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## Analysis of a Permanent Prohibition on Implementing the Major Health Care Legislation Enacted in March 2010

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*Congressional Budget Office*

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## Analysis of a Permanent Prohibition on Implementing the Major Health Care Legislation Enacted in March 2010

### Abstract

[Excerpt] This letter discusses many of the potential effects of a permanent ban on the use of appropriated funds to implement the health care laws and, where possible, provides information on whether those effects would increase or decrease direct spending or revenues. Because of the uncertainties discussed below, however, CBO and JCT do not have sufficient basis to provide a comprehensive estimate of the budgetary effects of legislation that would prohibit the use of funding to implement the 2010 health laws, yet would not repeal any provisions of that law.

### Keywords

health care, Congressional Budget Office, CBO, Patient Protection and Affordable Care Act of 2010, PPACA, Health Care and Education Reconciliation Act of 2010

### Comments

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May 26, 2011

Honorable Henry A. Waxman  
Ranking Member  
Committee on Energy  
and Commerce  
U.S. House of Representatives  
Washington, DC 20515

Dear Congressman:

In response to your request, this letter discusses the budgetary effects of legislation that would permanently prevent the use of appropriated funds to implement the Patient Protection and Affordable Care Act of 2010 (PPACA) and provisions related to health care in the Health Care and Education Reconciliation Act of 2010, Public Laws 111-148 and 111-152, respectively.<sup>1</sup>

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have previously estimated the effects of legislation that would temporarily prevent the use of appropriated funds to implement PPACA and the Reconciliation Act. Specifically, earlier this year, CBO and JCT estimated the budgetary effects of enacting section 4017 of H.R. 1, the Full-Year Continuing Resolution Act, as passed by the House of Representatives on February 19, 2011. That provision would have prevented the use of funds appropriated in H.R. 1—that is, any funding for fiscal year 2011—to implement PPACA and the Reconciliation Act.<sup>2</sup> CBO and JCT found that such a temporary prohibition, extending through the remainder of fiscal year 2011, would reduce the budget deficit by about \$1.4 billion in 2011 but would increase deficits by almost \$6 billion over the 2011-2021 period.<sup>3</sup> H.R. 1 was ultimately supplanted by H. R. 1473, the

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<sup>1</sup> The Reconciliation Act (P.L. 111-152) also included provisions affecting education. The effects of a prohibition on the use of funds to implement any provisions of PPACA and the Reconciliation Act would affect spending on education, but this letter focuses only on the health care provisions of the act.

<sup>2</sup> Section 4017 of H.R. 1 applied to both the health care and education provisions of the Reconciliation Act; CBO's estimate for H.R.1 therefore included both of those effects.

<sup>3</sup> Congressional Budget Office, [cost estimate for H.R. 1, Full-Year Continuing Appropriations Act of 2011](#) (March 10, 2011).

Department of Defense and Continuing Appropriations Act of 2011, which did not include a provision like section 4017 of H.R. 1.

The budgetary effects of a permanent prohibition would be much greater, but CBO and JCT cannot estimate the magnitude of those effects—or even whether the effects would, on balance, increase or decrease budget deficits. According to JCT, a permanent prohibition on the use of appropriated funding for implementation would result in a significant loss of revenues. However, CBO cannot determine whether changes in spending under a permanent prohibition would produce net costs or net savings relative to its baseline projection, which assumes full implementation.

PPACA and the Reconciliation Act provided some (mandatory) funding for implementing the health care and revenue provisions of those two acts. However, CBO and JCT estimate that existing funding is not sufficient to implement all of the provisions of the 2010 legislation; some additional funding will be needed in future years. In their March 2010 estimate for the health care legislation as it was enacted, CBO and JCT estimated that the Internal Revenue Service (IRS) and the Department of Health and Human Services (HHS) would each require about \$5 billion to \$10 billion over 10 years to implement the law.<sup>4</sup> Therefore, CBO and JCT expect that a permanent ban on the use of appropriations to implement PPACA and the health care provisions of the Reconciliation Act would significantly alter the effects of many provisions of the legislation, including changes to Medicare; the establishment of health insurance exchanges, tax credits, and cost-sharing subsidies designed to increase the number of Americans with health insurance; changes to Medicaid; and other provisions that affect federal revenues. Among other consequences, CBO and JCT expect that such a ban would reduce the number of people with health insurance coverage compared with what would occur if the health care laws are fully implemented.

