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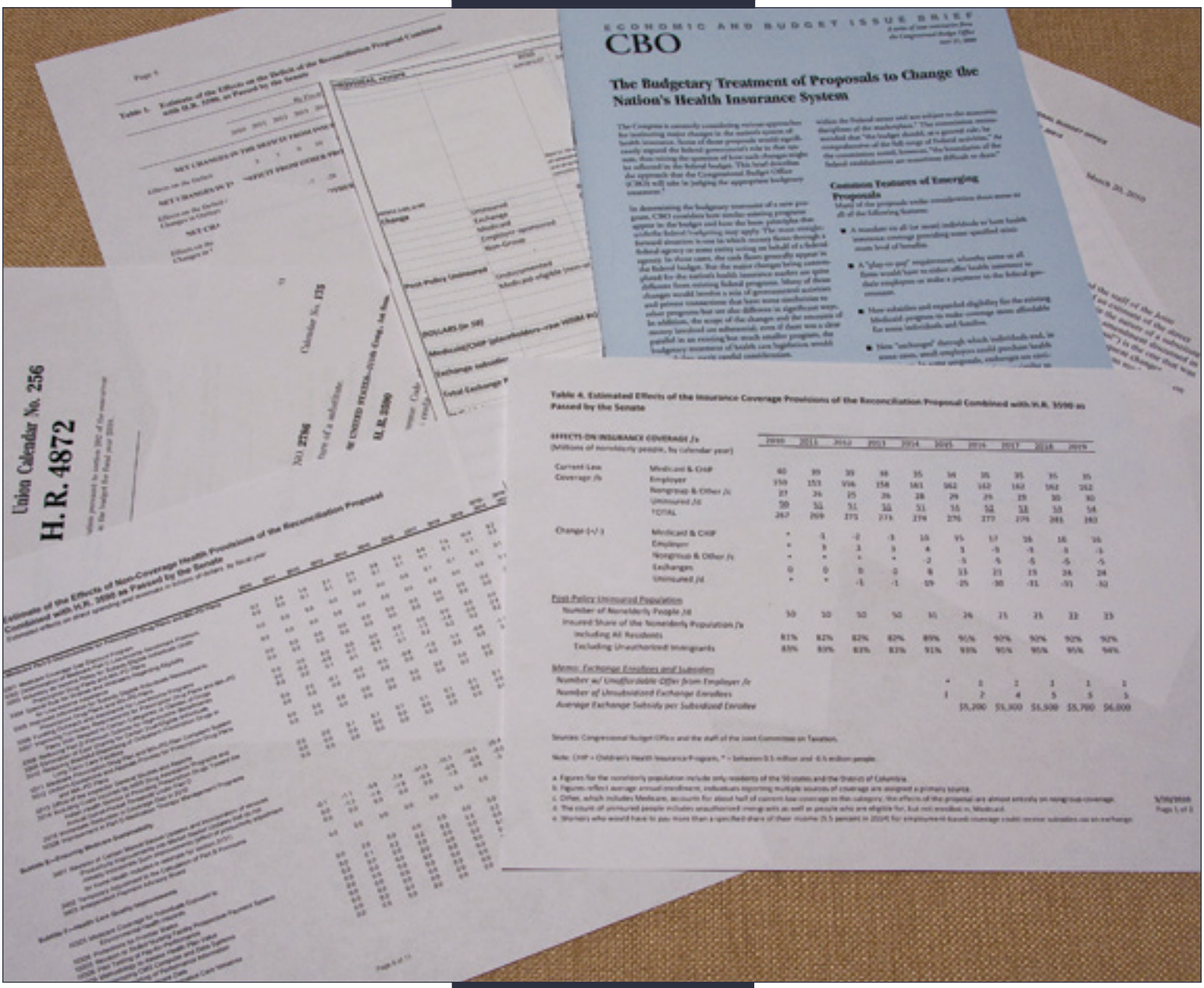
Selected CBO Publications Related to Health Care Legislation, 2009–2010



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December 2010

The Congress of the United States ■ Congressional Budget Office

Preface

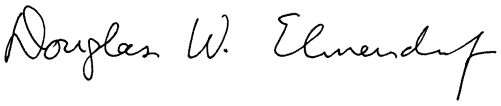
In March 2010, the Congress passed and the President signed into law legislation that makes major changes to the U.S. health care and health insurance systems. That legislation came in two parts: the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Among other things, those laws will establish a mandate for most legal residents of the United States to obtain health insurance; create insurance exchanges through which certain individuals and families will receive federal subsidies; significantly expand eligibility for Medicaid; reduce the growth of Medicare's payment rates for most services; impose an excise tax on insurance plans with relatively high premiums; impose certain taxes on individuals and families with relatively high incomes; and make various other changes to the federal tax code, Medicare, Medicaid, and other programs. (In addition, the Reconciliation Act substantially alters federal programs governing loans and grants for postsecondary education.)

In the course of the deliberations over health care legislation, the Congressional Budget Office (CBO) provided a wide variety of estimates and other analyses regarding the impact of proposals on the federal budget and on aspects of health care and health insurance that were of interest to policymakers. In many cases, those estimates and analyses were produced in collaboration with the staff of the Joint Committee on Taxation (JCT). That process began in early 2009 and continued past the enactment of the legislation in March of this year.

Responding to many requests, this report compiles a set of those estimates and analyses for easy reference. The report begins with the cost estimate for the final legislation and several analyses related to that legislation. It also includes several cost estimates and analyses of earlier versions of that legislation and alternative proposals that were considered in the House and Senate before final passage. In addition, this report brings together analyses that CBO issued during this period concerning insurance premiums and premium subsidies, the budgetary accounting of proposals, changes to the medical malpractice system, and certain related topics that arose during the Congressional debate. A number of related cost estimates and publications are not included in this volume but are available on CBO's Web site. In keeping with CBO's mandate to provide objective, nonpartisan analysis, this report makes no recommendations.

During the past two years, CBO's health team worked tirelessly to provide the Congress with information about numerous alternative proposals to change the nation's health care and health insurance systems. Representing one of the most challenging and significant analytical efforts that CBO has ever undertaken, this process involved dozens of CBO analysts, required modeling of thousands of complex and often interacting provisions, and included countless communications with staff members of many Congressional committees and offices. Significant contributions to this effort were made by the following people: David Auerbach, Colin Baker, Reagan Baughman, James Baumgardner, Patrick Bernhardt, Tom Bradley, Stephanie Cameron, Julia Christensen, Mindy Cohen, Anna Cook, Marion Curry, Sheila Dacey, Sandy Davis, Sunita D'Monte, Noelia Duchovny, Sean Dunbar, Philip Ellis, Peter Fontaine, Carol Frost, April Grady, Mark Hadley, Stuart Hagen, Holly Harvey, Tamara Hayford, Jean Hearne, Janet Holtzblatt, Lori Housman, Paul Jacobs, Daniel Kao, Julie Lee, Kate Massey, T.J. McGrath, Jamease Miles, Alexandra Minicozzi, Keisuke Nakagawa, Kirstin Nelson, Lyle Nelson, Andrea Noda, Sam Papenfuss, Matthew Pickford, Lisa Ramirez-Branum, Lara Robillard, Matt Schmit, John Skeen, Robert Stewart, Robert Sunshine, Bruce Vavrichek, Ellen Werble, Chapin White, Rebecca Yip, and Darren Young. CBO's health team is deeply indebted to our colleagues at JCT—especially Thomas Barthold, James Cilke, Tim Dowd, Pamela Moomau, and Bernard Schmitt—for their many contributions and insights.

Maureen Costantino prepared the report for publication, with assistance from Jeanine Rees, and designed the cover. Annette Kalicki prepared the electronic version for CBO's Web site (www.cbo.gov).



Douglas W. Elmendorf
Director

December 2010

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Enacted Legislation

In March 2010, the Congress passed and the President signed into law two pieces of legislation—the Patient Protection and Affordable Care Act (PPACA, Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)—that make major changes regarding the provision of health insurance, subsidies for insurance coverage, payments for health care through federal programs, and tax revenues. The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) provided a cost estimate for that legislation as well as several related analyses. The following items are included here:

1. CBO's final cost estimate for the health care legislation that was later enacted. That estimate, which was released on March 20, 2010, shows both the effects of the two acts combined and the incremental effects of the reconciliation legislation. (Related analyses not included in this volume are a preliminary cost estimate for the two acts, which was substantially similar to the final estimate and was released on March 18, 2010, and an estimate of the effects of enacting PPACA by itself, which was released on March 11, 2010.)

2. JCT's table providing detailed estimates of the effects on revenues of the provisions of the two acts that changed the federal tax code, which was released on March 20, 2010.

3. Answers to several questions about CBO's preliminary cost estimate for the two acts and the impact of modifying several provisions of the legislation, which were provided in a letter to Representative Paul Ryan dated March 19, 2010.

4. Additional information about the potential effects of PPACA on discretionary spending—that is, spending subject to future appropriation action—provided in a letter to Representative Jerry Lewis dated May 11, 2010. The legislation authorized federal agencies to establish new programs and conduct new activities, but in many cases it did not appropriate funds to implement those initiatives. Thus, future legislation would be required for the funds to be appropriated and spent. This letter provides more detail on those costs than was included in the cost estimate for the legislation.

5. A further clarification about the potential effects of PPACA on discretionary spending, which was provided on May 12, 2010.

6. An analysis of the legislation's impact on prices for prescription drugs, which was provided in a letter to Representative Paul Ryan dated November 4, 2010.

Around the time the legislation was being considered in the Congress or soon thereafter, CBO also released several shorter and less formal write-ups providing supplementary information about certain aspects of the legislation's estimated effects, consisting of the following:

7. Estimates of projected enrollment in Medicare Advantage plans (private insurance plans that provide Medicare's required benefits) and the subsidies for extra benefits provided by those plans (dated March 19, 2010).

8. A table showing how certain provisions of the legislation would change Medicare's payments to different types of health care providers (dated March 19, 2010).

9. Projected premiums for the Medicare drug benefit (known as Part D) under the two acts, with a comparison to the premiums that would have resulted from PPACA alone (dated March 19, 2010).

10. An analysis of estimated penalty payments that would be made for being uninsured and the people, by income category, who would pay those penalties in 2016 (dated April 30, 2010).

In addition to the publications listed above, CBO has discussed the budgetary implications of the enacted legislation in two reports. The June 2010 report *The Long-Term Budget Outlook* describes how the legislation affected CBO's projections of federal spending on health care over the long term (see, in particular, Chapter 2). The August 2010 report *The Budget and Economic Outlook: An Update* discusses how the effects of the legislation were incorporated into CBO's budgetary baseline for the 2011–2020 period (see Box 1-1).

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

March 20, 2010

Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, DC 20515

Dear Madam Speaker:

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have completed an estimate of the direct spending and revenue effects of an amendment in the nature of a substitute to H.R. 4872, the Reconciliation Act of 2010. The amendment discussed in this letter (hereafter called "the reconciliation proposal") is the one that was made public on March 18, 2010, as modified by subsequent changes incorporated in a proposed manager's amendment that was made public on March 20.

This estimate differs from the preliminary estimate that CBO issued on March 18 in that it reflects CBO and JCT's review of the legislative language of the earlier amendment and the manager's amendment, as well as modest technical refinements of the budgetary projections.[1] This estimate is presented in two ways:

- An estimate of the budgetary effects of the reconciliation proposal, in combination with the effects of H.R. 3590, the Patient Protection and Affordable Care Act (PPACA), as passed by the Senate; and

- An estimate of the *incremental* effects of the reconciliation proposal, over and above the effects of enacting H.R. 3590 by itself.[2]

[1] For the preliminary estimate by CBO and JCT of the direct spending and revenue effects of the reconciliation proposal, see Congressional Budget Office, letter to the Honorable Nancy Pelosi providing a preliminary analysis of the reconciliation proposal (March 18, 2010).

[2] For the estimate by CBO and JCT of the direct spending and revenue effects of H.R. 3590 as passed by the Senate, see Congressional Budget Office, cost estimate of H.R. 3590, Patient Protection and Affordable Care Act (March 11, 2010). JCT's detailed table of revenue effects is available at www.jct.gov.

CBO and JCT have not yet updated their preliminary and partial estimate of the budgetary impact of the reconciliation proposal under the assumption that H.R. 3590 is not enacted—that is, the reconciliation proposal's impact under current law.

H.R. 3590 would, among other things, establish a mandate for most residents of the United States to obtain health insurance; set up insurance exchanges through which certain individuals and families could receive federal subsidies to substantially reduce the cost of purchasing that coverage; significantly expand eligibility for Medicaid; substantially reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected under current law); impose an excise tax on insurance plans with relatively high premiums; and make various other changes to the federal tax code, Medicare, Medicaid, and other programs. The reconciliation proposal includes provisions related to health care and revenues, many of which would amend H.R. 3590. (The changes with the largest budgetary effects are described below.) The reconciliation proposal also includes amendments to the Higher Education Act of 1965, which authorizes most federal programs involving postsecondary education. (Those provisions and their budgetary effects are described below as well.)

Estimated Budgetary Impact of the Legislation

CBO and JCT estimate that enacting both pieces of legislation—H.R. 3590 and the reconciliation proposal—would produce a net reduction in federal deficits of $143 billion over the 2010–2019 period as result of changes in direct spending and revenues (see Table 1). That figure comprises $124 billion in net reductions deriving from the health care and revenue provisions and $19 billion in net reductions deriving from the education provisions. Approximately $114 billion of the total reduction would be on-budget; other effects related to Social Security revenues and spending as well as spending by the U.S. Postal Service are classified as off-budget. CBO has not completed an estimate of the potential impact of the legislation on discretionary spending, which would be subject to future appropriation action.

CBO and JCT previously estimated that enacting H.R. 3590 by itself would yield a net reduction in federal deficits of $118 billion over the 2010–2019 period, of which about $65 billion would be on-budget. The incremental effect of enacting the reconciliation proposal—assuming that H.R. 3590 had already been enacted—would be the difference between the estimate of their combined effect and the previous estimate for H.R. 3590. That

incremental effect is an estimated net reduction in federal deficits of $25 billion during the 2010–2019 period over and above the savings from enacting H.R. 3590 by itself; almost all of that reduction would be on-budget.[3]

Additional details on the budgetary effects of the reconciliation proposal and H.R. 3590 are provided in Tables 2 through 7 attached to this letter:

- Table 2 shows budgetary cash flows for direct spending and revenues associated with the two pieces of legislation combined.

- Table 3 summarizes the incremental changes in direct spending and revenues resulting from the reconciliation proposal, assuming that H.R. 3590 had already been enacted.

- For the two pieces of legislation combined, Table 4 provides estimates of the changes in the number of nonelderly people in the United States who would have health insurance and presents the primary budgetary effects of the provisions related to health insurance coverage.

- For the two pieces of legislation combined, Table 5 displays detailed estimates of the costs or savings from the health care provisions that are not related to health insurance coverage (primarily involving the Medicare program). The table does not include the effects of revenue provisions; those effects are reported separately by JCT in JCX-17-10 at www.jct.gov.

- Table 6 presents details on the incremental effects of the health care and revenue provisions of the reconciliation proposal—that is, the difference between the effects of those provisions in the two pieces of legislation combined and the effects of H.R. 3590 by itself (as shown in CBO's cost estimate of March 11, 2010).

- Table 7 summarizes the incremental effects of the health care, revenue, and education provisions of the reconciliation proposal, also assuming that H.R. 3590 had been enacted.

[3] As originally introduced, the reconciliation proposal would require transfers from on-budget general funds to the off-budget Social Security trust funds to offset any reduction in the balances of those trust funds resulting from other provisions of the proposal. The effects of that provision were reflected in CBO's preliminary estimate. However, the manager's amendment to the reconciliation proposal strikes that provision, so its effects are not included in this estimate.

The estimate provided here covers the 2010–2019 period to be consistent with the budget horizon used under S. Con. Res. 13, the Concurrent Resolution on the Budget for Fiscal Year 2010. The Congress has not yet adopted a new budget resolution that would extend the House and Senate budget enforcement periods through 2020.

Because the reconciliation proposal and H.R. 3590 would affect direct spending and revenues, pay-as-you-go procedures would apply. The time periods used for pay-as-you-go calculations under the new Statutory Pay-As-You-Go Act extend from 2010 through 2015 and from 2010 through 2020. Although CBO and JCT have not conducted a detailed analysis of the effects of the reconciliation proposal and H.R. 3590 in 2020, enacting that legislation would probably reduce the budget deficit modestly in that year. Reflecting that assessment, CBO and JCT estimate that enacting that legislation would reduce projected on-budget deficits both through 2015 and through 2020.[4]

The remainder of this letter discusses the major components of the education provisions contained in the reconciliation proposal; reviews the main changes that the reconciliation proposal would make to the health care and revenue provisions of H.R. 3590; describes the effects of the legislation on health insurance coverage; presents information about the effects of the legislation on discretionary spending; provides CBO's analysis of the legislation's impact on the federal budget beyond the first 10 years; and analyzes certain other effects of the legislation.

[4] Pay-as-you-go procedures do not apply to off-budget effects, which include changes to Social Security or the U.S. Postal Service. Under the Statutory Pay-As-You-Go Act, estimated changes in the on-budget deficit from direct spending and revenues are recorded on 5-year and 10-year "scorecards" by the Office of Management and Budget, which is required to order a sequestration (cancellation) of certain direct spending if either scorecard reflects a net cost in the budget year at the end of a Congressional session.

Table 1. Estimate of the Effects on the Deficit of the Reconciliation Proposal Combined with H.R. 3590, as Passed by the Senate

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
NET CHANGES IN THE DEFICIT FROM INSURANCE COVERAGE PROVISIONS [a,b]												
Effects on the Deficit	3	7	9	10	49	87	132	154	164	172	78	788
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING [c]												
Effects on the Deficit of Changes in Outlays	3	3	-7	-28	-50	-60	-70	-86	-101	-116	-79	-511
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [d]												
Effects on the Deficit of Changes in Revenues	*	-9	-12	-38	-50	-48	-59	-65	-69	-71	-109	-420
NET CHANGES IN THE DEFICIT [a]												
Net Increase or Decrease (-) in the Budget Deficit	6	1	-10	-56	-51	-20	3	4	-5	-15	-109	-143
On-Budget	6	1	-10	-55	-50	-18	8	10	2	-6	-108	-114
Off-Budget [e]	*	*	1	-1	-1	-2	-5	-6	-7	-9	-1	-29
Memorandum:												
Incremental Effects on the Deficit of H.R. 4872 Incorporating the Manager's Amendment, Relative to H.R. 3590 as Passed by the Senate												
Net Increase or Decrease	2	4	4	-3	-13	-4	-7	-3	-2	-3	-5	-25
On-Budget	2	4	4	-6	-14	-7	-11	-7	-6	-7	-10	-48
Off-Budget [e]	0	*	*	4	1	3	4	4	4	4	5	23
Effects on the Deficit of Provisions of the Reconciliation Proposal Combined with H.R. 3590												
Health Care and Revenue Provisions	6	1	-13	-50	-48	-16	7	6	-4	-13	-104	-124
Education Provisions	*	*	4	-6	-3	-5	-4	-2	-2	-2	-5	-19

Continued

Table 1. Continued.

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation (JCT).

Notes: Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Components may not sum to totals because of rounding; * = between $0.5 billion and -$0.5 billion.

a. Does not include effects on spending subject to future appropriations.

b. Includes excise tax on high-premium insurance plans.

c. These estimates reflect the effects of provisions affecting Medicare, Medicaid, and other federal health programs, and include the effects of interactions between insurance coverage provisions and those programs; they also reflect the effects of education provisions.

d. The changes in revenues include effects on Social Security revenues, which are classified as off-budget. The 10-year figure of $420 billion includes $406 billion in revenues from tax provisions (estimated by JCT) apart from receipts from the excise tax on high-premium insurance plans and $14 billion in revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by CBO and JCT). (For JCT's estimates, see JCX-17-10.)

e. Off-budget effects include changes in Social Security spending and revenues as well as U.S. Postal Service spending.

Education Provisions Contained in the Reconciliation Proposal

Subtitle A of title II of the reconciliation proposal would amend the Higher Education Act of 1965, which authorizes most federal postsecondary education programs. The reconciliation proposal would eliminate the federal program that provides guarantees for student loans and replace those loans with direct loans made by the Department of Education. It would also increase direct spending for the Pell Grant program and other education grant programs. CBO estimates that those provisions would reduce direct spending by $5 billion over the 2010–2014 period and $19 billion over the 2010–2019 period (see Table 7).

Federal Student Loan Programs. On net, CBO estimates that the reconciliation proposal would reduce direct spending in the federal student loan programs by $28 billion over the 2010–2014 period and $58 billion over the 2010–2019 period.

In the Federal Family Education Loan (FFEL) program, private lenders originate loans to postsecondary students; the federal government makes payments to those lenders, guarantees them against significant loss in the case of default, and provides funds to guaranty agencies to help administer those loans. In the direct loan program, eligible borrowers receive nearly identical loans that are administered by the Department of Education and funded through the U.S. Treasury.

The reconciliation proposal would eliminate new loans in the FFEL program beginning in July 2010. Under the proposal, CBO expects that all of the guaranteed loans that would have been made under current law—estimated to be roughly $500 billion through 2019—would instead be made through the direct loan program.

The Federal Credit Reform Act specifies that the cost of new federal loans and loan guarantees be recorded in the budget in the year that the loans are disbursed, and that the cost be calculated as the net present value of the government's expected cash flows over the lifetime of a loan or guarantee, using interest rates on Treasury securities of comparable maturity to discount the estimated cash flows.[5] Using this methodology, CBO estimates that eliminating new guaranteed loans and replacing them with direct loans would yield reductions in direct spending of $61 billion over the 2010–2019 period. CBO also estimates that the expanded program for direct loans would incur about $5 billion in additional administrative costs during that period. However, those additional costs are classified as discretionary spending and are subject to future appropriation; they are not incorporated in the estimates of changes in direct spending and revenues reported in this letter.

The legislation would also make other changes to federal loan programs for education. CBO estimates that those changes would increase direct spending by $1 billion over the 2010–2014 period and $3 billion over the 2010–2019 period—partially offsetting the gross savings from eliminating new guaranteed loans in the FFEL program.

Federal Pell Grant Program. The reconciliation proposal would alter the structure of the Pell Grant program and provide additional funding for that program. CBO estimates that those changes would increase direct spending by $21 billion over the 2010–2014 period and $36 billion over the 2010–2019 period.

Under current law, Pell grants are funded through both discretionary and mandatory funding. The annual discretionary appropriation sets a base award level, and a mandatory account provides additional funding to

[5] An alternative approach to estimating the cost of federal loans and loan guarantees is to estimate what a private entity would need to be paid to assume the costs and risks to the government from providing such loans or guarantees. For further discussion of that so-called "fair-value" methodology, and for estimates of the cost of replacing guaranteed loans with direct loans based on different methodologies, see Congressional Budget Office, letter to the Honorable Judd Gregg regarding the budgetary impact of the President's proposal to alter federal student loan programs (March 15, 2010).

students eligible for the program. The dollar amount of the additional mandatory awards is determined by the amount directly appropriated in the Higher Education Act.

Beginning in fiscal year 2010, the reconciliation proposal would appropriate the amounts necessary to cover the cost of specified award levels in the Pell Grant program. For academic years through 2012–2013, the proposal would maintain the additional mandatory award at $690, as specified in current law for 2010–2011 and 2011–2012. (Under current law, however, there are not sufficient funds to cover all the costs of providing that $690 add-on to all Pell grant recipients; the proposal would provide the incremental funds necessary to do so.) Beginning in academic year 2013–2014, the mandatory award would increase according to a formula specified in the legislation. CBO estimates that the add-on would reach $1,115 for academic year 2017–2018 and subsequent years.

CBO estimates that the increase in the mandatory add-on for Pell grants would raise direct spending by $23 billion over the 2010–2019 period. In addition, the legislation would provide roughly $14 billion in further mandatory funds to the Pell Grant program; CBO expects that most of that additional funding would be spent in fiscal years 2011 and 2012.

Other Education Grant Programs. Finally, the education subtitle would appropriate $255 million per year through 2019 for grants to Historically Black Colleges and Universities and other Minority Serving Institutions. It would also appropriate $150 million per year through 2014 for College Access Challenge Grants. CBO estimates that those provisions would increase direct spending by $2 billion over the 2010–2014 period and by $3 billion over the 2010–2019 period.

Changes to H.R. 3590 Contained in the Reconciliation Proposal
The reconciliation proposal would make a variety of changes to H.R. 3590, as passed by the Senate. The changes with the largest budgetary effects over the 2010–2019 period include these:

- Increasing the subsidies for premiums and cost sharing that would be offered through the new insurance exchanges;

- Increasing the penalties for employers that do not offer health insurance and modifying the penalties for individuals who do not obtain insurance;

- Increasing the federal share of spending for certain Medicaid beneficiaries;

- Changing eligibility for Medicaid in a way that effectively increases the income threshold from 133 percent of the federal poverty level to 138 percent for certain individuals;

- Reducing overall payments to insurance plans under the Medicare Advantage program;

- Expanding Medicare's drug benefit by phasing out the "doughnut hole" in that benefit;

- Modifying the design and delaying the implementation of the excise tax on insurance plans with relatively high premiums; and

- Increasing the rate and expanding the scope of a tax that would be charged to higher-income households.

Effects of the Legislation on Insurance Coverage

CBO and JCT estimate that by 2019, the combined effect of enacting H.R. 3590 and the reconciliation proposal would be to reduce the number of nonelderly people who are uninsured by about 32 million, leaving about 23 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under the legislation, the share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 94 percent.

Approximately 24 million people would purchase their own coverage through the new insurance exchanges, and there would be roughly 16 million more enrollees in Medicaid and the Children's Health Insurance Program than the number projected under current law. Relative to currently projected levels, the number of people purchasing individual coverage outside the exchanges would decline by about 5 million.

Under the legislation, certain employers could allow all of their workers to choose among the plans available in the exchanges, but those enrollees would not be eligible to receive subsidies via the exchanges (and thus are shown in Table 4 as enrollees in employment-based coverage rather than as exchange enrollees). Approximately 5 million people would obtain coverage in that way in 2019, bringing the total number of people enrolled in exchange plans to about 29 million in that year.

On balance, the number of people obtaining coverage through their employer would be about 3 million lower in 2019 under the legislation, CBO and JCT estimate. The net change in employment-based coverage under the proposal would be the result of several flows, which can be illustrated using the estimates for 2019:

- Between 6 million and 7 million people would be covered by an employment-based plan under the proposal who would not be covered by one under current law (largely because the mandate for individuals to be insured would increase workers' demand for coverage through their employers).

- Between 8 million and 9 million other people who would be covered by an employment-based plan under current law would not have an offer of such coverage under the proposal. Firms that would choose not to offer coverage as a result of the proposal would tend to be smaller employers and employers that predominantly employ lower-wage workers—people who would be eligible for subsidies through the exchanges—although some workers who would not have employment-based coverage because of the proposal would not be eligible for such subsidies. Whether those changes in coverage would represent the dropping of existing coverage or a lack of new offers of coverage is difficult to determine.

- Between 1 million and 2 million people who would be covered by their employer's plan (or a plan offered to a family member) under current law would instead obtain coverage in the exchanges. Under the legislation, workers with an offer of employment-based coverage would generally be ineligible for exchange subsidies, but that "firewall" would be enforced imperfectly and an explicit exception to it would be made for workers whose offer was deemed unaffordable.

Effects of the Legislation on Discretionary Costs

CBO has not completed an estimate of the potential impact of the legislation on discretionary spending, which would be subject to future appropriation action. Discretionary costs would arise from the effects of the legislation on several federal agencies and on a number of new and existing programs subject to future appropriation. Those discretionary costs fall into three general categories.

The first category is implicit authorization of discretionary costs associated with implementing the new policies established under the legislation. Although no provisions in the legislation specifically authorize such spending, it would be necessary for agencies to carry out the responsibilities that would be required of them by the bill. For example:

- CBO expects that the cost to the Internal Revenue Service of implementing the eligibility determination, documentation, and verification processes for premium and cost sharing subsidies would probably be between $5 billion and $10 billion over 10 years.

- CBO expects that the costs to the Department of Health and Human Services (especially the Centers for Medicare and Medicaid Services) and the Office of Personnel Management of implementing the changes in Medicare, Medicaid, and the Children's Health Insurance Program, as well as certain reforms to the private insurance market, would probably be at least $5 billion to $10 billion over 10 years. (The administrative costs of establishing and operating the exchanges were included as direct spending in CBO's estimate for the legislation.)

The second category of discretionary costs is explicit authorizations for a variety of grant and other programs for which specified funding levels for possible future appropriations are set in the act for one or more years. (Such cases include provisions where a specified funding level is authorized for an initial year along with the authorization of such sums as may be necessary for continued funding in subsequent years.) CBO has identified at least $50 billion in such specified and estimated authorizations in H.R. 3590, as passed by the Senate.[6]

A third category of discretionary spending is explicit authorizations for a variety of grant and other programs for which no funding levels are specified in the legislation. CBO has not yet completed estimates of the amounts of such authorizations.

Effects of the Legislation Beyond the First 10 Years

Although CBO does not generally provide cost estimates beyond the 10-year budget projection period, certain Congressional rules require some information about the budgetary impact of legislation in subsequent

[6] For further details, see Congressional Budget Office, Potential Effects of the Patient Protection and Affordable Care Act on Discretionary Spending (March 15, 2010).

decades, and many Members have requested CBO's analysis of the long-term budgetary impact of broad changes in the nation's health care and health insurance systems. Therefore, CBO has developed a rough outlook for the decade following the 2010–2019 period by grouping the elements of the legislation into broad categories and (together with JCT) assessing the rate at which the budgetary impact of each of those broad categories is likely to increase over time.

Effects on the Deficit. Using this analytic approach, CBO estimated that enacting H.R. 3590, as passed by the Senate, would reduce federal budget deficits over the ensuing decade relative to those projected under current law—with a total effect during that decade in a broad range between one-quarter percent and one-half percent of gross domestic product (GDP).[7] The imprecision of that calculation reflects the even greater degree of uncertainty that attends to it, compared with CBO's 10-year budget estimates.

The reconciliation proposal would make a variety of changes to H.R. 3590 that would have significant effects on the legislation's overall budgetary impact—both in the 10-year projection period and in the ensuing decade. For example, the reconciliation proposal would increase the premium subsidies offered in the new insurance exchanges beginning in 2014, but would also change the annual indexing provisions beginning in 2019 so that those subsidies would grow more slowly thereafter. Over time, the spending on exchange subsidies would therefore fall back toward the level under H.R. 3590 by itself. As another example, the reconciliation proposal would reduce the impact in the 10-year projection period of an excise tax on health insurance plans with relatively high premiums, but would index the thresholds for the tax, beginning in 2020, to the rate of general inflation rather than to inflation plus 1 percentage point (as in H.R. 3590).

Reflecting the changes made by the reconciliation proposal, the combined effect of enacting H.R. 3590 and the reconciliation proposal would also be to reduce federal budget deficits over the ensuing decade relative to those projected under current law—with a total effect during that decade in a broad range around one-half percent of GDP. The incremental effect of enacting the reconciliation bill (over and above the effect of enacting H.R. 3590 by itself) would thus be to further reduce federal budget deficits

[7] For a more extensive explanation of that analysis, see Congressional Budget Office, letter to the Honorable Harry Reid regarding the longer-term effects of the manager's amendment to the Patient Protection and Affordable Care Act (December 20, 2009).

in that decade, with an effect in a broad range between zero and one-quarter percent of GDP.

CBO has not extrapolated estimates further into the future because the uncertainties surrounding them are magnified even more. However, in view of the projected net savings during the decade following the 10-year budget window, CBO anticipates that the reconciliation proposal would probably continue to reduce budget deficits relative to those under current law in subsequent decades, assuming that all of its provisions continued to be fully implemented.

Congressional rules governing the consideration of reconciliation bills also require an assessment of their budgetary impact separately by title, as shown in Table 7 for the 2010–2019 period. Relative to H.R. 3590, CBO's analysis of the longer-term effects of the reconciliation proposal, by title, is as follows:

- Most of the changes to H.R. 3590 having significant budgetary effects would be made by title I of the reconciliation proposal, so the conclusions about the longer-term impact for the proposal as a whole—that it would reduce deficits relative to those under H.R. 3590—also apply to that title.

- The changes regarding health care contained in title II would have a much smaller budgetary impact than those in title I and would, by themselves, increase budget deficits somewhat during the 2010–2019 period and in the ensuing decade. That title also contains the proposal's education provisions, which CBO estimates would reduce deficits during the next 10 years and in the following decade. In CBO's estimation, the savings generated by the education provisions would outweigh the costs related to health care arising from title II, so the title as a whole would reduce budget deficits in both the 10-year projection period and subsequent years.

CBO has not yet completed an assessment of the impact for the longer term of enacting the reconciliation proposal by itself—that is, an assessment of the reconciliation proposal's longer-term impact under current law.

Key Considerations. Those longer-term calculations reflect an assumption that the provisions of the reconciliation proposal and H.R. 3590 are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation. For example, the sustainable growth rate

mechanism governing Medicare's payments to physicians has frequently been modified (either through legislation or administrative action) to avoid reductions in those payments, and legislation to do so again is currently under consideration by the Congress.

The reconciliation proposal and H.R. 3590 would maintain and put into effect a number of policies that might be difficult to sustain over a long period of time. Under current law, payment rates for physicians' services in Medicare would be reduced by about 21 percent in 2010 and then decline further in subsequent years; the proposal makes no changes to those provisions. At the same time, the legislation includes a number of provisions that would constrain payment rates for other providers of Medicare services. In particular, increases in payment rates for many providers would be held below the rate of inflation (in expectation of ongoing productivity improvements in the delivery of health care). The projected longer-term savings for the legislation also reflect an assumption that the Independent Payment Advisory Board established by H.R. 3590 would be fairly effective in reducing costs beyond the reductions that would be achieved by other aspects of the legislation.[8]

Under the legislation, CBO expects that Medicare spending would increase significantly more slowly during the next two decades than it has increased during the past two decades (per beneficiary, after adjusting for inflation). It is unclear whether such a reduction in the growth rate of spending could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or through reductions in access to care or the quality of care. The long-term budgetary impact could be quite different if key provisions of the legislation were ultimately changed or not fully implemented.[9] If those changes arose from future legislation, CBO would estimate their costs when that legislation was being considered by the Congress.

Other Effects of the Legislation

Many Members have expressed interest in the effects of proposals on various other measures of spending on health care. One such measure is the

[8] The Independent Payment Advisory Board would be required, under certain circumstances, to recommend changes to the Medicare program to limit the rate of growth in that program's spending. The Board's recommendations would go into effect automatically unless blocked by subsequent legislative action.

[9] For an example of the long-term budgetary effect of altering several key features of the legislation, see Congressional Budget Office, letter to the Honorable Paul Ryan responding to questions about the preliminary estimate of the reconciliation proposal (March 19, 2010).

