are not affected. It's averaging together over a full income decile; what are the gains, what are the losses in that decile. How does it compare with what the average income was in that part of the income distribution before reform? Those are the numbers we're showing.

MR. AARON: If we had more budget, I think it would have been a useful thing for us to go through and identify those households whose incomes are affected and calculate the average for that subset within each decile. We look forward to the Government transferring to us some of the exchanges budget so that we can continue.

MR. BURTLESS: Probably near, in one month's budget cut for healthcare.gov, we'll be fine, we'll accept that.

MR. AARON: Gene Steuerle.

MR. BURTLESS: Gene Steuerle in the back. Is that --

MR. STEUERLE: Gene Steuerle from the Urban Institute. And I don't really

know the answer to this question, but I'd be curious to hear speculation. I think that one of the big 21st century issues for social welfare policy is the extent to which the money we spend on social welfare is captured by providers, whether it's Brookings and Urban Institute researchers or Princeton professors or doctors and lawyers along the way. And if you assume that the additional spending on health care, a significant portion, I don't know what number you might want to use, is captured by providers; how would that affect your results?

And the reason I'm not sure how that works, because you did have the additional spending at the bottom of the income distribution, but you have the Medicare cuts at the top. So I'm not even sure how much additional money in the end is actually going to health care on the grand scheme of things on net, you know, how you count the taxes on everybody else. So I'm just curious whether there's, if it's worth speculating to some extent if some of this money is captured by providers, how that might affect the results?

MR. AARON: Isn't the critical questions whether the, to use the economics jargon we're talking about rents for providers. If what we're talking about is providers providing -- being paid for an increased flow of services to beneficiaries, that's what one would hope for, and it would be a sign of success. I think what you're referring to, and I think there is reason to think about, is the question of whether the increase in demand simply enables people to jack up prices.

MR. STEUERLE: Okay.

MR. AARON: And that raises the question that Gary spoke of in his

presentation. We don't address the impact of the Affordable Care Act on prices. That's a very, very complicated story. I mean, just to name a few; the establishment of the exchanges, its purpose is to increase competition among insurers which should, to the extent that consumers respond to price differentials, create some back pressure against providers trying to cream off extra income.

The Affordable Care Act contains a variety of mechanisms directly to reduce reimbursements to providers. I alluded to the ones under Medicare. There's the tax that Doug Holtz-Eakin mentioned on devices. We don't know now how that is all going to play out. If the recent trends, the slowdown in the growth of health care spending, are reinforced by that factor; those impacts can be as large as or larger than anything we talk about, not necessarily for the individual family who gets Medicaid or who gets a sizable refundable tax credit, but in the large for society at large.

And on the other hand, there are going to be more people insured. Demand is going to rise, that may create leverage for providers to increase what they charge for their services. Again, you can make an argument on both sides. At this point, I, for one, don't have a strong prior as to how that's all going to play out. My instinct is that, as I said, there are pilots, experiments, trials, you name it; we have a long history of them not succeeding all that well in terms of Federal efforts to see what works.

But we're going to be trying out new payment mechanisms, regulatory devices to hold down the growth of health care spending, and we might get lucky. And if we do, then that could be a first order impact captured not

at all by the estimates we do. But others here may have some comment.

MS. MOON: The one place where your analysis does kind of capture that is in the Medicare Advantage reductions, because you're assuming that's a loss to individuals, where in a sense it could be. You know, Medicare Advantage plans have to become more wily than they have been, reduce their rent and so forth. And so you have a, in that case an assumption that that's a reduction in benefits to individuals.

MR. BURTLESS: I mean, I want to first just echo what Hank said, we just don't know. And it is the most important question. But if you think in the extreme that this all turns into price effects, you're on that plow, you're about 500 billion into the health care sector, if it's all price effects, the low end is going to get a trillion dollars and face $500 billion in higher prices. They're going still be relatively better off. The high end is going to be worse off plus pay the taxes.

And so the answer to the question in the paper, we know qualitatively what it's going to look like. We do care about how we get there, though, because there's, you know, you can change the income distribution at a high level of well being or at a low level. And that's at a lower level.