This letter discusses many of the potential effects of a permanent ban on the use of appropriated funds to implement the health care laws and, where possible, provides information on whether those effects would increase or decrease direct spending or revenues. Because of the uncertainties discussed below, however, CBO and JCT do not have sufficient basis to provide a comprehensive estimate of the budgetary effects of legislation that would prohibit the use of funding to implement the 2010 health laws, yet would not repeal any provisions of that law.

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<sup>4</sup> Congressional Budget Office, [cost estimate for H.R. 4872, Reconciliation Act of 2010 \(Final Health Care Legislation\)](#) (March 20, 2010).

## General Issues

A permanent prohibition on the use of appropriated funds for implementation would have varying impacts on different provisions of the health care laws, and the specific effects of such a prohibition would depend on the specific legislative language. The 2010 health care legislation includes some provisions that will go into effect without any further administrative action on the part of the federal government and others that have already been implemented. Many provisions with substantial effects on spending and revenues, however, require some administrative actions and thus would be significantly affected by a prohibition on the use of future appropriated funds for implementation.

The effects of a permanent prohibition would depend to a large extent on how the Administration chose to interpret the prohibition on use of funds for implementation. For some provisions of law, it is difficult to delineate between activities that HHS would be able to undertake and those that would be prohibited.<sup>5</sup> Other provisions of the health care laws established some legal rights on the part of providers, states, or individuals who could demand certain benefits or payments. Still other provisions created new responsibilities for individuals, businesses, and other entities. A legislative prohibition on the use of funding to implement the health care laws would not necessarily abrogate those rights or responsibilities. It is very difficult for CBO and JCT to determine with any certainty how affected agencies would resolve the conflict between tasks required by the health care laws and the lack of funding to administer those requirements.

Finally, some provisions direct other entities—such as states and pharmaceutical manufacturers—to implement changes. It is unclear whether and how those entities would move forward in response to the laws without any guidance or direction from HHS, the IRS, or the Centers for Medicare and Medicaid Services (CMS).

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<sup>5</sup> The funding for Medicare benefits and matching payments to states for Medicaid is mandatory, so the funds to make those payments would be available; the question is whether a ban on using appropriated funds would block or inhibit the process of determining and making those payments.

A permanent prohibition on the use of discretionary funding to implement PPACA and the Reconciliation Act would have some effects that would reduce the federal deficit and others that would increase the federal deficit. For example, such a prohibition could:

- Prevent CMS from modifying Medicare's payment rates on an annual basis;
- Preclude CMS from engaging in the rate-setting process and signing contracts with the private insurers that offer Medicare Advantage and Part D (prescription drug) plans;
- Preclude the Secretary of HHS from implementing recommendations of the Independent Payment Advisory Board (IPAB), aimed at limiting Medicare costs;
- Prevent enforcement of the mandate for U.S. residents to obtain health insurance;
- Prevent the federal government from setting up insurance exchanges if states chose not to establish them;
- Preclude CMS from issuing guidance or offering technical assistance to states on expanding their Medicaid programs to newly eligible people;
- Prevent CMS from assessing and collecting its share of higher rebates from pharmaceutical manufacturers for drugs dispensed to Medicaid beneficiaries; and
- Bar the IRS from modifying forms, instructions, and publications to reflect changes in tax law.

By reducing or preventing enforcement of the mandate to obtain insurance coverage, support for states to expand their Medicaid programs, the availability of new insurance exchanges, and the use of tax subsidies for insurance purchased through those exchanges, a permanent prohibition on the use of discretionary funding would reduce the number of people with health insurance coverage compared with what would occur if the health care laws are fully implemented.

For purposes of this analysis, CBO and JCT assumed that a permanent funding prohibition would be enacted late in fiscal year 2011 and would be effective as of October 1, 2011 (the beginning of fiscal year 2012). As a result, ongoing activities to begin the process of implementing the health care legislation would continue through the remainder of this fiscal year; those efforts would accomplish some of the steps necessary for full implementation, but would fall well short of completing all the actions necessary to implement and enforce the 2010 laws.