"federal budgetary commitment to health care," a term that CBO uses to describe the sum of net federal outlays for health programs and tax preferences for health care.[10] CBO estimated that H.R. 3590, as passed by the Senate, would increase the federal budgetary commitment to health care over the 2010–2019 period; the net increase in that commitment would be about $210 billion over that 10-year period. The combined effect of enacting H.R. 3590 and the reconciliation proposal would be to increase that commitment by about $390 billion over 10 years. Thus, the incremental effect of the reconciliation proposal (if H.R. 3590 had been enacted) would be to increase the federal budgetary commitment to health care by about $180 billion over the 2010–2019 period.

In subsequent years, the effects of the provisions of the two bills combined that would tend to decrease the federal budgetary commitment to health care would grow faster than the effects of the provisions that would increase it. As a result, CBO expects that enacting both proposals would generate a reduction in the federal budgetary commitment to health care during the decade following the 10-year budget window—which is the same conclusion that CBO reached about H.R. 3590, as passed by the Senate.

Members have also requested information about the effect of the legislation on health insurance premiums. On November 30, 2009, CBO released an analysis prepared by CBO and JCT of the expected impact on average premiums for health insurance in different markets of PPACA as originally proposed.[11] Although CBO and JCT have not updated the estimates provided in that letter, the effects on premiums of the legislation as passed by the Senate and modified by the reconciliation proposal would probably be quite similar.

CBO and JCT previously determined that H.R. 3590, as passed by the Senate, would impose several intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO and JCT estimated that the total costs of those mandates to state, local, and tribal governments and the private sector would greatly exceed the annual thresholds established in UMRA ($70 million and $141 million,

[10] For additional discussion of that term, see Congressional Budget Office, letter to the Honorable Max Baucus regarding different measures for analyzing current proposals to reform health care (October 30, 2009).

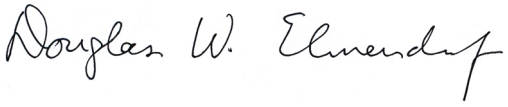
[11] See Congressional Budget Office, letter to the Honorable Evan Bayh providing an analysis of health insurance premiums under the Patient Protection and Affordable Care Act (November 30, 2009).

respectively, in 2010, adjusted annually for inflation) in each of the first five years that the mandates would be in effect.

If both the reconciliation proposal and H.R. 3590 were enacted, that combination would impose similar mandates on both intergovernmental and private-sector entities with costs exceeding the thresholds established in UMRA. The incremental effect of enacting the reconciliation proposal—assuming that H.R. 3590 had already been enacted—would be to increase the costs of the mandates on private-sector entities. That increase in costs would exceed the annual UMRA threshold as well.

I hope this analysis is helpful for the Congress's deliberations. If you have any questions, please contact me or CBO staff. Many people at CBO have contributed to this analysis, but the primary staff contacts are David Auerbach, Colin Baker, Reagan Baughman, James Baumgardner, Tom Bradley, Stephanie Cameron, Julia Christensen, Mindy Cohen, Anna Cook, Noelia Duchovny, Sean Dunbar, Philip Ellis, Peter Fontaine, April Grady, Stuart Hagen, Holly Harvey, Tamara Hayford, Jean Hearne, Janet Holtzblatt, Lori Housman, Justin Humphrey, Paul Jacobs, Deborah Kalcevic, Daniel Kao, Jamease Kowalczyk, Julie Lee, Kate Massey, Alexandra Minicozzi, Keisuke Nakagawa, Kirstin Nelson, Lyle Nelson, Andrea Noda, Sam Papenfuss, Lisa Ramirez-Branum, Lara Robillard, Robert Stewart, Robert Sunshine, Bruce Vavrichek, Ellen Werble, Chapin White, and Rebecca Yip.

Sincerely,



Douglas W. Elmendorf
Director

Enclosures

cc: Honorable John A. Boehner
Republican Leader

Honorable John M. Spratt Jr.
Chairman
Committee on the Budget

Honorable Paul Ryan
Ranking Member

Honorable Harry Reid
Senate Majority Leader

Honorable Mitch McConnell
Senate Republican Leader

Honorable Kent Conrad
Chairman
Senate Committee on the Budget

Honorable Judd Gregg
Ranking Member

TABLE 2. Estimate of Changes in Direct Spending and Revenue Effects of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

	By Fiscal Year, in Billions of Dollars											
	2010	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2010-2014**	**2010-2019**
						CHANGES IN DIRECT SPENDING (OUTLAYS)						
Education	*	*	4	-6	-3	-5	-4	-2	-2	-2	-5	-19
Health Insurance Exchanges												
Premium and Cost Sharing Subsidies	0	0	0	0	14	32	59	75	82	88	14	350
Start-up Costs	*	*	*	1	*	*	0	0	0	0	2	2
Other Related Spending	0	1	2	2	1	*	*	*	*	0	5	5
Subtotal	0	2	2	2	15	33	59	75	82	88	21	358
Reinsurance and Risk Adjustment Payments[a]	0	0	0	0	11	18	18	18	19	21	11	106
Effects of Coverage Provisions on Medicaid and CHIP	*	-1	-2	-4	29	56	81	87	91	97	22	434
Medicare and Other Medicaid and CHIP Provisions												
Reductions in Annual Updates to Medicare FFS Payment Rates	*	-1	-5	-9	-13	-19	-25	-33	-41	-51	-28	-196
Medicare Advantage Rates based on Fee-for-Service Rates	0	-2	-6	-9	-13	-17	-19	-21	-23	-25	-30	-136
Medicare and Medicaid DSH Payments	0	0	*	*	-1	-4	-5	-7	-9	-11	*	-36
Other	2	1	*	*	-16	-11	-10	-14	-18	-22	-12	-87
Subtotal	2	-2	-11	-17	-42	-50	-59	-75	-92	-108	-71	-455
Other Changes in Direct Spending												
Community Living Assistance Services and Supports	0	0	-5	-9	-10	-11	-11	-9	-8	-7	-24	-70
Other	2	6	8	5	5	4	2	-1	-1	*	26	30
Subtotal	2	6	2	-4	-5	-7	-10	-10	-8	-7	2	-40
Total Outlays	4	5	-5	-28	6	44	86	92	90	90	-20	382
On-Budget	4	5	-5	-28	5	44	85	92	89	89	-20	379
Off-Budget	0	*	*	*	*	*	1	1	1	1	*	4

Continued

TABLE 2. Estimate of Changes in Direct Spending and Revenue Effects of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN REVENUES												
Coverage-Related Provisions												
Exchange Premium Credits	0	0	0	0	-5	-11	-18	-22	-24	-26	-5	-107
Reinsurance and Risk Adjustment Collections	0	0	0	0	12	16	18	18	19	22	12	106
Small Employer Tax Credit	-2	-4	-5	-6	-5	-3	-3	-3	-4	-4	-21	-37
Penalty Payments by Employers and Uninsured Individuals	0	0	0	0	3	9	12	13	13	14	3	65
Excise Tax on High-Premium Plans	0	0	0	0	0	0	0	0	12	20	0	32
Associated Effects of Coverage Provisions on Revenues	*	-1	-2	-5	1	6	14	18	10	7	-8	46
Other Provisions												
Fees on Certain Manufacturers and Insurers[b]	0	2	3	5	12	15	15	18	19	18	22	107
Additional Hospital insurance Tax	0	0	1	21	17	29	33	35	37	39	38	210
Other Revenue Provisions[c]	*	7	8	13	22	4	11	12	13	14	49	103
Total Revenues	-3	3	5	27	57	65	83	89	95	104	89	525
On-Budget	-3	4	5	27	55	62	78	82	87	95	88	492
Off-Budget	*	*	-1	1	2	3	5	7	8	9	1	33
NET IMPACT ON THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES[d]												
Net Change in the Deficit	6	1	-10	-56	-51	-20	3	4	-5	-15	-109	-143
On-Budget	6	1	-10	-55	-50	-18	8	10	2	-6	-108	-114
Off-Budget	*	*	1	-1	-1	-2	-5	-6	-7	-9	-1	-29

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation (JCT).

Note: Does not include effects on spending subject to future appropriation. Components may not sum to totals because of rounding.
* = between $0.5 billion and -$0.5 billion.
CHIP = Children's Health Insurance Program; FFS = Fee-for-service; DSH = Disproportionate Share Hospital.

a. Risk-adjustment payments lag revenues shown later in the table by one quarter. Reinsurance payments total $20 billion over the 10-year period.
b. Amounts include fees on manufacturers and importers of branded drugs and certain medical devices as well as fees on health insurance providers.
c. Amounts include $89 billion in increased revenues, as estimated by JCT, for tax provisions other than those broken out separately in the table.
In addition, this line includes an increase in revenues of about $14 billion for other provisions shown in Table 5.
d. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Table 3. Estimate of the Incremental Effects on Deficits of the Reconciliation Proposal, Relative to H.R. 3590 as Passed by the Senate

By Fiscal Year, in Billions of Dollars

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN DIRECT SPENDING												
Change in Outlays	*	6	6	-1	*	-1	3	5	5	4	12	27
On Budget	*	6	6	-1	*	-1	3	6	5	4	12	28
Off Budget	0	*	*	*	*	*	*	*	*	*	*	-1
CHANGES IN REVENUES												
Change in Revenues	-2	2	2	2	13	3	10	8	7	7	17	52
On Budget	-2	3	2	5	13	6	14	13	11	12	21	76
Off Budget	0	*	*	-4	-1	-3	-4	-5	-4	-4	-5	-24
NET IMPACT ON DEFICITS FROM CHANGES IN DIRECT SPENDING AND REVENUES /a												
Net Change in Deficits	2	4	4	-3	-13	-4	-7	-3	-2	-3	-5	-25
On Budget	2	4	4	-6	-14	-7	-11	-7	-6	-7	-10	-48
Off Budget	0	*	*	4	1	3	4	4	4	4	5	23

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation (JCT).

Notes: Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
Components may not sum to totals because of rounding; * = between $0.5 billion and -$0.5 billion.

a. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Table 4. Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

EFFECTS ON INSURANCE COVERAGE /a (Millions of nonelderly people, by calendar year)		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law Coverage /b	Medicaid & CHIP	40	39	39	38	35	34	35	35	35	35
	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup & Other /c	27	26	25	26	28	29	29	29	30	30
	Uninsured /d	50	51	51	51	51	51	52	53	53	54
	TOTAL	267	269	271	273	274	276	277	279	281	282
Change (+/-)	Medicaid & CHIP	*	-1	-2	-3	10	15	17	16	16	16
	Employer	*	3	3	3	4	1	-3	-3	-3	-3
	Nongroup & Other /c	*	*	*	*	-2	-3	-5	-5	-5	-5
	Exchanges	0	0	0	0	8	13	21	23	24	24
	Uninsured /d	*	*	-1	-1	-19	-25	-30	-31	-31	-32
Post-Policy Uninsured Population											
Number of Nonelderly People /d		50	50	50	50	31	26	21	21	22	23
Insured Share of the Nonelderly Population /a											
Including All Residents		81%	82%	82%	82%	89%	91%	92%	92%	92%	92%
Excluding Unauthorized Immigrants		83%	83%	83%	83%	91%	93%	95%	95%	95%	94%
Memo: Exchange Enrollees and Subsidies											
Number w/ Unaffordable Offer from Employer /e						*	1	1	1	1	1
Number of Unsubsidized Exchange Enrollees						1	2	4	5	5	5
Average Exchange Subsidy per Subsidized Enrollee							$5,200	$5,300	$5,500	$5,700	$6,000

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program; * = between 0.5 million and -0.5 million people.

a. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.
b. Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source.
c. Other, which includes Medicare, accounts for about half of current-law coverage in this category; the effects of the proposal are almost entirely on nongroup coverage.
d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.
e. Workers who would have to pay more than a specified share of their income (9.5 percent in 2014) for employment-based coverage could receive subsidies via an exchange.

Table 4. Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

EFFECTS ON THE FEDERAL DEFICIT / a,b (Billions of dollars, by fiscal year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Medicaid & CHIP Outlays /c	0	-1	-2	-4	29	56	81	87	91	97	434
Exchange Subsidies & Related Spending /d	0	2	2	2	20	45	77	97	106	113	464
Small Employer Tax Credits /e	2	4	5	6	5	4	3	3	4	4	40
Gross Cost of Coverage Provisions	2	5	5	5	54	104	161	187	201	214	938
Penalty Payments by Uninsured Individuals	0	0	0	0	0	-2	-3	-4	-4	-4	-17
Penalty Payments by Employers /e	0	0	0	0	-3	-8	-10	-10	-10	-11	-52
Excise Tax on High-Premium Insurance Plans /e	0	0	0	0	0	0	0	0	-12	-20	-32
Other Effects on Tax Revenues and Outlays /f	1	3	4	5	-1	-7	-15	-20	-11	-7	-48
NET COST OF COVERAGE PROVISIONS	**3**	**7**	**9**	**10**	**49**	**87**	**132**	**154**	**164**	**172**	**788**

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program.

a. Does not include federal administrative costs that would be subject to appropriation.
b. Components may not sum to totals because of rounding; positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
c. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2010-2019 period would increase by about $20 billion as a result of the coverage provisions.
d. Includes $5 billion in spending for high-risk pools and the net budgetary effects of proposed collections and payments for reinsurance and risk adjustment.
e. The effects on the deficit of this provision include the associated effects of changes in taxable compensation on tax revenues.
f. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about $2 billion over the 2010-2019 period, and that the coverage provisions would have negligible effects on outlays for other federal programs.

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
Changes in Direct Spending Outlays													
TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS													
Subtitle A—Immediate Improvements in Health Care Coverage for All Americans													
1001 Amendments to the Public Health Service Act	Included in estimate for expanding health insurance coverage.												
1002 Helping Consumers Receive Quality Accountable Coverage	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle B—Immediate Assistance to Preserve and Expand Coverage													
1101 Temporary High Risk Health Insurance Pool	Included in estimate for expanding health insurance coverage.												
1102 Reinsurance for Early Retirees	1.3	2.5	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.0	5.0	**0.0**
1103 Assistance to Consumers in Identifying Affordable Coverage Options	Included in estimate for expanding health insurance coverage.												
1104 Administrative Simplification													
Effects on Medicaid spending	0.0	0.0	-0.1	-0.1	-0.2	-0.4	-0.9	-1.7	-1.9	-2.1	-0.4	-7.3	**-0.2**
Effects on exchange subsidies	0.0	0.0	0.0	0.0	-0.1	-0.3	-0.6	-1.0	-1.2	-1.2	-0.1	-4.3	**0.0**
Subtitle C—Effective Coverage for All Americans	Included in estimate for expanding health insurance coverage.												
Subtitle D—Available Coverage for All Americans	Included in estimate for expanding health insurance coverage.												
Subtitle E—Affordable Coverage for All Americans	Included in estimate for expanding health insurance coverage.												
Subtitle F—Shared Responsibility for Health Care	Included in estimate for expanding health insurance coverage.												
Subtitle G—Miscellaneous Provisions													
1556 Equity for Certain Eligible Survivors	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Sections 1551-1555 and 1557-1562	Included in estimate for expanding health insurance coverage.												
TITLE II—ROLE OF PUBLIC PROGRAMS													
Subtitle A—Improved Access to Medicaid													
Sections 2001-2004	Included in estimate for expanding health insurance coverage.												
2005 Payments to Territories	0.0	0.3	0.7	0.7	0.9	0.9	0.9	1.0	1.0	1.0	2.5	7.3	**2.0**
2006 Special Adjustment to FMAP Determination for Certain States Recovering from a Major Disaster	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	**0.0**
2007 Medicaid Improvement Fund Rescission	0.0	0.0	0.0	0.0	0.0	-0.2	-0.2	-0.2	-0.2	0.0	0.0	-0.6	**0.0**
Subtitle B—Enhanced Support for the Children's Health Insurance Program													
2101 Additional Federal Financial Participation for CHIP	Included in estimate for expanding health insurance coverage.												
2102 Technical Corrections	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
Subtitle C—Medicaid and CHIP Enrollment Simplification	Included in estimate for expanding health insurance coverage.												

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
Subtitle D—Improvements to Medicaid Services													
2301 Coverage for Freestanding Birth Center Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2302 Concurrent Care for Children	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	**0.0**
2303 State Eligibility Option for Family Planning Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2304 Clarification of Definition of Medical Assistance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle E—New Options for States to Provide Long-Term Services and Supports													
2401 Community First Choice Option	0.0	0.0	0.1	0.2	0.3	0.8	0.9	1.0	1.2	1.4	0.6	6.0	**-0.9**
2402 Removal of Barriers to Providing Home and Community-Based Services	0.0	0.1	0.1	0.1	0.2	0.3	0.4	0.4	0.4	0.4	0.5	2.4	**0.0**
2403 Money Follows the Person Rebalancing Demonstration	0.0	0.0	0.0	0.0	0.1	0.2	0.3	0.4	0.3	0.3	0.2	1.7	**0.0**
2404 Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment	0.0	0.0	0.0	0.0	0.2	0.3	0.3	0.3	0.3	0.2	0.2	1.5	**0.0**
2405 Funding to Expand State Aging and Disability Resource Centers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	**0.0**
2406 Sense of the Senate Regarding Long-Term Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10202 Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes	0.0	0.0	0.1	0.2	0.3	0.3	0.2	0.2	0.2	0.2	0.7	1.8	**0.2**
Subtitle F—Medicaid Prescription Drug Coverage	-0.4	-2.5	-3.2	-3.3	-3.7	-4.1	-4.7	-5.0	-5.4	-5.8	-13.1	-38.1	**-0.1**
Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments	0.0	0.0	0.0	0.1	-0.5	-0.6	-0.6	-1.8	-5.0	-5.6	-0.4	-14.0	**4.1**
Subtitle H—Improved Coordination for Dual Eligible Beneficiaries													
2601 5-Year Period for Demonstration Projects	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2602 Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle I—Improving the Quality of Medicaid for Patients and Providers													
2701 Adult Health Quality Measures	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.2	0.3	**0.0**
2702 Payment Adjustment for Health Care-Acquired Conditions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2703 State Option to Provide Health Homes for Enrollees With Chronic Conditions	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.7	**0.0**
2704 Demonstration Project to Evaluate Integrated Care Around a Hospitalization	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2705 Medicaid Global Payment System Demonstration Project	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2706 Pediatric Accountable Care Organization Demonstration Project	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2707 Medicaid Emergency Psychiatric Demonstration Project	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)													
2801 MACPAC Assessment of Policies Affecting All Medicaid Beneficiaries	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

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Subtitle K—Protections for American Indians and Alaska Natives													
2901 Special Rules Relating to Indians													
No Cost Sharing for Indians with Income at or Below 300 Percent of Poverty	Included in estimate for expanding health insurance coverage.												
Payer of Last Resort	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Facilitating Enrollment of Indians Through the Express Lane Option	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2902 Elimination of Sunset for Reimbursement for All Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	**0.0**
Indian Health Improvement Act	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle L—Maternal and Child Health Services													
2951 Maternal, Infant, and Early Childhood Home Visiting Programs	0.0	0.1	0.3	0.4	0.4	0.2	0.1	0.0	0.0	0.0	1.2	1.5	**0.0**
2952 Support, Education, and Research for Postpartum Depression	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2953 Personal Responsibility Education	0.0	0.0	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.3	0.4	**0.0**
2954 Restoration of Funding for Abstinence Education	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
2955 Inclusion of Information About The Importance of Having a Health-Care Power of Attorney in Transition Planning for Children Aging Out of Foster Care and Independent Living Programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Support for Pregnant and Parenting Teens and Women	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	**0.0**
TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE													
Subtitle A—Transforming the Health Care Delivery System													
PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM													
3001 Hospital Value-Based Purchasing Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3002 Physician Quality Reporting System													
PPO Stabilization Fund	0.0	0.0	0.0	0.0	-0.1	0.0	0.0	0.0	0.0	0.0	-0.1	-0.2	**0.0**
Physicians' Services	0.0	0.0	0.2	0.2	0.2	0.3	-0.1	-0.2	-0.2	-0.2	0.6	0.3	**0.0**
3003 Improvements to the Physician Feedback Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3004 Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	**0.0**
3005 Quality Reporting for PPS-Exempt Cancer Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3006 Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3007 Value-based Payment Modifier Under the Physician Fee Schedule	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3008 Payment Adjustment for Conditions Acquired in Hospitals	0.0	0.0	0.0	0.0	0.0	-0.2	-0.3	-0.3	-0.3	-0.3	0.0	-1.4	**0.0**
PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY													
3011 National Strategy	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3012 Interagency Working Group on Health Care Quality	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3013 Quality Measure Development	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3014 Quality Measurement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
3015 Data Collection; Public Reporting	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Effect of Quality-Measure Development/Endorsement Provisions on Medicare Spending	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

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PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS													
3021 Establishment of Center for Medicare and Medicaid Innovation	0.0	0.1	0.2	0.2	0.2	0.2	0.0	-0.3	-0.7	-1.2	0.7	-1.3	**0.0**
3022 Medicare Shared Savings Program	0.0	0.0	0.0	-0.1	-0.3	-0.6	-0.7	-0.9	-1.0	-1.2	-0.5	-4.9	**0.0**
3023 National Pilot Program on Payment Bundling	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3024 Independence at Home Demonstration Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3025 Hospital Readmissions Reduction Program	0.0	0.0	0.0	-0.1	-0.3	-1.1	-1.3	-1.3	-1.4	-1.5	-0.5	-7.1	**0.0**
3026 Community-Based Care Transitions Program	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.3	0.5	**0.0**
3027 Extension of Gainsharing Demonstration	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle B—Improving Medicare for Patients and Providers													
PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES													
3101 Increase in the Physician Payment Update	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3102 Extension of the Work Geographic Index Floor and Revisions to the Practice Expense Geographic Adjustment Under the Medicare Physician Fee Schedule	0.9	1.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.2	2.2	**0.4**
3103 Extension of Exceptions Process for Medicare Therapy Caps	0.3	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.8	**0.0**
3104 Extension of Payment for Technical Component of Certain Physician Pathology Services	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
3105 Extension of Ambulance Add-Ons	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
3106 Extension of Certain Payment Rules for Long-Term Care Hospital Services and of Moratorium on the Establishment of Certain Hospitals and Facilities	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	**0.0**
3107 Extension of Physician Fee Schedule Mental Health Add-On	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3108 Permitting Physician Assistants to Order Post-Hospital Extended Care Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3109 Exemption of Certain Pharmacies From Accreditation Requirements	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3110 Part B Special Enrollment Period for Disabled TRICARE Beneficiaries	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3111 Payment for Bone Density Tests	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
3112 Revision to the Medicare Improvement Fund	0.0	0.0	0.0	0.0	-15.6	-5.2	0.0	0.0	0.0	0.0	-15.6	-20.7	**0.0**
3113 Treatment of Certain Complex Diagnostic Laboratory Tests	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
3114 Improved Access for Certified-Midwife Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

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PART II—RURAL PROTECTIONS													
3121 Extension of Outpatient Hold Harmless Provision	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	**0.0**
3122 Reasonable Costs Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3123 Extension of the Rural Community Hospital Demonstration Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3124 Extension of the Medicare-Dependent Hospital (MDH) Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3125 Payment Adjustment for Low-Volume Hospitals	0.0	0.0	0.1	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	**0.0**
3126 Demonstration Project on Community Health Integration Models	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3127 Study on Adequacy of Medicare Payments in Rural Areas	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3128 Technical Correction Related to Critical Access Hospital Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3129 Medicare Rural Hospital Flexibility Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
PART III—IMPROVING PAYMENT ACCURACY													
3131 Payment Adjustments for Home Health Care (includes effect of section 3401)	0.0	-0.4	-0.8	-1.1	-1.9	-3.3	-5.3	-7.5	-9.0	-10.3	-4.2	-39.7	**0.0**
3132 Hospice Reform	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	**0.0**
3133 Medicare Disproportionate Share Hospital (DSH) Payments	0.0	0.0	0.0	0.0	0.0	-3.6	-4.0	-5.0	-4.4	-5.1	0.0	-22.1	**3.0**
3134 Misvalued Codes Under the Physician Fee Schedule	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3135 Equipment Utilization Factor for Advanced Imaging Services	0.0	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.9	-2.3	**-1.2**
3136 Revision of Payment for Power-Driven Wheelchairs	0.0	-0.4	-0.1	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.6	-0.8	**0.0**
3137 Hospital Wage Index Improvement	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.3	**0.0**
3138 Treatment of Certain Cancer Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3139 Payment for Biosimilar Biological Products	Included in estimate for title VII, subtitle A.												
3140 Medicare Hospice Concurrent Care Demonstration Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3141 Application of Budget Neutrality on a National Basis in the Calculation of the Medicare Hospital Wage Index Floor	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3142 HHS Study on Urban Medicare-Dependent Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle C—Provisions Relating to Part C													
3201 Medicare Advantage Payments	0.0	-1.8	-6.0	-9.4	-13.1	-16.7	-19.2	-21.3	-23.2	-25.0	-30.3	-135.6	**-17.5**
3202 Benefit protection and simplification	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3203 Repealed	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.7**
3204 Simplification of Annual Beneficiary Election Periods	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3205 Extension for Specialized MA Plans for Special Needs Individuals	0.0	0.1	0.2	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.6	0.7	**-0.2**
3206 Extension of Reasonable Cost Contracts	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3207 Technical Correction to MA Private Fee-for-Service Plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	**0.0**
3208 Making Senior Housing Facility Demonstration Permanent	Included in estimate for section 3205.												
3209 Authority to Deny Plan Bids	Included in estimate for section 3201.												
3210 Development of New Standards for Certain Medigap Plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	**0.0**

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Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans													
3301 Medicare Coverage Gap Discount Program	0.2	2.4	1.6	2.1	2.9	3.8	5.2	6.4	7.6	10.4	9.2	42.6	**24.8**
3302 Determination of Medicare Part D Low-Income Benchmark Premium	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.7	**0.0**
3303 Voluntary de minimis Policy for Subsidy Eligible Individuals Under Prescription Drug Plans and MA–PD Plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.4	**0.0**
3304 Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	**0.0**
3305 Improved Information for Subsidy Eligible Individuals Reassigned to Prescription Drug Plans and MA–PD Plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3306 Funding Outreach and Assistance for Low-Income Programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3307 Improving Formulary Requirements for Prescription Drug Plans and MA–PD Plans With Respect to Certain Categories or Classes of Drugs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3308 Reducing Part D Premium Subsidy for High-Income Beneficiaries	0.0	-0.3	-0.5	-0.7	-0.9	-1.1	-1.3	-1.6	-2.0	-2.4	-2.4	-10.7	**0.0**
3309 Elimination of Cost Sharing for Certain Dual Eligible Individuals.	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	1.1	**0.0**
3310 Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-Term Care Facilities	0.0	0.0	-0.1	-0.3	-0.5	-0.8	-1.0	-1.0	-0.9	-1.1	-1.0	-5.7	**0.0**
3311 Medicare Prescription Drug Plan and MA–PD Plan Complaint System	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3312 Uniform Exceptions and Appeals Process for Prescription Drug Plans and MA–PD Plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3313 Office of the Inspector General Studies and Reports	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3314 Including Costs Incurred by AIDS Drug Assistance Programs and Indian Health Service in Providing Prescription Drugs Toward the Annual Out-of-Pocket Threshold Under Part D	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6	**0.0**
3315 Immediate Reduction in Coverage Gap in 2010	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10328 Improvement in Part D Medication Therapy Management Programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle E—Ensuring Medicare Sustainability													
3401 Revision of Certain Market Basket Updates and Incorporation of services Productivity Improvements into Market Basket Updates that do not Already Incorporate Such Improvements (effect of productivity adjustment for home health included in estimate for section 3131)	-0.1	-1.1	-3.8	-7.4	-11.3	-15.3	-19.5	-25.4	-32.3	-40.5	-23.7	-156.6	**-9.9**
3402 Temporary Adjustment to the Calculation of Part B Premiums	0.0	-1.3	-1.9	-1.9	-2.5	-2.6	-2.8	-3.2	-4.0	-4.9	-7.5	-25.0	**0.0**
3403 Independent Payment Advisory Board	0.0	0.0	0.0	0.0	0.0	-1.5	-2.6	-3.0	-3.7	-4.7	0.0	-15.5	**12.6**
Subtitle F—Health Care Quality Improvements	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10323 Medicare Coverage for Individuals Exposed to Environmental Health Hazards	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3	**0.0**
10324 Protections for Frontier States	0.0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.8	2.0	**0.0**
10325 Revision to Skilled Nursing Facility Prospective Payment System	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10326 Pilot Testing of Pay-for-Performance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10329 Methodology to Assess Health Plan Value	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10330 Modernizing CMS Computer and Data Systems	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10331 Public Reporting of Performance Information	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10332 Availability of Medicare Data	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10333 Community-based Collaborative Care Networks	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

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TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH													
Subtitle A—Modernizing Disease Prevention and Public Health Systems													
4002 Prevention and Public Health Fund	0.1	0.6	0.8	1.0	1.3	1.6	1.8	1.9	2.0	2.0	3.7	12.9	**0.0**
Sections 4001, 4003, 4004	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle B—Increasing Access to Clinical Preventive Services													
4101 School-Based Health Centers	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	**0.0**
4102 Oral Healthcare Prevention Activities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4103 Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan	0.0	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.5	1.4	3.6	**0.0**
4104 Removal of Barriers to Preventive Services in Medicare	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8	**0.0**
4105 Evidence-Based Coverage of Preventive Services in Medicare	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.7	**0.0**
4106 Improving Access to Preventive Services for Eligible Adults in Medicaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	**0.0**
4107 Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	**0.0**
4108 Incentives for Prevention of Chronic Diseases in Medicaid	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
Subtitle C—Creating Healthier Communities													
4201 Community Transformation Grants	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4202 Healthy Aging, Living Well; Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
4203 Removing Barriers and Improving Access to Wellness for Individuals With Disabilities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4204 Immunizations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4205 Nutrition Labeling of Standard Menu Items at Chain Restaurants	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4206 Demonstration Project Concerning Individualized Wellness Plan	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4207 Reasonable Break Time for Nursing Mothers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle D—Support for Prevention and Public Health Innovation													
4301 Research On Optimizing The Delivery of Public Health Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4302 Understanding Health Disparities: Data Collection and Analysis													
Data Collection, Analysis, and Quality	0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	**0.0**
Addressing Health Care Disparities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4303 CDC and Employer-Based Wellness Programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4304 Epidemiology-Laboratory Capacity Grants	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4305 Advancing Research and Treatment for Pain-Care Management	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4306 Funding for Childhood Obesity Demonstration Project	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10407 Better Diabetes Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10408 Grants for Workplace Wellness	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10409 Cures Acceleration Network	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10410 Centers of Excellence for Depression	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10411 Programs Relating to Congenital Heart Disease	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10412 Automated Defribrillation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10413 Young Women's Breast Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle E—Miscellaneous Provisions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

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TITLE V—HEALTH CARE WORKFORCE													
Subtitle A—Purpose and Definitions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle B—Innovations in the Health Care Workforce	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle C—Increasing the Supply of the Health Care Workforce	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle D—Enhancing Health Care Workforce Education and Training													
Sections 5301-5314	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
5315 United States Public Health Sciences Track	Included in estimate for section 4002.												
5316 Family Nurse Practitioner Training Programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle E—Supporting the Existing Health Care Workforce	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle F—Strengthening Primary Care and Other Workforce Improvements													
5501 Expanding Access to Primary Care Services and General Surgery Services	0.0	0.4	0.6	0.7	0.7	0.8	0.3	0.0	0.0	0.0	2.5	3.5	**0.0**
5502 Medicare Federally Qualified Health Center Improvements	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.4	**0.0**
5503- 5506 Medicare Graduate Medical Education Policies	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.3	1.1	**0.0**
5507 Demonstration Projects to Address Health Professions Workforce Needs and Extension of Family-To-Family Health Information Centers	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.4	0.4	**0.0**
5508 Increasing Teaching Capacity	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	**0.0**
5509 Graduate Nurse Education Demonstration Program	0.0	0.0	0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.2	**0.0**
Subtitle G—Improving Access to Health Care Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
5707 Infrastructure to Expand Access to Care	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
5606 State Grants to Health Care Providers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Medical Training in Underserved Communities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Preventive Medicine and Public Health Training Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Scholarship and Loan program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
5708 Community Health Centers and the National Health Service Corps Fund	0.0	0.7	2.2	1.8	2.3	3.3	1.8	0.2	0.0	0.0	7.0	12.3	**2.5**
5709 Demonstration Project to Provide Access to Affordable Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle H—General Provisions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY													
Subtitle A—Physician Ownership and Other Transparency													
6001 Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5	**0.1**
6002 Reporting of Physician Ownership or Investment Interests	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6003 Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6004 Prescription Drug Sample Transparency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6005 Pharmacy Benefit Managers Transparency Requirements	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

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Subtitle B—Nursing Home Transparency and Improvement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
Subtitle D—Patient-Centered Outcomes Research													
6301 Patient-Centered Outcomes Research													
Medicare	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.2	0.1	-0.3	**0.0**
Non-Medicare	0.0	0.0	0.1	0.1	0.2	0.3	0.4	0.4	0.4	0.5	0.4	2.5	**0.0**
6302 Federal Coordinating Council for Comparative Effectiveness Research	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions													
6401 Provider Screening and Other Enrollment Requirements Under Medicare, Medicaid, and CHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	**0.0**
6402 Enhanced Medicare and Medicaid Program Integrity Provisions	0.0	-0.2	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-1.1	-2.9	**0.3**
6403 Elimination of Duplication Between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6404 Maximum Period for Submission of Medicare Claims	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6405 Physicians Who Order Items or Services Required to Be Medicare-Enrolled Physicians or Eligible Professionals	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.2	-0.4	**0.0**
6406 Requirement for Physicians to Provide Documentation on Referrals to Programs At High Risk of Waste and Abuse	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6407 Face to Face Encounter With Patient Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment Under Medicare	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.3	-1.0	**0.0**
6408 Enhanced Penalties	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6409 Medicare Self-Referral Disclosure Protocol	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6410 Adjustments to the Competitive Acquisition Program in Medicare for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	0.0	0.0	0.0	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-1.4	**0.0**
6411 Expansion of the Recovery Audit Contractor (RAC) Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10606 Health Care Fraud Enforcement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle F—Additional Medicaid Program Integrity Provisions													
6501 Termination of Provider Participation Under Medicaid If Terminated Under Medicare or Other State Plan	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6502 Medicaid Exclusion From Participation Relating to Certain Ownership, Control, and Management Affiliations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6503 Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6504 Requirement to Report Expanded Set of Data Elements Under MMIS to Detect Fraud and Abuse	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6505 Prohibition on Payments to Institutions or Entities Located Outside of the United States	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6506 Overpayments	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
6507 Mandatory State Use of National Correct Coding Initiative	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.3	**0.0**
6508 General Effective Date	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