MR. AARON: And I observed that a while ago that Uwe Reinhardt wrote a really terrific article which you should all read as the health care system as an income redistribution device. And I think that's the nature of your question. The providers are the ones who gain income under our peculiar system of health provision here in the United States. But having heard many people express the belief that if we raise incomes to the health sector, it's necessarily raising

incomes to the top portion of the income distribution. I once did a little analysis with the annual income survey of the Census Bureau asking, well, what does the distribution of income look like of families containing somebody who is a health care worker or someone employed by the health insurance or health device, health drug industries; it's not, it is more unequal than the distribution and it is somewhat higher, but there's a huge, gigantic overlap.

Because remember, lots of people who work in the health care industry do not earn terrific incomes. And so the notion that automatically the ones that would gain are the ones that are high-income workers in the health care industry does not really follow. It could be that if the poor are obtaining more Medicaid-covered insurance, they will obtain health coverage in a fairly inexpensive way because that's what a lot of states have directed their Medicaid enrollees into.

Joe Andersen.

MR. ANDERSEN: A couple of technical questions. Remind us what the sample size of the MEPS is. And it looked like to measure these effects, you'd have to slice and dice the sample quite a bit. And did you have a minimum sample size on any of the cells that you ended up with to provide an estimate? And then the second question follows from Marilyn's comment, if you can just describe briefly the non-ACA base case in 2016, did you project any trends in health insurance or health coverage that might have been, that might have occurred without the ACA, and did you project the effects of potential changes in the aggregate unemployment rate or did you just take 2006 and

statically age it to 2016?

And are there any major implications for your creation of the base case for your results?

MR. AARON: The sample that we used consists of between 60,000 and 65,000 individual people. And all of the numbers we gave are in terms of individual Americans ranked by their position in these different distributions that are described. So that means that when we are reporting for the entire population, the bottom 10th we're talking about a cell size with 6,000 or so people. So it's fairly sizable. I can't promise you that's what it is when we divide the population by age group and by income quintiles, but still I think we're talking about fairly large sample sizes of people.

The trends in health coverage, we take as a baseline what people report in the 2006 and 2008 medical expenditure panel study with regard to their source of health coverage. We then look at what the Congressional Budget Office forecast coverage is going to be in the non-aged population in 2016. By the way, the center for Medicare and Medicaid services also has projections and we looks at those, too. But we've primarily tried to target our projections to duplicate the broad predictions that the Congressional Budget Office makes.

And so whatever the CBO has built in, in terms of the trends that you're interested in, that's essentially what we are adopting. But it turned out we did not have to vary our own estimates, based on the medical expenditure panel survey, after we had done an age shift, an age and gender shift in the population to reflect what the Census Bureau thinks the population is going to look like.

So it didn't actually require very much of a modification at all in our MEPS sample. We were projecting the same baseline in 2016 pretty closely as the CBO was projecting.

Yes.

MR. KAHN: Hi. I'm Richard Kahn from the University of North Carolina, a clinician. Two questions. The first is that the concept of the ACA decreasing uncompensated care. And if you do that, there would be some shift in where, in who's going to pay for the cost of care. Because possibly people who are insured would pay less currently at the top. And that would mean, if their hypothesis is true, that wages would then go up. So the first question is, is uncompensated care considered at all in the study?

And the second thing, a corollary to that is the notion that if you decrease the cost of insurance, you're going to increase wages. Is there really empirical evidence, solid evidence suggesting that's true as opposed to decreasing the cost of insurance? And that, I'll call it savings to the employer, goes to profit margin or any other expense?

MR. AARON: Do you want to tell him?

MR. BURTLESS: With regard to what happens to wages when there's a change in some kind of employer compensation in some other form like increased health care costs or higher workers compensation costs or increased cost of health insurance because a new element of that coverage has become mandatory, my impression is that this particular assumption that it's borne, that the increase -- these increases in costs of the health parts of the compensation

package are indeed reflected in lower money wages is, in fact, clearly well supported in the evidence, the empirical evidence.