## **Effects on Medicare**

PPACA and the Reconciliation Act modified Medicare's payment rules for nearly all providers and services and made a number of other changes to Medicare that would be affected by a prohibition on the use of appropriated funds.

**Fee-for-Service Payments.** Nearly all fee-for-service providers, except physicians, are scheduled to receive downward adjustments to their annual payment updates, reflecting expected productivity gains. The health care laws made no specific changes to annual updates to payment rates for physician services, but payments to doctors would nonetheless be affected because other changes made by the laws will affect the calculation of the conversion factor that is the basis for Medicare's payments to physicians. Therefore, a ban on the use of discretionary funding for implementation could prevent CMS from modifying payment rates on an annual basis.

There is no obvious alternative to the updated payment rates, as the relevant provisions of the Social Security Act (as amended by PPACA and the Reconciliation Act) would not change—and the previous laws governing payment rates no longer apply. As a practical matter, that probably means that there would be no update to the computer programs (the so-called pricers) that contractors use to process and pay fee-for-service claims. Thus, unless the Administration found a way to use other authority—such as demonstration authority—to modify payment rates or the courts intervened following litigation, the effective result would probably be that payment rates would remain at current levels. Assuming that a funding prohibition would take effect on October 1, 2011, Medicare fee-for-service payment systems that operate on a fiscal-year basis (primarily those for institutional providers, like hospitals) would not be affected until fiscal year 2013, as CMS would be able to establish the fiscal year 2012 rates before a funding prohibition took effect. Calendar-year payment systems (those for physicians and other outpatient providers) would be affected immediately—that is, for calendar year 2012.<sup>6</sup>

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<sup>6</sup> Most payment systems in Part A of Medicare (including those for hospitals and skilled nursing facilities) operate on a fiscal-year basis—that is, new payment amounts and policies take effect on October 1 of each year. CMS issues the final payment rules for fiscal-year systems around August 1. Payment systems in Medicare Part B (including those for physicians and other outpatient providers) operate on a calendar-year basis; new payment amounts and policies are effective on January 1 of each year. CMS issues the final payment rules for calendar-year providers around November 1.

Freezing payment rates for physicians' services would increase spending relative to current law because those rates are scheduled to drop in 2012; in contrast, freezing payment rates for other fee-for-service providers would reduce spending because those rates are scheduled to rise under current law. Thus, if a ban on the use of discretionary funding had the effect of freezing payment rates in the fee-for-service sector, Medicare spending would increase in 2012 and 2013, and would be reduced—compared with projected spending under current law—in 2014 and subsequent years.

**Medicare Advantage and Part D.** PPACA and the Reconciliation Act included changes to both Medicare Advantage (MA) and the Part D drug benefit programs, including modifications to the payment rates for MA plans and benefit enhancements in Part D. Both MA and Part D operate on a calendar-year basis, and each year's benefit structure and payment policies will reflect the changes made by the health care laws. A prohibition on the use of funds for administrative activities would not have an effect until calendar year 2013, because CBO expects that CMS would sign contracts with plans for the 2012 plan-year prior to October 1, 2011.<sup>7</sup> Beginning with plan-year 2013, however, a prohibition on the use of funds could preclude CMS from engaging in the rate-setting process and signing contracts with the private insurers that offer MA and Part D plans. As contracts expired on December 31, 2012, there would probably be nothing to replace them and therefore no MA and Part D plans for Medicare beneficiaries. If there were no Part D drug benefit, federal spending would decline. (Under current law, CBO projects gross payments for Part D benefits to total \$77 billion in 2013 and \$1.1 trillion over the 2012-2021 period.) With respect to MA plans, CBO anticipates that all beneficiaries would instead receive health care services through the fee-for-service program, which would also reduce Medicare spending.<sup>8</sup>

**The Independent Payment Advisory Board.** The 2010 laws established the IPAB, which is charged with restraining the growth rate of Medicare spending per enrollee. If the growth of such spending is projected to exceed specified targets, the IPAB will be required to submit proposals to reduce it, and the HHS Secretary will be required to implement those proposals unless the Congress acts to change them or otherwise alter the IPAB process. In its most recent baseline (issued in March 2011), CBO projected that Medicare spending will not exceed the specified targets during the

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<sup>7</sup> CMS engages in the rate-setting and bid review process beginning early in the year before the next plan year—that is, the process would begin in February 2012 for MA and Part D plans wishing to offer benefits in 2013.