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Subtitle G—Additional Program Integrity Provisions													**0.0**
10607 State Demonstration Programs: Alternatives to Tort Litigation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10608 Liability Coverage in Free Clinics	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	**0.0**
10609 FDA Labeling Changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	**0.0**
Subtitle H—Elder Justice Act	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle I—Sense of the Senate Regarding Medical Malpractice	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES													
Subtitle A—Biologics Price Competition and Innovation	0.0	0.0	0.0	0.0	-0.1	-0.3	-0.7	-1.2	-1.9	-2.7	-0.1	-7.0	**0.1**
Subtitle B—More Affordable Medicines for Children and Underserved Communities													
7101 Expanded Participation in 340B Program	Included in estimate for section 2501.												
7102 Improvements to 340B Program Integrity	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
7103 GAO Study to Make Recommendations on Improving the 340B Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
TITLE VIII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS	0.0	0.0	-5.4	-8.8	-10.0	-11.3	-11.1	-9.1	-7.6	-7.0	-24.1	-70.2	**0.0**
TITLE IX—REVENUE PROVISIONS	Estimates provided by the Joint Committee on Taxation in a Separate Table (see JCX-17-10).												
PROVISIONS OF RECONCILIATION BILL THAT ARE NOT INCLUDED IN ESTIMATES FOR PROVISIONS OF H.R. 3590													
1005 Administrative Funding	0.0	0.4	0.5	0.1	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	**1.0**
1109 Payment for Qualifying Hospitals		0.1	0.3	0.0							0.4	0.4	**0.4**
1202 Improving Payments to Primary Care Practitioners	0.0	0.0	0.0	1.9	3.0	1.6	0.9	0.8	0.1	0.0	4.9	8.3	**8.3**
1206 Drug Rebates for New Formulations of Existing Drugs	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6	**0.6**
1301, 1302, 1304 Program Integrity Provisions: Sections 1301, 1302,1304	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.9	**-0.9**
1305 Increased Funding to Fight Fraud, Waste, and Abuse	Included in estimate for section 6402.												**0.0**
1501 Community College and Career Training Grant Program	0.0	0.0	0.4	0.5	0.5	0.5	0.1	0.0	0.0	0.0	1.3	2.0	**2.0**
2303 Drugs Purchased by Covered Entities	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.4	0.4	0.8	2.5	**2.5**
INTERACTIONS													
Medicare Advantage Interactions	0.0	0.0	-0.6	-1.9	-7.9	-7.8	-8.9	-11.7	-14.1	-17.2	-10.4	-70.3	**-52.9**
Premium Interactions	0.0	-0.2	0.5	1.1	6.3	4.8	4.8	6.0	7.0	8.1	7.6	38.4	**6.8**
Medicare Part D Interactions with Medicare Advantage Provisions	0.0	0.0	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.4	1.5	**-1.5**
Medicare Part B Interactions with Medicare Part D Provisions	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8	**0.0**
Medicaid Interactions with Medicare Part D Provisions	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.1	0.7	**0.0**
Medicare Interaction with 340b	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5	**0.0**
TRICARE Interaction	0.0	0.0	-0.1	-0.2	-0.3	-0.4	-0.6	-0.8	-1.0	-1.2	-0.5	-4.4	**-0.9**
FEHB Interaction (on-budget)	0.0	0.0	0.0	0.0	0.2	0.3	0.3	0.4	0.8	0.9	0.3	2.9	**0.1**
FEHB Interaction (off-budget)	0.0	0.0	0.0	0.0	0.2	0.2	0.2	0.1	0.3	0.3	0.3	1.3	**-0.2**
Total, Changes in On-Budget Direct Spending	**3.0**	**3.0**	**-10.7**	**-22.0**	**-47.5**	**-55.7**	**-66.6**	**-83.2**	**-99.1**	**-114.7**	**-74.1**	**-493.3**	**-13.7**
Total, Changes in Unified-Budget Direct Spending	**3.0**	**3.0**	**-10.6**	**-22.0**	**-47.3**	**-55.5**	**-66.4**	**-83.1**	**-98.9**	**-114.4**	**-73.8**	**-492.0**	**-13.9**

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
Changes in Revenues													
Transitional Reinsurance - Collections for Early Retirees	0.0	0.0	0.0	0.0	1.5	1.5	0.8	0.0	0.0	0.0	1.5	3.8	**0.0**
Fraud, Waste, and Abuse (on-budget)	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.9	**0.0**
Effect of Administrative Simplification on Revenues[b]	0.0	-0.2	-0.2	0.0	0.5	0.9	1.3	1.9	2.0	2.0	0.1	8.2	**0.0**
Effect on Revenues of Changes in Health Insurance Premiums as a Result of Comparative Effectiveness Research, Changes in the Medicaid Drug Program, Biosimilar Biological Products, and FDA Labeling													
Income and Medicare payroll taxes (on-budget)	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.3	0.3	0.1	1.0	**0.0**
Social Security payroll taxes (off-budget)	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.0	0.5	**0.0**
Total, Changes in Unified-Budget Revenues[c]	**0.0**	**-0.1**	**-0.1**	**0.2**	**2.1**	**2.6**	**2.4**	**2.2**	**2.5**	**2.6**	**2.1**	**14.3**	**0.0**
Total, Changes in Unified-Budget Deficits[c]	**3.0**	**3.1**	**-10.6**	**-22.1**	**-49.4**	**-58.1**	**-68.7**	**-85.3**	**-101.4**	**-117.0**	**-75.9**	**-506.4**	**-13.9**
Memorandum													
Non-scoreable Effects													
Savings from HCFAC and Medicaid Integrity Spending	0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-0.5	-2.1	
Recovery Audit Contractor (RAC) Program in Medicaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.2	

Notes: AIDS = Acquired Immune-Deficiency Syndrome; CDC = Center for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; FMAP = federal medical assistance percentage; FDA = Food and Drug Administration; FEHB = Federal Employees Health Benefits program; GAO = Government Accountability Office; HCFAC = Health Care Fraud and Abuse Control; HHS = Department of Health and Human Services; MA = Medicare Advantage; MA-PD = Medicare Advantage prescription drug plan; MMIS = Medicaid Management Information System; PPO = preferred provider organization; PPS = prospective payment system; TRICARE is the health plan operated by the Department of Defense.

a. Incremental effects over the 2010-2019 period of health provisions of the reconciliation proposal relative to H.R. 3590 as passed by the Senate.
b. Includes both on and off-budget revenues.
c. The revenue effects of the provisions of title IX are estimated by the Joint Committee on Taxation, and are not included in this table.

Table 6. Estimate of the Incremental Effects of the Health and Revenue Provisions of the Reconciliation Proposal Relative to H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Changes in Deficits												
TITLE I—COVERAGE, MEDICARE, MEDICAID, AND REVENUES												
Subtitle A—Coverage (direct spending and revenues)												
Coverage Provisions (sections 1001-1004, 1201, and 1401)	0	0.2	0.3	5.9	14.2	17.4	21.6	30.2	35.0	35.6	20.6	160.4
1005 Implementation Funding	0	0.4	0.5	0.1	0	0	0	0	0	0	1.0	1.0
Subtitle B—Medicare (direct spending)												
1101 Closing the Medicare Prescription Drug ''Donut Hole''	0.2	1.5	-0.3	0.7	1.3	2.0	3.0	4.1	5.0	7.2	3.5	24.8
1102 Medicare Advantage Payments	0	4.2	1.0	1.4	-1.8	-4.4	-5.2	-4.5	-4.2	-3.4	4.8	-17.0
1103 Savings from Limits on MA Plan Administrative Costs	Interacts with section 1102; budgetary effects are included in estimate for that section.											
1104 Disproportionate Share Hospital (DSH) Payments	0	0	0	0	*	0.2	0.5	0.7	0.7	0.9	*	3.0
1105 Market Basket Updates	0	0	0	0	-0.2	-0.2	-0.4	-1.6	-3.0	-4.5	-0.2	-9.8
1106 Physician Ownership-Referral	*	*	*	*	*	*	*	*	*	*	*	0.1
1107 Payment for Imaging Services	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.5	-1.2
1108 Practice Expense Geographic Practice Cost Index Adjustment for 2010	0.3	0.2	0	0	0	0	0	0	0	0	0.4	0.4
1109 Payment for Qualifying Hospitals	0	0.1	0.3	*	0	0	0	0	0	0	0.4	0.4
Subtitle C—Medicaid (direct spending)												
1201 Federal Funding for States	Included in coverage estimate.											
1202 Payments to Primary Care Physicians	0	0	0	1.9	3.0	1.6	0.9	0.8	0.1	0	4.9	8.3
1203 Disproportionate Share Hospital Payments	0	0	*	*	-0.5	2.2	3.0	2.0	-1.1	-1.6	-0.4	4.1
1204 Funding for the Territories	0	0.2	0.5	0.6	0.2	0.1	0.1	0.1	0.1	0.1	1.5	2.0
1205 Delay in Community First Choice Option	0	-0.1	-0.1	-0.1	-0.3	-0.1	*	-0.1	*	-0.1	-0.6	-0.9
1206 Drug Rebates for New Formulations of Existing Drugs	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
Subtitle D—Reducing Fraud, Waste, and Abuse (direct spending)												
1301 Community Mental Health Centers	0	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
1302 Medicare Prepayment Medical Review Limitations	0	0	*	*	*	*	*	*	*	*	*	-0.1
1303 Funding to Fight Fraud, Waste, and Abuse	0	0.1	0.1	*	*	*	*	*	*	*	0.2	0.3
1304 90-Day Period of Enhanced Oversight for Initial Claims of DME Suppliers	0	*	*	*	*	*	*	*	*	*	-0.1	-0.2
Subtitle E—Revenues (direct spending and revenues)[a]	1.9	-2.6	-2.3	-7.7	-23.0	-15.3	-24.1	-26.6	-27.8	-28.7	-33.6	-155.9
Subtitle F—Community College and Career Training Grant Program (direct spending)	0	*	0.4	0.5	0.5	0.5	0.1	*	0	0	1.3	2.0

Table 6. Estimate of the Incremental Effects of the Health and Revenue Provisions of the Reconciliation Proposal Relative to H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
INTERACTIONS (direct spending)												
Effect of Coverage Provisions on Medicare/Medicaid/CHIP Spending	*	-0.2	-0.1	*	*	-0.2	-0.2	-0.4	-0.1	-0.1	-0.4	-1.3
Medicare Advantage Interactions	0	0	-0.2	-0.9	-6.1	-5.9	-6.5	-8.9	-11.1	-13.3	-7.1	-52.9
Premium Interactions	0	-0.4	-0.1	-0.1	1.1	1.0	1.1	1.2	1.4	1.5	0.5	6.8
IPAB Interactions	0	0	0	0	0	*	1.5	2.6	3.9	4.6	0	12.6
TRICARE Interaction	0	*	*	*	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.1	-0.9
FEHB Interaction (off-budget)	0	*	-0.1	-0.1	0.1	*	-0.1	-0.1	*	*	-0.1	-0.2
Subtotal, Title I Changes in Unified-Budget Deficits	**2.4**	**3.6**	**-0.2**	**2.2**	**-11.9**	**-1.3**	**-4.8**	**-0.8**	**-1.4**	**-2.3**	**-3.8**	**-14.4**
TITLE II—HEALTH, EDUCATION, LABOR, AND PENSIONS												
Subtitle A—Education (direct spending)	See Table 7.											
Subtitle B—Health (direct spending and revenues)												
2301 Insurance Reforms	0	0.3	0.4	0.3	0.7	0.6	0.5	0.4	0.4	0.3	1.6	3.8
2302 Drugs Purchased by Covered Entities	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.4	0.4	0.8	2.5
2303 Community Health Centers	0	0.2	0.3	0.4	0.5	0.6	0.3	*	0	0	1.5	2.5
Subtotal, Title II Subtitle B Changes in Unified-Budget Deficits	**0.1**	**0.6**	**0.9**	**0.9**	**1.4**	**1.6**	**1.1**	**0.8**	**0.7**	**0.7**	**3.9**	**8.7**
Total Changes in Unified-Budget Deficits for Title I and Subtitle B of Title II	**2.5**	**4.2**	**0.7**	**3.1**	**-10.4**	**0.3**	**-3.7**	**-0.1**	**-0.7**	**-1.6**	**0.1**	**-5.7**

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation

Notes: * = between -$50 million and $50 million. Negative numbers indicate reductions in the deficit.
CHIP = Children's Health Insurance Program; DME = durable medical equipment; FEHB = Federal Employees Health Benefits program;
IPAB = Independent Payment Advisory Board; MA = Medicare Advantage; TRICARE is the health plan operated by the Department of Defense.

a. Estimated effects on the deficit of section 1401 (High-cost plan excise tax) are included in the estimate for coverage provisions in Title I, Subtitle A.

Table 7. Estimate of the Incremental Effects of the Reconciliation Proposal, Relative to H.R. 3590 as Passed by the Senate

Includes effects of education provisions as well as health care and revenue provisions

Billions of Dollars, by Fiscal Year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING OR REVENUES												
Title I - Coverage, Medicare, Medicaid, and Revenues[a]												
Subtotal, Title I	2.4	3.6	-0.2	2.2	-11.9	-1.3	-4.8	-0.8	-1.4	-2.3	-3.8	-14.4
On-Budget	2.4	3.5	-0.2	-1.2	-12.6	-3.6	-8.2	-5.1	-5.3	-6.3	-8.1	-36.6
Off-Budget[b]	0	0.1	0.1	3.4	0.7	2.3	3.4	4.3	3.9	4.0	4.3	22.2
Title II - Health, Education, Labor, and Pensions												
Subtitle A - Education	-0.3	-0.4	3.7	-5.6	-2.5	-4.5	-3.6	-2.4	-1.8	-1.7	-5.1	-19.2
Subtitle B - Health	0.1	0.6	0.9	0.9	1.4	1.6	1.1	0.8	0.7	0.7	3.9	8.7
Subtotal, Title II	-0.3	0.2	4.6	-4.6	-1.1	-3.0	-2.5	-1.7	-1.0	-1.0	-1.2	-10.5
On-Budget	-0.3	0.1	4.5	-4.7	-1.3	-3.2	-2.7	-1.8	-1.1	-1.1	-1.7	-11.7
Off-Budget[b]	0	0.1	0.1	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.5	1.2
Net Increase or Decrease (-) in the Deficit	2.2	3.8	4.4	-2.5	-12.9	-4.2	-7.3	-2.5	-2.4	-3.4	-5.0	-24.9
On-Budget	2.2	3.6	4.2	-5.9	-13.9	-6.8	-10.9	-6.9	-6.4	-7.4	-9.8	-48.3
Off-Budget[b]	0	0.2	0.2	3.5	0.9	2.6	3.6	4.4	4.0	4.1	4.8	23.4

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: Components may not sum to totals because of rounding.

a. Also includes funding for Community College and Career Training Grant Program.
b. Off-budget effects include changes in Social Security spending and revenues as well as spending by the U.S. Postal Service.

JOINT COMMITTEE ON TAXATION
March 20, 2010
JCX-17-10

ESTIMATED REVENUE EFFECTS OF THE AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 4872, THE "RECONCILIATION ACT OF 2010," AS AMENDED, IN COMBINATION WITH THE REVENUE EFFECTS OF H.R. 3590, THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT ('PPACA')," AS PASSED BY THE SENATE, AND SCHEDULED FOR CONSIDERATION BY THE HOUSE COMMITTEE ON RULES ON MARCH 20, 2010

Fiscal Years 2010 - 2019

[Billions of Dollars]

Provision	Effective	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
I. Revenue Provisions													
1. 40% excise tax on health coverage in excess of $10,200/$27,500 (subject to adjustment for unexpected increase in medical costs prior to effective date) and increased thresholds of $1,650/$3,450 for over age 55 retirees or certain high-risk professions, both indexed for inflation by CPI-U plus 1%; adjustment based on age and gender profile of employees; vision and dental excluded from excise tax; levied at insurer level; employer aggregates and issues information return for insurers indicating amount subject to the excise tax; nondeductible [1]	tyba 12/31/17	---	---	---	---	---	---	---	---	12.2	19.8	---	32.0
2. Employer W-2 reporting of value of health benefits	tyba 12/31/10	*Negligible Revenue Effect*											
3. Conform the definition of medical expenses for health savings accounts, Archer MSAs, health flexible spending arrangements, and health reimbursement arrangements to the definition of the itemized deduction for medical expenses (excluding over-the-counter medicines prescribed by a physician) [1]	tyba 12/31/10	---	0.4	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	2.1	5.0
4. Increase in additional tax on distributions from HSAs and Archer MSAs not used for qualified medical expenses to 20%	dma 12/31/10	---	[4]	[4]	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.3	1.4
5. Limit health flexible spending arrangements in cafeteria plans to $2,500; indexed to CPI-U after 2013 [1] [5]	tyba 12/31/12	---	---	---	1.5	2.1	2.1	2.0	1.9	1.7	1.7	3.6	13.0
6. Require information reporting on payments to corporations	pma 12/31/11	---	---	0.4	3.3	2.0	2.1	2.2	2.3	2.4	2.5	5.6	17.1

Provision	Effective	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
7. Additional requirements for section 501(c)(3) hospitals	tyba DOE	*Negligible Revenue Effect*											
8. Impose annual fee on manufacturers and importers of branded drugs ($2.5 billion for 2011, $2.8 billion per year for 2012 and 2013, $3.0 billion per year for 2014 through 2016, $4.0 billion for 2017, $4.1 billion for 2018, and $2.8 billion for 2019 and thereafter)	cyba 12/31/10	---	2.2	2.9	2.9	2.9	2.9	2.9	3.4	4.0	2.9	10.9	27.0
9. Impose 2.3% excise tax on manufacturers and importers of certain medical devices	sa 12/31/12	---	---	---	1.8	2.7	2.8	3.0	3.1	3.2	3.4	4.5	20.0
10. Impose annual fee on health insurance providers ($8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017, $14.3 billion in 2018, and indexed to medical cost growth thereafter)	[3]	---	---	---	---	6.1	9.3	9.5	11.4	11.7	12.1	6.1	60.1
11. Study and report of effect on veterans health care	DOE	*No Revenue Effect*											
12. Eliminate deduction for expenses allocable to Medicare Part D subsidy	tyba 12/31/12	---	---	---	0.4	0.6	0.6	0.6	0.7	0.7	0.8	1.0	4.5
13. Raise 7.5% AGI floor on medical expenses deduction to 10%; AGI floor for individuals age 65 and older (and their spouses) remains at 7.5% through 2016	tyba 12/31/12	---	---	---	0.4	1.5	1.6	1.7	2.5	3.7	3.9	2.0	15.2
14. $500,000 deduction limitation on taxable year remuneration to officers, employees, directors, and service providers of covered health insurance providers	[6]	---	---	---	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
15. Broaden Medicare Hospital Insurance Tax Base for High-Income Taxpayers - additional HI tax of of 0.9% on earned income in excess of $200,000/$250,000 (unindexed) [1], and Unearned Income Medicare Contribution on 3.8% on investment income for taxpayers with AGI in excess of $200,000/$250,000 (unindexed)	tyba 12/31/12	---	---	1.3	20.5	16.6	29.3	32.7	34.8	36.6	38.5	38.3	210.2
16. Modification of section 833 treatment of certain health organizations	tyba 12/31/09	[4]	0.1	0.1	[4]	[4]	[4]	[4]	[4]	[4]	[4]	0.2	0.4
17. Impose 10% excise tax on indoor tanning services	spo/a 7/1/10	[4]	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	1.0	2.7
Total of Revenue Provisions		**[4]**	**2.9**	**5.5**	**31.9**	**35.6**	**51.8**	**55.8**	**61.3**	**77.5**	**86.9**	**75.8**	**409.2**
Other Provisions													
1. Provide income exclusion for specified Indian tribe health benefits	[7]	---	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]
2. Simple cafeteria plan nondiscrimination safe harbor for certain small employers	tyba 12/31/10	*Negligible Revenue Effect*											
3. Qualifying therapeutic discovery project credit (sunset 12/31/10)	[8]	-0.4	-0.2	-0.1	-0.1	[2]	[2]	---	---	---	---	-0.9	-0.9
4. Exclusion for assistance provided to participants in State student loan repayment programs for certain health professionals	tyba 12/31/08	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	-0.1

Provision	Effective	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
5. Make the adoption credit refundable; increase qualifying expenses threshold, and extend the adoption credit through 2011	tyba 12/31/09	-0.2	-0.6	-0.5	[4]	---	---	---	---	---	---	-1.2	-1.2
6. Exclusion of unprocessed fuels from the cellulosic biofuel producer credit	fsoua 12/31/09	---	6.6	6.5	5.5	3.0	1.5	0.4	---	---	---	21.6	23.6
7. Codify economic substance doctrine and impose penalties for underpayments	teia DOE	0.1	0.3	0.4	0.5	0.5	0.5	0.5	0.6	0.6	0.6	1.8	4.5
8. Increase by 15.75 percentage points the required corporate estimated tax payments factor for corporations with assets of at least $1 billion for payments due in July, August, and September 2014	DOE	---	---	---	---	8.8	-8.8	---	---	---	---	8.8	---
Total of Other Provisions		**-0.5**	**6.1**	**6.4**	**5.9**	**12.3**	**-6.8**	**0.9**	**0.6**	**0.6**	**0.6**	**30.1**	**25.9**
Revenue-Related Provision - Impose Fee on Insured and Self-Insured Health Plans; Patient-Centered Outcomes Research Trust Fund	**[9]**	---	---	---	**0.1**	**0.3**	**0.3**	**0.4**	**0.4**	**0.5**	**0.7**	**0.4**	**2.6**
NET TOTAL		**-0.5**	**9.0**	**11.9**	**37.9**	**48.2**	**45.3**	**57.1**	**62.3**	**78.6**	**88.2**	**106.2**	**437.8**

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding. The date of enactment is assumed to be May 1, 2010.

Legend for "Effective" column:

cyba = calendar years beginning after
dma = distributions made after
DOE = date of enactment
fsoua = fuel sold or used after
pma = payments made after
sa = sales after
spo/a = services performed on or after
teia = transactions entered into after
tyba = taxable years beginning after

[1] Estimate includes the following off-budget effects:	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
40% excise tax on health coverage	---	---	---	---	---	---	---	---	2.8	4.4	---	7.2
Conform the definition of medical expenses	---	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.6	1.4
Limit health flexible spending arrangements	---	---	---	0.4	0.6	0.5	0.5	0.5	0.4	0.4	1.0	3.4
0.9 percentage point increase to hospital insurance tax	---	---	---	0.5	-0.2	-0.1	[2]	[2]	[2]	-0.1	0.2	[4]

[2] Loss of less than $50 million.

[3] Effective for calendar years beginning after December 31, 2013; fee is allocated based on market share of net premiums written for any United States health risk for calendar years beginning after December 31, 2012.

[4] Gain of less than $50 million.

[5] Estimate includes interaction with the high premium excise tax.

[6] Effective for remuneration paid in taxable years beginning after 2012 with respect to services performed after 2009.

[7] Effective for health benefits and coverage provided after the date of enactment.

[8] Effective for amounts paid or incurred after December 31, 2008, in taxable years beginning after December 31, 2008.

[9] Effective for each policy plan year ending after September 30, 2012, but does not apply to policy years ending after September 31, 2019.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

March 19, 2010

Honorable Paul Ryan
Ranking Member
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

This letter responds to several questions you have asked about the effects of an amendment in the nature of a substitute to H.R. 4872, the Reconciliation Act of 2010, which was made public on March 18, 2010. That amendment (hereafter called "the reconciliation proposal") represents one component of the health care legislation being considered by the Congress; the other component is a bill, H.R. 3590, that the Senate passed in December. The analysis provided in this letter is based on the preliminary estimate of the direct spending and revenue effects of that amendment that was prepared by the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT).[1]

The Combined Budgetary Impact of Enacting the Reconciliation Proposal, H.R. 3590, and H.R. 3961

You asked about the total budgetary impact of enacting the reconciliation proposal (the amendment to H.R. 4872), the Senate-passed health bill (H.R. 3590), and the Medicare Physicians Payment Reform Act of 2009 (H.R. 3961). CBO estimates that enacting all three pieces of legislation would add $59 billion to budget deficits over the 2010–2019 period.

Under current law, Medicare's payment rates for physicians' services will be reduced by about 21 percent in April 2010 and by an average of about 2 percent per year for the rest of the decade.[2] H.R. 3961 would increase those payment rates

[1] See Congressional Budget Office, letter to the Honorable Nancy Pelosi about a preliminary analysis by CBO and JCT of the direct spending and revenue effects of the reconciliation proposal (March 18, 2010).

[2] The payment rates shown here reflect the March 2009 baseline, updated for a final rule regarding payments to physicians that was promulgated by the Centers for Medicare and Medicaid Services

by 1.2 percent in 2010 and would restructure the sustainable growth rate mechanism beginning in 2011. Those changes would result in significantly higher payment rates for physicians than those that would result under current law. CBO estimates that enacting H.R. 3961, by itself, would cost about $208 billion over the 2010–2019 period. (That estimate reflects the enactment of two short-term extension acts, which lowered the cost in 2010 by about $2 billion compared with CBO's estimate of November 4, 2009.)[3]

H.R. 3590, the Patient Protection and Affordable Care Act, as passed by the U.S. Senate on December 24, 2009, would establish a mandate for most residents of the United States to obtain health insurance, set up insurance "exchanges" through which certain individuals could receive federal subsidies to reduce the cost of purchasing that coverage, and make numerous other changes in the health insurance system, in federal health care programs, and in the federal tax code. The reconciliation proposal would modify the Senate-passed health bill in several ways (including changing federal programs involving postsecondary education). CBO and JCT estimate that enacting both the reconciliation proposal and H.R. 3590, as passed by the Senate, would reduce budget deficits by $138 billion over the 2010–2019 period through their effects on direct spending and revenues (including the savings achieved through the education provisions).

CBO estimates that enacting H.R. 3961 together with those two bills would add $59 billion to budget deficits over the 2010–2019 period. That amount is about $10 billion less than the figure that would result from summing the effects of enacting the bills separately. The $10 billion difference occurs primarily because H.R. 3590 and the reconciliation proposal would modify how the government's payments to Medicare Advantage plans are set. The higher payment rates for physicians that would stem from the enactment of H.R. 3961 would, under current law, result in higher payments to those plans. But the changes made by the other bills would moderate that increase.

The Budgetary Impact of Enacting the Reconciliation Proposal and H.R. 3590 with Some Provisions Altered

You also asked about the effects on the federal budget beyond the 2010–2019 period of enacting the reconciliation proposal (the amendment to H.R. 4872) and the Senate-passed health bill (H.R. 3590) if several provisions were altered, either now or at some point in the future. In particular, you asked about the effects if:

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on October 30, 2009; CBO's estimate of the cost of this legislation was constructed relative to that scoring base. Additionally, payment rates were scheduled to be reduced by 21 percent in January 2010, but the Congress enacted short-term extensions that delayed the reduction.

[3] See Congressional Budget Office, cost estimate for H.R. 3961, the Medicare Physician Payment Reform Act of 2009 (November 4, 2009), available at http://www.cbo.gov/ftpdocs/107xx/doc10704/hr3961.pdf.

- the excise tax on insurance plans with relatively high premiums—which would take effect in 2018 and for which the thresholds would be indexed at a lower rate beginning in 2020—was never implemented;

- the annual indexing provisions for premium subsidies offered through the insurance exchanges continued in the same way after 2018 as before—in contrast with the arrangements under the reconciliation proposal, which would slow the growth of subsidies after 2019;

- the adjustment to payment rates for physicians under Medicare contained in H.R. 3961 and described above was included; and

- the Independent Payment Advisory Board—which would be required, under certain circumstances, to recommend changes to the Medicare program to limit the rate of growth in that program's spending, and whose recommendations would go into effect automatically unless blocked by subsequent legislative action—was never implemented.

A detailed year-by-year projection, like those that CBO prepares for the 10-year budget window, would not be meaningful over a longer horizon because the uncertainties involved are simply too great. Among other factors, a wide range of changes could occur—in people's health, in the sources and extent of their insurance coverage, and in the delivery of medical care (such as advances in medical research, technological developments, and changes in physicians' practice patterns) —that are likely to be significant but are very difficult to predict, both under current law and under any proposal.

CBO has therefore developed a rough outlook for the decade following the 10-year budget window. Under the analytic approach described in the agency's previous letters, the combined effect of enacting H.R. 3590 and the reconciliation proposal would be to reduce federal budget deficits over the decade beyond 2019 relative to those projected under current law—with a total effect during that decade in a broad range around one-half percent of gross domestic product (GDP). If the changes described above were made to the legislation, CBO would expect that federal budget deficits during the decade beyond 2019 would *increase* relative to those projected under current law—with a total effect during that decade in a broad range around one-quarter percent of GDP.

The Budgetary Impact of Enacting the Reconciliation Proposal and H.R. 3590 Excluding Cash Flows of the Hospital Insurance Trust Fund

You further asked about the budgetary impact of enacting the reconciliation proposal (the amendment to H.R. 4872) and the Senate-passed health bill (H.R. 3590) excluding the cash flows of the Hospital Insurance (HI) trust fund, from which Medicare Part A benefits are paid.

On the basis of the economic forecast and technical assumptions underlying CBO's March 2009 baseline, CBO projected that, under current law, the HI trust fund would be exhausted—that is, the balance of the trust fund would decline to zero—during fiscal year 2017. Enacting the reconciliation proposal and the Senate-passed health bill would reduce net outlays for Part A of Medicare by $286 billion over the 2010–2019 period relative to that baseline, CBO estimates. Enacting that legislation would also increase HI payroll tax receipts by about $112 billion over that period, according to estimates by CBO and JCT. Together, those changes in outlays and revenues would diminish budget deficits and add $398 billion plus interest earnings to the trust fund's balances over that 10-year period. Given those changes in the financial flows of the trust fund, CBO estimates that the HI trust fund would have a positive balance of about $219 billion at the end of fiscal year 2019.

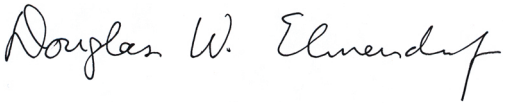
In the March 18, 2010, preliminary analysis of the budgetary effects of the reconciliation proposal, CBO and JCT estimated that the direct spending and revenue effects of enacting that proposal together with the Senate-passed health bill (H.R. 3590) would yield a net reduction in federal deficits of $138 billion over the 2010–2019 period. Thus, the legislation's effects on the rest of the budget—other than the cash flows of the HI trust fund—would amount to a net *increase* in federal deficits of $260 billion over the same period.

For the decade beyond 2019, CBO expects that enacting the reconciliation proposal and the Senate-passed health bill would reduce federal budget deficits relative to those projected under current law—with a total effect during that decade in a broad range around one-half percent of GDP. The legislation would have positive effects on the cash flows of the HI trust fund in that decade that would be larger than its effects on federal budget deficits as a whole. Therefore, leaving aside the cash flows of the HI trust fund, CBO expects that the reconciliation proposal and the Senate-passed health bill would yield a net *increase* in budget deficits during the decade beyond 2019.

The increase in the balances of the HI trust fund that would result from enacting H.R. 3590 and the reconciliation proposal might suggest that significant additional resources—$398 billion plus additional interest to be credited to the trust fund over time—had been set aside to pay for future Medicare benefits. However, only the additional savings by the government as a whole truly increase the government's ability to pay for future Medicare benefits or other programs, and those would be much smaller ($138 billion plus interest savings to be achieved over time). In effect, the majority of the HI trust fund savings under H.R. 3590 and the reconciliation proposal would be used to pay for other spending and therefore would not enhance the ability of the government to pay for future Medicare benefits.

I hope this information is useful to you. If you wish further details, CBO would be happy to provide them. The staff contacts for these estimates are Phil Ellis, Lori Housman, and Tom Bradley.

Sincerely,



Douglas W. Elmendorf
Director

cc: Honorable John M. Spratt Jr.
Chairman

Honorable Nancy Pelosi
Speaker

Honorable John Boehner
Republican Leader

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

May 11, 2010

Honorable Jerry Lewis
Ranking Member
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

As you requested, the Congressional Budget Office is providing additional information about the potential effects of H.R. 3590, the Patient Protection and Affordable Care Act (PPACA, Public Law 111-148), on discretionary spending. The following analysis updates and expands upon the analysis of potential discretionary spending under PPACA that CBO provided on March 13, 2010. In particular, it provides an update of the earlier tally of specified authorization amounts, as well as a list of programs or activities for which no specific funding levels are identified in the legislation but for which the act authorizes the appropriation of "such sums as may be necessary."

Potential discretionary costs under PPACA arise from the effects of the legislation on a variety of federal programs and agencies. The law establishes a number of new programs and activities, as well as authorizing new funding for existing programs. By their nature, however, all such potential effects on discretionary spending are subject to future appropriation actions, which could result in greater or smaller costs than the sums authorized by the legislation. Moreover, in many cases, the law authorizes future appropriations but does not specify a particular amount.

CBO does not have a comprehensive estimate of all of the potential discretionary costs associated with PPACA, but we can provide information on the major components of such costs. Those discretionary costs fall into three general categories:

- The costs that will be incurred by federal agencies to implement the new policies established by PPACA, such as administrative expenses for the Department of Health and Human Services (HHS) and the Internal Revenue Service for carrying out key requirements of the legislation.

- Explicit authorizations for a variety of grant and other program spending for which specified funding levels for one or more years are provided in the act. (Such cases include provisions where a specified funding level is authorized for an initial year along with the authorization of such sums as may be necessary for continued funding in subsequent years.)

- Explicit authorizations for a variety of grant and other program spending for which no specific funding levels are identified in the legislation. That type of provision generally includes legislative language that authorizes the appropriation of "such sums as may be necessary," often for a particular period of time.

CBO estimates that total authorized costs in the first two categories probably exceed $115 billion over the 2010-2019 period, as detailed below.[1] We do not have an estimate of the potential costs of authorizations in the third category.

Implementation Costs For Federal Agencies
The administrative and other costs for federal agencies to implement the act's provisions will be funded through the appropriations process; sufficient discretionary funding will be essential to implement this legislation in the time frame called for. Major costs for such implementation activities will include:

- Costs to the Internal Revenue Service (IRS) of implementing the eligibility determination, documentation, and verification processes for premium and cost-sharing credits. CBO expects that those costs will probably total between $5 billion and $10 billion over 10 years.

- Costs to HHS, especially the Centers for Medicare and Medicaid Services, and the Office of Personnel Management for implementing the changes in Medicare, Medicaid, and the Children's Health Insurance Program, as well as certain reforms to the private insurance market. CBO expects that those costs will probably total at least $5 billion to $10 billion over 10 years.

Explicit Authorizations of Discretionary Funding
Explicit authorizations are identified in Tables 1 and 2. Table 1 presents a list of items for which PPACA specifies the authorized amount of funding for at least one year. It also includes items for which initial specified funding levels existed under prior law but for which PPACA extends the authority for continued spending. The specified and estimated amounts shown in Table 1 total about $105 billion over the 2010-2019 period.

1. Subsequent legislation, H.R. 4872, the Health Care and Education Reconciliation Act (P.L. 111-152), modified a number of provisions of H.R. 3592. However, H.R. 4872 contains no authorizations or changes in authorizations of discretionary spending.

Table 1 differs from CBO's table of specified authorizations provided on March 13, 2010, in the following ways:

- Certain provisions that extend (existing) authorizations with a specified level have been added. (In the previous version of that table, only new authorizations were included.) Also, provisions that provide mandatory grants for 2010 but authorize future spending of such sums as necessary (subject to appropriation) have been included. Those provisions are noted in the updated table.

