



CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

September 12, 2005

H.R. 2355

Health Care Choice Act of 2005

As ordered reported by the House Committee on Energy and Commerce on July 20, 2005

SUMMARY

H.R. 2355 would amend the Public Health Service Act to permit an entity licensed by one state (the “primary” state) to offer health insurance coverage to individuals residing in that state, to also offer that health insurance coverage to individuals residing in a “secondary” state. Enacting H.R. 2355 would affect the federal budget in two ways: it would increase federal revenues from payroll and income taxes, and it would increase direct spending for Medicaid. Those changes would begin in 2007, because the bill's provisions would take effect one year after enactment.

The increase in revenues would result largely from a reduction in the number of people who receive health insurance through employer-sponsored plans. That would reduce the share of compensation that is tax-advantaged (health insurance premiums) and increase the share that is taxable (wages and salaries). CBO estimates that enacting H.R. 2355 would increase federal revenues by \$1.9 billion over the 2007-2010 period and \$12.6 billion over the 2007-2015 period. Social Security payroll taxes, which are off-budget, account for about 30 percent of that amount.

The increase in direct spending would result from the enrollment in Medicaid of people who, under current law, would either be covered through an employer-sponsored plan or purchase an individual insurance policy. CBO estimates that enacting H.R. 2355 would increase federal direct spending for Medicaid by \$160 million over the 2007-2010 period and \$1.0 billion over the 2007-2015 period.

Pursuant to section 407 of H. Con. Res. 95 (the Concurrent Resolution on the Budget, Fiscal Year 2006), CBO estimates that enacting H.R. 2355 would cause an increase in direct spending of greater than \$5 billion in at least one of the 10-year periods between 2016 and 2055.

H.R. 2355 would preempt a broad range of state insurance laws that otherwise would apply to health insurance issuers that are licensed in one state and sell policies in another. The preemptions would limit the application of state laws, and thus would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). These preemptions of state regulatory authority would not result in additional spending by states. States may, however, lose some revenues as a result of lower collections for licensing fees, but those losses would be minimal. Consequently, CBO estimates that the cost of the mandates would be far below the threshold established in UMRA (\$62 million in 2005, adjusted annually for inflation).

The bill would have other effects on state budgets—increasing spending for Medicaid, but also increasing revenues from some tax sources. CBO estimates that increased enrollment in Medicaid would result in additional spending by states of \$760 million over the 2007-2015 period.

H.R. 2355 contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 2355 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By Fiscal Year, in Millions of Dollars									
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
CHANGES IN REVENUES										
Income and HI Payroll Taxes (on-budget)	0	70	170	370	640	980	1,340	1,520	1,620	1,710
Social Security Payroll Taxes (off-budget)	0	40	90	200	330	490	660	740	780	820
Total Changes in Revenues	0	110	260	570	970	1,470	2,000	2,260	2,400	2,530
CHANGES IN DIRECT SPENDING										
Estimated Budget Authority	0	10	20	50	80	120	160	170	190	200
Estimated Outlays	0	10	20	50	80	120	160	170	190	200

Note: HI = Hospital Insurance (Part A of Medicare).

BASIS OF ESTIMATE

The provisions of H.R. 2355 would take effect one year after enactment. For this estimate, CBO assumes that H.R. 2355 will be enacted in the fall of 2005. Therefore, the bill would affect spending and revenues beginning in fiscal year 2007. For simplicity, the following discussion of distributional effects (such as changes in premiums and in the number of people with health insurance coverage) assumes that the ultimate effects would be realized in the first year. The estimated budgetary effects, however, reflect CBO's expectation that it would take 5 to 10 years before the ultimate effects on health insurance markets of enacting the bill would be realized.

H.R. 2355 would amend the Public Health Service Act to permit an entity licensed by one state to offer health insurance coverage to individuals residing in that state, to also offer that health insurance coverage to individuals residing in a secondary state. The bill would permit such individual health insurance coverage¹ to be offered in a secondary state only if the primary state uses a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

The individual health insurance policies offered in a secondary state would be exempt from the laws and regulations of that state with respect to consumer protections, mandated coverage of services or benefits, and other rules affecting the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage. Those policies would be required to comply with the laws and regulations of the primary state, and the insurance issuer would be required to provide for a process for covered individuals to appeal coverage decisions to an independent medical reviewer.

Under current law, issuers of individual health insurance must be licensed in the state in which they offer such coverage, and the coverage must comply with the laws and regulations of that state. There is considerable variation across states in two areas that have a substantial effect on the price of individual health insurance:

- Mandates that require coverage of certain services or benefits, and
- Rules affecting the extent to which insurers may charge different prices for coverage offered to individuals expected to incur costs above or below the average.

1. Individual health insurance coverage is offered to individuals, rather than through a group (such as an employer.) Such individual coverage may provide health insurance benefits to a single individual, or to several people (such as the members of a family).