<sup>8</sup> All else equal, a fee-for-service Medicare beneficiary costs less than a beneficiary enrolled in an MA plan, because of the methodology used to set MA payment rates.



2012-2021 period and, therefore, that the IPAB process will not be triggered during that period.

The IPAB has its own mandatory funding under the health laws, so it would not be affected directly by a permanent funding ban. Therefore, if in future years, per-capita spending for Medicare increased at a rate sufficient to trigger IPAB action, the IPAB could engage in the process of developing policies to reduce the program's spending. However, if there were a prohibition on the use of appropriated funds, the Secretary probably would not be able to implement the IPAB's recommendations.

**Other Effects on Medicare.** The health care laws made numerous other changes to Medicare, including modifying payment rates and policies for specific providers, changing cost-sharing requirements for beneficiaries, and setting policies to reduce waste, fraud, and abuse. The laws also mandated demonstrations and pilot projects designed to improve the quality and efficiency of care. A permanent prohibition on the use of appropriated funding could prevent CMS from implementing many of these changes and initiatives—reducing spending in some cases and increasing it in others.

### **Effects on Implementation of Insurance Coverage Provisions**

The 2010 health care legislation established a mandate for most U.S. residents to obtain health insurance and provided funding and guidance to facilitate the creation of state-based insurance exchanges and subsidies for certain individuals and families who purchase coverage through exchanges. The legislation also imposed certain new requirements on insurers who offer insurance through exchanges and established penalties for certain employers if any of their workers obtain subsidized coverage through the exchanges. Those insurance and subsidy provisions are scheduled to take effect on January 1, 2014.

If federal agencies could not use appropriated funds to administer those provisions, CBO and JCT expect that qualified health plans and subsidies for qualifying individuals would not be readily accessible and the mandate for residents to obtain health insurance could not be enforced. Although some individuals and families would probably comply with the requirement to obtain health insurance who would not have obtained it in the absence of the mandate, the number of individuals and families with health insurance would be lower than under current law, and significantly fewer would receive coverage through the exchanges.<sup>9</sup> Therefore, a prohibition on the

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<sup>9</sup> CBO estimates that under current law, by 2021 almost 20 million people will receive subsidized health insurance through exchanges.

use of appropriated funding would substantially reduce the amount spent by the government on subsidies for cost sharing and premiums; under current law, that amount is projected to total more than \$700 billion over the 2012-2021 period.<sup>10</sup>

PPACA and the Reconciliation Act provided mandatory funding to HHS for grants to states that choose to set up health insurance exchanges. If states do not establish those exchanges, the federal government is required to step in and set them up. Funding for those state grants—estimated by CBO to total about \$1.9 billion between 2012 and 2015—was provided in PPACA. However, federal administrative activities would be required to review grant applications and award and renew grants, so a prohibition on the use of appropriations for such administrative activities would probably have the result of preventing grants to states from being issued. CBO expects that a permanent prohibition would slow down the establishment of insurance exchanges.

CBO anticipates that some states would choose to establish health insurance exchanges even if the federal government provided neither regulatory guidance nor financial assistance to states. Other states, however, might be reluctant to establish exchanges (and insurers might be unwilling to participate) if subsidies to help purchase health insurance were not available. If states chose not to establish exchanges, the prohibition on the use of discretionary funds would probably prevent the federal government from setting them up itself.<sup>11</sup>

### **Effects on Medicaid and the Children’s Health Insurance Program (CHIP)**

Matching funds that the federal government provides to states under Medicaid and CHIP are mandatory and would be unaffected by a ban on using discretionary funds for implementation. However, states administer Medicaid and CHIP in accordance with federal law and guidance. In addition, the federal government must review and approve most major changes to state Medicaid and CHIP plans. It is difficult to predict how