- Table 1 includes an estimate of the cost of section 10221 of PPACA, which incorporates the provisions of S. 1790, the Indian Health Care Improvement Reauthorization and Extension Act by reference. (CBO had not completed an estimate of the Indian health provisions for the March 13 version of the authorization table.) Those provisions authorize the appropriation of such sums as are necessary for the Indian Health Service (IHS) for carrying out responsibilities broadly similar to those in law prior to enactment of PPACA. As a result, the amounts included in Table 1 reflect recent appropriations for those IHS programs, with adjustments for anticipated inflation in later years.

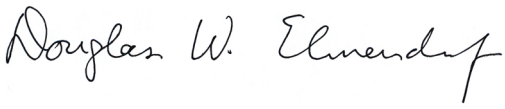
- Table 1 also includes a few corrections to the table provided on March 13. For example, section 5207, which authorizes funding for the National Health Service Corps, was inadvertently left off the March 13 table but is included in Table 1.

Table 2 presents a list of new activities for which PPACA includes only a broad authorization for the appropriation of "such sums as may be necessary." For those activities, the lack of guidance in the legislation about how new activities should be conducted means that, in many cases, CBO does not have a sufficient basis for estimating what the "necessary" amounts might be over the 2010-2020 period.

Although Tables 1 and 2 provide more information about the discretionary costs associated with PPACA, they do not represent all of the potential budgetary implications of changes to existing discretionary programs—including both potential increases and decreases relative to recent appropriations. Some of those changes could affect spending under existing authorizations or may lead the Congress to consider making changes—up or down—in the funding for existing programs. Moreover, some of the potential new costs for individual provisions of the legislation may be covered by the broad estimate of $5 billion to $10 billion for administrative costs to HHS.

I hope you find this information useful. If you have any questions about this updated analysis of PPACA's implications for future discretionary appropriations, please contact me or CBO staff. The primary staff contacts for this analysis are Jean Hearne and Julie Lee.

Sincerely,



Douglas W. Elmendorf
Director

Enclosures

cc: Honorable David R. Obey
Chairman

Identical letter sent to the Honorable Thad Cochran.

Table 1. Specified and Certain Estimated Authorizations for Spending Subject to Appropriation in H.R. 3590, the Patient Protection and Affordable Care Act (P.L. 111-148)

(By fiscal year, in millions of dollars)

Title and Section		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019 Total
Title I												
1002	Health insurance consumer information[1]	0	31	32	34	36	38	40	41	43	45	340
Title II												
2952	Post-partum depression	3	3	3	0	0	0	0	0	0	0	9
Title III												
3013	Quality measure development	75	75	75	75	75	0	0	0	0	0	375
3129	Extension of Medicare rural hospital flexibility[2]	0	42	44	0	0	0	0	0	0	0	87
3501	Health care delivery system research	20	<= Authorized for fiscal years 2010-2014									20
3504	Regionalized systems for emergency care response	24	24	24	24	24	0	0	0	0	0	120
3505	Trauma care centers	103	105	110	117	124	129	0	0	0	0	689
	Grants to states for trauma services	100	100	100	100	100	100	0	0	0	0	600
3510	Patient navigator program[2]	0	4	4	4	4	4	0	0	0	0	20
Title IV												
4304	Epidemiology-laboratory capacity grants	190	190	190	190	0	0	0	0	0	0	760
Title V												
5102	State health care workforce development --											
	Planning grants	8	8	8	8	8	8	8	8	8	8	80
	Implementation grants	150	154	162	171	181	189	198	206	214	223	1,848
5103	Health care workforce assessment - National center	8	8	8	8	8	0	0	0	0	0	38
	State and regional centers	5	5	5	5	5	0	0	0	0	0	23
5203	Health care workforce loan repayment program--											
	Pediatric medical and surgical specialists	30	30	30	30	30	0	0	0	0	0	150
	Pediatric mental & behavioral health specialists	20	20	20	20	0	0	0	0	0	0	80
5204	Public health workforce loan repayment program	195	200	210	223	235	246	0	0	0	0	1,310
5206	Training for mid-career public and allied health professionals	60	62	65	69	72	76	0	0	0	0	403
5207	Funding for the National Health Service Corps[3]	320	414	535	691	893	1,154	1,204	1,255	1,305	1,357	9,128
5208	Nurse managed health clinics	50	51	54	57	60	0	0	0	0	0	273
5210	Commissioned corp and ready reserve corp	18	18	18	18	18	0	0	0	0	0	88
5301	Primary care training & enhancement	125	128	135	143	151	0	0	0	0	0	682
	Integrating academic adminstrative units	1	1	1	1	1	0	0	0	0	0	4
5302	Training for direct care workers	0	10	<= Authorized for fiscal years 2011-2013								10
5303	Pediatric and public health dentistry	30	31	32	34	36	38	0	0	0	0	201
5305	Geriatric workforce development	0	11	<= Authorized for fiscal years 2011-2014								11
	Geriatric career incentive awards	0	10	<= Authorized for fiscal years 2011-2013								10

Continued

Table 1. Specified and Certain Estimated Authorizations for Spending Subject to Appropriation in H.R. 3590, the Patient Protection and Affordable Care Act (P.L. 111-148)

(By fiscal year, in millions of dollars)

Title and Section	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019 Total
5306 Mental and behavioral health education and training grants	35	<= Authorized for fiscal years 2010-2013									35
5312 Parts B-D of Title VIII	338	347	364	386	408	427	445	0	0	0	2,715
5314 Fellowship training in public health	40	40	40	40	0	0	0	0	0	0	158
5401 Centers of excellence	50	50	50	50	50	50	52	54	57	59	522
5402 Scholarships for disadvantaged students	51	52	55	58	62	0	0	0	0	0	278
Loan repayments and fellowships for faculty	5	5	5	5	5	0	0	0	0	0	25
Educational assistance for individuals from disadvantaged backgrounds	60	62	65	69	72	0	0	0	0	0	327
5403 Area health education centers	125	125	125	125	125	0	0	0	0	0	625
Continuing educational support for health professionals in underserved communities	5	5	5	5	5	5	5	6	6	6	53
5405 Primary care extension program	0	120	120	127	134	0	0	0	0	0	502
5508 Teaching health centers	25	50	50	53	56	59	61	64	66	69	552
5601 FQHC grants	2,989	3,862	4,991	6,449	7,333	8,333	0	0	0	0	33,956
5603 Wakefield emergency medical services program	25	26	28	29	30	0	0	0	0	0	138
5604 Co-locating primary and specialty mental health care	50	51	54	57	60	0	0	0	0	0	273
5605 Key national indicators	10	8	8	8	8	8	8	8	8	0	70
Title VI											
6703 Elder uustice--											
Elder Justice Coordinating Council and Advisory Board	0	7	7	7	7	0	0	0	0	0	28
Elder Abuse, Neglect and Exploitation Forensic Centers	0	4	6	8	8	0	0	0	0	0	26
Enhancement of LTC	0	20	18	15	15	0	0	0	0	0	68
Adult protective services - secretarial responsibilities	0	3	4	4	4	0	0	0	0	0	15
Grants for adult protective services	0	100	100	100	100	0	0	0	0	0	400
State demonstration programs	0	25	25	25	25	0	0	0	0	0	100
Grants to support LTC ombudsman program	0	5	8	10	10	0	0	0	0	0	33
Ombudsman training programs	0	10	10	10	10	0	0	0	0	0	40
National training institute for surveyers	0	12	<= Authorized for fiscal years 2011-2014								12
Grants to state survey agencies	0	5	5	5	5	0	0	0	0	0	20

Continued

Table 1. Specified and Certain Estimated Authorizations for Spending Subject to Appropriation in H.R. 3590, the Patient Protection and Affordable Care Act (P.L. 111-148)

(By fiscal year, in millions of dollars)

Title and Section		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019 Total
Title X												
10221	Indian health improvement act (S. 1790)[4]	4,170	3,780	3,840	3,740	3,780	3,750	3,910	3,990	4,070	4,160	39,190
10408	Grants for workplace wellness programs	0	200	<= Authorized for fiscal years 2011-2015								200
10409	Cures acceleration network	500	514	539	571	603	631	659	686	713	742	6,159
10410	Centers of excellence for depression	0	100	100	100	100	100	150	150	150	150	1,100
10412	Automated defibillation in Adam's memory[2]	25	25	25	25	25	25	25	25	25	25	250
10413	Young women's breast health awareness	9	9	9	9	9	0	0	0	0	0	45
10501	Rural physician training grants	4	4	4	4		0	0	0	0	0	16
	Preventive medicine & public health training grants	0	43	45	48	50	53	0	0	0	0	239
10607	State demonstration programs on alternatives to medical tort litigation	0	50	<= Authorized for fiscal years 2011-2015								50
	Total of Specified Authorizations											**105,575**

Notes: The table does not represent a comprehensive estimate of discretionary spending authorized by H.R. 3590. It includes:

- Amounts specified in the act, plus estimated authorizations for subsequent years where H.R. 3590 provides a specified authorization for 2010 or 2011 and an authorization of such sums as may be necessary for later years.
- Estimated authorizations for subsequent years where there is an appropriation under prior law for 2010 and H.R. 3590 provides for an authorization of such sums as necessary for later years.

Subsequent legislation, H.R. 4872, the Health Care and Education Reconciliation Act (P.L. 111-152), modified a number of provisions of H.R. 3590. However, H.R. 4872 contains no authorizations or changes in authorizations of discretionary spending.

1. H.R. 3590 authorized and appropriated amounts for 2010 and such sums as necessary for subsequent years. The 2010 amounts were included in the March 13 estimate for H.R. 3590 Spending for years subsequent to 2010 are calculated here to be equal to the 2010 amounts increased (or decreased) based on the CBO's estimates of GDP growth for those subsequent years.
2. Current-law appropriations exist for 2010. H.R. 3590 authorizes such sums as necessary for subsequent years. Those amounts are calculated here to be equal to the 2010 appropriation increased (or decreased) based on the CBO's estimates of GDP growth for those subsequent years.
3. For 2016 and subsequent years, H.R. 3590 establishes a formula for calculating spending authority. Those amounts are estimated here based on the CBO's estimates of GDP growth for those subsequent years.
4. H.R. 3590 incorporates the Indian Health Care Improvement Reauthorization and Extension Act (S. 1790) by reference. That act authorizes the appropriation of such sums as are necessary for the Indian Health Service (IHS) for carrying out responsibilities broadly similar to those in current law. These amounts reflect CBO's baseline for discretionary spending for IHS programs.

FQHC = Federally qualified health centers; LTC = Long-term care

Table 2. Provisions of H.R. 3590, the Patient Protection and Affordable Care Act (P.L. 111-148), with Authorizations of Appropriations Without Specified Amounts

Title and Section		
Title II		
2705	Medicaid global payment system demonstration	Such sums as necessary
2706	Pediatric ACO demonstration	Such sums as necessary
Title III		
3015	Data collection of quality and resource use measures	Such sums as necessary for fiscal years 2010-2014
	Public reporting of performance information	Such sums as necessary for fiscal years 2010-2014
3504	Support for emergency medicine research	Such sums as necessary for fiscal years 2010-2014
3506	Shared decisionmaking	Such sums as necessary
3509	HHS Office on women's health	Such sums as necessary for fiscal years 2010-2014
	CDC Office on women's health	Such sums as necessary for fiscal years 2010-2014
	AHRQ Office on women's health	Such sums as necessary for fiscal years 2010-2014
	HRSA Office on women's health	Such sums as necessary for fiscal years 2010-2014
	FDA Office on women's health	Such sums as necessary for fiscal years 2010-2014
3511	General authorizaton of appropriations for sections 3501-3510	Such sums as necessary
Title IV		
4003	Preventive services task force	Such sums as necessary
	Community preventive services task force	Such sums as necessary
4004	Education and outreach campaign regarding preventive benefits	Such sums as necessary
4101	Operations grants for school-based health centers	Such sums as necessary for fiscal years 2010-2014
4102	Oral health prevention activities	Such sums as necessary
	Oral health infrastructure	Such sums as necessary for fiscal years 2010-2014
	Oral health surveillance activites -- PRAMS	Such sums as necessary
	Oral health surveillance system	Such sums as necessary for fiscal years 2010-2014
4201	Community transformation grants	Such sums as necessary for fiscal years 2010-2014
4202	Healthy aging, living well	Such sums as necessary for fiscal years 2010-2014
4204	Demonstration to improve immunization coverage	Such sums as necessary for fiscal years 2010-2014
	Re-authorizaton of immunization program	Such sums as necessary
4206	Demonstration program for individualized wellness plans	Such sums as necessary
4302	Health disparities data	Such sums as necessary for fiscal years 2010-2014
4305	IOM conference on pain	Such sums as necessary for fiscal years 2010-2011
	Program for education & training in pain care	Such sums as necessary for fiscal years 2010-2012
Title V		
5101	National health care workforce commission	Such sums as necessary
5103	Health care workforce assessment -- longitudinal evaluation grants	Such sums as necessary for fiscal years 2010-2014
5304	Alternative dental demonstration project	Such sums as necessary
5305	Comprehensive geriatric education	Such sums as necessary for fiscal years 2010-2014

Continued

Table 2. Provisions of H.R. 3590, the Patient Protection and Affordable Care Act (P.L. 111-148), with Authorizations of Appropriations Without Specified Amounts

Title and Section		
5307	Cultural competancy training	Such sums as necessary for fiscal years 2010-2015
	Grants for health professions education	Such sums as necessary for fiscal years 2010-2015
5309	Nurse education, practice, and quality grants	Such sums as necessary for fiscal years 2010-2014
	Nurse retention grants	Such sums as necessary for fiscal years 2010-2012
5311	Nurse faculty loan program	Such sums as necessary for fiscal years 2010-2014
5313	Community health workforce grants	Such sums as necessary for fiscal years 2010-2014
Title VI		
6112	National independent monitor demonstration project	Such sums as necessary
6114	Demonstrations on culture change and use of information technology in nursing homes	Such sums as necessary
6703	National nurse aid registry and report	Such sums as necessary
Title VII		
7002	Approval pathway for biosimilar products - user fee program	Such sums as necessary for fiscal years 2010-2012
7102	340B program integrity	Such sums as necessary
Title VIII		
8002	CLASS Independence Advisory Council	Such sums as necessary for fiscal year 2011 and beyond
Title X		
10104	Multi-state plans in exchange	Such sums as necessary
10333	Community based collaborative care program	Such sums as necessary for fiscal years 2011-2015
10334	Office of minority health	Such sums as necessary for fiscal years 2011-2016
10407	Better diabetes care	Such sums as necessary
10411	Programs related to congenital heart disease	Such sums as necessary for fiscal years 2011-2015
10501	Family nurse practitioner training programs	Such sums as necessary for fiscal years 2011-2014
	National diabetes prevention program	Such sums as necessary for fiscal years 2010-2014
10504	Demonstration to provide access to affordable care	Such sums as necessary

Notes: Subsequent legislation, H.R. 4872, the Health Care and Education Reconciliation Act (P.L. 111-152), modified a number of provisions of H.R. 3590. However, H.R. 4872 contains no authorizations or changes in authorizations of discretionary spending.

ACO = Accountable Care Organization; PRAMS = Pregnancy Risk Assessment Monitoring System; IOM = Institute of Medicine; HHS = Health and Human Services; CDC = Centers for Disease Control; AHRQ = Agency for Health Care Research and Quality; HRSA = Health Resources and Services Administration; FDA= Food and Drug Administration; GME = Graduate Medical Education; CLASS = Community Living Assistance Services and Supports

Additional Information on the Potential Discretionary Costs of Implementing the Patient Protection and Affordable Care Act (PPACA)

On March 13, 2010, CBO provided preliminary information about the potential effects of the Patient Protection and Affordable Care Act on discretionary spending. (Because of time constraints, CBO could not do a complete analysis of discretionary costs at that time.) CBO described discretionary effects of those provisions that could total at least $60 billion over 10 years ($50 billion in specified items and at least $10 billion in estimated costs to the Internal Revenue Service and the Department of Health and Human Services).

Since then, CBO has had an opportunity to analyze other provisions with potential effects on discretionary spending. On May 11, 2010, CBO added to its previous analysis, identifying additional discretionary items including those authorized under current law but continued in PPACA, and some additional items for which the legislation would authorize continued funding after 2010. That information, provided in identical letters to Congressman Jerry Lewis and Senator Thad Cochran, also provided a list of programs or activities for which no specific funding levels are identified in the legislation but for which the act authorizes the appropriation of "such sums as may be necessary." The May 11 letter identified possible discretionary spending of at least $115 billion over the 2010-2019 period. Whether that spending will ultimately occur will depend on future appropriation actions.

The potential discretionary costs identified in both CBO's earlier analysis and the letters provided on May 11 include many items whose funding would be a continuation of recent funding levels for health-related programs or that were previously authorized and that PPACA would authorize for future years. Some of those items include:

- Section 3129 – Extension of Medicare rural hospital flexibility program ($0.1 billion over the 2010–2019 period)
- Section 5207 – Funding for the National Health Service Corp ($9.1 billion over the 2010–2019 period)
- Section 5312 – Funding for Parts B-D of Title VIII of the Public Health Service Act (relating to nursing workforce development) ($2.7 billion over the 2010–2019 period)
- Section 5401 – Centers of Excellence ($0.5 billion over the 2010–2019 period)
- Section 5402 – Scholarships, loans and educational assistance relating to students from disadvantaged backgrounds ($0.6 billion over the 2010–2019 period)
- Section 5601 – Federally qualified health center grants ($33.6 billion over the 2010–2019 period)
- Section 5603 – Wakefield emergency medical services program ($0.1 billion over the 2010–2019 period)

- Section 10221 – Indian health improvement act ($39.2 billion over the 2010–2019 period)
- Section 10412 -- Automated defibrillation ($0.25 billion over the 2010–2019 period)

CBO estimates that the amounts authorized for these items exceed $86 billion over the 10-year period (out of the roughly $105 billion total shown in the table that was provided along with the May 11 letter). Thus, CBO's discretionary baseline, which assumes that 2010 appropriations are extended with adjustments for anticipated inflation, already accounts for much of the potential discretionary spending under PPACA.

In addition, there are a number of other items that could overlap some or even by a considerable amount with current law activities assumed in CBO's baseline. Title V of PPACA includes many of those items. For example, section 5210 and sections 5301-5303 of PPACA replace provisions of prior law with new provisions offering a great deal more detail. The May 11 letter addresses these potential sources of overlap. The last paragraph on page 3 of that letter states: "Although Tables 1 and 2 provide more information about the discretionary costs associated with PPACA, they do not represent all of the potential budgetary implications of changes to existing discretionary programs—including both potential increases and decreases relative to recent appropriations…"

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

November 4, 2010

Honorable Paul Ryan
Ranking Member
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

As you requested, this letter describes how the Congressional Budget Office (CBO) analyzed the effects on prescription drug prices of certain provisions of the Patient Protection and Affordable Care Act, or PPACA, (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

That legislation requires manufacturers of brand-name drugs to provide new discounts and rebates for drugs purchased through Medicare and Medicaid, with the amount of those discounts and rebates based on the prices of the drugs. Manufacturers thus have an incentive to raise those prices to offset the costs of providing the new discounts and rebates, although other forces will limit their ability to do so.

For drugs covered by Medicare's drug benefit, CBO estimated that those provisions of the legislation would raise the prices paid by pharmacies less any rebates paid to insurers by manufacturers by about 1 percent, on average. That increase in prices would make federal costs for Medicare's drug benefit and the costs faced by some beneficiaries slightly higher than they would be in the absence of those provisions, while the new discounts would make the costs faced by other beneficiaries substantially lower. For newly introduced drugs purchased through Medicaid, CBO estimated that those provisions would raise the prices paid by pharmacies by about 4 percent, on average. For currently available drugs purchased through Medicaid, which account for the bulk of projected Medicaid drug spending over the next decade, other provisions of law will constrain manufacturers' ability to raise prices to offset the new rebates. The combined effect of the increase in prices and new rebates is that Medicaid would pay less for drugs, on average, than it would in the absence of those provisions.

The legislation contains several other provisions that will affect drug prices as well:

- It establishes an abbreviated pathway for approving "follow-on" biological drugs, and the resulting increase in competition will yield substantially lower prices for certain drugs. However, the affected drugs represent a relatively small share of projected total drug spending over the next decade, so CBO estimated that the average effect on drug prices would be modest—a reduction of about 2 percent in 2019.

- The legislation also imposes an annual fee on manufacturers and importers of brand-name drugs. CBO expects that the fee will probably increase the prices of drugs purchased through Medicare and the prices of newly introduced drugs purchased through Medicaid and other federal programs by about 1 percent. Those increases will be in addition to the ones described above that stem from the new requirements for discounts and rebates.

- Furthermore, the legislation expands drug coverage under the Medicare benefit (by gradually filling in the coverage gap, or "doughnut hole") and extends insurance coverage to people who would otherwise have been uninsured (more than 30 million non-elderly people by the second half of the decade, according to CBO's estimates). Both of those expansions in coverage could affect drug prices—but CBO estimated the expansions' overall effects on insurance premiums and federal spending and not their effects on drug prices in particular.

The various provisions of the legislation will exert competing pressures on drug prices paid by private purchasers. CBO estimated that the overall impact on those prices would be small, on average.

Given the intricacy of the mechanisms for setting drug prices and the numerous features of the health care legislation that affected those prices, CBO's estimates of the effects of the legislation on drug prices were necessarily uncertain. The actual effects could be larger or smaller than CBO estimated.

Brief Background on Prescription Drug Pricing

Analyzing the effects of any legislation on prescription drug prices is a complex task because the mechanisms for setting those prices are complex. As drugs move from manufacturers to consumers, a series of transactions occur that also involve wholesalers, pharmacies, and insurers. In particular, the price paid by a pharmacy to acquire a brand-name drug is generally not the net cost of obtaining the drug from the manufacturer because manufacturers frequently pay rebates on brand-name drugs to insurers. Although there are many different prices paid along the supply chain, CBO's analysis has generally focused on two prices—the price paid

by a pharmacy, and the so-called "net price," which is the price paid by the pharmacy less any rebates paid to insurers by the manufacturer.[1]

The rebate amounts vary by payer and by drug and are determined in different ways. Federal law requires manufacturers to pay a statutory rebate for drugs dispensed to Medicaid beneficiaries, whereas in Medicare Part D and in the private sector, insurers negotiate with brand-name drug manufacturers over the rebate amounts.[2] Manufacturers offer rebates to purchasers who act in ways that increase the market shares of their drugs. For example, health plans can increase the market shares of certain drugs by charging a lower copayment for those preferred drugs than for other (non-preferred) drugs that are therapeutically similar. A purchaser's bargaining power with manufacturers reflects its ability to influence which drug is purchased from a set of therapeutically similar drugs and, to a lesser extent, depends on its volume of purchases. Because those characteristics vary across purchasers, different purchasers can pay different net prices for the same drug.

Effects of the New Required Medicare Discount

Currently, the standard outpatient prescription drug benefit under Part D of Medicare has the following features: an annual deductible for which the beneficiary is responsible; a dollar range of coverage in which the beneficiary pays 25 percent of the cost of covered drugs; and a catastrophic threshold above which the beneficiary pays about 5 percent of the cost of covered drugs. In the gap between the end of the initial coverage range and the catastrophic threshold—commonly referred to as the doughnut hole—most beneficiaries are liable for all of their drug costs. For Part D insurance coverage, most beneficiaries pay premiums that finance about 25 percent of the cost of the coverage (on average); the federal government pays the remaining 75 percent. Beneficiaries with limited means, however, may enroll in a low-income subsidy (LIS) program, through which the federal government covers a much larger share of their prescription drug costs—including their premiums and most of their spending in the doughnut hole.

Starting in 2011, the health care legislation requires manufacturers to provide a 50 percent discount to Part D beneficiaries who are not enrolled in the LIS program for brand-name drugs they purchase in the doughnut hole. (The legislation also phases in coverage under Part D for both brand-name and generic drugs purchased in that range of spending, increasing the generosity of the Part D benefit.) Under Part D, private plans deliver the drug benefit and negotiate their own prices with drug manufacturers and pharmacies while competing with each other for enrollees. The new discount will be taken as a percentage of those negotiated prices. Although it would not be feasible for manufacturers to increase

[1] For further discussion of drug pricing, see Congressional Budget Office, *Prescription Drug Pricing in the Private Sector* (January 2007).

[2] In addition, many state Medicaid programs negotiate with manufacturers to obtain supplemental rebates for Medicaid drugs.

net prices only for the people receiving the discount, they will have some latitude to offset at least part of the impact of the new discount by increasing net prices charged to all Part D beneficiaries either by increasing prices charged to pharmacies or by reducing rebates paid to insurers.

Effects on Drug Prices and Federal Costs in Part D. CBO expected that pharmaceutical manufacturers would respond to the discount program by slightly increasing the net prices charged for Part D drugs.

The increase in net prices is expected to be small for two reasons. First, the discount is required for a relatively small share of spending under Part D; CBO estimates that spending on brand-name drugs in the doughnut hole by beneficiaries who were not enrolled in the LIS program constituted about 10 percent of total Part D spending in 2007, and that share is probably similar today. (There will likely be a small increase in spending eligible for the discount because of the increased generosity of the Part D benefit.) Therefore, an increase in net prices for all drugs sold in Part D of roughly 5 percent would fully offset the total costs of the required discount. Second, CBO did not anticipate that manufacturers would completely offset the costs of providing the discount because they would still have to negotiate with drug plans and offer rebates to receive preferred status. Given the pattern of existing rebates described above, CBO expected that the change in net prices would likely differ by drug, with larger increases for drugs with few substitutes and smaller increases for drugs with many competitors.

Overall, CBO expected that net prices of drugs (as defined above, the prices paid by pharmacies less any rebates paid by manufacturers) under Part D would increase by about 1 percent, on average, as a result of the manufacturers' response to the discount program. Thus, CBO expected that federal costs for premium and cost-sharing subsidies would be about 1 percent higher than they would otherwise be.

Effects on Beneficiaries in Part D. The premiums of drug plans will increase along with the increase in net drug prices, so the premiums paid by beneficiaries will increase slightly.[3] The effects of higher net drug prices on out-of-pocket spending by Part D beneficiaries will vary depending on whether they are enrolled in the LIS program and, if not, on the amount of their spending:

- Beneficiaries enrolled in the LIS program face little or no cost sharing, so their out-of-pocket spending will be largely unaffected (although some copayments in the LIS program are indexed to spending growth and thus will be slightly higher).

[3] The gradual elimination of the coverage gap under the legislation will generate a larger increase in premiums. See Congressional Budget Office, "The Estimated Change in Medicare Part D Premiums from Provisions in H.R. 3200, America's Affordable Health Choices Act of 2009," letter to the Honorable Dave Camp (August 28, 2009).

- Beneficiaries who are not enrolled in the LIS program and have spending below the benefit's initial coverage limit will, on average, pay slightly more toward their deductibles, coinsurance, and copayments.

- Beneficiaries who are not enrolled in the LIS program and reach the coverage gap will pay substantially less for those drugs because the discount will be 50 percent and the average increase in net prices will be much smaller. For most such beneficiaries, this effect will probably outweigh the effect of higher out-of-pocket payments for drugs purchased in the initial coverage range, and thus they will probably pay less for their drugs overall.

- Beneficiaries who reach the catastrophic phase of the benefit will generally pay only a little more for those drugs because their cost sharing is about 5 percent.

Effects of the Increased Rebate under Medicaid
The health care legislation also increases the minimum rebate that manufacturers of brand-name drugs must provide under Medicaid. To see how that requirement is likely to affect drug prices, it is useful to review the key features of Medicaid's rebate program.

The Medicaid Rebate Program. Pharmaceutical manufacturers that participate in the Medicaid program are required to provide a rebate for drugs dispensed to Medicaid beneficiaries, which reduces federal and state Medicaid spending. Medicaid rebates are calculated on the basis of two prices:

- the "best price," which is essentially the lowest price paid by a private purchaser (including some but not all private rebates); and

- the average manufacturer price (AMP), which is the average price paid by retail pharmacies (not counting any rebates to private insurers).

Initially, the Medicaid rebate for brand-name drugs is the greater of a fixed percentage of the AMP that is specified in law, or the difference between the AMP and the best price; as a result, Medicaid pays an amount less than or equal to the best price. An additional rebate for a brand-name drug is required if its price rises faster than overall inflation (as measured by the consumer price index for all urban consumers). The Medicaid rebate for generic drugs is a fixed percentage of the AMP. Some states also negotiate supplementary rebates with manufacturers, and those rebates are shared with the federal government. Such supplementary rebates totaled roughly 10 percent of all rebates collected by Medicaid in fiscal year 2009. [4]

[4] For a more detailed discussion of the Medicaid rebate program, see Congressional Budget Office, *Prices for Brand-Name Drugs under Selected Federal Programs* (July 2005).

Effects of the Legislation. The health care legislation increased Medicaid's minimum rebate for most brand-name drugs from 15.1 percent to 23.1 percent of the AMP. CBO expected that manufacturers would offset some of the higher rebates they will pay by charging higher launch prices for new drugs—particularly breakthrough drugs that use new mechanisms to treat illnesses. Additionally, CBO expected manufacturers to reduce slightly the amount of supplementary rebates offered to states.

Manufacturers' ability to raise prices on drugs that are already on the market is constrained, however, by the additional rebate required for drugs whose prices grow faster than inflation. Moreover, competition from drugs already on the market will probably limit the extent to which manufacturers charge higher prices for certain new drugs, particularly those that are different formulations or strengths of products already on the market. In addition, states' continuing efforts to negotiate supplemental rebates in return for preferred treatment will tend to limit manufacturers' ability to reduce such rebates.

Overall, CBO expected that the combination of the higher required Medicaid rebate and the new required Medicare discount would lead manufacturers to increase the average price paid by retail pharmacies for new drugs by about 4 percent. The effect of those higher prices on the average price that Medicaid pays for all drugs would be very small at first but would increase gradually over time as spending on newly introduced drugs becomes a larger share of total drug spending. Even so, CBO expected that the increase in the average price paid by retail pharmacies would not fully offset the increase in the rebate, so that Medicaid would pay a lower price for drugs, on average.

Effects of Establishing a New Approval Process for Biological Drugs
For brand-name drugs that have been approved under the federal Food, Drug, and Cosmetic Act, an abbreviated regulatory process exists for approving generic alternatives once a patent expires. As a result, following the expiration of a patent, a number of lower-priced generic drugs usually become available, generating substantial savings to purchasers. By contrast, such competition has been largely absent in the market for biological drugs (which are much more complex molecules derived from living organisms). Those products are usually licensed under the Public Health Service Act (PHSA), which had no comparable abbreviated regulatory process for licensing "follow-on" products that are similar to—but may not be exact copies of—the original brand-name products. (Such drugs are sometimes called follow-on biologics or "bio-similars.")

The health legislation established an abbreviated approval pathway for follow-on biologics licensed under the PHSA. The lower cost of obtaining approval under the abbreviated pathway will encourage multiple manufacturers of follow-on biologics to enter the market more quickly, particularly for top-selling products, and the resulting competition will generate savings to purchasers of those drugs.

CBO estimated that follow-on biologics would initially have prices about 25 percent below their brand-name counterparts and after several years of competition would have prices about 40 percent below those counterparts (on an average sales-weighted basis). Biological drugs that will probably face competition from follow-on biologics over the next ten years currently account for roughly 10 percent of total drug spending in the United States. Because follow-on biologics may not be viewed as perfect substitutes for their brand-name counterparts—especially when they first become available—sales of those brand-name versions will probably continue to represent a large share of total sales through 2019. As a result, CBO estimated that the average reduction in prices across all drugs resulting from the abbreviated approval pathway for follow-on biologics would be about 2 percent in 2019.

Effects of Other Provisions of the Legislation

The health care legislation imposes a fee on manufacturers and importers of brand-name prescription drugs, which will be allocated among firms on the basis of drug sales to government programs. Because that fee will not impose an additional cost for drugs sold in the private market, CBO and the staff of the Joint Committee on Taxation expected that it would not result in measurably higher costs for private purchasers. However, CBO expects that prices for drugs purchased through Medicare, and for newly introduced drugs purchased through Medicaid and other federal programs, will probably increase by about 1 percent as a result of the fee. The amount of the fee will vary from year to year over the coming decade, so the impact on prices may vary as well.

Additionally, provisions of the legislation requiring that individuals purchase health insurance and providing subsidies for private health insurance coverage are expected to raise the number of individuals with health insurance. The people who would not otherwise have had insurance to cover part of their drug spending will be less sensitive to the prices of their prescriptions, which would give manufacturers room, all else equal, to raise drug prices slightly. However, entities that administer the expanded coverage might make aggressive use of cost-management tools, some of which could result in substantial price discounts and changes in the mix of drugs prescribed or purchased. Furthermore, CBO estimated that many of the people who become newly insured will be covered by Medicaid, which pays relatively low net prices for drugs. CBO's analysis did not include a separate estimate of such provisions' effects on drug prices; instead, those effects were subsumed in the overall estimate of the cost of expanding insurance coverage.

Effects on Drug Prices in the Private Sector

Although CBO anticipated that the average prices paid by pharmacies for certain Medicare and Medicaid drugs would increase because of the health care legislation, the agency expected that some private purchasers would be affected by those increases and others would not. Uninsured individuals, who do not have health plans negotiating prices on their behalf, would probably face those price

increases—although the effects might be offset in part by existing discount programs offered by manufacturers for uninsured people with lower income.

However, for people covered by employment-based health plans, CBO expected that net prices would probably not increase because those plans would be able to negotiate larger rebates that roughly offset the higher prices paid by pharmacies. Specifically, manufacturers were presumably planning to charge net prices that maximized their profits under prior law, and those calculations would be largely unaffected by the new legislation; thus, the likely outcome of negotiations over prices and rebates under the legislation would be the same net prices. (By contrast, the new discounts and rebates for purchases under Medicare and Medicaid will reduce manufacturers' profits, an effect they will presumably seek to offset subject to the constraints discussed above.)

Certain provisions in the health care legislation will encourage manufacturers to negotiate larger rebates with private purchasers. The best-price formula in Medicaid's rebate program has discouraged manufacturers from offering rebates larger than the minimum Medicaid rebate to certain private purchasers such as health maintenance organizations and mail order pharmacies, because any such rebates would have automatically triggered a larger rebate to Medicaid. However, the provisions in the legislation that increase Medicaid's minimum rebate effectively give manufacturers greater flexibility to offer larger rebates on existing drugs to a subset of private purchasers.