In general, health insurance that includes coverage of mandated benefits will cost more than it would if those benefits were not required. In aggregate, this estimate assumes that if only those benefit mandates imposed by the states with the lowest-cost mandates were in effect in all states, the price of individual health insurance would be reduced by about 5 percent, on average.

Limiting the extent of variation in the prices charged to individuals expected to incur costs above or below the average tends to increase the price charged to individuals expected to have lower-than-average costs, while lowering the price for people expected to have higher-than-average costs. Such price compression also tends to increase the average price compared to an alternative in which variation in the prices charged more closely reflects the costs that individuals are expected to incur. That is because price compression makes coverage more affordable to people who expect to incur relatively high costs (so more of them purchase the coverage), whereas price compression increases the cost of coverage for people who would be expected to incur relatively low costs (so fewer of them purchase the coverage than if those individuals were charged prices that more closely reflect their expected cost).

Under H.R. 2355, CBO expects that individual health insurance would be offered across state lines to individuals in states with relatively expensive coverage mandates and rate-setting rules that permit relatively little variation in the prices an insurer may charge. The insurers offering those policies would be licensed in, and regulated by, states that do not have those characteristics.

For most people in a secondary state, the price of individual health insurance coverage offered by an insurer licensed in a primary state would be lower than the price under current law of individual coverage offered by an insurer licensed by their state. Conversely, individual health insurance coverage from out-of-state insurers either would not be offered to people expected to have relatively high health care costs, or it would be offered at a price that is higher than the price under current law of individual coverage offered by an insurer licensed by their state. The shift of individuals expected to have relatively low health care costs to out-of-state insurance coverage would increase the price of coverage offered by insurers licensed in-state, and could lead to erosion of the availability of such coverage by insurers located in secondary states.

Federal Revenues

CBO estimates that enacting H.R. 2355 would increase federal tax revenues by \$1.9 billion over the 2007-2010 period and \$12.6 billion over the 2007-2015 period. (The bill would have no effect on revenues in 2006.) Social Security payroll taxes, which are off-budget,

account for about 30 percent of those amounts. Those amounts are the net effect of increases in revenue resulting from a reduction in the number of people covered by employer-sponsored health insurance, increases in revenue from self-employed individuals who will purchase individual coverage under current law, and decreases in revenue from a rise in the number of self-employed individuals who purchase individual health insurance. The reduction in the number of people covered by employer-sponsored health insurance accounts for over 90 percent of the estimated change in federal tax revenues.

Some employers (especially smaller ones) would find it desirable to stop offering coverage to their employees because the insurance available in the individual market had become cheaper. In addition, some people with relatively low health care costs who, under current law, will obtain health insurance coverage through an employer, would choose instead to purchase individual health insurance coverage from an out-of-state insurer. That would increase the per-person cost of the employer's group health insurance, and would result in additional employers deciding to drop the group coverage. Based on CBO's analysis of research on the responses of individuals and firms to changes in the price of health insurance, CBO estimates that, if the full effect of H.R. 2355 were realized immediately, about 1 million people—including both employees and covered dependents—would lose employer-sponsored health insurance coverage.

Under current law, the employer's share of premiums for employer-sponsored health insurance and most of the employees' share of those premiums are exempt from taxation. By reducing the number of people covered by employer-sponsored health insurance, H.R. 2355 would reduce the share of employees' compensation that is tax-advantaged (health insurance premiums) and would increase the share that is taxable (wages and salaries). CBO estimates that H.R. 2355 ultimately would reduce annual spending on employer-sponsored health insurance by \$5 billion in 2006 dollars. (That change is less than 1 percent of total tax-advantaged spending on employer-sponsored health insurance in the United States.) Some of the resulting increase in taxable income from wages and salaries would be offset by higher itemized deductions for taxpayers who lose employer-sponsored health insurance, itemize their deductions, and spend more than 7.5 percent of their adjusted gross income on health care and health insurance.

The tax treatment of spending on individual health insurance coverage generally is less generous than for employer-sponsored coverage. However, spending on individual coverage by self-employed individuals is deductible. For the self-employed who will buy individual health insurance under current law, CBO estimates that H.R. 2355 ultimately would reduce spending on premiums by \$600 million in 2006 dollars. Almost all of that reduction would result from a net reduction in premiums for self-employed people who continue to purchase individual insurance. (Some of those self-employed people who retain individual coverage would pay higher premiums.) Self-employed individuals who would drop coverage in

response to higher premiums account for less than \$50 million of that estimated change in spending on premiums.

H.R. 2355 would reduce the price of individual insurance for some self-employed people who are expected to incur relatively low health care costs, live in secondary states, and will be uninsured under current law. Ultimately, CBO estimates that some of those self-employed people would spend about \$300 million (in 2006 dollars) to buy individual coverage under H.R. 2355.