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<sup>10</sup> This figure includes all premium and cost sharing subsidies. Subsidies for health insurance premiums are structured as refundable tax credits; the portions of such credits that exceed taxpayers’ liabilities are classified as outlays, while the portions that reduce tax payments are reflected in the budget as reductions in revenues

<sup>11</sup> See Congressional Budget Office, [cost estimate for H.R. 1213, a bill to repeal funding provided to states in the Patient Protection and Affordable Care Act to establish American Health Benefit exchanges](#) (April 27, 2011). CBO estimated that the bill, if enacted, would reduce deficits by about \$14 billion over the 2012-2021 period.

states would respond to the lack of guidance from the federal government that would probably occur if there were a prohibition on federal agencies' use of funds to implement changes to Medicaid and CHIP. Although such a prohibition would not affect the underlying law requiring states to undertake particular changes to their Medicaid and CHIP programs, they might be reluctant to make those changes without further federal guidance or approval.

Under current law, CBO estimates that about 17 million additional individuals will be added to the Medicaid and CHIP rolls by 2021, as the programs become the primary source of health insurance for nearly all legal residents with income below 138 percent of the poverty level. Because states administer the enrollment process, CBO anticipates that these newly eligible Medicaid and CHIP enrollees could join the programs even if discretionary appropriations were not available at the federal level.

States might find that process to be more difficult, however, if CMS were unable to provide guidance and support. For example, under current law CBO expects that CMS will issue guidance to states about implementing the eligibility expansions mandated by the health care laws. If prohibited from using appropriated funds to implement the laws, CMS would probably not be able to issue such guidance or offer technical advice to the states on expanding their Medicaid programs. It is therefore unclear what actions states would take to expand coverage as required by law, and different states might interpret the law or implement the changes differently. In addition, it is uncertain whether states' ability to determine eligibility based on people's income would be affected by the restrictions on the IRS's use of discretionary funds to implement the health care laws.

Apart from the health insurance expansion, the health care laws made other changes to Medicaid and CHIP. For example, the laws increased the rebate that pharmaceutical manufacturers pay on drugs dispensed to Medicaid beneficiaries. If CMS cannot use discretionary funding to support the activities needed to administer the revised rebate agreements, it probably would not be able to assess and collect its share of the higher rebates. The federal government would therefore not realize savings from increased rebates or from other policies that would reduce drug spending in Medicaid. CBO estimates that, under current law, savings from all Medicaid drug policies under PPACA will total about \$48 billion over the 2012-2021 period.

As with Medicare, PPACA and the Reconciliation Act included provisions to reduce waste, fraud, and abuse in Medicaid and CHIP, as well as to improve the quality and efficiency of the care provided to the programs' enrollees. Without the ability to use appropriated funds, CMS could not begin or continue these activities. Similarly, the inability to provide technical guidance regarding other Medicaid provisions, like the required two-year increase in Medicaid's reimbursement rates for providers, could impede states' ability to implement those changes.

Given these uncertainties, it is difficult to estimate whether a permanent funding ban would increase or decrease Medicaid costs. On the one hand, if the Medicaid and CHIP expansions did not occur at all, or if states enrolled some but not all of the individuals that CBO estimated would obtain Medicaid and CHIP coverage as a result of PPACA and the Reconciliation Act, federal spending would be reduced. On the other hand, if the expansions occurred anyway, CMS's inability to implement other Medicaid provisions, such as the change in drug rebates, would increase federal spending.

### **Effects on Revenues**

JCT expects that a permanent prohibition on the use of discretionary funding to implement the revenue provisions of PPACA and the Reconciliation Act would significantly reduce receipts from the revenue provisions that are not related to insurance coverage. A variety of factors could affect the extent of this reduction. The prohibition would not amend the Internal Revenue Code or otherwise change the laws affecting taxation; it would only inhibit the ability of the IRS to administer the law. For example, the prohibition would prevent the IRS from developing and publishing new regulations, new tax forms or revisions to tax forms, and taxpayer instructions. The prohibition would also prevent the IRS from contacting taxpayers or initiating other enforcement activities to collect underpayments or liabilities generated by the health care laws. Nevertheless, PPACA and the Reconciliation Act created rights and responsibilities for taxpayers that are in force whether or not the IRS is able to take action to administer the law.