If you have questions about this analysis, please contact me or CBO staff. The CBO staff contacts are Ellen Werble and Rebecca Yip.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

cc: Honorable John M. Spratt Jr.
Chairman

Comparison of Projected Enrollment in Medicare Advantage Plans and Subsidies for Extra Benefits Not Covered by Medicare Under Current Law and Under Reconciliation Legislation Combined with H.R. 3590 as Passed by the Senate
(based on draft legislative language and modifications discussed with staff)

Current Law

Under current law, CBO projects that the number of Medicare beneficiaries enrolled in Medicare Advantage plans will grow from 10.6 million in 2009 to 13.9 million in 2019. We also project that the amount by which payments to those plans will exceed their bids will grow from an average of $87 per member per month in 2009 to $135 per member per month in 2019. Medicare Advantage plans use those additional payments to provide their enrollees with extra benefits that are not covered by Medicare: either health care services, such as vision care or dental care, or subsidies of beneficiaries' out-of-pocket costs for Part B or Part D premiums or cost sharing for Medicare-covered benefits. CBO does not have a basis for projecting the distribution of additional benefits among those categories.

The "rebate"—that is, the amount of the subsidy that plans receive to provide extra benefits—depends on the difference between the plan's bid and a benchmark that is set using a formula. The benchmarks currently range from about 100 percent to over 150 percent of local per capita spending in the fee-for-service (FFS) sector. The difference between bids and benchmarks tends to be largest in areas where plans are able to provide Medicare-covered services for less than the average cost per enrollee in the FFS sector. If the plan's bid is below the benchmark, Medicare pays the plan 75 percent of the difference between the bid and benchmark to subsidize extra benefits not covered by Medicare. On average, CBO projects that rebates to plans in areas with bids that currently are below FFS costs will average $172 per member per month in 2019. By contrast, CBO projects that rebates to plans in areas where bids are above FFS costs will average $98 per member per month in 2019 (see attached table).

Proposed Law

Under the legislation, benchmarks would continue to be tied to local FFS spending, with benchmarks ranging from 95 percent of local FFS spending in areas with relatively high FFS spending to 115 percent in areas with relatively low FFS spending. Similar to current law, a plan that bids below the benchmark would receive a rebate equal to 75 percent of the difference between the bid and the benchmark, which it would be required to pass through to its enrollees in the form of health care services not covered by Medicare or reduced cost sharing. (Plans could no longer use the rebates to subsidize Part B or Part D premiums.) Plans that bid above the benchmark would be required to charge the difference to its enrollees. In addition, plans that achieve certain quality ratings would receive additional payments, as would plans that are located in particular counties. Plans would be required to use those additional payments to provide additional benefits. Those

changes would be phased in over the 2011-2017 period. The proposal would also permanently extend the authority of the Secretary to adjust risk scores to account for differences in coding patterns between Medicare Advantage plans and FFS providers.

CBO's preliminary estimate is that enacting the proposed changes would reduce federal spending by $117 billion over the 2010-2019 period. (A reduction in gross Medicare spending of $132 billion would be offset, in part, by a $15 billion reduction in Part B premium receipts.) Nationwide, the average value of the extra benefits not covered by Medicare (that is, rebates plus additional payments) would be about $67 per member per month in 2019. That average would be about $48 in areas with bids currently above FFS costs and $79 in areas with bids below FFS costs. CBO estimates that enrollment in Medicare Advantage plans in 2019 would be 4.8 million lower than we project under current law, with most of those reductions (2.7 million) occurring in areas where bids currently are above FFS costs.

Preliminary Estimate of Effects of the Medicare Advantage (MA) Provisions of Reconciliation Legislation Combined with H.R. 3590 as Passed by the Senate on Enrollment in MA Plans and on Federal Subsidies for Enrollees in MA Plans of Benefits Not Covered by Medicare

Based on draft legislative language and modifications discussed with staff

Under Current Law

	Enrollment in MA Plans (millions)		Average Subsidy of Extra Benefits Not Covered by Medicare (dollars per month)	
	2009	2019	2009	2019
All Areas	10.6	13.9	87	135
Areas with Bids that Average Less than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector	4.7	6.9	120	172
Areas with Bids that Average More than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector	5.9	7.0	61	98

Under Proposed Law

	Reduction in Enrollment in MA Plans, 2019		Net Reduction in Medicare Spending 2010-2019	Average Subsidy of Extra Benefits Not Covered by Medicare, 2019
	Percent	Millions	Billions of Dollars	Dollars Per Month
All Areas	-35	-4.8	-117 [a]	67
Areas with Bids that Average Less than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector	-31	-2.1	-57	79
Areas with Bids that Average More than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector	-39	-2.7	-60	48

Note: Under current law, extra benefits include health care services not covered by Medicare, such as vision care and dental care, and subsidies of beneficiaries' out-of-pocket costs for Part B or Part D premiums or cost sharing for Medicare-covered benefits.

Under the Patient Protection and Affordable Care Act, extra benefits would include health care services not covered by Medicare and subsidies of beneficiaries' out-of-pocket costs for cost sharing for Medicare-covered benefits.

a. The estimate of a $117 billion net reduction in Medicare spending over the 2010-2019 period reflects a $132 billion reduction in Medicare payments that would be offset, in part, by a $15 billion reduction in Part B premium receipts.

Distribution Among Types of Providers of Savings from the Changes to Updates in Section 1105 of Reconciliation Legislation and Sections 3401 and 3131 of H.R. 3590 as Passed by the Senate. *(Based on draft legislative language and modifications discussed with staff.)*

10-Year Change in Spending (in billions of dollars)

	Reconciliation Language Combined with H.R. 3590 as Passed by the Senate
Hospitals (IPPS, HOPD, IRF, IPF, LTCH)	-112.9
SNF	-14.6
Hospice	-6.8
All Other Part B (DME, P&O, Other, Labs, ASC, Ambulance, ESRD)	-22.3
Home Health (includes effects of changes in payment rates under section 3131)	-39.7
Total	-196.3

Notes:

ASC = Ambulatory surgical center; DME = Durable medical equipment; ESRD = End-stage renal disease; HOPD = Hospital outpatient department; IPPS = Inpatient prospective payment system; IPF = Inpatient psychiatric facility; IRF = Inpatient rehabilitation facility; LTACH = Long-term acute-care hospital; P&O = Prosthetics and orthotics; SNF = Skilled nursing facility.

Comparison of Projected Medicare Part D Premiums Under Current Law and Under Reconciliation Legislation Combined with H.R. 3590 as Passed by the Senate
(based on draft legislative language and modifications discussed with staff)

We have received inquiries regarding the change in Medicare Part D premiums that would result from certain provisions contained in the amendment in the nature of a substitute to H.R. 4872, the Reconciliation Act of 2010.

The Patient Protection and Affordable Care Act (PPACA) introduced a manufacturer discount program in Medicare Part D for brand-name drugs purchased in the coverage gap, often referred to as the "doughnut hole." CBO assumes this policy would increase the number of Part D beneficiaries receiving catastrophic coverage, since prescription drugs would be more affordable to the beneficiary, causing Part D spending to increase overall. As a result of these changes, we estimate that Part D premiums would increase by about 3 percent starting in 2011. Compared to our baseline assumptions, the Part D premium would be about 3 percent higher through 2019.

The reconciliation bill would make additional changes to the structure of the Part D benefit. In addition to the discount program provided by manufacturers, Section 1101 would require that Part D plans cover more prescription drug costs for non-low income subsidy individuals in the doughnut hole over time. This policy change further increases Part D spending, compared to PPACA, because the benefit is more generous. Beneficiaries and the federal government share in program costs, which leads to an increase in premiums. According to CBO's preliminary estimate, enacting those changes would lead to an average increase in premiums for Part D beneficiaries of about 4 percent in 2011, rising to about 9 percent in 2019. This estimate is based on draft legislative language with clarifications from staff.

The incremental difference in premiums between PPACA and reconciliation of 1 percent in 2011 and 6 percent in 2019 can largely be attributed to the policy of closing the doughnut hole.

However, it is important to note that beneficiaries' out-of-pocket spending on prescription drugs apart from those premiums would fall, on average, as would their overall out-of-pocket drug spending including premiums in both scenarios – PPACA and PPACA including changes included in the reconciliation language.

For additional information regarding how CBO has estimated provisions related to Medicare Part D, please see CBO's letter to Congressman Camp, issued on August 28, 2009 (http://www.cbo.gov/ftpdocs/105xx/doc10543/08-28-MedicarePartD.pdf).

CONGRESSIONAL BUDGET OFFICE

Payments of Penalties for Being Uninsured
Under the Patient Protection and Affordable Care Act

Revised[1] – April 30, 2010

Beginning in 2014, the Patient Protection and Affordable Care Act (Public Law 111-148), in combination with the Health Care and the Education Reconciliation Act of 2010 (Public Law 111-152), requires most residents of the United States to obtain health insurance and imposes a financial penalty for being uninsured. That penalty will be the greater of a flat dollar amount per person that rises to $695 in 2016 and is indexed by inflation thereafter (the penalty for children will be half that amount and an overall cap will apply to family payments) or a percentage of the household's income that rises to 2.5 percent for 2016 and subsequent years (also subject to a cap).

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have estimated that about 21 million nonelderly residents will be uninsured in 2016, but the majority of them will not be subject to the penalty. Unauthorized immigrants, for example, are exempted from the mandate to obtain health insurance. Others will be subject to the mandate but exempted from the penalty—for example, because they will have income low enough that they are not required to file an income tax return, because they are members of Indian tribes, or because the premium they would have to pay would exceed a specified share of their income (initially 8 percent in 2014 and indexed over time). CBO and JCT estimate that between 13 million and 14 million of the uninsured in 2016 will qualify for one or more of those exemptions.

Of the remaining 7 million to 8 million uninsured, some individuals will be granted exemptions from the penalty because of hardship, and others will be exempted from the mandate on the basis of their religious beliefs. Among the uninsured who do not obtain an exemption, many will voluntarily report on their tax returns that they are uninsured and pay the amount owed. However, other individuals will try to avoid making payments. Therefore, the estimates presented here account for likely compliance rates, as well as the ability of the Internal Revenue Service (IRS) to administer and collect the penalty. After accounting for all of those factors, CBO and JCT estimate that about 4 million people will pay a penalty because they will be uninsured in 2016 (a figure that includes uninsured dependents who have the penalty paid on their behalf).

CBO and JCT estimate that total collections from those penalties will be about $4 billion per year over the 2017–2019 period. The attached table shows the distribution of payments that are projected to be made for being uninsured in 2016 (which the IRS will actually collect in 2017)

[1] Compared with the version that CBO released on April 22, this revised document simply provides additional information about the total number of people who are expected to qualify for certain exemptions from the insurance mandate or its associated penalty. No changes have been made to the estimate that about 4 million people will pay a penalty because they will be uninsured in 2016 or to any of the other numbers reported in the text or the attached table.

by income measured as a percentage of the federal poverty level (FPL). In general, households with lower income will pay the flat dollar penalty, and households with higher income will pay a percentage of their income. In 2016, households with income that exceeds 400 percent of the FPL are estimated to constitute about one-third of people paying penalties and to account for about two-thirds of the receipts from those penalties.

Estimated Distribution of Individual Mandate Penalties 4/22/2010
Under the Patient Protection and Affordable Care Act (PL 111-148)
Combined with the Health Care and Education Reconciliation Act (PL 111-152)

Calendar Year 2016

Adjusted Gross Income Relative to the Federal Poverty Level (FPL)	Individual Mandate Penalties			
	Total Payers (millions)	Share of Payers (%)	Total Payments ($ billions)	Share of Payments (%)
Less than 100%	0.4	9	0.2	4
100% to 200%	0.6	16	0.3	7
200% to 300%	0.8	21	0.5	11
300% to 400%	0.7	18	0.5	13
400% to 500%	0.5	12	0.5	11
Greater than 500%	0.9	24	2.3	55
Total	3.9	100	4.2	100

Source: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes:
a) Individual penalty payments are classified by the income of the tax return filing unit.
b) In 2016, the FPL is projected to equal about $11,800 for a single person and about $24,000 for a family of four.
c) Components may not sum to totals due to rounding.
d) Liabilities incurred for being uninsured in calendar year 2016 would be paid in fiscal year 2017.
e) Counts of payers include dependents who have payments made on their behalf.

Earlier Proposals

Prior to enactment of PPACA in March 2010, the Congress considered a number of other proposals that would have made major changes regarding the provision of health insurance and payments for health care through federal programs. CBO provided analyses and cost estimates for many of those proposals, including these:

1. A letter to Representative Dave Camp, dated July 26, 2009, providing information about the impact of the specifications related to health insurance coverage that were reflected in H.R. 3200, the America's Affordable Health Choices Act. (CBO had provided a preliminary analysis of those specifications in a letter issued on July 14, 2009, after that proposal was released by several committees of the House of Representatives.) Among other topics, the letter provides information about CBO's estimate of the proposal's impact on enrollment in employment-based health insurance, in the proposed "public plan," and in Medicaid.

2. A letter to Senator Michael B. Enzi, dated September 10, 2009, responding to questions about the Affordable Health Choices Act, which was considered by the Senate Committee on Health, Education, Labor, and Pensions (HELP). (CBO had issued a preliminary and partial analysis of that legislation on July 2, 2009, shortly after it was introduced.) The letter provides information about the potential costs of expanding eligibility for Medicaid, the impact of the proposed "public plan," and the effects of the proposal on employers, employees, and national spending for health care.

3. A preliminary analysis of the Affordable Health Care for America Act (H.R. 3962), which was sent to House Ways and Means Committee Chairman Charles B. Rangel on October 29, 2009; JCT's detailed estimates for the revenue provisions of that legislation are also included here. After some modifications, that legislation was passed by the House of Representatives. (CBO's final cost estimate for that bill—including its modification through a manager's amendment—differed somewhat from the preliminary estimate included here but provided less information about the various effects of the bill; that final estimate was released on November 5, 2009, and was updated on November 6 and November 20.)

4. A preliminary analysis of an amendment in the nature of a substitute for H.R. 3962, which was sent to House Republican Leader John A. Boehner on November 4, 2009. That legislation represented an alternative approach for changing the health care and health insurance systems.

5. A response to several questions regarding Medicare's payments to physicians and the budgetary impact of enacting changes in those payments along with H.R. 3962, which was sent to Representative Paul Ryan on November 19, 2009.

6. A cost estimate for the legislation that would become H.R. 3590, the Patient Protection and Affordable Care Act, which was sent to Senate Majority Leader Harry Reid on December 19, 2009; JCT's detailed estimates for the revenue provisions of that legislation are also included here. (CBO and JCT subsequently produced estimates of the impact of H.R. 3590 as passed by the Senate; those estimates differed modestly from the original estimates and were released on March 11, 2010.)

7. A subsequent correction regarding the cost estimate for H.R. 3590—affecting only the estimate of the legislation's impact on federal budget deficits after 2019—which was sent to Senate Majority Leader Harry Reid on December 20, 2009.

CBO provided several other analyses of major legislative proposals that are not included in this volume but are available on CBO's Web site. In addition to the items noted parenthetically above, those publications included other analyses of H.R. 3200 and of the legislation considered by the Senate HELP Committee, as well as analyses of proposals considered by the Senate Finance Committee in September and October of 2009 and of PPACA as originally introduced in the Senate in November 2009.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

July 26, 2009

Honorable Dave Camp
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

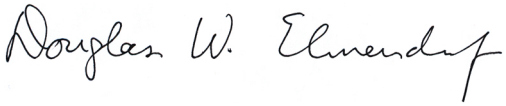
The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) recently completed a preliminary analysis of the specifications related to health insurance coverage that are reflected in the America's Affordable Health Choices Act, which was released by the House Committee on Ways and Means on July 14, 2009.

Among other things, those specifications would establish a mandate for most legal residents to obtain health insurance, significantly expand eligibility for Medicaid, regulate the pricing and terms of private health insurance policies, set up insurance "exchanges" through which certain individuals and families could receive federal subsidies to reduce the cost of purchasing insurance, and offer a "public plan" option similar to Medicare through those exchanges. For reasons outlined in CBO's July 14 letter summarizing that analysis—and in our letter of July 17, which took into account the other parts of the legislation that would raise taxes or reduce other spending—our analysis to date does not represent a formal or complete cost estimate for the draft legislation.

The attached analysis responds to your request for additional information about the effects of the specifications regarding health insurance coverage. In particular, you asked about the effects on enrollment in private coverage, in the new public plan, and in Medicaid; the effects on private-sector insurance premiums and the labor market; the longer-term cost of the plan; and the allocation of its net budget impact between outlays and revenues. Because of the complexity of the changes that have been proposed and their potential effects, we are unable to address all aspects of every question that you raised.

I hope this information is helpful to you. If you have any further questions, please contact me or CBO staff. The primary staff contacts for this analysis are Philip Ellis and Holly Harvey.

Sincerely,



Douglas W. Elmendorf
Director

Identical letters sent to the Honorable Joe Barton, the Honorable John Kline, and the Honorable Paul Ryan.

Attachment

cc: Honorable Charles B. Rangel
Chairman

Congressional Budget Office

Additional Information Regarding the Effects of Specifications in the America's Affordable Health Choices Act Pertaining to Health Insurance Coverage

July 26, 2009

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) recently completed a preliminary analysis of the specifications related to health insurance coverage that are reflected in the America's Affordable Health Choices Act. That analysis, which was transmitted in a letter to the House Committee on Ways and Means, was released on July 14, 2009; subsequent analysis, which took into account the other parts of the legislation that would raise taxes or reduce other spending, was released on July 17. Among other things, those specifications would establish a mandate for most legal residents to obtain health insurance, significantly expand eligibility for Medicaid, regulate the pricing and terms of private health insurance policies, set up insurance "exchanges" through which certain individuals and families could receive federal subsidies to reduce the cost of purchasing insurance, and offer a "public plan" option similar to Medicare through those exchanges.

This report provides additional information about the effects of the specifications in that act regarding health insurance coverage. In particular, it examines their likely effects on enrollment in private coverage, in the new public plan, and in Medicaid; the effects on private-sector insurance premiums and the labor market; the longer-term cost of the plan; and the allocation of its net budget impact between outlays and revenues. For reference, the table released on July 14 summarizing the preliminary analysis of the coverage specifications is included in this report. The report, however, does not represent a formal or complete cost estimate for the draft legislation.

Effects on Enrollment in Private Coverage

Compared with what would happen under current law, the legislation would induce some people to move out of employment-based coverage and others to move into employment-based coverage, and our estimate of the net effect of those changes is shown in the attached table. A number of questions have arisen about that estimate—particularly regarding our conclusion that only a small share of firms would choose to stop offering health insurance to their workers once the new subsidies became available in the insurance exchanges. Several factors contribute to that conclusion:

- Workers who get insurance through their employer receive a significant subsidy because the cost of that insurance is not treated as taxable earnings for the worker and thus avoids both income and payroll taxes. In most cases, that exclusion applies to the portion of the premium that workers pay as well as the amount the employer

contributes. On average, that tax exclusion gives workers a subsidy of roughly 30 percent for purchasing insurance through their employer—a subsidy that would be forgone if the employer chose not to offer coverage and the workers instead obtained coverage in the new insurance exchanges.

- In general, firms that decided to stop sponsoring insurance coverage for their workers would not be able to reduce their operating costs because, in a competitive labor market, they would have to offer higher wages and other forms of compensation instead. Indeed, workers might be particularly motivated to demand such increases under the proposal because they would be required to obtain insurance. That added compensation would generally be taxable. (This consideration and the preceding one help explain why most workers are offered health insurance by their employers today.)

- Under the proposal, nearly 90 percent of workers would be employed by firms that would either have to offer qualified coverage and contribute a significant share toward the premium or pay a tax equal to 8 percent of their total payroll. That "play-or-pay" penalty would constitute a substantial portion of the average cost of providing insurance coverage, which has been estimated at about 12 percent of payroll currently (but which would rise over time). In dollar terms, the penalty would obviously vary depending on a firm's payroll; for example, a firm with average wages of $40,000 per year that did not offer qualified coverage would have to pay a penalty of $3,200 per worker. Moreover, that penalty would make no direct contribution to those workers' insurance costs; they would then need to obtain coverage from another source in order to fulfill the individual mandate.

- Many firms have a mix of employees with differing levels of individual or family income—some of whom would qualify for relatively generous subsidies in the new insurance exchange and some of whom would not. Consistent with the available evidence, we anticipate that an employer would generally take into account the effects on all of its workers in deciding whether or not to offer coverage. In most cases, having their employer offer coverage would be the best option for the workforce overall, even with the new insurance exchanges.

- Finally, the available evidence indicates that in making decisions about offering insurance, many firms are not very responsive to the availability of outside options for their workers to obtain coverage; in particular, that responsiveness tends to decline as firm size increases. One reason is that larger firms have relatively low administrative costs that would generally make it advantageous for their workers to keep that coverage rather than pay higher administrative costs for a plan in an

insurance exchange. Because larger firms account for the lion's share of all employment-based coverage, that lack of responsiveness limits the likely extent of any erosion in coverage.[1]

In most cases, the combination of the subsidy from the current tax exclusion and the penalty for firms that did not offer qualified coverage would provide a strong financial inducement for employers to continue offering coverage to their workers.[2] To give an example in today's terms, the average employment-based health insurance plan currently has a premium of about $5,000 for single coverage and $13,000 for family coverage. The subsidy provided by the tax exclusion is thus worth about $1,500 for single coverage and about $4,000 for family coverage, on average. For a firm with average wages of $40,000, the $3,200 penalty combined with the subsidy from the tax exclusion would roughly equal the total amount of the single premium and would constitute more than half of the typical cost of family coverage. Only workers who would receive larger percentage subsidies in the exchanges would be better off if their employer stopped offering coverage—and that would be a distinct minority of workers.[3]

Taking those considerations into account, some firms would probably decide not to offer coverage, CBO and the JCT staff estimate. That option would be most attractive to firms with lower-wage workers—both because the play-or-pay penalty for not offering coverage would be smaller in dollar terms and because their workers would be eligible for larger subsidies in the insurance exchanges (or through Medicaid). An additional factor is that smaller firms (those with an annual payroll of less than $400,000) would either be exempt from the play-or-pay penalty or would pay a lower tax rate. However, an offsetting consideration is that small employers with low-wage workers would be eligible for a tax credit covering up to 50 percent of the employer's contribution toward health insurance premiums. On balance, CBO and the JCT staff estimate that, in 2016, about 3 million people (including spouses and dependents of workers) who would be covered by an employment-based plan under current law would not have an offer of coverage under the proposal.

Other people would have an offer of coverage from an employer but would choose to make use of the subsidies that would be available in certain cases through the exchanges.

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[1] For further discussion of the factors affecting employer coverage, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 4–8 and 43–48; and *CBO's Health Insurance Simulation Model: A Technical Description*, Background Paper (October 2007).

[2] In the legislation considered by the Senate Committee on Health, Education, Labor, and Pensions, the penalty amounts per worker are much smaller. However, that proposal would also provide less inducement for employers to stop offering coverage, because it would provide no new subsidies for insurance coverage for individuals with income below 150 percent of the federal poverty level.

[3] Over time, as the costs of health care rose more rapidly than payrolls, the penalties would gradually decline in importance relative to the tax exclusion and exchange subsidies. That evolution is incorporated in CBO's analysis and helps explain why the estimated effect of the proposal on employer coverage changes gradually over time.

In 2016, nearly 3 million people who would be covered under an employment-based plan under current law—and who could be covered by that plan under the proposal—would choose instead to obtain coverage in the exchanges because the employer's offer would be deemed unaffordable and they would therefore be eligible to receive subsidies through the exchanges. In addition, some part-time employees, who could receive subsidies via an exchange even though they had an employer's offer of coverage, would choose to do so. All told, we estimate that, in 2016, about 9 million people who would otherwise have had employer coverage would not be enrolled in an employment-based plan under the proposal.

The net effect of the proposal on employment-based health insurance reflects larger changes in the other direction, however. We estimate that about 12 million people who would not be enrolled in an employment-based plan under current law would be covered by one in 2016, largely because the mandate for individuals to be insured would increase workers' demand for insurance coverage through their employer. On net, therefore, about 3 million more people would have their primary coverage through an employer under the proposal than under current law (as shown in the attached table).

Enrollment in the Public Plan

A related question concerns how many firms would provide coverage to their workers but would do so by letting their workers purchase coverage in the insurance exchanges—and, in particular, how many of those enrollees would end up in the new public plan. Under the proposal, firms with 20 or fewer workers would be given the option to let their workers buy coverage through the insurance exchanges starting in 2014, and the official overseeing the exchanges would be allowed to let larger employers purchase coverage in that way starting in 2015. In those cases, the workers would not receive exchange subsidies but would instead be subsidized through the tax exclusion as under current law; as a result, CBO's table showing the effect of the proposal on sources of insurance coverage counts those enrollees as being covered by employment-based insurance rather than as exchange enrollees.

For the preliminary estimate of the proposal, CBO and the JCT staff assumed that only firms with 50 or fewer employees would be permitted to buy coverage through the exchanges, and we estimated that about 6 million workers and their dependents would obtain coverage in that way. We also estimated that about one third of those enrollees would choose the public plan—an assessment that is consistent with our overall estimate of the share of people in the exchanges choosing that plan.

What options employers would have under the proposal depends on whether the official overseeing the insurance exchanges would give larger firms access to the exchanges, and predicting what that official would do is difficult. On the one hand, workers at some firms would find that option attractive, particularly in areas where the public plan has relatively low premiums, and they might apply pressure to be admitted to the exchanges. On the other hand, providers of health care and private insurers might be opposed to expanding access to the public plan, and they might apply pressure to keep larger firms

out of the exchanges. In addition, the official might be concerned about the potential for adverse selection into the exchanges, which could arise if employers choosing to take advantage of the option had older or less healthy workers.

If we assumed that workers at larger firms would be allowed to purchase coverage through the exchanges, our estimate of the number of enrollees involved would undoubtedly be greater than 6 million, but we have not estimated the magnitude. Analysts at the Lewin Group recently estimated that if all employers were given access to the insurance exchanges, more than 100 million people would end up enrolling in the public plan.[4] For several reasons, we anticipate that our estimate of the number of enrollees in the public plan would be substantially smaller than the Lewin Group's, even if we assumed that all employers would have that option.

One consideration that would affect our analysis is that large employers would generally have lower administrative costs for health insurance than would plans offered in the exchanges, because (under the proposal) those plans would need to sign up enrollees individually; as a result, employees of large firms would be less likely than those of small firms to find the option of purchasing coverage through the exchange attractive, holding other factors equal. Although we assumed that the public plan would have somewhat lower administrative cost per enrollee than would private plans in the exchanges, the public plan would probably have to incur much of the same cost in order to attract and retain members.

More generally, the Lewin analysis uses a much larger gap than does our analysis between the premium of the public plan and the premiums of the private plans against which it would be competing. As indicated in our letter of July 14, we estimate that the public plan's premium would, on average, be about 10 percent lower than that of a typical private plan offered in the insurance exchanges. That estimate is based in part on available data from the Medicare Advantage program about the difference in costs incurred by private plans and the traditional Medicare plan to provide the same set of benefits. Indeed, the most recent analysis of that difference concluded that the costs of the traditional Medicare plan were only 2 percent lower, on average, than the costs of private plans participating in Medicare to provide the same benefits (though that difference varied geographically and by the type of private plan that was offered).[5]

Another factor relevant to our estimate is our assessment that some providers would choose not to participate in the public plan, which would discourage some enrollees from choosing that plan despite its lower average premium. Even so, we expect that the

[4] Statement of John Sheils, Vice President, The Lewin Group, before the House Committee on Energy and Commerce, *The Impact of the House Health Reform Legislation on Coverage and Provider Incomes* (June 25, 2009).

[5] See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2009), Chapter 3. CBO's larger estimate of the gap in premiums between the public plan and private plans under the proposal also incorporates expected differences in such factors as benefit management and providers' payment rates.

provider network would be large enough to attract a sizable minority of participants in the exchanges.

Because all of these factors are uncertain, estimating enrollment in the public plan is especially difficult—as we emphasized in our earlier letter. Given our assessment of the likely difference in premiums, however, offering more firms the option of letting their workers purchase insurance through the exchanges would probably have a limited effect on the proposal's net budgetary impact. As noted above, workers with employment-based insurance who obtained coverage through the exchanges would receive no exchange subsidies and would have the same tax preference as if they had obtained coverage outside the exchanges. Thus, if more employers purchased coverage through the exchanges than we anticipate and purchased somewhat less expensive insurance via the public plan, the principal effect on federal deficits is that those employers would end up increasing their workers' taxable compensation and thereby would generate slightly higher tax revenues. Greater enrollment in the public plan would also increase the plan's outlays and premium collections, which would be included in the federal budget, but as long as the public plan charged premiums that covered its costs (as it is supposed to do under the proposal), those amounts would be offsetting.

Effects of the Proposed Medicaid Expansion

A further question is the number of people who we estimate would enroll in Medicaid under the proposal that would have private coverage under current law. CBO does not anticipate a substantial shift from private insurance to Medicaid. Specifically, we estimate that about 1 million people who would otherwise have employment-based insurance or individually purchased coverage would end up enrolling in Medicaid in 2016. We also estimate that about 10 million people would newly enroll in Medicaid under the proposal, but the great majority of them would be people who would otherwise be uninsured rather than privately insured. As a result, our estimated rate of crowd-out—that is, the share of people gaining Medicaid coverage who would otherwise be insured privately—is about 10 percent under this proposal.

Although the proposal would sharply increase the number of people eligible for Medicaid, several factors help to explain the relatively low rate of crowd-out of private insurance that we expect:

- The expansion of Medicaid would encompass relatively poor people (including some childless adults whose income is well below the poverty level), who are less likely than people with higher income to have private insurance coverage. Our analysis indicates that only about a quarter of the people who would be made newly eligible for Medicaid under the proposal would have private coverage under current law.

- Unlike prior expansions of public coverage on which estimates of crowd-out are generally based, this proposal would impose a considerable penalty on employers that did not offer qualified insurance and contribute a substantial share of the premium.

Those requirements would help offset the incentives under the proposal for employers to cease offering coverage as a result of the expansion in Medicaid eligibility.

- Unlike past expansions of Medicaid, the proposal would include a requirement for people to obtain insurance. As a result, those who would be eligible for Medicaid (whether under current law or because of the expansion) and who would otherwise be uninsured would be more likely to enroll in that program.

In sum, because of the specific features of the proposal, the number of people who might leave private coverage for Medicaid would be relatively small, and the number of people who would newly enroll in Medicaid would be relatively large—so together, those features of the proposal would reduce the expected rate of crowd-out.[6]

Effects on Private-Sector Premiums

Many observers have asked about the effect of the proposal on health insurance premiums in the private sector outside the insurance exchanges. After 2012, all newly issued policies purchased by individuals would have to be bought through the insurance exchanges; as a result, the proposal's effects on premiums outside the exchanges would be seen in premiums for coverage provided by or through employers (which is the predominant source of insurance for the nonelderly population under current law and would remain so, in our estimation, under this proposal). The proposal contains a number of elements that could affect those premiums, both directly and indirectly—some of which could cause the premiums to increase and some of which could cause them to decrease. Although the direction of the overall impact is not certain, the magnitude of the effect on average premiums would probably be modest.

Effects on the Risk Pool

One concern that has been expressed about proposals to establish and subsidize coverage through the new insurance exchanges is that firms would see their relatively young or healthy enrollees switch to those plans. If that happened, the average costs for covering the remaining enrollees would be higher. Under the proposal, however, full-time workers with an offer of coverage from their employer would generally be prohibited from receiving subsidies through the exchanges—a restriction known as a "firewall," which we believe would be largely effective.[7] Moreover, the proposal would allow premiums in the insurance exchanges to vary only by age and then only to a limited degree, so the plans available in the exchanges might not be substantially more attractive to younger and

[6] For more information about the potential effect of expanding public insurance coverage on the number of people with private insurance, see Congressional Budget Office, *The State Children's Health Insurance Program* (May 2007), pp. 7–13.

[7] An exception would be granted for full-time workers who had to pay more than 11 percent of their income for their employer's insurance. In addition, part-time workers could receive subsidies via the exchanges regardless of the availability or cost of coverage through their employers. As noted above, CBO and the JCT staff estimated that several million workers would take advantage of those exceptions.

healthier workers than they would be for other workers—reducing the incentive to circumvent the firewall.

At the same time, CBO and the JCT staff estimate that several million more people, on balance, would enroll in employment-based insurance than is projected under current law. The resulting pool of enrollees would be somewhat healthier, on average, than is the pool of enrollees in employment-based insurance today; as a consequence, the average cost of covering those enrollees would be several percent lower than under current law (holding other factors equal). The extent and manner in which that change would affect premiums for employment-based coverage is more difficult to determine; for example, that effect might be seen primarily in the premiums for single coverage (rather than family coverage) because most of the younger and healthier enrollees who would sign up for employment-based coverage as a result of the proposal would choose that type, but how premium costs are allocated within firms is less clear. Also, the main reason some people would be paying less for their coverage is because newly enrolled people would be making premium payments they would not otherwise have made—so the changes in premiums would largely represent a transfer among workers rather than an improvement in the efficiency of employment-based insurance plans.

The proposal's restrictions on insurance markets could also affect premiums for employment-based coverage. In particular, the proposal would prohibit insurers from varying the premiums charged to employers to reflect differences in the health status or likely costs of their employees. Existing policies would be exempt from that requirement through 2017 but would then have to come into compliance with that prohibition. (Insurers would still be permitted to adjust premiums, albeit to a limited degree, to reflect the age of the enrollees.) That change would not apply to employers who chose to bear the financial risk of providing health insurance to their workers, but it would affect employers who purchased such coverage from an insurer. Relative to current law (under which relatively few states impose the same restrictions on variation in premiums), those limits might not have a substantial effect on the average premium paid by employers, but they would tend to increase premiums for firms with relatively healthy workers and decrease them for firms with relatively unhealthy workers.

Effects of Cost Shifting

A less direct way in which the proposal could cause private-sector premiums to change is by affecting the extent of "cost shifting"—a phenomenon in which lower rates paid to health care providers for some patients (such as uninsured people or enrollees in government insurance programs) can lead to higher payment rates for others (privately insured individuals). The proposal would have opposing effects on the pressures for such cost shifting to occur.

On the one hand, the proposal's expansion of eligibility for Medicaid and other provisions would substantially increase enrollment in that program (by an estimated 10 million to 11 million people in the latter part of the 2010–2019 period). In addition, many provisions of the proposal would reduce payments to hospitals and other providers

under Medicare. Furthermore, the legislation would establish a public plan to be offered in the insurance exchanges; that plan would be set up by the Secretary of Health and Human Services and pay Medicare-based rates to providers of health care. By themselves, those changes would tend to increase the pressure on providers to shift costs to private payers.

On the other hand, we estimate that the proposal would ultimately reduce the uninsured population by roughly two-thirds, which would greatly attenuate the pressure to shift costs that arises today when uncompensated or undercompensated care is provided to people who lack health insurance. One recent estimate indicates that hospitals provided about $35 billion in such care in 2008—an amount that would grow under current law but would be expected to decline considerably under the proposal. (Recent evidence also indicates that physicians collectively provide much smaller amounts of uncompensated or undercompensated care, so all else held equal, the overall impact of expanded insurance coverage on their payments rates would also be smaller.)