Direct Spending

H.R. 2355 would affect the number of people who enroll in Medicaid. Some people who would lose employer-sponsored health insurance would enroll in Medicaid, whereas others who, under current law, would be covered by Medicaid would instead enroll in health insurance. On net, CBO estimates that enacting H.R. 2355 would increase federal spending for Medicaid by \$160 million over the 2007-2010 period and \$1.0 billion over the 2007-2015 period.

Medicaid Spending for People Who Lose Private Coverage. About 25 percent of employees are in families with incomes under 200 percent of the Federal Poverty Line (FPL). Some of those people would potentially be eligible for Medicaid. CBO estimates that about 40 percent of people losing employer-sponsored coverage would have incomes under 200 percent of the FPL, about 25 percent of them would be eligible for Medicaid, and about 50 percent of them would enroll. CBO assumes that those people would be somewhat more costly than the average Medicaid-eligible individual, and that federal spending for Medicaid would increase by about \$1.1 billion over the 2007-2015 period.

Medicaid Savings for People Who Gain Private Coverage. Of the people gaining employer-sponsored insurance under H.R. 2355, CBO estimates that approximately 10 percent would have incomes under 200 percent of the FPL. Of these, about one-half are children and one-half are adults. About one-third of those children would otherwise be enrolled in Medicaid, and about 8 percent of adults would otherwise be enrolled in Medicaid, CBO estimates. Assuming that those children and adults would be less costly than average, implementing H.R. 2355 would decrease federal Medicaid spending by about \$100 million over the 2007-2015 period as a result of this shift to private health insurance coverage.

Effect of H.R. 2355 on the Number of People With and Without Health Insurance

CBO estimates that enacting H.R. 2355 would not have a substantial effect on the number of people who have health insurance coverage: compared to current law, there could be a small increase or decrease in the number of uninsured individuals. We estimate that about 1 million people would lose or drop employer-sponsored coverage. Many of those people would obtain individual health insurance coverage, as would many people who are uninsured under current law—resulting in a small net impact on the number of people with health insurance.

H.R. 2355 would reduce the price of individual health insurance coverage for people expected to have relatively low health care costs, while increasing the price of coverage for those expected to have relatively high health care costs. Therefore, CBO expects that there would be an increase in the number of relatively healthy individuals, and a decrease in the number of individuals expected to have relatively high cost, who buy individual coverage. Relatively healthy individuals are likely to be more price-sensitive than unhealthy individuals (and there are more relatively healthy people). As a result, CBO assumes that there would be a net increase in the total number of people with individual coverage. We expect that the magnitude of that increase would be roughly similar to the number of people who lose employer-sponsored coverage.

ESTIMATED LONG-TERM EFFECTS ON DIRECT SPENDING

Pursuant to section 407 of H. Con. Res. 95 (the Concurrent Resolution on the Budget, Fiscal Year 2006), CBO estimates that enacting H.R. 2355 would cause an increase in direct spending of greater than \$5 billion in at least one of the 10-year periods between 2016 and 2055. Those costs would come from increased spending on Medicaid. We estimate that the increase in Medicaid spending would reach \$200 million in 2015, and would continue to grow.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 2355 would preempt a broad range of insurance laws that otherwise would apply to health insurance issuers that are licensed in one state (the primary state) and provide insurance coverage in another state (a secondary state). The preemptions would limit the application of state laws, and thus would be intergovernmental mandates as defined in UMRA. Health insurance issuers would be exempt from laws in secondary states that establish coverage requirements or regulate insurance with the exception of requirements to register with the secondary state, submit to financial reviews under limited circumstances,

participate in solvency associations, or comply with state laws governing fraud, abuse, or unfair claims settlements. The bill specifically would allow secondary states to collect premium taxes on policies sold within the state.

The preemption of state regulatory authority would impose no duty on states that would result in additional spending. States may, however, lose some revenues as a result of lower collections for licensing fees, but those losses would be minimal.

The bill would have other effects on state budgets—increasing spending for Medicaid, but also increasing revenues from state income taxes. CBO estimates that increased enrollment in Medicaid would result in additional spending by states of \$760 million over the 2007-2015 period.

CBO estimates that the bill would have a positive impact on income tax collections by state governments, but the magnitude of that change is unclear. A decrease in the proportion of employer-sponsored insurance, which many states exempt from income for tax purposes, as part of total compensation packages would result in more compensation that is subject to state income tax collections. Because of uncertainty about the expected changes in coverage among individual states and different tax rates in each state, CBO cannot estimate the magnitude of the increase. State collections of premium taxes would also change, but because of uncertainty about shifts between types of insurance that are taxable and those that are exempt from taxes and because of different tax rates among the states, CBO cannot estimate either the direction or the magnitude of any net change in those collections.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

H.R. 2355 contains no private-sector mandates as defined in UMRA.

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