The effect of prohibiting the use of appropriated funds for such purposes would depend on the reaction of the public and the IRS to this lack of administrative action by the agency. Taxpayers' willingness to adhere to PPACA and Reconciliation Act provisions would depend in part on factors such as whether the change in law would be clearly reflected on the form to

be submitted to the IRS, whether it would be reflected in regulations and tax filing instructions, and, over time, whether the IRS would appear to be enforcing compliance with the provisions.

**Provisions that are Effective in 2011.** In the case of most revenue provisions that are effective before the end of fiscal year 2011, tax forms and instructions already reflect the provisions, and most taxpayers would probably comply with them in the short term. To the extent that those forms and instructions could not be changed for subsequent taxable years, some degree of compliance might continue, but would probably diminish over time. Taxpayers would be more likely to ignore provisions that increased their liability than those that reduced their liability.

Provisions effective in 2011 that increase liability include an increase in the tax on nonqualified distributions from a health savings account from 10 percent to 20 percent, an excise tax on indoor tanning services, penalties for underpayment of taxes resulting from violation of the economic substance doctrine, and a fee for manufacture and importation of certain pharmaceutical products (discussed further below). Those provisions are currently projected to produce roughly \$40 billion in revenues over the 2012-2021 period. JCT and CBO expect that, over time, there would be a significant reduction in revenues collected from these provisions.

The main provision in effect in 2011 that reduces tax liability is a tax credit for the purchase of employees' health insurance by certain small businesses. Taxpayers who might be eligible to claim the small business tax credit will probably claim it on their return, and would continue to claim it in future years if no changes were made to returns or instructions. Over time, some taxpayers might take a more aggressive position, claiming eligibility for the credit even if they did not meet all of the eligibility requirements if they believe that the IRS would be unable to enforce any limitations on the provision.

**Provisions that will be Implemented After 2011.** For provisions that are only effective for years after 2011, it is likely that the forms and instructions would not reflect the changes enacted in the health care laws, and guidance on how to comply with those changes in law would not be published. The permanent prohibition might present a conundrum for the IRS as to what it could include in its forms and instructions if it could not accurately explain present law. For example, in the case of the change in the threshold as a percentage of adjusted gross income that a taxpayer's medical expenses must exceed before the expenses are deductible, the IRS

might not be able to provide any explanation of the threshold in publications for tax years after 2012 because the threshold will have increased from 7.5 percent of AGI to 10 percent. Specifically, in 2013 and beyond, the IRS would not have the authority to administer that provision as it was in effect prior to 2013 (by reflecting the calculation on Schedule A of Form 1040 and in the instructions for Schedule A) as that will no longer be present law. However, the funding prohibition would prevent resources from being spent on changing forms, instructions, and publications to reflect changes made by PPACA and the Reconciliation Act. Therefore, the IRS might believe it could do no more than explain to taxpayers that there are limitations on the amount deductible, perhaps instructing taxpayers to consult with a tax professional about the limitations on the deduction.

Two provisions of PPACA and the Reconciliation Act that raise significant revenues do not become effective until 2013: an additional Hospital Insurance (HI) tax of 0.9 percent on earned income of single filers who earn more than \$200,000 and on joint filers who earn more than \$250,000; and a new "Unearned Medical Contribution" tax of 3.8 percent on investment income of single filers with adjusted gross incomes above \$200,000 and joint filers with adjusted gross incomes above \$250,000. A third significant source of new revenues from PPACA is a 40 percent excise tax on health insurance coverage in excess of certain thresholds, which will be effective beginning in 2018. Several other provisions in the health care laws that are expected to raise revenues, including an excise tax on medical devices, a limitation on the deductibility of certain compensation to insurance executives, and the elimination of the deductibility of subsidies for Medicare Part D will also take effect in 2013. Because the IRS would not be able to prepare forms and instructions to facilitate collection of those taxes, and would not be able to take enforcement actions in the event that taxpayers fail to pay these taxes, most of the revenues anticipated from those taxes would probably not be collected. (JCT and CBO estimate that, under current law, those provisions of the health care laws will bring in several hundred billion dollars over the 2012-2021 period.)