The net effect of those opposing pressures would thus depend on their relative magnitude and also on the degree to which cost shifting occurred in each case. Given the size of the annual decline in undercompensated care that seems likely to ensue, the adverse effects on hospital finances stemming from greater enrollment in Medicaid, cuts in Medicare payment rates, and enrollment in the public plan would also have to be substantial to offset those savings for hospitals as a group. (The net effect would differ from hospital to hospital.) As for the extent of cost shifting, CBO's assessment of the evidence is that some does occur but that it is not as widespread or extensive as is commonly assumed. Well-designed studies have found that a relatively small share of the changes in payment rates for the government's programs is passed on to private payment rates, and the impact of changes in uncompensated care is likely to be similar.[8] Overall, therefore, the effect the proposal would have on private-sector premiums via cost shifting is unclear.

Changes in Payment Methods

In addition to proposed changes in Medicare's payment rates, the proposal would also alter some of Medicare's payment methods—or at least test such changes—which might ultimately reduce private insurance costs to a limited degree. For example, the proposal would establish a demonstration project to examine the use of "accountable care organizations" and would make other modifications that could encourage reductions in health care spending.[9] To the extent that future steps to implement such changes in a more aggressive way also changed how doctors treated privately insured patients, some benefits could "spill over" to the private sector. However, such effects would probably represent a small fraction of privately insured medical costs over the next 10 years,

[8] For a more extensive discussion of this issue and the evidence about its effects, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 112–116.

[9] For an explanation of how accountable care organizations might reduce Medicare spending, see Option 37 in Congressional Budget Office, *Budget Options, Volume 1: Health Care* (December 2008), p. 72.

paralleling the relatively small effects in Medicare itself as a proportion of total program spending in that period.

Impact on the Labor Market

This proposal, like others to reform the health insurance system, could affect labor markets in several ways.[10] In general:

- Requiring employers to offer health insurance—or pay a fee if they do not—would be likely to reduce employment, although the effect would probably be small.

- Providing new subsidies for health insurance that decline in value as a person's income rises could discourage some people from working more hours.

- Increasing the availability of health insurance that is not related to employment could lead more people to retire before age 65 or choose not to work at younger ages. It might also encourage other workers to take jobs that better match their skills, because they would not have to stay in less desirable jobs solely to maintain their health insurance.

Under the proposal, employers with annual payroll above specified levels would be required to offer health insurance to their workers and contribute a significant share toward the premium or pay a tax equal to as much as 8 percent of their total payroll. For the firms that chose not to offer qualified insurance, that penalty would increase the cost of employing each worker by somewhat less than 8 percent (because total compensation generally exceeds the taxable payroll to which this fee would apply). The overall impact on employment would probably be muted, however, because employers would be expected to pass the costs of such fees on to workers in the form of lower wages than would otherwise be paid—just as the costs paid by employers for health insurance are generally passed on to workers. Because the requirement would not be instituted until 2013, employers would be able to plan for its implementation; CBO also projects that the economy will have largely recovered from the current recession by that date.

Nonetheless, such a change would tend to reduce the hiring of workers at or near the minimum wage, because their wages might not be able to decline by the full amount of the fee (or by the costs of the health insurance that would have to be provided to avoid the fee). Still, the impact of the proposal on low-wage workers would probably be small because studies suggest that moderate increases in the minimum wage generally have limited effects on employment. An 8 percent increase in the cost of hiring a worker

[10] For a more extensive discussion, see Congressional Budget Office, *Effects of Changes to the Health Insurance System on Labor Markets*, Issue Brief (July 13, 2009). The overall impact of health reform proposals on labor markets is difficult to predict. Although economic theory and experience provide some guidance as to the effect of specific provisions, large-scale changes to the health insurance system could have more extensive repercussions than have previously been observed and could also involve numerous factors that would interact—affecting labor markets in significant but potentially offsetting ways.

making the minimum wage—which was just increased to $7.25 per hour—would amount to roughly $0.60 per hour, which is also about the size of the increase in the minimum wage that just took effect. Moreover, firms with an annual payroll below $250,000 would be exempt from the play-or-pay requirement.

Another feature of the proposal relevant to labor markets is that the subsidies for insurance coverage offered via the exchanges would phase out as enrollees' income rose, effectively reducing the compensation they would receive for each additional hour worked. That effect, which is an "implicit tax," can lead people to work fewer hours than they otherwise would, in the same way that income and payroll taxes can. Specifically, the proposal would provide subsidies to help cover the costs of purchasing insurance and would phase out those subsidies as income increased from 133 percent to 400 percent of the federal poverty level. Over that range, the share of income that enrollees would have to pay in premiums for coverage in the exchanges would increase from 1.5 percent to 11 percent, and the extent of coverage that would be subsidized would also decline so that enrollees with higher income would pay higher out-of-pocket costs as well. With limited exceptions, the subsidies would not be available to the vast majority of workers who had a qualified offer of health insurance from their employer; in addition, some workers who would not have employment-based insurance would have income above 400 percent of the poverty level. As a result, changes in the work hours of people affected by this implicit tax would have a much smaller proportionate effect on total hours worked in the U.S. economy.[11]

To express those effects in round terms using current levels of premiums and income, the subsidy might decline from roughly $5,000 to zero for single adults over an income range of about $30,000, and from roughly $13,000 to zero for a family of four over an income range of about $60,000. Thus, the implicit tax rate over that income range—that is, the extent to which those subsidies would decline as income rose—would be around 20 percent (but would vary somewhat across income levels because the subsidies would not phase out in a uniform way).[12] A proposal that phased out subsidies more quickly would yield even higher implicit tax rates; for example, the implicit tax rate would range from about 28 percent to about 35 percent if the same subsidies were phased out uniformly between 133 percent and 300 percent of the federal poverty level. Conversely, those implicit tax rates could be reduced by extending the subsidies further up the income scale, but doing so would expand the number of people affected by this implicit tax and would also increase the budgetary cost of the proposal. In any event, the implicit tax rates created by the phase-out of subsidies would come on top of existing income and payroll tax rates.

[11] The proposal would also raise tax rates on higher-income taxpayers through a surcharge. This report does not address the effects of that surcharge.

[12] Over time, as the costs of health care rose more rapidly than income, the implicit tax rate would increase.

Through the insurance exchanges and expanded eligibility for Medicaid, the proposal would enhance access to health insurance for people who are not employed and would provide subsidies for insurance to people with income below 400 percent of the federal poverty level who do not have employment-based coverage. Those provisions could encourage more people to retire before age 65, and they might lead some people to choose not to work at younger ages. The provisions might also lead to better matches between workers and jobs, because workers would not have to stay in less desirable jobs solely to maintain their health insurance.

Longer-Term Costs of the Proposal

Estimating the effects of major changes to the health care and health insurance systems over the next 10 years is very difficult and involves substantial uncertainty; generating longer-term estimates is even more challenging and is fraught with even greater uncertainty. As a result, CBO does not provide formal cost estimates beyond the 10-year budget window. However, we have said that in evaluating proposals to reform health care, the agency will endeavor to offer a qualitative indication of whether they would be more likely to increase or decrease the budget deficit over the second decade.[13]

The starting point for such an analysis of the recent House proposal is our estimate of the proposal's impact on the federal budget deficit in the first 10 years. As discussed in CBO's letter of July 17, we estimate that the proposal as a whole would increase federal deficits by $239 billion over the 2010–2019 period. That estimate has three major components: the net effect of the coverage specifications, which affect both spending and revenues and which would add an estimated $1,042 billion to cumulative deficits over that period; the effect of other provisions, primarily regarding Medicare, that would reduce direct spending by a net $219 billion; and the effect of still other provisions (primarily, an income tax surcharge on high-income individuals) that would increase revenues by $583 billion. Under the proposal, federal spending on health care would increase by approximately the difference between the net cost of the coverage specifications and the reductions in direct spending.

Looking ahead to the decade beyond 2019, CBO tries to evaluate the rate at which the budgetary impact of each of those broad categories would be likely to change over time. The net cost of the coverage provisions would be growing at a rate of more than 8 percent per year in nominal terms between 2017 and 2019; we would anticipate a similar trend in the subsequent decade. The reductions in direct spending would also be larger in the second decade than in the first, and they would represent an increasing share of spending on Medicare over that period; however, they would be much smaller at the end of the 10-year budget window than the cost of the coverage provisions, so they would not be likely to keep pace in dollar terms with the rising cost of the coverage expansion. Revenue from the surcharge on high-income individuals would be growing at about 5 percent per year in nominal terms between 2017 and 2019; that component would

[13] For discussion of our approach to developing such qualitative information, see the CBO Director's Blog, "The Effects of Health Reform Legislation beyond the Next Decade" (July 24, 2009).

continue to grow at a slower rate than the cost of the coverage expansion in the following decade. In sum, relative to current law, the proposal would probably generate substantial increases in federal budget deficits during the decade beyond the current 10-year budget window.

Under any proposal that provided new federal subsidies for the purchase of health insurance, the rate of growth in federal spending would depend importantly on how the subsidies were indexed over time. As long as overall spending for health care continued to expand as a share of the economy, people's share of insurance costs would continue to rise faster than their income, or the government's subsidy costs would continue to rise faster than the tax base, or both. The proposal limits the share of income that eligible people would have to pay when they purchased coverage in the insurance exchanges, and that share of income would not change over time. In addition, insurance plans offered through the exchanges would be required to pay a specified share of costs for covered services (on average), and that share also would not change over time. Combining those provisions, increases in health care spending in excess of the rate of growth in income would be borne entirely by the federal government in the form of higher subsidy payments—because those payments would have to cover the entire difference between the total premium for insurance coverage and the capped amount that enrollees would pay. Those factors help explain why the costs of the coverage provisions would continue to grow rapidly in the decade after 2019.

Allocation of the Net Budgetary Impact Between Outlays and Revenues

On July 14, CBO and the JCT staff provided preliminary estimates of the effects of the proposal's specifications regarding insurance coverage on the federal budget; the relevant table from that letter is attached for reference. Those estimates included the major cash flows that would affect the budget and the net effects on the budget deficit during the 2010–2019 period, but they did not allocate the net budgetary impact into changes in outlays and changes in revenues. Moreover, the preliminary estimates did not include all of the cash flows that would appear in a formal and complete cost estimate.

The amounts shown in the table for new federal spending on Medicaid and the Children's Health Insurance Program would be outlays, as would the spending for subsidies to purchase insurance coverage through the new exchanges. Those two streams of outlays would amount to an estimated $1,211 billion over 10 years.

All of the other flows of funds shown in the table would represent changes in revenues, netting to a projected increase in federal revenues of $169 billion over 10 years. Increases in revenues would include the payments by employers to the exchanges for workers who received coverage there (amounting to $45 billion); payments of penalties by uninsured individuals ($29 billion); and payments of play-or-pay penalties by employers ($163 billion). Together, those provisions would increase federal revenues by a total of $238 billion over 10 years. Other flows would represent decreases in revenues. Under the

proposal, firms with relatively few employees and relatively low average wages would also be eligible for tax credits to cover up to half of their contributions toward health insurance premiums, which would reduce revenues by an estimated $53 billion over 10 years. The proposal would also have other effects on tax revenues, largely stemming from changes in the mix of compensation provided to workers between taxable wages and salaries and nontaxable health insurance benefits; on net, those changes would reduce federal revenues by $15 billion over 10 years.

In addition to the cash flows that are shown in the table, some additional transactions would appear in the budget but would net to zero and thus would not affect the deficit. Those transactions, which CBO and the JCT staff have not yet estimated, would appear either as outlays and offsetting receipts or collections (that is, offsets to outlays), or as outlays and revenues. One set of additional cash flows would be the outlays for the public plan and its premiums, which would be offsetting receipts or collections. Another set of cash flows would be the risk-adjustment transfers among plans operating in the insurance exchanges—going from those with relatively healthy enrollees (which would be revenues) to those with relatively unhealthy enrollees (which would be outlays of an equal and offsetting magnitude).

Finally, as CBO noted in its letter of July 14, the preliminary analysis of the proposal did not include federal administrative costs or account for all effects on other federal programs. Including those factors and refining the preliminary analysis in other ways could affect our estimates of the changes in outlays and revenues generated by the proposal and thus its impact on federal deficits.

Preliminary Analysis of the Insurance Coverage Specifications Provided by the House Tri-Committee Group

EFFECTS ON INSURANCE COVERAGE /a (Millions of nonelderly people, by calendar year)		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law Coverage /b	Medicaid/CHIP	40	39	39	38	35	34	35	35	35	35
	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup	13	12	12	12	13	14	14	14	14	15
	Other /c	14	14	14	14	14	15	15	15	15	16
	Uninsured /d	50	51	51	51	51	51	52	53	53	54
	TOTAL	267	269	271	273	274	276	277	279	281	282
Change (+/-)	Medicaid/CHIP	*	-1	-2	6	4	9	10	10	11	11
	Employer	*	*	1	10	7	4	3	3	2	2
	Nongroup/Other /c	*	*	*	-3	-4	-6	-6	-6	-6	-6
	Exchanges	0	0	0	11	20	27	28	29	29	30
	Uninsured /d	*	1	1	-23	-28	-35	-35	-36	-37	-37
Post-Policy Insurance Coverage											
Number of Uninsured People /d		51	52	52	27	23	16	16	17	17	17
Insured Share of the Nonelderly Population											
Including All Residents		81%	81%	81%	90%	92%	94%	94%	94%	94%	94%
Excluding Unauthorized Immigrants		83%	83%	83%	92%	94%	97%	97%	97%	97%	97%
Memo: Exchange Enrollees and Subsidies											
Number w/ Unaffordable Offer from Employer /e					*	2	2	2	3	3	3
Number of Unsubsidized Exchange Enrollees					1	2	3	3	3	3	3
Approximate Average Subsidy per Subsidized Enrollee						$4,600	$4,800	$5,100	$5,300	$5,700	$6,000

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program; * = fewer than 0.5 million people.

a. Components may not sum to totals because of rounding.
b. Figures reflect average annual enrollment. Individuals reporting mutiple sources of coverage are assigned a primary source.
c. Includes Medicare, TRICARE, and other sources; the effects of the proposal are almost entirely on nongroup coverage.
d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.
e. Full-time workers who would have to pay more than 11 percent of their income for employment-based coverage could receive subsidies via an exchange (see text).

Preliminary Analysis of the Insurance Coverage Specifications Provided by the House Tri-Committee Group

EFFECTS ON THE FEDERAL DEFICIT / a,b,c (Billions of dollars, by fiscal year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Medicaid/CHIP Outlays /d,e	3	4	1	29	42	58	66	72	78	84	438
Exchange Subsidies	0	0	0	33	72	105	123	134	146	160	773
Payments by Employers to Exchanges /f,g	0	0	0	0	-3	-6	-8	-8	-9	-11	-45
Associated Effects on Tax Revenues /f	*	*	*	10	10	3	-1	-1	-2	-4	15
Subtotal	3	4	1	72	122	160	180	196	213	230	1,182
Small Employer Credits /h	0	0	0	4	7	8	8	8	10	10	53
Payments by Uninsured Individuals	0	0	0	0	-6	-5	-4	-5	-5	-5	-29
"Play-or-Pay" Payments by Employers /f,h	0	0	0	-7	-16	-21	-26	-29	-31	-33	-163
NET IMPACT OF COVERAGE SPECIFICATIONS	**3**	**4**	**1**	**69**	**107**	**141**	**158**	**171**	**187**	**202**	**1,042**

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program; * = between $0.5 billion and -$0.5 billion.

a. Does not include federal administrative costs or account for all effects on other federal programs.
b. Components may not sum to totals because of rounding.
c. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
d. Includes effects of coverage provisions and the proposed increase in Medicaid payment rates for primary care physicians (see text).
e. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2010-2019 period would be reduced by about $10 billion under the proposal (see text).
f. Increases in tax revenues reduce the deficit.
g. Employers would generally have to pay 8 percent of their average payroll per worker for each employee who received subsidies via an exchange (see text).
h. The effects on the deficit shown for this provision include the associated effects of changes in taxable compensation on tax revenues.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

September 10, 2009

Honorable Michael B. Enzi
Ranking Member
Committee on Health, Education,
Labor, and Pensions
United States Senate
Washington, DC 20510

Dear Senator:

This letter responds to several questions that you raised following my appearance before the Committee on Health, Education, Labor, and Pensions (HELP) during its consideration of the Affordable Health Choices Act. The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) issued a preliminary and partial analysis of that legislation as it was introduced on July 1, 2009.[1] We have not completed an assessment of the legislation as it was ultimately approved by the committee, including the amendments that were adopted during markup of the bill.

Effects of Expanding the Medicaid Program

You asked what the total cost would be of combining the committee's legislation with an expansion of eligibility for Medicaid for all legal U.S. residents with income below 150 percent of the federal poverty level (FPL). As you know, the Affordable Health Choices Act, as introduced, would not expand eligibility for Medicaid, but an earlier draft included language indicating that such an expansion would be added by the Senate Finance Committee (which has jurisdiction over Medicaid). Because our analysis of the introduced legislation examined only the changes in law that would result from it, we could not presume an expansion of eligibility for Medicaid or other new subsidies for health insurance beyond those that were specified. Overall, our preliminary assessment was that the provisions of the legislation pertaining to insurance coverage (contained in title I of the

[1] Congressional Budget Office, letter to the Honorable Edward M. Kennedy providing CBO's preliminary analysis of title I of the Affordable Health Choices Act (July 2, 2009).

bill) would increase federal deficits by $645 billion over the 2010–2019 period.

As CBO indicated in its letter to Senator Gregg on July 6, 2009, expanding eligibility for Medicaid to legal residents with income up to 150 percent of the FPL would increase the federal cost of the legislation considerably—by an amount that is probably on the order of $500 billion over 10 years.[2] (CBO did not estimate the costs to state governments of such a Medicaid expansion, but those costs would probably be relatively small because the options that CBO examined to expand Medicaid would have required states to cover a much smaller share of total spending than is seen in the current Medicaid program.) Therefore, the 10-year cost of the coverage expansion to the federal government, including such a change in Medicaid eligibility, would probably exceed $1 trillion. Combining such an expansion with the Affordable Health Choices Act as introduced would also yield a substantially larger reduction in the number of people who are uninsured than would arise from the act alone, because about half of the people projected to be uninsured under current law would have income below 150 percent of the FPL.

Because the magnitude of the effects on both federal costs and rates of insurance coverage for the combination of the committee's legislation and a Medicaid expansion would depend importantly on the details of the proposal, we cannot give you a more precise estimate at this time. For example, the effects would depend on how eligibility for Medicaid was determined and on whether the expansion started in 2010 or at a later date. The effects would also depend on what share of the costs for newly eligible people was borne by the federal government and what share was borne by the states. Furthermore, the effects would depend on whether states faced a maintenance-of-effort requirement relative to their current Medicaid programs. Regardless of its specific features, adding a Medicaid expansion to the introduced bill would not only affect federal costs for Medicaid but also have implications for other components of our preliminary estimate—because employers and individuals would probably respond to the bill's other provisions differently in that case.

An illustration of the effects of including a substantial expansion of Medicaid can be seen in the preliminary analysis that CBO and JCT have provided of the coverage specifications reflected in H.R. 3200, the

[2] Congressional Budget Office, letter to the Honorable Judd Gregg regarding the likely effects of substantially expanding eligibility for Medicaid (July 8, 2009).

America's Affordable Health Choices Act of 2009, as introduced in the House of Representatives on July 14, 2009.[3] That proposal would expand eligibility for Medicaid to all nonelderly individuals with income below 133 percent of the FPL (with all of the costs for newly eligible enrollees borne by the federal government) and would provide subsidies via insurance exchanges on a sliding scale for those with income up to 400 percent of the FPL. CBO estimated that federal outlays for Medicaid would increase by $438 billion over the 2010–2019 period because of that expansion of eligibility for the program and related measures. That figure includes the estimated costs of a proposed increase in Medicaid's payment rates for primary care physicians, but does not include the costs of providing subsidies for insurance to people with income between 133 percent and 150 percent of the FPL (which have not been separately estimated).

Effects on Employers and Employees

You also asked whether the costs borne by employers as a result of the proposal would be passed on to workers in the form of lower wages than they would otherwise be paid, and about the effects of the proposal on employment-based health insurance. Under the legislation as introduced, firms with more than 25 workers would have to offer health insurance (and contribute a specified share of the premiums) or pay a penalty. In general, CBO believes that firms that are subject to the penalty but opt not to offer health insurance would pass that cost on to their workers, primarily in the form of lower wages—just as firms that offer insurance today and contribute toward the premiums pay lower wages than they otherwise would, keeping their total compensation costs about the same. One exception would be workers earning close to the minimum wage, because their wages might not be able to adjust downward to offset the cost of the penalty; as a result, employment of those workers might be adversely affected, though that impact is likely to be small.[4]

As for the effects of the legislation on employment-based health insurance, CBO and JCT estimated that the version that was introduced on July 1 would not have a major effect on the aggregate number of people obtaining coverage through an employer; we estimated that in 2016, for example, the total number of people covered by an employment-based plan would be

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[3] Congressional Budget Office, letter to the Honorable Charles B. Rangel providing a preliminary analysis of the America's Affordable Health Choices Act of 2009 (July 17, 2009).

[4] For additional discussion, see Congressional Budget Office, *Effects of Changes to the Health Insurance System on Labor Markets,* Issue Brief (July 13, 2009).

about 163 million, or about 1 million more than is projected under current law.

That net figure reflects changes going in both directions. Some people would gain employment-based coverage, because the mandate to obtain health insurance would induce some employers to make an offer of such coverage that would not have been made otherwise or would induce some individuals to take advantage of an existing offer that they would not have accepted otherwise. At the same time, we estimated that about 6 million people who would have employment-based coverage under current law would not have such coverage under the proposal. That figure includes about 2 million workers (and their dependents) who would have an offer from their employer that would be deemed "unaffordable" under the proposal, thus allowing them to purchase subsidized coverage through the new insurance exchanges. It also includes about 4 million people who would have coverage through an employer under current law but would not have such an offer under the proposal. To what extent those changes in coverage would represent the dropping of existing coverage or expected offers of coverage that would fail to materialize is difficult to determine.

Effects of a "Public Plan"

You also asked whether the federally administered "public plan" that would be offered under the legislation as introduced would have a substantial effect on federal spending for health care. Under that proposal, the public plan would be managed by the Department of Health and Human Services, would pay negotiated rates to providers of health care, and would have to be financially self-sufficient (albeit with the government bearing some risk, as discussed below). Given those provisions, CBO's assessment is that premiums for the public plan would typically be roughly comparable to the average premiums of private plans offered in the insurance exchanges—and thus the existence of such a plan would not directly affect the amount of federal subsidies for health insurance under the legislation.

Nevertheless, including a public plan would probably have two small effects on the premiums of the private plans against which it is competing, both of which would tend to lower federal subsidy payments through the exchanges to some degree—but we have not quantified that effect by comparing the legislation as introduced to a proposal that was identical in all other respects but did not include a public plan.

- First, a public plan as structured in the introduced bill would probably attract a substantial minority of enrollees (in part because it

would include a relatively broad network of providers and would be likely to engage in only limited management of its health care benefits). As a result, it would add some competitive pressure in many insurance markets that are currently served by a limited number of private insurers. That competitive pressure would probably lower private premiums in the insurance exchanges to a small degree.

- Second, a public plan is also apt to attract enrollees who, overall, are less healthy than average (again, because it would include a relatively broad network of providers and would probably engage in limited management of benefits). Although the payments that all plans in the exchanges receive would be adjusted to account for differences in the health of their enrollees, the methods used to make such adjustments are imperfect. As a result, the higher costs of those less healthy enrollees in the public plan would probably be offset partially but not entirely; the rest of the added costs would have to be reflected in the public plan's premiums. Correspondingly, the costs and premiums of competing private plans would, on average, be slightly lower than if no public plan was available.

At the same time, including a public plan in the proposal would increase the *gross* amount of federal spending on health care simply because all of the payments to and from that plan should be recorded in the federal budget, in CBO's judgment.[5] For the public plan, all payments to providers, administrative costs, and government subsidy payments would be federal expenses, and all subsidy payments and enrollees' premiums would be counted as offsetting receipts (a credit against direct spending). For private health insurance plans participating in the new insurance exchanges, by contrast, the portion of premiums that is subsidized would be recorded as federal outlays; the remainder of private plans' receipts and costs would not appear in the federal budget. Under the assumption that the public plan would charge premiums that covered its costs—as it is supposed to do—*net* federal outlays on health care would not be appreciably different as a result of applying those accounting rules. However, the federal government would be assuming the financial risk that the premiums charged in any given year might not fully cover all of the public plan's costs.

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[5] Congressional Budget Office, *The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System*, Issue Brief (May 27, 2009).

Effects on Overall Expenditures for Health Care

You also asked what effect the introduced legislation would have on national spending on health care. By itself, a substantial expansion of insurance coverage could cause an increase of between 2 percent and 5 percent in national spending on health care, largely because insured people generally receive somewhat more medical care than do uninsured people—notwithstanding the fact that some newly insured people would avoid expensive treatments by getting care sooner, before their illness progressed.[6] However, the rise in national spending on health care would be less than the increase for the federal government because some costs that are now paid by others would be shifted to the government (via the subsidies provided by the bill). Expanding insurance coverage would make it modestly easier to achieve certain types of reductions in national and federal spending on health care; for example, some governmental payments to hospitals that treat a disproportionate share of poor and uninsured patients might be trimmed accordingly.

More broadly, legislation could seek to offset the impact of an insurance expansion—on both federal costs and total spending for health care—by including other provisions affecting either the major federal programs that finance health care or the private insurance system. The bill as introduced would encourage private insurers to adopt measures to improve the coordination of the care they provide, but private insurers would be inclined to adopt cost-reducing strategies even in the absence of new legislation, so the effect of those provisions on costs is not clear. The insurance market reforms included in the bill would reduce administrative costs for individually purchased policies, but the resulting savings would probably be small relative to the increase in spending brought about by the insurance expansion. Given its overall scope, the bill would probably increase national spending on health care modestly.

[6] For additional discussion, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 71–76.

I hope this information is helpful to you. If you have any questions, please contact me or CBO's primary staff contacts for this analysis, Philip Ellis and Holly Harvey.

Sincerely,

Douglas W. Elmendorf
Director

cc: Honorable Tom Harkin
Chairman

Honorable Christopher J. Dodd

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

October 29, 2009

Honorable Charles B. Rangel
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have completed a preliminary analysis of H.R. 3962, the Affordable Health Care for America Act, as introduced on October 29, 2009. For several reasons described later, this analysis does not constitute a final and comprehensive cost estimate for the bill.

Among other things, H.R. 3962 would establish a mandate for most legal residents of the United States to obtain health insurance; set up insurance "exchanges" through which certain individuals and families could receive federal subsidies to substantially reduce the cost of purchasing that coverage; significantly expand eligibility for Medicaid; substantially reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected under current law); impose an income tax surcharge on high-income individuals; and make various other changes to the federal tax code, Medicaid, Medicare, and other programs.

CBO and JCT's preliminary assessment of the bill's impact on the federal budget deficit is summarized in Table 1 below. Tables 2 and 3 provide estimates of the changes in the number of nonelderly people in the United States who would have health insurance, present the primary budgetary effects of H.R. 3962's provisions directly related to insurance coverage, and display detailed estimates of the cost or savings from other proposed changes (primarily to the Medicare program) that would affect the federal government's direct spending and some aspects of federal revenue. The analysis also examines the longer-term effects of the proposal on the federal budget and reviews the main reasons why this analysis differs from the

preliminary analysis CBO released in July for H.R. 3200, the America's Affordable Health Choices Act of 2009, as introduced on July 14, 2009.

Estimated Budgetary Impact of H.R. 3962

According to CBO and JCT's assessment, enacting H.R. 3962 would result in a net reduction in federal budget deficits of $104 billion over the 2010–2019 period (see Table 1). In the subsequent decade, the collective effect of its provisions would probably be slight reductions in federal budget deficits. Those estimates are all subject to substantial uncertainty.

The estimate includes a projected net cost of $894 billion over 10 years for the proposed expansions in insurance coverage. That net cost itself reflects a gross total of $1,055 billion in subsidies provided through the exchanges (and related spending), increased net outlays for Medicaid and the Children's Health Insurance Program (CHIP), and tax credits for small employers; those costs are partly offset by $167 billion in collections of penalties paid by individuals and employers. On balance, other effects on revenues and outlays associated with the coverage provisions add $6 billion to their total cost.

Over the 2010–2019 period, the net cost of the coverage expansions would be more than offset by the combination of other spending changes, which CBO estimates would save $426 billion, and receipts resulting from the income tax surcharge on high-income individuals and other provisions, which JCT and CBO estimate would increase federal revenues by $572 billion over that period.[1]

Provisions Regarding Insurance Coverage

H.R. 3962 would take several steps designed to increase the number of legal U.S. residents who have health insurance. It would require individuals to purchase health insurance, starting in 2013, and would in many cases impose a financial penalty on people who did not do so. The bill also would establish new insurance exchanges and would generally subsidize the purchase of health insurance through those exchanges for qualified individuals and families with income between 150 percent and 400 percent of the federal poverty level (FPL).

[1] The $572 billion figure includes $558 billion in revenues from tax provisions (estimated by JCT) and $14 billion in additional revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by JCT and CBO). (For JCT's estimates, see JCX-43-09.)

TABLE 1. PRELIMINARY ESTIMATE OF THE EFFECTS ON THE DEFICIT OF H.R. 3962, THE AFFORDABLE HEALTH CARE FOR AMERICA ACT, AS INTRODUCED ON OCTOBER 29, 2009

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
NET CHANGES IN THE DEFICIT FROM INSURANCE COVERAGE PROVISIONS [a]												
Effects on the Deficit	*	1	2	57	93	123	137	148	160	173	153	894
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING [b]												
Effects on the Deficit of Changes in Outlays	7	17	-16	-25	-52	-51	-54	-72	-85	-96	-69	-426
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [c]												
Effects on the Deficit of Changes in Revenues [d]	*	-33	-35	-57	-62	-67	-72	-77	-82	-86	-188	-572
NET CHANGES IN THE DEFICIT [a]												
Net Increase or Decrease (-) in the Budget Deficit	6	-15	-49	-25	-21	5	11	-1	-7	-9	-104	-104
On-Budget	6	-15	-49	-27	-23	4	10	-3	-8	-10	-108	-115
Off-Budget [e]	*	*	*	2	2	2	2	1	1	1	4	11

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation (JCT).

Notes: Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Components may not sum to totals because of rounding; * = between $0.5 billion and -$0.5 billion.

a. Does not include effects on spending subject to future appropriations.

b. These estimates reflect the effects of interactions between insurance coverage provisions and other Medicare and Medicaid provisions. In addition, CBO has included $33 billion of spending over the 2010–2019 period for public health, prevention, and wellness provisions in these direct spending totals, as directed by the Committee on the Budget, even though that spending would be subject to future appropriation action.

c. The changes in revenues include effects on Social Security revenues, which are classified as off-budget.

d. The 10-year figure of $572 billion includes $558 billion in revenues from tax provisions (estimated by JCT) and $14 billion in additional revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by JCT and CBO). (For JCT's estimates see JCX-43-09.)

e. Off-budget effects include changes in Social Security spending and revenues.

Policies purchased through the exchanges (or directly from insurers) would have to meet several requirements: In particular, insurers would have to accept all applicants, could not limit coverage for preexisting medical conditions, and could not vary premiums to reflect differences in enrollees' health.[2] The options available in the insurance exchange would include private health insurance plans as well as a public plan that would be administered by the Secretary of Health and Human Services (HHS). The public plan would negotiate payment rates with all providers and suppliers of health care goods and services; providers would not be required to participate in the public plan in order to participate in Medicare. The public plan would have to charge premiums that covered its costs, including the costs of paying back start-up funding that the government would provide.

Starting in 2013, nonelderly people with income below 150 percent of the FPL would generally be made eligible for Medicaid; the federal government would pay a share of the costs of covering newly eligible enrollees that averaged about 91 percent. (Under current rules, the federal government usually pays about 57 percent, on average, of the costs of Medicaid benefits.) In addition, states would be required to maintain current coverage levels for individuals under Medicaid and some children in CHIP through 2019. Beginning in 2014, states would shift some children in CHIP to Medicaid, but the federal government would continue to provide enhanced reimbursement, which currently averages about 70 percent, to states for providing such benefits. CBO estimates that state spending on Medicaid would increase on net by about $34 billion over the 2010–2019 period as a result of the provisions affecting insurance coverage reflected in Table 2. That estimate reflects states' flexibility to make programmatic and other budgetary changes to Medicaid and CHIP.

H.R. 3962 contains a number of other key provisions related to insurance coverage. It would impose a "play-or-pay" requirement on employers, who would either have to offer qualifying insurance to their employees and contribute a substantial share toward the premiums, or pay a fee to the federal government that would generally equal 8 percent of their payroll. Smaller employers (those with an annual payroll of less than $750,000) would either pay a lower rate or be exempt from that requirement

[2] The analysis also takes into account the provisions of section 262 of Division A regarding the application of federal antitrust laws to health insurers. CBO estimates that implementing those provisions would have no significant effects on either the federal budget or the premiums that private insurers charged for health insurance. For an analysis of a similar proposal, see CBO's cost estimate for H.R. 3596, the Health Insurance Industry Antitrust Enforcement Act of 2009 (October 23, 2009).

altogether. As a rule, full-time employees with a qualifying offer of coverage from their employers would not be eligible to obtain subsidies via the exchanges, but an exception to that "firewall" would be allowed for workers who had to pay more than 12 percent of their income for their employers' insurance. In that case, the employers would have to pay an amount equal to the per-worker fee due for firms subject to the play-or-pay penalty. Under certain circumstances, firms with relatively few employees and relatively low average wages would also be eligible for tax credits to cover up to half of their contributions toward health insurance premiums.

On a preliminary basis, CBO and JCT estimate that H.R. 3962's provisions affecting health insurance coverage would result in a net increase in federal deficits of $894 billion over fiscal years 2010 through 2019. That estimate primarily reflects $425 billion in net federal outlays for Medicaid and CHIP and $605 billion in federal subsidies that would be provided to purchase coverage through the new insurance exchanges and related spending.[3] The other main element of the coverage provisions that would increase federal deficits is the tax credit for certain small employers who offer health insurance, which is estimated to reduce revenues by $25 billion over 10 years. Those costs would be partly offset by a net increase in receipts, totaling $167 billion over the period, from two sources: penalty payments by uninsured individuals, which would yield receipts of about $33 billion, and penalty payments by employers under the play-or-pay requirement, which would total about $135 billion. Other effects on tax revenues and outlays for Social Security that are associated with the coverage provisions would increase deficits by $6 billion.[4]

By 2019, CBO and JCT estimate, the number of nonelderly people who are uninsured would be reduced by about 36 million, leaving about 18 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under H.R. 3962, the share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 96 percent. Roughly 21 million people would purchase their own coverage through the new insurance exchanges, and there would

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[3] Related spending includes the administrative costs of establishing and operating the exchanges, as well as $5 billion in spending for high-risk insurance pools.