I mean, and people have looked at in different ways, but I think that one reason that it enjoys widespread support among labor economists is because it seems to be supported at least in the empirical way in which I'm talking about.

MR. REINHARDT: Yeah. I think Jon Gruber and Anna Kruger had some work on it with respect to maternity benefits that were mandated and pretty much shifted back. I mean, the question whether it works the other way --

MR. KAHN: Yeah, that's the other question I was going to ask.

MR. REINHARDT: -- well, I'm not sure I know. Actually at the moment I can recall a paper that addresses those. I bet you if we dig, we might find them, but that's a good question, whether it really works symmetrically. I mean, the theory of labor market, of competitive labor markets suggest it really should or the whole theory doesn't work. And it works in one direction. It does seem to work. There's even, you know, on this whole backwards shifting, a company buys a group policy and pays a lump sum for that. And then the question is how that gets apportioned to the individual worker by class, by skill level. We really don't have a good theory.

MR. AARON: That's right.

MR. REINHARDT: I've never seen a good theory.

MR. KAHN: It doesn't even have been apportioned to the individual. It can be apportioned to research and development costs, capital costs.

MR. REINHARDT: No, no, it could be. But I mean our theory says it goes to wages. But then the question is, if you have a highly skilled engineer and then you have janitors where there's an excess supply of it in the field, will the shifting back be the same. And then you reach a wage floor level beneath which you really can't shift back. It is really rather complicated. I have seen some studies that show, for example, that there is some backwards shifting for people who are overweight, if they are very much overweight, wages are actually lower, other things being equal. There's such research. Although, what, there could be many confounding factors. It's --

MS. MOON: What I'm not certain about, though, is if when there's a study that's done of a company facing a change, that's different than also when you're talking about --

MR. REINHARDT: The whole market.

MS. MOON: -- the whole market and you make a change in the whole market. I think that that's an interesting question of -- and whether or not if half of the market is doing one thing now and the other half is not and now you make them all do it, how does that affect? And I think those are questions that are a little beyond what most of the literature has been able to address.

MR. BURTLESS: We have some evidence on that from differences across state lines and county lines where people have looked at, you know, presumably competitors in the same product having different rules depending on what state they're in. They get mandates in one state and not another state. They do seem to get pushed into wages pretty uniformly. It's a very strong empirical finding.

Now how fast is something we don't know much about, and how it gets distributed within the firm we know even less about.

MR. AARON: I think the issue within the firm is critical. I mean, you think of a firm that employs a thousand people --

MR. BURTLESS: Right.

MR. AARON: -- ranging from highly skilled professionals down to people who are doing minimum wage work, they have a group plan, they are quoted a price based on an actuary study based on the characteristics of the employees and a certain rate is given to the company, which incidentally is going to change at least for small groups in some states because of regulations that the exchanges can put into effect. They're going to get quoted different rates because different criteria are going to be legally mandated for rating policies.

But this rate comes to the company and they look at their work face and do they know what health insurance premium is associated with which job? This is the inside-the-company phenomenon. The deeper you dig on this, the more complicated it gets. That said, we talked standard economic theory for this study. And so the questions you're asking and the complications we're now introducing are suppressed.

MR. KAHN: So maybe it's wiser not to just say immediately that, oh, these insurance wages go up because we really don't have real good tests within small, medium, or large --

MR. AARON: Well, how it's going to be distributed, for example, among employees.

MR. REINHARDT: That's the real issue, right?

MR. AARON: Yes.

MR. REINHARDT: You know, we've never really --

MR. KAHN: (Inaudible).

MR. REINHARDT: Yeah.

MR. KAHN: Did you use the uncompensated here? Was that taken into consideration?

MR. AARON: That's complicated also because one of the things we didn't look at was the ending of the grants given to hospitals for uncompensated care. We took the price of health care services, the cost of care as reported in the medical expenditure panel survey, aged it, and I think did not actually take account of what are the offsetting effects, the reductions in uncompensated care, but also reductions in grants to hospitals that they now receive that are going to end.

MR. BURTLESS: Yes.