Some provisions of the laws present special problems because the IRS has to take a direct role in implementing them. For example, collecting the pharmaceutical and insurance industry fees imposed by PPACA and the Reconciliation Act will require the IRS to make a determination of each taxpayer's liability each year. The pharmaceutical industry fee takes effect in 2011, and the IRS expects to complete its determination and collection of the fee this year prior to the assumed effective date of the prohibition. The insurance industry fee, however, is not effective until 2013. It is unlikely

that the insurance or pharmaceutical industry fees would be collected in years after the effective date of legislation that prohibits spending funds for implementation because the IRS would not be permitted to administer the fees and make the necessary taxpayer determinations. (JCT and CBO estimate that, under current law, those fees will generate receipts totaling more than \$100 billion from 2012 through 2021.)

The tax provision in PPACA and the Reconciliation Act that provides the largest benefit to taxpayers is the refundable tax credit for insurance purchased through health insurance exchanges. That provision does not become effective until 2014. (CBO and JCT estimate that the credit will result in a reduction in revenues and additional spending totaling more than \$600 billion over the 2014-2021 period.)<sup>12</sup> Prohibiting the use of discretionary funding for implementation of the health care laws would result in many states failing to establish health insurance exchanges and would probably prevent the federal government from setting them up itself. Nevertheless, some states would probably set up exchanges, and persons who chose to purchase insurance through those exchanges would be eligible to claim the tax credits. Barring the use of funding to administer the tax credits would prevent both screening of individuals for eligibility and advance payment of the credits. It would also prevent HHS and the IRS from publishing guidance about claiming the credit and providing appropriate tax filing instructions. Thus, there would probably be a significant reduction in use of the tax credit. (However, because some people would still be eligible for the credit, there would probably be some loss of revenue, possibly through claims appended to tax returns.) In addition, the existence of a large refundable credit that the IRS is prohibited from overseeing could create tax compliance problems. On net, JCT and CBO estimate that a large share of the federal government's costs associated with the exchange credit would be eliminated by a prohibition on the use of appropriations to implement the health care laws.

**Role of the Private Sector.** Finally, an additional source of uncertainty in estimating the effects of prohibiting federally appropriated funds from being spent to implement PPACA and the Reconciliation Act is the role of the private sector in the tax filing process. Many taxpayers, both individuals and business entities, rely on professional assistance or computer software to complete their tax forms and calculate their tax liability. It is unclear how

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<sup>12</sup> In addition to tax credits for premium assistance, certain individuals with lower income will also be entitled to subsidies to reduce the amount they will be required to pay for cost sharing for medical services. Those subsidies are classified as outlays in the budget and are not included in this figure.

professional return preparers and software manufacturers might alter the advice they provide, knowing that the IRS was prohibited from administering certain provisions of the tax code or other laws. Such preparers and manufacturers have a duty to provide advice consistent with the law, and thus might feel compelled to accurately reflect the tax liability on the returns they prepare for their customers (and software they develop) despite the collection constraints placed on the IRS. Such advice would be consistent with their professional responsibility, and it is reasonable to expect that many would advise clients to file in accordance with the tax law changes enacted under PPACA and the Reconciliation Act, to the extent that they understood those changes to be in effect despite a lack of funding for implementation.<sup>13</sup> However, many others, either because they interpreted the statutory denial of implementation funding as a de facto rescission or moratorium, or because they believed it was in the best interest of their clients, regardless of their professional duties, might alert their customers to the fact that the IRS was prohibited from using funds to take action to enforce the law so the customers might be able to safely ignore the law.

I hope this information is helpful. The staff contacts for this analysis are Tom Bradley and Jean Hearne for CBO and Bernard Schmitt for JCT.

Sincerely,

Douglas W. Elmendorf  
Director

cc: Honorable Fred Upton  
Chairman

Thomas A. Barthold  
Chief of Staff  
Joint Committee on Taxation

Identical letters sent to the Honorable George Miller, the Honorable Chris Van Hollen, and the Honorable Sander M. Levin

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<sup>13</sup> 31 C.F.R. 10.