[4] Changes in the extent of employment-based health insurance affect federal revenues because most payments for that coverage are tax-preferred. If employers increase or decrease the amount of compensation they provide in the form of health insurance (relative to current-law projections), CBO and JCT assume that offsetting changes will occur in wages and other forms of compensation—which are generally taxable—to hold total compensation roughly the same. Such effects also arise with respect to specific elements of the proposal (such as the tax credits for small employers), and those effects are included within the estimate for those elements.

be roughly 15 million more enrollees in Medicaid than the total number projected for Medicaid and CHIP combined under current law. (Under the bill, CHIP would no longer exist in 2019.) Relative to currently projected levels, the number of people purchasing individual coverage outside of the exchanges would decrease by about 6 million, and the number obtaining coverage through employers would increase by about 6 million.

Under the proposal, certain employers could allow all of their workers to choose among the plans available in the exchanges, but those enrollees would not be eligible to receive subsidies via the exchanges (and thus are shown in Table 2 as enrollees in employment-based coverage rather than as exchange enrollees). CBO and JCT expect that approximately 9 million people would obtain coverage in that way in 2019, bringing the total number of people enrolled in exchange plans to about 30 million in that year. Roughly one-fifth of the people purchasing coverage through the exchanges would enroll in the public plan, meaning that total enrollment in that plan would be about 6 million.

That estimate of enrollment reflects CBO's assessment that a public plan paying negotiated rates would attract a broad network of providers but would typically have premiums that are somewhat higher than the average premiums for the private plans in the exchanges. The rates the public plan pays to providers would, on average, probably be comparable to the rates paid by private insurers participating in the exchanges. The public plan would have lower administrative costs than those private plans but would probably engage in less management of utilization by its enrollees and attract a less healthy pool of enrollees. (The effects of that "adverse selection" on the public plan's premiums would be only partially offset by the "risk adjustment" procedures that would apply to all plans operating in the exchanges.)

Provisions Affecting Medicare, Medicaid, and Other Programs

Other components of H.R. 3962 would alter spending for Medicare, Medicaid, and other federal health programs. The bill would make numerous changes to payment rates and payment rules in those programs (the budgetary effects of which are summarized in Table 1 and detailed in Table 3). In total, CBO estimates that enacting those provisions would reduce direct spending by about $426 billion over the 2010–2019 period.[5]

[5] In addition, the effects of certain Medicare and Medicaid and other provisions would increase federal revenues by about $14 billion over the 2010–2019 period.

Numerous changes to Medicare and Medicaid would reduce direct spending over the 2010–2019 period. The provisions that would result in the largest budgetary effects include these:

- Permanent reductions in the annual updates to Medicare's payment rates for most services in the fee-for-service sector (other than physicians' services), yielding budgetary savings of $229 billion over 10 years. (That calculation excludes interactions between those provisions and others—namely, the effects of those changes on payments to Medicare Advantage plans and collections of Part B premiums.)

- Setting payment rates in the Medicare Advantage program on the basis of Medicare spending per beneficiary in the fee-for-service sector and changing the way that payments to Medicare Advantage plans reflect differences in the health status of enrollees, yielding savings of an estimated $170 billion (before interactions) over the 2010–2019 period.

- Increasing Medicaid's payment rates to physicians and other health care professionals for the provision of primary care services to Medicaid beneficiaries, costing roughly $57 billion over 10 years.

CBO expects that the Centers for Medicare and Medicaid Services (CMS) will soon announce payment rates and changes in payment rules for physicians' services and other services that are set on a calendar year basis. Those payment rates and rules may differ from the current-law assumptions underlying CBO's baseline projections. If so, CBO will update its estimates of Medicare spending under current law to reflect those changes and will revise these preliminary estimates of the impact of H.R. 3962 to reflect the effects of the new rules on spending under current law and under the bill.

H.R. 3962 includes a number of other provisions with a significant budgetary effect. They include the following:

- Community Living Assistance Services and Supports (CLASS) provisions, which would establish a voluntary federal program for long-term care insurance. Active workers could purchase coverage, usually through their employer. Premiums would be set to cover the full cost of the program as measured on an actuarial basis. However, the program's cash flows would initially show net receipts in early years, followed by net outlays in later years. In particular, the

program would pay out far less in benefits than it would receive in premiums over the 10-year budget window, reducing deficits by about $72 billion over that period.

- A Public Health Investment Fund and a Prevention and Wellness Trust, which would be funded through future appropriations of about $34 billion to finance various public health, prevention, and wellness programs. (Although outlays from that funding—estimated to total $33 billion over the 2010-2019 period—would be subject to future appropriation action, the Committee on the Budget has directed CBO to count those outlays as direct spending for purposes of budget scorekeeping in the House of Representatives.)

- Requirements that the Secretary of HHS adopt and regularly update standards for electronic administrative transactions that enable electronic funds transfers, claims management processes, and verification of eligibility, among other administrative tasks. These provisions would result in about $9 billion in federal savings in Medicaid and reduced subsidies paid through the insurance exchanges. In addition, these standards would result in an increase in revenues of about $13 billion as an indirect effect of reducing the cost of private health insurance plans.

- An abbreviated approval pathway for follow-on biologics (biological products that are highly similar to or interchangeable with their brand-name counterparts), which would yield direct spending savings of an estimated $6 billion over the 2010–2019 period.

Effect of H.R. 3962 on Discretionary Costs

CBO has not completed a comprehensive estimate of the discretionary costs that would be associated with H.R. 3962. Total costs would include those arising from the effects of H.R. 3962 on a variety of federal programs and agencies as well as from a number of new and existing programs subject to future appropriations.

The federal agencies that would be responsible for implementing the provisions of H.R. 3962 are funded through the appropriation process; sufficient appropriations would be essential for them to implement this legislation in the time frame it specifies. Major costs for programs subject to future appropriations would include these:

- Costs to the Internal Revenue Service of implementing the eligibility determination, documentation, and verification processes for subsidies. Those costs would probably be between $5 billion and $10 billion over 10 years.

- Costs to HHS (and especially CMS) of implementing the changes in Medicare, Medicaid, and CHIP as well as certain reforms to the private insurance market. Those costs would probably be at least $5 billion to $10 billion over 10 years. (The administrative costs of establishing and operating the exchanges, which are direct spending, are included in Table 1.)

- Costs of a number of grant programs and other changes in Divisions C and D of the legislation. CBO has not completed a review of those provisions.

Because those costs depend on future appropriations, they are not counted for enforcement of Congressional "pay-as-you-go" procedures, and are not included in Table 1.

As noted in the previous section and in Table 1, funding for the proposed Public Health Investment Fund and Prevention and Wellness Trust would also be subject to future appropriation action. The bill would authorize appropriations totaling about $34 billion for those purposes (of which approximately $33 billion would be spent over the next 10 years). The Committee on the Budget has directed CBO to count such spending as direct spending for purposes of budget scorekeeping in the House of Representatives.

Important Caveats Regarding This Preliminary Analysis

For a number of reasons, the preliminary analysis that is provided in this letter does not constitute a final and comprehensive cost estimate for H.R. 3962:

- Although CBO completed a preliminary review of legislative language prior to its release, the agency has not thoroughly reviewed the introduced legislation to verify its consistency with the previous draft. Moreover, the analysis does not reflect all of the provisions of the bill. In particular, the analysis does not reflect the impact of section 110 of Division A, which would impose certain requirements on employers that currently provide health insurance to retirees.

- The budgetary information shown in the above table reflects many of the major cash flows that would affect the federal budget as a result of implementing the specified policies and provides a preliminary assessment of the net effects on the federal budget deficit. However, some cash flows (such as risk adjustment payments and collections as well as certain cash flows related to the public plan) would appear in the budget but would net to zero and thus would not affect the deficit; CBO and JCT have not yet estimated all of those cash flows. Furthermore, CBO and JCT have not yet divided all of the estimated cash flows into spending and revenue components.

Comparison with CBO and JCT's Estimate for H.R. 3200

On July 17, 2009, CBO transmitted a preliminary analysis by CBO and JCT of H.R. 3200, the America's Affordable Health Choices Act of 2009, as introduced on July 14, 2009. The estimates provided here differ from the ones in that analysis for two primary reasons: First, the provisions of H.R. 3962 differ from those of H.R. 3200 in a number of significant ways. Second, CBO and JCT have made some technical refinements in their estimating procedures as well as some changes in the classification of certain provisions and their budgetary effects. Prominent examples of such changes are as follows:

- The current proposal expands eligibility for Medicaid to people with income up to 150 percent of the FPL, rather than 133 percent; and after 2014, it would have the federal government cover about 91 percent of the cost of newly eligible enrollees, rather than 100 percent.

- Previously, CBO had included the costs of increasing payments to primary care physicians under Medicaid (totaling roughly $60 billion over 10 years) in the table showing the budgetary effects of the provisions related to insurance coverage; however, those costs are more appropriately reflected in the table showing the budgetary effects of provisions affecting Medicare, Medicaid, and other programs (see Table 3).

- The estimated costs of providing subsidies through the new insurance exchanges are now lower for several reasons: the larger expansion of Medicaid means that fewer people would be eligible for coverage through the exchanges; the shares of income that enrollees would have to contribute toward their premiums in 2013

were increased; and those shares were also indexed so that they would rise gradually over time (meaning that federal subsidy payments would grow somewhat more slowly than those under H.R. 3200).

- More firms were exempted from the play-or-pay requirement, reducing the amount of revenue collected from those penalties. In addition, CBO and JCT now estimate that the federal administrator overseeing the insurance exchanges might well allow medium-sized and large firms to purchase coverage through the exchanges. That change affects the expected number of people enrolling via the exchanges and the number of firms likely to offer coverage to their workers; consequently, projected play-or-pay revenues are lower than they would have been under the previous assumptions.

- The current proposal does not include any changes to the sustainable growth rate (SGR) mechanism for setting Medicare's payment rates for physicians' services. A provision of H.R. 3200 that would have restructured that mechanism added about $245 billion to CBO's estimate of the net cost of that bill.

Effects of H.R. 3962 Beyond the First 10 Years

Although CBO does not generally provide cost estimates beyond the 10-year budget projection period (2010 through 2019 currently), many Members have requested CBO analyses of the long-term budgetary impact of broad changes in the nation's health care and health insurance systems. However, a detailed year-by-year projection, like those that CBO prepares for the 10-year budget window, would not be meaningful because the uncertainties involved are simply too great. Among other factors, a wide range of changes could occur—in people's health, in the sources and extent of their insurance coverage, and in the delivery of medical care (such as advances in medical research, technological developments, and changes in physicians' practice patterns)—that are likely to be significant but are very difficult to predict, both under current law and under any proposal.

CBO has therefore developed a rough outlook for the decade following the 10-year budget window by grouping the elements of the bill into broad categories and assessing the rate at which the budgetary impact of each of those broad categories is likely to increase over time. Under H.R. 3962, the major categories are as follows:

- The gross cost of the coverage expansions, consisting of exchange subsidies, the net costs of expanded eligibility for Medicaid, and tax credits for employers: Those provisions have an estimated cost of $208 billion in 2019, and that cost is growing at about 8 percent per year toward the end of the 10-year budget window. As a rough approximation, CBO assumes continued growth at about that rate during the following decade.

- The income tax surcharge on high-income individuals: JCT estimates that the provision would generate about $68 billion in additional revenues in 2019, and those revenues are growing a little faster than 5 percent per year toward the end of the 10-year budget window. As a rough approximation, CBO assumes continued growth at about that rate during the following decade.

- Other taxes and the effects of coverage provisions on revenues: The increase in revenues from those provisions is estimated to total about $52 billion in 2019 and is growing a little faster than 5 percent per year toward the end of the budget window. As a rough approximation, CBO assumes continued growth at about that rate during the following decade.

- Changes to the Medicare program and changes to Medicaid and CHIP other than those associated directly with expanded insurance coverage: Savings from those provisions are estimated to total $96 billion in 2019, and CBO projects that, in combination, they will increase by 10 percent to 15 percent per year in the next decade.

All told, H.R. 3962 would reduce the federal deficit by $9 billion in 2019, CBO and JCT estimate. After that, the added revenues and cost savings are projected to grow slightly more rapidly than the cost of the coverage expansions. In the decade after 2019, the gross cost of the coverage expansions would probably exceed 1 percent of gross domestic product (GDP), but the added revenues and cost savings would probably be greater. Consequently, CBO expects that the legislation would slightly reduce federal budget deficits in that decade relative to those projected under current law—with a total effect during that decade that is in a broad range between zero and one-quarter percent of GDP. The imprecision of that calculation reflects the even greater degree of uncertainty that attends to it, compared with CBO's 10-year budget estimates, and the effects of the bill could fall outside of that range.

As noted earlier, the CLASS program included in the bill would generate net receipts for the government in the initial years when total premiums would exceed total benefit payments, but it would eventually lead to net outlays when benefits exceed premiums. As a result, the program would reduce deficits by $72 billion during the 10-year budget window and would reduce them by a smaller amount in the ensuing decade (an amount that is included in the calculations described in the preceding paragraphs). In the decade following 2029, the CLASS program would begin to increase budget deficits. However, the magnitude of the increase would be fairly small compared with the effects of the bill's other provisions, so the CLASS program does not substantially alter CBO's assessment of the longer-term effects of the legislation.

Many Members have expressed interest in the effects of reform proposals on various measures of spending on health care. CBO uses the term "federal budgetary commitment to health care" to describe the sum of net federal outlays for health programs and tax preferences for health care—a broad measure of the resources committed by the federal government that includes both its spending for health care and the subsidies for health care that are conveyed through reductions in federal taxes (for example, through the exclusion of premiums for employment-based health insurance from income and payroll taxes). In H.R. 3962, the gross cost of the coverage expansions would represent an increase in this commitment. That increase would be offset only in part by the changes to net spending for Medicare, Medicaid, CHIP, and other federal programs (other than those associated directly with expanded insurance coverage), as well as some small changes in the revenues lost through tax expenditures related to health care. On balance, during the decade following the 10-year budget window, the bill would increase both federal outlays for health care and the federal budgetary commitment to health care, relative to the amounts under current law.

Members have also requested information about the effect of proposals on national health expenditures. CBO does not analyze those expenditures as closely as it does the federal budget, however, and at this point the agency has not assessed the net effect of H.R. 3962 on them, either within the 10-year budget window or for the subsequent decade.

These longer-term projections assume that the provisions of H.R. 3962 are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation. For example, the SGR mechanism governing Medicare's payments to physicians has frequently been modified

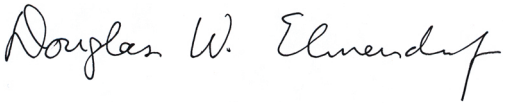
to avoid reductions in those payments, and legislation to do so again is currently under consideration in the Congress. The bill would put into effect (or leave in effect) a number of procedures that might be difficult to maintain over a long period of time. It would leave in place the 21 percent reduction in the payment rates for physicians currently scheduled for 2010. At the same time, the bill includes a number of provisions that would constrain payment rates for other providers of Medicare services. In particular, increases in payment rates for many providers would be held below the rate of inflation (in expectation of ongoing productivity improvements in the delivery of health care). Based on the extrapolation described above, CBO expects that Medicare spending under the bill would increase at an average annual rate of roughly 6 percent during the next two decades—well below the roughly 8 percent annual growth rate of the past two decades, despite a growing number of Medicare beneficiaries as the baby-boom generation retires.[6]

The long-term budgetary impact of H.R. 3962 could be quite different if those provisions generating savings were ultimately changed or not fully implemented. If those changes arose from future legislation, CBO would estimate their costs when that legislation was being considered by the Congress.

[6] Based on the same extrapolation, Medicare spending per beneficiary under the bill would increase roughly 4 percent per year, on average, during the next two decades—compared with a 7 percent average growth rate (excluding the effect of establishing Part D) during the past two decades.

I hope this preliminary analysis is helpful for your deliberations. If you have any questions, please contact me or CBO staff. The primary staff contacts for this analysis are Philip Ellis and Holly Harvey.

Sincerely,



Douglas W. Elmendorf
Director

Enclosures

cc: Honorable Dave Camp
Ranking Member

Identical letters sent to the Honorable George Miller, the Honorable Henry A. Waxman, and the Honorable John D. Dingell.

TABLE 2. Preliminary Analysis of the Insurance Coverage Provisions Contained in H.R. 3962

EFFECTS ON INSURANCE COVERAGE /a (Millions of nonelderly people, by calendar year)		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law Coverage /b	Medicaid & CHIP	40	39	39	38	35	34	35	35	35	35
	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup & Other /c	27	26	25	26	28	29	29	29	30	30
	Uninsured /d	50	51	51	51	51	51	52	53	53	54
	TOTAL	267	269	271	273	274	276	277	279	281	282
Change (+/-)	Medicaid & CHIP	*	-1	-2	8	7	13	14	14	15	15
	Employer	1	1	1	12	11	7	7	7	7	6
	Nongroup & Other /c	*	*	*	-3	-4	-6	-6	-6	-6	-6
	Exchanges	0	0	0	9	14	19	20	20	20	21
	Uninsured /d	*	*	1	-25	-28	-34	-34	-35	-35	-36
Post-Policy Insurance Coverage											
Number of Uninsured People /d		50	51	51	26	23	17	18	18	18	18
Insured Share of the Nonelderly Population /a											
Including All Residents		81%	81%	81%	91%	92%	94%	94%	94%	94%	94%
Excluding Unauthorized Immigrants		83%	83%	83%	92%	93%	96%	96%	96%	96%	96%
Memo: Exchange Enrollees and Subsidies											
Number w/ Unaffordable Offer from Employer /e					*	1	1	1	1	1	1
Number of Unsubsidized Exchange Enrollees					1	2	3	3	3	3	3
Approximate Average Subsidy per Subsidized Enrollee							$5,500	$5,800	$6,100	$6,500	$6,800

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program; * = fewer than 0.5 million people.

a. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.
b. Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source.
c. Other includes Medicare; the effects of the proposal are almost entirely on nongroup coverage.
d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.
e. Workers who would have to pay more than 12 percent of their income for employment-based coverage could receive subsidies via an exchange.

TABLE 2. Preliminary Analysis of the Insurance Coverage Provisions Contained in H.R. 3962

EFFECTS ON THE FEDERAL DEFICIT / a,b (Billions of dollars, by fiscal year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Medicaid & CHIP Outlays /c	-1	-2	-3	27	43	58	66	72	79	85	425
Exchange Subsidies & Related Spending /d	1	2	4	29	57	82	96	103	111	120	605
Small Employer Tax Credits /e	0	0	0	4	8	5	2	2	2	2	25
Gross Cost of Coverage Provisions	0	1	0	59	108	146	165	177	192	208	1,055
Penalty Payments by Uninsured Individuals	0	0	0	0	-5	-6	-5	-5	-6	-6	-33
Penalty Payments by Employers /e	0	0	0	-6	-14	-18	-22	-23	-25	-27	-135
Associated Effects on Tax Revenues & Outlays /f	0	1	1	4	5	1	-1	-1	-1	-2	6
NET COST OF COVERAGE PROVISIONS	**0**	**1**	**2**	**57**	**93**	**123**	**137**	**148**	**160**	**173**	**894**

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program.

a. Does not include federal administrative costs that are subject to appropriation.
b. Components may not sum to totals because of rounding; positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
c. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that, under the proposal, state spending on Medicaid and CHIP would increase by about $34 billion over the 2010-2019 period as a result of the insurance coverage provisions that are reflected in this table.
d. Includes $5 billion in spending for high-risk insurance pools.
e. The effects on the deficit shown for this provision include the associated effects of changes in taxable compensation on tax revenues.
f. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about $2 billion over the 2010-2019 period, and that the coverage provisions would have negligible effects on outlays for other federal programs.

Table 3. Preliminary Estimate of the Effects on Direct Spending and Revenues of Divisions B, C, and D and Sections 111, 115, and 346 of H.R. 3962, the Affordable Health Care for America Act, as Introduced on October 29, 2009

By Fiscal Year, in Billions of Dollars

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN DIRECT SPENDING													
DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS													
TITLE I—IMPROVING HEALTH CARE VALUE													
Subtitle A—Provisions Related to Medicare Part A													
PART 1—MARKET BASKET UPDATES													
1101	Skilled Nursing Facility Payment Update (includes interaction with section 1103)	-0.4	-0.9	-1.3	-1.6	-1.9	-2.4	-2.9	-3.5	-4.1	-4.8	-6.0	-23.9
1102	Inpatient Rehabilitation Facility Payment Update (includes interaction with section 1103)	-0.1	-0.2	-0.3	-0.4	-0.4	-0.5	-0.6	-0.8	-0.9	-1.0	-1.4	-5.3
1103	Incorporating Productivity Improvements Into Market Basket Updates That Do Not Already Incorporate Such Improvements	-1.2	-3.5	-5.1	-6.5	-8.0	-10.3	-12.9	-15.4	-18.1	-21.1	-24.2	-102.0
PART 2—OTHER MEDICARE PART A PROVISIONS													
1111	Payments to Skilled Nursing Facilities	0	0	0	0	0	0	0	0	0	0	0	0
1112	Medicare DSH Report and Payment Adjustments in Response to Coverage Expansion	0	0	0	0	0	0	0	-3.0	-3.5	-3.8	0	-10.3
1113	Extension of Hospice Regulation Moratorium	*	*	0	0	0	0	0	0	0	0	0.1	0.1
1114	Permitting Physician Assistants to Order Post-Hospital Extended Care Services and to Provide for Recognition of Attending Physician Assistants as Attending Physicians to Serve Hospice Patients	*	*	*	*	*	*	*	*	*	*	*	*
Subtitle B—Provisions Related to Part B													
PART 1—PHYSICIANS' SERVICES													
1121	Resource-Based Feedback Program for Physicians	0	0	0	0	0	0	0	0	0	0	0	0
1122	Misvalued Codes Under the Physician Fee Schedule	*	*	*	*	*	*	*	*	*	*	0.1	0.2
1123	Payments for Efficient Areas	0	0.1	0.2	0.1	0	0	0	0	0	0	0.4	0.4
1124	Modifications to the Physician Quality Reporting Initiative	0	0	0.5	0.8	0	0	0	0	0	0	1.3	1.3
1125	Adjustment to Medicare Payment Localities	0	*	0.1	0.1	0.1	0.1	0	0	0	0	0.2	0.3

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PART 2—MARKET BASKET UPDATES													
1131	Incorporating Productivity Improvements Into Market Basket Updates That Do Not Already Incorporate Such Improvements	-0.5	-1.2	-1.8	-2.4	-3.0	-3.9	-5.2	-6.5	-7.8	-9.1	-9.0	-41.6
PART 3—OTHER PROVISIONS													
1141	Rental and Purchase of Power-Driven Wheelchairs	0	-0.4	-0.1	*	*	*	*	-0.1	-0.1	-0.1	-0.6	-0.8
1141A	Election to Take Ownership, or to Decline Ownership, of Certain Complex Durable Medical Equipment After the 13-Month Capped Rental Period Ends	0	0	0	0	0	0	0	0	0	0	0	0
1142	Extension of Payment Rule for Brachytherapy	*	*	*	0	0	0	0	0	0	0	*	*
1143	Home Infusion Therapy Report to Congress	0	0	0	0	0	0	0	0	0	0	0	0
1144	Require Ambulatory Surgical Centers to Submit Data	0	0	0	0	0	0	0	0	0	0	0	0
1145	Treatment of Certain Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
1146	Payment for Imaging Services	0	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-1.2	-3.0
1147	Durable Medical Equipment Program Improvements	*	*	*	*	*	*	*	*	*	*	*	0.1
1148	MedPAC Study and Report on Bone Mass Measurement	0	0	0	0	0	0	0	0	0	0	0	0
1149	Timely Access to Post-Mastectomy Items	*	*	*	*	*	*	*	*	*	*	*	*
1149A	Payment for Biosimilar Biological Products	Included in estimate for section 2565											
1149B	Study and Report on DME Competitive Bidding Process	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle C—Provisions Related to Medicare Parts A and B													
1151	Reducing Potentially Preventable Hospital Readmissions	*	*	-0.3	-0.6	-1.2	-1.3	-1.4	-1.4	-1.5	-1.6	-2.0	-9.3
1152	Post-Acute-Care Services Payment Reform Plan and Bundling Pilot Program	*	*	*	*	0	0	0	0	0	0	*	*
1153 - 1155	Home Health Changes	-0.7	-2.8	-3.8	-4.4	-5.0	-5.9	-6.8	-7.9	-9.1	-10.3	-16.7	-56.7
1155A	MedPAC Study on Variation in Home Health Margins	0	0	0	0	0	0	0	0	0	0	0	0
1155B	Home Health: Initial Assessment Visit for Rehabilitation Cases	0	*	*	*	*	*	*	*	*	*	*	*
1156	Limitation on Medicare Exceptions to the Prohibition on Certain Physician Referrals Made to Hospitals	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-1.0
1157	Study of Geographic Adjustment Factors	0	0	0	0	0	0	0	0	0	0	0	0
1158	Revision of Medicare Payment Systems to Address Geographic Inequities	0	0	2.7	2.7	-14.1	-5.6	0	0	0	0	-8.7	-14.3
1159	Study of Geographic Variation in Health Care Spending and Promoting High-Value Health Care	*	*	0	0	0	0	0	0	0	0	*	*
1160	Implementation, and Congressional Review, of Proposal to Revise Medicare Payments to Promote High-Value Health Care	0	0	0	0	0	0	0	0	0	0	0	0

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Subtitle D—Medicare Advantage Reforms													
PART 1—PAYMENT AND ADMINISTRATION													
1161	Phase-In of Payment Based on Fee-for-Service Costs, and Quality Bonus Payments	0	-4.7	-10.2	-14.8	-17.7	-18.9	-19.8	-21.1	-22.7	-24.4	-47.5	-154.3
1162	Coding Intensity Adjustment	0	-0.2	-0.6	-0.9	-1.2	-1.6	-2.0	-2.5	-3.0	-3.5	-2.9	-15.5
1163	Simplification of Annual Beneficiary Election Periods	0	0	0	0	0	0	0	0	0	0	0	0
1164	Extension of Reasonable Cost Contracts	0	*	*	0	0	0	0	0	0	0	*	*
1165	Limitation of Waiver Authority for Employer Group Plans	0	0	0	0	0	0	0	0	0	0	0	0
1166	Improving Risk Adjustment for Payments	0	0	0	0	0	0	0	0	0	0	0	0
1167	Elimination of MA Regional Plan Stabilization Fund	0	0	0	0	-0.2	-0.1	0	0	0	0	-0.2	-0.2
1168	Study Regarding Calculation of Medicare Advantage Payment Rates	0	0	0	0	0	0	0	0	0	0	0	0
PART 2—BENEFICIARY PROTECTIONS AND ANTI-FRAUD													
1171	Limitation on Cost-Sharing for Individual Health Services	0	0	0	0	0	0	0	0	0	0	0	0
1172	Continuous Open Enrollment for Enrollees in Plans With Enrollment Suspension	0	0	0	0	0	0	0	0	0	0	0	0
1173	Information on MA Plan Administrative Costs	0	0	0	0	0	0	0	0	0	0	0	0
1174	Strengthening Audit Authority	0	0	0	0	0	0	0	0	0	0	0	0
1175	Authority to Deny Plan Bids	0	0	0	0	0	0	0	0	0	0	0	0
1175A	State Authority to Enforce Standardized Marketing Requirements	0	0	0	0	0	0	0	0	0	0	0	0
PART 3—TREATMENT OF SPECIAL NEEDS PLANS													
1176 - 1178	Special Needs Plans	0	0.1	0.1	*	*	*	*	*	*	*	0.2	0.1
Subtitle E—Improvements to Medicare Part D													
1181 - 1182	Elimination of Coverage Gap; Discounts for Certain Part D Drugs in Original Coverage Gap	0.1	-7.1	-5.3	-4.9	-3.9	-4.1	-3.4	-4.6	-5.4	-3.7	-21.1	-42.3
1183	Submission of Claims by Pharmacies Located in or Contracting With Long-Term Care Facilities	0	0	0	0	0	0	0	0	0	0	0	0
1184	Including Costs Incurred by AIDS Drug Assistance Programs and Indian Health Service in Providing Prescription Drugs Toward the Annual Out-of-Pocket Threshold Under Part D	0	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
1185	No Mid-Year Formulary Changes Permitted	0	0	0	0	0	0	0	0	0	0	0	0
1186	Negotiation of Lower Covered Part D Drug Prices on Behalf of Medicare Beneficiaries	0	0	0	0	0	0	0	0	0	0	0	0
1187	Accurate Dispensing in Long-Term Care Facilities	0	0	-0.1	-0.3	-0.5	-0.8	-1.0	-1.0	-0.9	-1.1	-1.0	-5.7
1188	Free Generic Fill	0	-0.2	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-1.1	-3.0
1189	State Certification Prior to Waiver of Licensure Requirements Under Medicare Prescription Drug Program	0	0	0	0	0	0	0	0	0	0	0	0

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		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Subtitle F—Medicare Rural Access Protections													
1191	Telehealth Expansion and Enhancements	*	*	*	*	*	*	*	*	*	*	*	*
1192	Extension of Outpatient Hold Harmless Provision	0.1	0.1	*	0	0	0	0	0	0	0	0.2	0.2
1193	Extension of Section 508 Hospital Reclassifications	0.2	0.3	*	0	0	0	0	0	0	0	0.5	0.5
1194	Extension of Geographic Floor for Work	0.3	0.5	0.2	0	0	0	0	0	0	0	1.1	1.1
1195	Extension of Payment for Technical Component of Certain Physician Pathology Services	*	0.1	*	0	0	0	0	0	0	0	0.1	0.1
1196	Extension of Ambulance Add-Ons	0.1	0.1	*	0	0	0	0	0	0	0	0.2	0.2
TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS													
Subtitle A—Improving and Simplifying Financial Assistance for Low Income Medicare Beneficiaries													
1201 - 1207	Medicare Savings Program and Low-Income Subsidy Program												
	Effects on Medicare spending	0.1	0.3	0.6	1.0	1.2	1.3	1.6	1.7	1.8	2.2	3.2	11.8
	Effects on Medicaid spending	0	0	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.4	1.7
Subtitle B—Reducing Health Disparities													
1221	Ensuring Effective Communication in Medicare	*	*	0	0	0	0	0	0	0	0	*	*
1222	Demonstration to Promote Access for Medicare Beneficiaries With Limited English Proficiency	0	*	*	*	*	*	0	0	0	0	*	*
1223	Report on Impact of Language-Access Services	0	0	0	0	0	0	0	0	0	0	0	0
1224	Definitions	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle C—Miscellaneous Improvements													
1231	Extension of Therapy Caps Exceptions Process	0.6	0.9	0.2	0	0	0	0	0	0	0	1.7	1.7
1232	Extended Months of Coverage of Immunosuppressive Drugs and Other Renal Dialysis Provisions	0	*	*	*	*	*	*	*	*	*	*	-0.1
1233	Voluntary Advance Care Planning Consultation	0	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.6	1.9
1234	Part B Special Enrollment Period and Waiver of Limited Enrollment Penalty for TRICARE Beneficiaries	*	*	*	*	*	*	*	*	*	*	*	*
1235	Exception for Use of More Recent Tax Year in Case of Gains From Sale of Primary Residence in Computing Part B Income-Related Premium	*	*	*	*	*	*	*	*	*	*	*	*
1236	Demonstration Program: Patient Decisions Aids	*	*	*	*	*	*	*	*	*	*	*	*

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TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE													
1301	Accountable Care Organization Pilot Program	0	0	*	*	-0.1	-0.3	-0.3	-0.4	-0.7	-0.8	-0.2	-2.6
1302	Medical Home Pilot Program	0.2	0.3	0.3	0.3	0.3	0.2	0.1	*	0	0	1.5	1.8
1303	Payment Incentive for Selected Primary Care Services	0.2	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.6	0.6	2.0	4.7
1304	Payment for Certified Nurse-Midwives	*	*	*	*	*	*	*	*	*	*	*	*
1305	Coverage and Waiver of Cost-Sharing for Preventive Services	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.4	0.4	1.0	2.7
1306	Waive Deductible for Colorectal Cancer Screening Tests	0	0	0	0	0	0	0	0	0	0	0	0
1307	Excluding Clinical Social Worker Services From Coverage Under the Medicare Skilled Nursing Facility Prospective Payment System and Consolidated Payment	0	0	0	0	0	0	0	0	0	0	0	0
1308	Coverage of Marriage and Family Therapist Services and Mental Health Counselor Services	*	*	*	*	*	*	*	0.1	0.1	0.1	0.1	0.4
1309	Extension of Physician Fee Schedule Mental Health Add-On	*	*	*	0	0	0	0	0	0	0	0.1	0.1
1310	Expanding Access to Vaccines	0	*	*	0.1	0.1	0.1	0.2	0.2	0.3	0.4	0.2	1.4
1311	Expansion of Medicare-Covered Preventive Services at Federally Qualified Health Centers	*	*	*	*	*	*	*	*	*	*	0.1	0.1
1312	Independence at Home Demonstration Program	*	*	*	*	*	*	0	0	0	0	*	*
1313	Recognition of Certified Diabetes Educators as Providers	*	*	*	*	*	*	*	*	*	*	*	*
TITLE IV—QUALITY													
Subtitle A—Comparative Effectiveness Research													
1401	Comparative Effectiveness Research (effects on outlays)												
	Medicare	*	0.1	0.1	*	*	*	*	-0.1	-0.1	-0.2	0.2	-0.1
	Non-Medicare	0	*	*	0.1	0.2	0.2	0.2	0.2	0.2	0.1	0.3	1.2
Subtitle B—Nursing Home Transparency		*	*	*	0	0	0	0	0	0	0	0.1	0.1
Subtitle C—Quality Measurements		*	*	0.1	0.1	0.1	*	*	0	0	0	0.2	0.3
Subtitle D—Physician Payments Sunshine Provision		0	0	0	0	0	0	0	0	0	0	0	0
Subtitle E—Public Reporting on Health Care-Associated Infections		0	0	*	*	*	*	*	*	*	*	*	*
TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION													
1501 - 1505	Graduate Medical Education Provisions	*	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.5	1.5