JOSHUA: First of all, thank you all for coming and for taking the time to discuss the paper. My name is Joshua. I'm currently an intern with the Heritage Foundation. And I was curious about, given the 2016 data in the paper, how would that be affected by enrollment numbers? If we can imagine a scenario where twice as many people as expected have enrolled by 2016 through the exchanges and then another scenario where only half as many have enrolled, how would that affect the data in your paper for income redistribution?

MR. AARON: Well, remember, the cost measures that Congress adopted

that we reflect are the ones that are reflected. So to the degree that there are more people enrolling in state, through state exchanges to obtain care that is subsidized, that increases the apparent benefits without changing the costs. Now if you don't think that that's a very likely scenario because you think Congress will do something to cover the additional costs, well, then it's not going to be, it's not going to work out very well.

But it is worth remarking that when Congress passed the Affordable Care Act, it tried to have increases in expected revenues to cover the additional spending that was foreseen. And the Supreme Court then ruled in a way that reduced the net benefits that will be received by the lowest income Americans because Medicaid coverage is not going to expand as much. So that meant that the relationship between the benefits and the tax revenues, which of course represent losses to the people who are paying, changed. It increased -- it reduced the size of the benefits, but it left unchanged the cost that individual American families are going to bear in order to sustain it.

The right thing to do in response to your question is a lot more sensitivity tests. Just, we did a certain amount of sensitivity tests in deriving these estimates, but just reporting this level of results probably was burdensome enough for our poor readers. And reporting the results of a very long string of sensitivity tests would be informative only, I think, to real experts.

MR. BURTLESS: Well, let me just endorse something Doug said earlier, which is I think that maybe it comes to what you're asking, but I think the area of genuine uncertainty concerns employer behavior over the long haul. We have

this very peculiar system of linking health insurance to your job. It has been criticized on both the right and the left for different reasons. People have pronounced it going extinct and then came the 1990s and enrollment rose. Since the 2000, the Internet bubble popped, enrollment through employers has been declining and maybe it is going to continue.

There is a real question as to whether employers are going to say, there's this alternative, now is the time we can stick to our knitting and get out of the health insurance business. And if that were to happen, the CBO's projections, based to a significant degree on modeling by Jon Gruber at MIT, would be falsified and the numbers would change a whole lot.

MR. AARON: Yeah. The reason we don't think that will happen, though, to a huge degree is the employers now face, if they have employees with moderate incomes who are eligible for subsidies, policies obtained through the exchange, they will owe $3,000 in penalties. What does the $3,000 penalty buy them? You might say, well, that's cheaper than paying for the coverage for this person. True, that is. On the other hand, they're paying $3,000 and they're not getting a happier employee.

And I think a widespread view is, if they pay $3,000 for every person who leaves and goes and receives subsidized health insurance, that will be a deterrent to giving up the employer-sponsored plan because they're not getting anything for the $3,000 in penalties that they face. They're getting nothing. Their employees are getting nothing. And as far as we can tell, employees enrolled in employer-sponsored plans do value the coverage they

receive under those plans quite highly.

So I would be a little skeptical that there's going to be massive leaving of the system. We still project that there will be some decline, but we think it will be decline in people in part-time positions, mostly in small employers and people who have seasonal jobs who currently do get some employer-provided health insurance, not much, but they do get some, and we think that those people will get less insurance.

MR. BURTLESS: Yes, sir.

MR. ALTMAN: Hi. I'm Troy Altman. I'm just wondering overall, the reason for doing forecasts as opposed to waiting just to see what happens is you may, there may be things you want to do because of the forecast. From your results, are there any actions that you would think would be beneficial?

MR. AARON: Good question.

MR. BURTLESS: Well, let's be clear on what we did. We did not make a forecast. We made a conditional estimate on how incomes will change if people behave according to the underlying decision rules that we incorporated into the model. So and moreover we benchmarked to the Congressional Budget Office office estimates of the numbers of people who would be affected. So its stretching things a bit to describe, to ennoble what we did as a forecast. It is more in the nature of a projection which is exploring the implications of certain underlying assumptions.

That said, your question stands, and I have in a way been stalling for time and hoping somebody else would come up with a good answer.

(Laughter)

MR. BURTLESS: I would just say that the thing that is quite striking is that in the lowest ranks of the income distribution how much the effects have been affected by the Supreme Court decision. And by the way, if things continue the way they currently have, if no additional states sign on to increase their eligibility limits for Medicaid, then actually the situation will be worse, I think, then our projections. And it is very striking how a lot of the benefits are derived, not by the people who are in the very poorest circumstances and have, by the way, the lowest levels of health coverage right now, but people who are a little bit higher than that.

Obviously the people who would be gaining do not currently have health insurance benefits or many of them do not or many of them have excessively costly health benefits that they will give up in exchange for the new kinds of insurance. But there's just, it's pretty amazing that the bottom end of the distribution, the very bottom of the money income distribution how high rates of noncoverage will remain even after this goes into effect.

MR. AARON: Anybody else wish to ask questions or --

MR. BURTLESS: Yes, sir.

MR. MOORE: I'm Allen Moore of the Stimson Center. First of all, I've been thinking about this counterfactual notion that a couple of you referenced. And although I know this isn't a political conversation, I'm reminded that the counterfactual for the ACA isn't necessarily this ACA or no ACA. Because there was an effort early on in the Congress, particularly among a half a

dozen members of the finance committee, to do bipartisan bill which was making some progress. And then what I refer to is the curse of 60 votes in the Senate emerged and all of a sudden the process in the Senate became more political.

I mention that only because it's not for me, this or nothing, but this or something quite different. The question I have, though, and I know it's not something you looked at it, but it comes to the, it relates to the question of uncompensated care, what we've seen in terms of sign ups, people who haven't signed up. Some of it is the problem with the website obviously, but some of it comes from people going onto the website, looking at their options, not liking their options as they begin to understand them, and simply saying, I can still go to the emergency room.

And when I look at your data and think about the second and third decile, those that benefit the most, that, those people obviously have to sign up. And what I'm thinking now is, given how some of their options are set up with co-pays and co insurance and deductibles is, some of the people who sign up, in fact, I'm concerned that quite a few of them who sign up will have a need, they will go for services, and they won't be able to pay their deductible and that will be another source of cost, if you will, that I assume would, in this day, to come back into that second and third decile.

I know you didn't look at, but I wonder if -- we've got some really smart people here -- if any of you could reflect a little bit on that question.

MR. AARON: Well, if they go from being uninsured to having this insurance, even insurance that has expected co-pays for individual services, we still

presume that they will receive, they will purchase, they will consume more health care goods and services than they would in the absence of the ACA. I mean, granted everything you say is true, but the -- for a person who gains insurance who previously did not have insurance, facing a co-pay still reduces the cost of those services and increases the likelihood services will be consumed, I think.

MR. HOLTZ-EAKIN: And just a small --

MR. AARON: Go ahead.

MR. HOLTZ-EAKIN: Just a small, we don't know much really about enrollment to date or what it will be, and so everything should be taken with a big grain of salt. But what we do know so far is that the bronze plans where people are most concerned about, very large deductible and things, have not been what people are signing up for. 60 percent of signups are in solo plans for which low income individuals get help with the co-pays and the deductibles. So, you know, so far that scenario hasn't really played out in the data.

MR. AARON: I think this is actually a really good note to end on, and the reason is it's a good note to end on is that we took the ACA as it is. Your question points to the fact that that assumption, itself, is not likely to hold valid indefinitely. Whatever direction things go on, problems have already been identified, additional shortcomings are going to emerge, market effects that nobody anticipates are going to occur across the United States, and it is inevitable far beyond the usual technical corrections legislation that alas has proven impossible to enact in the current political atmosphere, far beyond that future Congresses are going to modify the ACA.

So it's a real mistake, I think, for anyone, and we certainly don't want to, to treat this as if it is graven in stone and is the legislation for the ages. Congress will be revisiting this, at which point we very much hope the Rockefeller foundation will give us another grant, and then we'll study it. Thank you.

(Applause)

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