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TITLE VI—PROGRAM INTEGRITY													
Subtitle A—Increased Funding to Fight Waste, Fraud, and Abuse		0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.9
Subtitle B—Enhanced Penalties for Fraud and Abuse		*	*	*	*	*	*	*	*	*	*	-0.1	-0.2
Subtitle C—Enhanced Program and Provider Protections		*	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.7	-2.1
Subtitle D—Access to Information Necessary to Prevent Fraud, Waste, and Abuse		0	0	0	0	0	0	0	0	0	0	0	0
TITLE VII—MEDICAID AND CHIP													
Subtitle A—Medicaid and Health Reform													
1701	Eligibility for Individuals With Income Below 150 Percent of the Federal Poverty Level	Included in estimate for expanding health insurance coverage (except for Medicare cost-sharing assistance).											
	Medicare cost sharing assistance - - Medicare effects	0	0	0	0.3	0.6	0.7	0.8	0.9	0.9	1.0	0.9	5.3
	Medicare cost sharing assistance - - Medicaid effects	0	0	0	0.6	0.9	1.0	1.0	1.1	1.2	1.3	1.5	7.2
1702	Special Rules for Certain Medicaid Eligible Individuals	Included in estimate for expanding health insurance coverage.											
1703	CHIP and Medicaid Maintenance of Eligibility	Included in estimate for expanding health insurance coverage.											
1704	Reduction in Medicaid DSH	*	*	*	*	*	*	*	-1.5	-2.5	-6.0	*	-10.0
1705	Expanded Outstationing	Included in estimate for expanding health insurance coverage.											
Subtitle B—Prevention													
1711	Required Coverage of Preventive Services	*	0.2	0.2	0.8	0.8	1.3	1.5	1.7	1.9	2.1	2.1	10.7
1712	Tobacco Cessation	*	*	*	*	*	*	*	*	*	*	*	0.1
1713	Optional Coverage of Nurse Home Visitation Services	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
1714	State Eligibility Option for Family Planning Services	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle C—Access													
1721	Payments to Primary Care Practitioners	3.3	6.4	5.5	6.5	6.9	6.4	5.7	5.7	5.1	5.4	28.7	57.0
1722	Medical Home Pilot Program	*	0.1	0.1	0.1	0.1	*	0	0	0	0	0.5	0.5
1723	Translation or Interpretation Services	*	*	*	*	*	*	*	*	*	0.1	0.1	0.3
1724	Optional Coverage for Freestanding Birth Center Services	*	*	*	*	*	*	*	*	*	*	*	*
1725	Inclusion of Public Health Clinics Under the Vaccines for Children Program	*	0.1	0.1	0.1	0.1	*	*	0	0	0	0.4	0.5
1726	Requiring Coverage of Services of Podiatrists	*	*	*	*	*	*	*	*	*	*	0.1	0.2
1726A	Requiring Coverage of Services of Optometrists	*	*	*	*	*	*	*	*	*	*	*	0.1
1727	Therapeutic Foster Care	*	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
1728	Assuring Adequate Payment Levels for Services	0	0	0	0	0	0	0	0	0	0	0	0
1729	Preserving Medicaid Coverage for Youths Upon Release From Public Institutions	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.6
1730	Quality Measures for Maternity and Adult Health Services Under Medicaid and CHIP	*	*	*	*	*	*	*	*	*	0	*	*
1730A	Accountable Care Organization Pilot Program	0	0	*	*	*	*	*	*	*	*	*	-0.1
1730B	FQHC Coverage	0	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	1.0

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Subtitle D—Coverage													
1731	Optional Medicaid Coverage of Low-Income HIV-Infected Individuals	0.1	0.4	0.4	0.1	0	0	0	0	0	0	1.1	1.1
1732	Extending Transitional Medicaid Assistance	0	0.2	1.1	1.0	0.1	*	0	0	0	0	2.4	2.4
1733	Requirement of 12-Month Continuous Coverage Under Certain CHIP Programs	Included in estimate for expanding health insurance coverage.											
1734	Preventing the Application Under CHIP of Coverage Waiting Periods for Certain Children	Included in estimate for expanding health insurance coverage.											
1735	Adult Day Health Care Services	0	0	0	0	0	0	0	0	0	0	0	0
1736	Medicaid Coverage for Citizens of Freely Associated States	*	*	*	*	*	*	*	*	*	*	0.1	0.2
1737	Medicaid Coverage of Nonemergency Transportation to Medically Necessary Services	*	*	*	*	*	*	*	*	*	*	*	*
1738	State Option to Disregard Certain Income in Providing Continued Medicaid Coverage for Certain Individuals With Extremely High Prescription Costs	*	0.2	0.2	*	0	0	0	0	0	0	0.5	0.5
1739	Community Living Assistance Services and Supports	Included in estimate for section 2581.											
Subtitle E—Financing													
1741 - 1743	Medicaid Pharmacy Reimbursement and Prescription Drug Rebate Provisions (includes interactions with section 2501)	-0.4	-1.9	-2.5	-2.7	-2.9	-2.7	-2.8	-2.8	-2.9	-3.0	-10.4	-24.6
1744	Payments for Graduate Medical Education	0	0	0	0	0	0	0	0	0	0	0	0
1745	Nursing Facility Supplemental Payment Program	0.4	1.1	1.5	1.5	1.1	0.4	0	0	0	0	5.6	6.0
1746	Report on Medicaid Payments	0	0	0	0	0	0	0	0	0	0	0	0
1747	Reviews of Medicaid	0	0	0	0	0	0	0	0	0	0	0	0
1748	Extension of Delay in Managed Care Organization Provider Tax Elimination	0.4	0	0	0	0	0	0	0	0	0	0.4	0.4
1749	Extension of ARRA Increase in FMAP	0	23.5	0	0	0	0	0	0	0	0	23.5	23.5
Subtitle F—Waste, Fraud, and Abuse													
1751	Health Care Acquired Conditions	0	0	*	*	*	*	*	*	*	*	*	*
1752	Evaluations and Reports	0	0	0	0	0	0	0	0	0	0	0	0
1753	Require Providers and Suppliers to Adopt Programs to Reduce Waste, Fraud, and Abuse	0	0	0	0	0	0	0	0	0	0	0	0
1754	Overpayments	0.1	0	*	0	*	*	*	*	*	*	0.1	0.1
1755	Managed Care Organizations	0	0	0	0	0	0	0	0	0	0	0	0
1756	Termination of Provider Participation Under Medicaid and CHIP if Terminated Under Certain Other Plans	0	0	0	0	0	0	0	0	0	0	0	0
1757	Medicaid and CHIP Exclusion From Participation Relating to Certain Ownership and Other Affiliations	0	0	0	0	0	0	0	0	0	0	0	0
1758	Report Expanded Set of Data Elements Under MMIS	0	0	0	0	0	0	0	0	0	0	0	0
1759	Alternate Payees Required to Register Under Medicaid	0	0	0	0	0	0	0	0	0	0	0	0
1760	Denial of Payments for Litigation-Related Misconduct	0	0	0	0	0	0	0	0	0	0	0	0
1761	Mandatory State Use of National Correct Coding Initiative	0	0	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3
Subtitle G—Payments to the Territories													

Table 3. Preliminary Estimate of the Effects on Direct Spending and Revenues of Divisions B, C, and D and Sections 111, 115, and 346 of H.R. 3962, the Affordable Health Care for America Act, as Introduced on October 29, 2009

By Fiscal Year, in Billions of Dollars

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
1771	Payment to Territories	0	0.8	0.9	0.8	0.9	1.0	1.1	1.2	1.2	1.4	3.4	9.3
Subtitle H—Miscellaneous													
1781	Technical Corrections	0	0	0	0	0	0	0	0	0	0	0	0
1782	Extension of QI Program	0	0.5	0.7	0.2	0	0	0	0	0	0	1.4	1.4
1783	Assuring Transparency of Information	0	0	0	0	0	0	0	0	0	0	0	0
1784	Medicaid and CHIP Payment and Access Commission	0	0	0	0	0	0	0	0	0	0	0	0
1785	Outreach and Enrollment of Medicaid- and CHIP-Eligible Individuals	0	0	0	0	0	0	0	0	0	0	0	0
1786	Prohibitions on Federal Medicaid and CHIP Payment for Undocumented Aliens	0	0	0	0	0	0	0	0	0	0	0	0
1787	Demonstration Project for Stabilization of Emergency Medical Conditions by Institutions for Mental Diseases	*	*	*	0	0	0	0	0	0	0	0.1	0.1
1788	Application of Medicare Improvement Fund	0	0	0	0	-0.1	-0.2	-0.2	-0.2	-0.2	0	-0.1	-0.7
1789	Treatment of Certain Medicaid Brokers	0	0	0	0	0	0	0	0	0	0	0	0
1790	Rule for Changes Requiring State Legislation	0	0	0	0	0	0	0	0	0	0	0	0
TITLE VIII—REVENUE-RELATED PROVISIONS		Estimates provided separately by the Joint Committee on Taxation (see JCX-43-09)											
TITLE IX—MISCELLANEOUS PROVISIONS													
1901	Repeal of Trigger Provision	0	0	0	0	0	0	0	0	0	0	0	0
1902	Repeal of Comparative Cost Adjustment Program	0	*	*	*	*	*	*	0	0	0	-0.1	-0.1
1903	Extension of Gainsharing Demonstration	*	*	*	*	*	0	0	0	0	0	*	*
1904	Grants to States for Quality Home Visitation Programs for Families With Young Children or Expecting Children	*	*	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.6	1.8
1905	Improved Coordination and Protection for Dual Eligibles	0	0	0	0	0	0	0	0	0	0	0	0
1906	Assessment of Medicare Cost-Intensive Diseases	0	0	0	0	0	0	0	0	0	0	0	0
1907	Center for Medicare and Medicaid Innovation												
	Funding for Center (including noncovered benefits)	0.1	0.2	0.4	0.6	0.7	0.8	0.9	1.0	0.9	0.9	2.0	6.5
	Effect on Medicare spending for benefits	0	-0.1	-0.2	-0.4	-0.5	-0.6	-0.9	-1.3	-1.8	-2.3	-1.2	-8.2
1908	Application of Emergency Services Laws	0	0	0	0	0	0	0	0	0	0	0	0
1909	Disregard Under the Supplemental Security Income Program of Compensation for Participation in Clinical Trials for Rare Diseases or Conditions	0	0	0	0	0	0	0	0	0	0	0	0
INTERACTIONS AMONG PROVISIONS													
	Tricare Interaction	-0.1	-0.2	-0.3	-0.3	-0.4	-0.5	-0.6	-0.8	-0.9	-0.8	-1.2	-4.8
	Medicare Advantage Interactions	0	-1.1	-1.9	-2.8	-8.8	-7.8	-7.8	-10.3	-12.4	-14.3	-14.6	-67.3
	Premium Interactions	0	0.4	0.9	1.5	5.5	4.8	4.6	5.4	6.2	7.0	8.3	36.3
	Implementation of Medicare Changes	0.2	*	*	*	*	*	*	*	*	*	0.3	0.3
	Medicare Interactions with Medicaid Provisions	0	0	0	0	0	0	1.8	3.0	3.7	4.0	0	12.4
	Medicare Interactions with 340B Provision	*	*	*	*	*	*	*	*	*	*	*	*
SUBTOTAL, DIVISION B		**3.9**	**13.6**	**-15.6**	**-22.5**	**-49.1**	**-47.5**	**-47.9**	**-61.6**	**-73.8**	**-84.4**	**-69.8**	**-385.0**

Table 3. Preliminary Estimate of the Effects on Direct Spending and Revenues of Divisions B, C, and D and Sections 111, 115, and 346 of H.R. 3962, the Affordable Health Care for America Act, as Introduced on October 29, 2009

By Fiscal Year, in Billions of Dollars

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT													
2001 - 2403	Public Health Investment Fund, and Prevention and Wellness Trust[a]	0	1.8	4.4	5.9	7.1	8.2	4.8	0.9	0.2	*	19.2	33.4
2501 - 2503	340B Drug Discount Programs	Included in estimate for sections 1741-1743											
2511	School-based Health Clinics	0	0	0	0	0	0	0	0	0	0	0	0
2572	Nutrition labeling at Chain Restaurants and Vending Machines	0	0	0	0	0	0	0	0	0	0	0	0
2573	Protecting Consumer Access to Generic Drugs	-0.1	-0.1	-0.1	-0.2	-0.1	-0.1	-0.1	-0.2	-0.3	-0.4	-0.7	-1.8
2575	Licensure Pathway for Biosimilar Biological Products	0	0	0	*	-0.1	-0.3	-0.6	-1.1	-1.7	-2.5	-0.1	-6.2
2581	Community Living Assistance Services and Supports	0	-3.7	-6.4	-8.7	-9.9	-11.2	-9.6	-8.6	-7.5	-6.8	-28.7	-72.5
SUBTOTAL, DIVISION C		**-0.1**	**-2.0**	**-2.2**	**-2.9**	**-3.0**	**-3.4**	**-5.6**	**-8.9**	**-9.4**	**-9.7**	**-10.2**	**-47.1**
DIVISION D—INDIAN HEALTH CARE IMPROVEMENT													
TITLE I—AMENDMENTS TO INDIAN LAWS													
3101	Scholarship And Loan Repayment Recovery Fund and Exemption From Payment From Certain Fees	*	*	*	*	*	*	*	*	*	*	*	*
TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT													
3201	Expansion of Payments Under Medicare	0	*	*	*	*	*	*	*	*	*	0.1	0.2
SUBTOTAL, DIVISION D		*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	**0.1**	**0.2**
OTHER (from Division A)													
111	Reinsurance Program for Retirees	3.0	5.0	2.0	0	0	0	0	0	0	0	10.0	10.0
115	Administrative Simplification												
	Effects on Medicaid spending	*	*	*	-0.1	-0.1	-0.2	-0.5	-1.0	-1.1	-1.2	-0.2	-4.2
	Effects on exchange subsidies	0	0	0	*	-0.1	-0.4	-0.7	-1.0	-1.1	-1.2	-0.2	-4.6
346	Special Rules for Application to Territories	0	0	0	0.7	0.7	0.7	0.7	0.7	0.7	0.7	1.4	5.0
Total, Changes in Direct Spending		**6.8**	**16.6**	**-15.8**	**-24.8**	**-51.7**	**-50.7**	**-53.9**	**-71.8**	**-84.7**	**-95.7**	**-68.9**	**-425.6**

Table 3. Preliminary Estimate of the Effects on Direct Spending and Revenues of Divisions B, C, and D and Sections 111, 115, and 346 of H.R. 3962, the Affordable Health Care for America Act, as Introduced on October 29, 2009

By Fiscal Year, in Billions of Dollars

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN REVENUES												
Fraud, Waste, and Abuse	*	*	*	*	*	*	*	*	*	*	0.1	0.2
Effect of Administrative Simplification on Revenues[b]	0	-0.1	-0.2	0.1	0.6	1.2	1.9	2.9	3.2	3.3	0.3	12.8
Effects on Revenues of Provisions Involving Comparative Effectiveness, Access to Generic Drugs, and Follow-On Biologicals												
Income and Medicare payroll taxes (on-budget)	*	*	*	*	*	*	0.1	0.2	0.2	0.3	0.1	0.9
Social Security payroll taxes (off-budget)	*	*	*	*	*	*	*	0.1	0.1	0.2	*	0.5
Total, Changes in Revenues (unified budget)	*****	**-0.1**	**-0.1**	**0.1**	**0.6**	**1.3**	**2.1**	**3.1**	**3.6**	**3.8**	**0.5**	**14.4**
CHANGES IN DEFICITS												
Total, Changes in Deficits (unified budget)	**6.8**	**16.7**	**-15.7**	**-24.9**	**-52.3**	**-52.0**	**-55.9**	**-74.9**	**-88.3**	**-99.5**	**-69.4**	**-440.0**
MEMORANDUM												
Non-scorable savings from increased HCFAC spending	0	*	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.4	-1.3

Notes:

***** Between -$50 million and $50 million.

a. The legislation would authorize the appropriation of approximately $34 billion over the 2011-2015 period for public health, prevention, and wellness provisions. Although that spending would not occur without the enactment of subsequent discretionary appropriations, the House Committee on the Budget has directed CBO to consider such spending as direct spending in this cost estimate.

b. Estimated by the Joint Committee on Taxation. Includes both on-budget and off-budget effects.

AIDS = acquired immune deficiency syndrome; ARRA = American Recovery and Reinvestment Act (Public Law 111-5); CHIP = Children's Health Insurance Program; DSH = disproportionate share hospital; DME = durable medical equipment; FMAP = federal medical assistance percentage; FQHC = federally qualified health center; HCFAC = health care fraud and abuse control account; HIV = human immunodeficiency virus; MA = Medicare Advantage; MedPAC = Medicare Payment Advisory Commission; MMIS = Medicaid Management Information System; PPS = prospective payment system; QI = qualifying individual.

JOINT COMMITTEE ON TAXATION
October 29, 2009
JCX-43-09

ESTIMATED REVENUE EFFECTS OF POSSIBLE MODIFICATIONS TO THE REVENUE PROVISIONS OF H.R. 3962, THE "AFFORDABLE HEALTH CARE FOR AMERICA ACT"

Fiscal Years 2010 - 2019

[Billions of Dollars]

Provision	Effective	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
I. Reform Proposals													
A. Tax on Individual Without Acceptable Health Care Coverage	tyba 12/31/12	- - - - - - - - *Estimate Provided by the Congressional Budget Office and the Joint Committee on Taxation [1]* - - - - - -											
B. Election to Satisfy Health Coverage Participation Requirements	pba 12/31/12	- - - - - - - - *Estimate Provided by the Congressional Budget Office and the Joint Committee on Taxation [1]* - - - - - -											
C. Health Care Contributions of Nonelecting Employers	pba 12/31/12	- - - - - - - - *Estimate Provided by the Congressional Budget Office and the Joint Committee on Taxation [1]* - - - - - -											
D. Credit for Small Business Employee Health Coverage Expenses	tyba 12/31/12	- - - - - - - - *Estimate Provided by the Congressional Budget Office and the Joint Committee on Taxation [1]* - - - - - -											
E. Disclosures to Carry Out Health Insurance Exchange Subsidies	DOE	- - - - - - - - *Estimate Provided by the Congressional Budget Office and the Joint Committee on Taxation [1]* - - - - - -											
F. Conform the Definition of Medical Expenses for Employer-Provided Health Coverage, Including Health Flexible Spending Arrangements and Health Reimbursement Arrangements, Health Savings Accounts, and Archer MSAs to the Definition for the Itemized Deduction [2]	eia 12/31/10	---	0.4	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	2.1	5.0
G. Limit Health Flexible Spending Arrangements in Cafeteria Plans to $2,500, Indexed to CPI-U	tyba 12/31/12	---	---	---	1.5	2.1	2.1	2.0	1.9	1.9	1.8	3.6	13.3
H. Increase the Penalty for Nonqualified Distributions from Health Savings Accounts to 20%	dmd tyba 12/31/10	---	[3]	[3]	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.2	1.3
I. Eliminate Deduction for Expenses Allocable to Medicare Part D Subsidy [4]	tyba 12/31/10	---	0.3	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.2	1.5	3.0
J. Exclusion from Gross Income for Indian Tribe Health Benefits	hbacpa DOE	---	---	[5]	[5]	[5]	[5]	[5]	[5]	[5]	[5]	[5]	[5]
Total of Reform Proposals		---	**0.7**	**1.0**	**2.6**	**3.2**	**3.2**	**3.1**	**3.0**	**3.1**	**2.9**	**7.4**	**22.6**

Provision	Effective	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
II. Other Revenue Provisions													
A. Impose a 5.4% Surtax on AGI in Excess of $500,000 ($1,000,000 for joint returns); Not Indexed for Inflation	tyba 12/31/10	---	30.9	31.7	45.0	49.3	53.2	56.9	60.6	64.4	68.4	156.9	460.5
B. Impose a 2.5% Ad Valorem Excise Tax on First Taxable Sale of Medical Devices	somda 12/31/12	---	---	---	1.9	2.7	2.8	3.0	3.1	3.2	3.3	4.6	20.0
C. Require information Reporting on Payments to Corporations	pma 12/31/11	---	---	0.4	3.3	2.0	2.1	2.2	2.3	2.4	2.5	5.6	17.1
D. Delay Implementation of Worldwide Interest Allocation Until 2020	tyba 12/31/10	---	0.5	1.4	3.1	3.2	3.3	3.5	3.6	3.7	3.8	8.2	26.1
E. Limit Treaty Benefits for Certain Deductible Payments	pma DOE	0.5	0.7	0.7	0.7	0.7	0.7	0.8	0.9	0.9	0.9	3.3	7.5
F. Codify Economic Substance Doctrine and Impose Penalties for Underpayments	teia DOE	0.1	0.4	0.5	0.6	0.6	0.7	0.7	0.7	0.7	0.7	2.3	5.7
G. Extend Certain Health Benefits Applicable to Spouses and Dependents to Eligible Designated Beneficiaries	tyba 12/31/09	-0.2	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-0.5	-0.5	-0.6	-1.6	-4.0
Total of Other Revenue Provisions		**0.4**	**32.2**	**34.4**	**54.2**	**58.1**	**62.4**	**66.7**	**70.7**	**74.8**	**79.0**	**179.3**	**532.9**
III. Revenue-Related Provisions													
A. Disclosures to Facilitate Identification of Individuals Likely to be Ineligible for Low-Income Subsidies Under the Medicare Prescription Drug Program to Assist Social Security Administration's Outreach to Eligible Individuals [6]	[7]	*No Revenue Effect*											
B. Impose Fee on Insured and Self-Insured Health Plans; Comparative Effectiveness Research Trust Fund	[8]	---	---	---	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.6	2.0
Total of Revenue-Related Provisions		**---**	**---**	**---**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.6**	**2.0**
NET TOTAL		**0.4**	**32.9**	**35.4**	**57.1**	**61.6**	**65.9**	**70.1**	**74.0**	**78.2**	**82.2**	**187.3**	**557.5**

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding.

Legend and Footnotes for JCX-43-09 are on the following page

Legend and Foots for JCX-43-09:

Legend for "Effective" column:

DOE = date of enactment
dmd = disbursements made during
eia = expenses incurred after
hbacpa = health benefits and coverage provided after
pba = periods beginning after
pma = payments made after
somda = sales of medical devices after
teia = transactions entered into after
tyba = taxable years beginning after

[1] Estimate included in Preliminary Analysis of the Insurance Coverage Specifications Provided by the House Tri-Committee Group, July 14, 2009, from the Congressional Budget Office to the Honorable Charles B. Rangel, Chairman, Committee on Ways and Means.
[2] Estimate includes interaction effect with FSA cap.
[3] Gain of less than $50 million.
[4] Estimate includes interaction with other proposals.
[5] Loss of less than $50 million.
[6] Any change in Medicare Part D outlays associated with this provision would be reflected in the Congressional Budget Office estimate of Title II—Medicare Beneficiary Improvements, Subtitle A.
[7] Effective for disclosures made after the date which is 12 months after the date of enactment.
[8] Effective with respect to policies and plans for portion of policies or plan years beginning on or after October 1, 2012.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

November 4, 2009

Honorable John A. Boehner
Republican Leader
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Leader:

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have completed a preliminary analysis of the amendment in the nature of a substitute for H.R. 3962, the Affordable Health Care for America Act, as you proposed on November 3, 2009. For several reasons described later, this analysis does not constitute a comprehensive cost estimate for the amendment.

The amendment includes a number of provisions intended to increase the availability and improve the affordability of private health insurance. CBO's and JCT's preliminary assessment of the amendment's impact on federal budget deficits is summarized in the following table. The enclosures with this letter provide estimates of the changes in the number of nonelderly people in the United States who would have health insurance, present the primary budgetary effects of the amendment's provisions related to insurance coverage, and give estimates of the costs or savings from other proposed changes that would affect the federal government's direct spending and revenues.

According to CBO and JCT's assessment, enacting the amendment would result in a net reduction in federal budget deficits of $68 billion over the 2010–2019 period. That estimate reflects a projected net cost of $8 billion over 10 years for the provisions directly related to insurance coverage; that net cost reflects a gross cost of $61 billion that is partly offset by about $52 billion in additional revenues associated with the coverage provisions. Over the same period, the other provisions of the amendment would reduce direct spending by $49 billion and increase tax revenues by $27 billion.

Honorable John A. Boehner
Page 2

PRELIMINARY ESTIMATE OF THE EFFECTS ON THE DEFICIT OF THE AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 3962, OFFERED BY REPRESENTATIVE BOEHNER

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
NET CHANGES IN THE DEFICIT FROM INSURANCE COVERAGE PROVISIONS [a]												
Effects on the Deficit	*	*	-2	14	-3	3	3	-1	-3	-2	8	8
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING												
Effects on the Deficit of Changes in Outlays	*	*	-2	-3	-5	-6	-7	-8	-9	-10	-9	-49
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [b]												
Effects on the Deficit of Changes in Revenues	0	*	*	-1	-2	-3	-4	-5	-6	-6	-4	-27
NET CHANGES IN THE DEFICIT [a]												
Net Increase or Decrease (-) in the Budget Deficit	*	*	-4	9	-10	-6	-7	-14	-18	-18	-5	-68
Memorandum:												
Changes from Direct Spending	*	*	-1	15	-4	2	2	-3	-6	-6	10	*
Changes from Revenues	*	-1	-3	-5	-6	-8	-10	-11	-12	-13	-15	-68

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Components may not sum to totals because of rounding; * = between $0.5 billion and -$0.5 billion.

a. Does not include effects on spending subject to future appropriations.

b. The changes in revenues include effects on Social Security revenues, which are classified as off-budget.

The figures presented here do not represent a comprehensive cost estimate for the amendment. The analysis does not take into account all of the proposal's effects on spending for other federal programs or the administrative costs for oversight and implementation. In addition, the estimates address the amendment's impact on direct spending and revenues but do not include the potential costs of provisions that would be subject to future appropriations or that would affect programs that are subject to future appropriations. Nevertheless, the estimates reflect the major net budgetary effects of the proposal.

CBO and JCT have assumed that the amendment's key provisions—including grant funds for high-risk pools and reinsurance programs and insurance market reforms—

would become effective on the date of enactment, which is assumed to be in December 2009. Provisions establishing association health plans (AHPs) would become effective 12 months after the date of enactment.

Effects of the Insurance Coverage Provisions

The amendment contains several provisions that are intended to increase rates of insurance coverage by reducing its costs or subsidizing its purchase, including:

- Regulatory reforms in the small group and nongroup markets, including establishing AHPs and individual membership associations, and allowing states to establish interstate compacts with a unified regulatory structure;

- A State Innovations grant program to provide federal payments to states that achieve specified reductions in the number of uninsured individuals or in the premiums for small group or individually purchased policies; [1]

- Federal funding for states to use for high-risk pools in the individual insurance market and reinsurance programs in the small group market; and

- Changes to health savings accounts (HSAs) to allow funds in them to be used to pay premiums under certain circumstances, to make net contributions to HSAs eligible for the saver's credit, and to provide a 60-day grace period for medical expenses incurred prior to the establishment of an HSA.

By 2019, CBO and JCT estimate, the number of nonelderly people without health insurance would be reduced by about 3 million relative to current law, leaving about 52 million nonelderly residents uninsured. The share of legal nonelderly residents with insurance coverage in 2019 would be about 83 percent, roughly in line with the current share. CBO and JCT estimate that enacting the amendment's insurance coverage provisions would increase deficits by $8 billion over the 2010–2019 period.

Effects of Other Provisions

Other provisions of the amendment would alter federal spending and revenues in significant ways as well. The key provisions include these:

- Limits on costs related to medical malpractice ("tort reform"), including capping noneconomic and punitive damages and making changes in the allocation of liability. CBO expects that those limits would reduce health

[1] We expect that states would also spend several billion dollars to help achieve the targets specified under the State Innovations program.

care costs directly—by reducing premiums for medical liability insurance and associated costs—and indirectly by slightly reducing the utilization of health care services. Over the 2010–2019 period, those changes would reduce spending on mandatory programs by about $41 billion and would increase revenues by $13 billion as an indirect effect of reducing the costs of private health insurance plans (which would result in a shift of some workers' compensation from nontaxable health insurance benefits to taxable wages).

- Requirements that the Secretary of Health and Human Services (HHS) adopt and regularly update standards for electronic administrative transactions that enable electronic funds transfers, claims management processes, and verification of eligibility, among other administrative tasks. Those provisions would result in about $6 billion in federal savings in Medicaid. In addition, those standards would result in an increase in revenues of about $13 billion as an indirect effect of reducing the costs of private health insurance plans.

- Establishment of an abbreviated approval pathway for follow-on biologics (biological products that are highly similar to or interchangeable with their brand-name counterparts), which would reduce direct spending by an estimated $5 billion and increase revenues by about $1 billion over the 2010-2019 period.

- An increase in funding for HHS's investigations into fraud and abuse, which would increase direct spending by an estimated $3 billion during the next 10 years.

In total, CBO estimates, the provisions of the amendment not directly related to insurance coverage would reduce direct spending by $49 billion, on net, over the 2010–2019 period and would increase revenues by $27 billion.

Effects on Health Insurance Premiums

CBO estimates that the combination of provisions included in the amendment would reduce average private health insurance premiums per enrollee in the United States relative to what they would be under current law. The average reductions would be larger in the markets for small group and individually purchased policies, which are the focus of many of the legislation's provisions. In the small group market, which represents about 15 percent of total private premiums, the amendment would lower average insurance premiums in 2016 by an estimated 7 percent to 10 percent compared with amounts under current law. In the market for individually purchased insurance, which represents a little more than 5 percent of total private premiums, the amendment would lower average insurance premiums in

2016 by an estimated 5 percent to 8 percent compared with amounts under current law. And in the large group market, which represents nearly 80 percent of total private premiums, the amendment would lower average insurance premiums in 2016 by zero to 3 percent compared with amounts under current law, according to CBO's estimates. The figures are presented for 2016 as an illustrative example.

Two caveats regarding those estimates bear emphasis:

- Many individuals and families would experience changes in premiums that differed from the changes in average premiums in their insurance market. As explained below, some provisions of the legislation would tend to decrease the premiums paid by all insurance enrollees, while other provisions would tend to increase the premiums paid by less healthy enrollees or would tend to increase the premiums paid by enrollees in some states relative to enrollees in other states. As a result, some individuals and families within each market would see reductions in premiums that would be larger or smaller than the estimated average reductions, and some people would see increases.

- The estimates of changes in average premiums are very preliminary and are subject to an unusually high degree of uncertainty, even compared with the significant uncertainty attending estimates of the effects of proposals making broad changes in the nation's health care and health insurance systems. Although the estimated budgetary effects of such proposals incorporate changes in aggregate premiums, disentangling the array of factors that affect premiums and estimating their overall effect on premiums per enrollee in different insurance markets is difficult. In response to many requests, CBO is now working to provide that sort of analysis for a number of health care reform proposals being discussed in the Congress. For proposals that make a number of complex and interrelated changes in the health care and health insurance systems, the challenge of estimating the effects on premiums is especially acute, and CBO has not yet finished that analysis. For proposals with a comparatively limited number of policy changes, like the amendment you proposed, the analysis is somewhat more straightforward. Still, the estimates reported here are tentative and could be revised as CBO continues its analysis of the many avenues through which elements of reform proposals might affect insurance premiums.

The changes in average premiums per enrollee that are expected to occur under the amendment can be attributed to three broad sources:

- Changes in the price of a given amount of insurance coverage for a given group of enrollees,

- Changes in the extent of insurance coverage purchased, and

- Changes in the distribution of enrollees with different characteristics among the various insurance markets and in the uninsured population.

The first source encompasses factors that affect an "apples-to-apples" comparison of the average price of equivalent insurance coverage for an equivalent population under the amendment and under current law. Provisions in the amendment that belong in this category include the medical malpractice reforms and the requirements for administrative simplification assigned to the Secretary of HHS. Those changes would reduce spending related to the delivery of health care services and would thereby reduce health insurance premiums without substantially changing the amount of coverage provided or the mix of enrollees covered. Similarly, the amendment's subsidies for reinsurance in the small group market would reduce the average premiums charged in that market because those subsidies would reduce the net costs that insurers incurred to provide that coverage.

The second source of change in average insurance premiums is changes in the average extent of coverage purchased. Those changes can reflect both changes in the *scope* of insurance coverage—the benefits or services that are included—and changes in the *share of costs* for covered services paid by the insurer—known as the "actuarial value." With other factors held equal, insurance policies that cover more benefits or services or have smaller copayments or deductibles have higher premiums, while policies that cover fewer benefits or services or have larger copayments or deductibles have lower premiums. Provisions in the amendment that would reduce insurance premiums by affecting the amount of coverage purchased include the State Innovations program, which would encourage states to reduce the number and extent of benefit mandates that they impose, and provisions that would allow individuals or affiliated groups to purchase insurance policies in other states that have less stringent mandates. CBO's assessment was that the amendment would not have a substantial effect on actuarial values. However, that assessment represents an important source of uncertainty in this analysis of effects on premiums, because some of the savings from avoiding state mandates of benefits might be used to purchase coverage with a higher actuarial value.

The third source of change in average insurance premiums is changes in the characteristics of the people who are enrolled in different insurance pools. If relatively healthy people join an insurance pool, then the average insurance premiums for that pool would tend to decline; conversely, an influx of relatively unhealthy people would tend to raise premiums for that pool. For example, provisions in the amendment that promote the automatic enrollment of workers in

health insurance and the coverage of dependents under age 26 in family policies would act to improve the average health status of both the small group and large group insurance markets and thereby reduce average premiums per enrollee in those markets.[2]

As another example of that third source of premium changes, the State Innovations program would induce states to take some actions affecting the average health status of people with insurance and people without insurance. For example, states that loosened rating rules in the market for individually purchased insurance to allow premiums to vary more on the basis of age would cause premiums for older people to increase and premiums for younger people to decrease. With other factors held equal, fewer older people (who tend to have higher health care costs) and more young people (who tend to have lower health care costs) would then sign up for coverage, and the improved average health status of insured people would lower average premiums; at the same time, the pool of people without health insurance would end up being less healthy, on average, than under current law.[3]

Effects of the Proposal Beyond the First 10 Years

Although CBO does not generally provide cost estimates beyond the 10-year budget projection period (2010 through 2019 currently), many Members have requested CBO analyses of the long-term budgetary impact of broad changes in the nation's health care and health insurance systems. However, a detailed year-by-year projection, like those that CBO prepares for the 10-year budget window, would not be meaningful because the uncertainties involved are simply too great. CBO has therefore developed a rough outlook for the decade following the 10-year budget window by considering which provisions of the amendment would persist beyond 2019 and assessing the rate at which the budgetary impact of those provisions is likely to change over time.

All told, the amendment would reduce the federal deficit by $18 billion in 2019, CBO and JCT estimate. As a rough approximation, CBO assumes that the effect of the proposal on budget deficits would grow at roughly the rate of health care spending during the following decade. Consequently, CBO expects that the legislation would slightly reduce federal budget deficits in that decade relative to those projected under current law—with a total effect during that decade that is in a broad range between zero and one-quarter percent of gross domestic product. The imprecision of that calculation reflects the even greater degree of uncertainty that

[2] The increase in the number of dependents covered would tend to raise premiums for family policies, but premiums per enrollee would decline, reflecting the better-than-average health of the new enrollees.

[3] For further discussion of this issue, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 82–84.

attends to it, compared with CBO's 10-year budget estimates, and the effects of the amendment could fall outside of that range.

Many Members have expressed interest in the effects of reform proposals on various measures of spending on health care. CBO uses the term "federal budgetary commitment to health care" to describe the sum of net federal outlays for health programs and tax preferences for health care—a broad measure of the resources committed by the federal government.[4] Because essentially all of the budgetary effects of the amendment involve federal spending for health care or subsidies for health care conveyed through reductions in federal tax expenditures, the effects of the amendment on federal deficits also represent its effects on the federal budgetary commitment to health care. Therefore, during both the 10-year budget window and the following decade, the amendment would decrease the federal budgetary commitment to health care, relative to the amounts under current law.

Members have also requested information about the effect of proposals on national health expenditures. However, CBO does not analyze those expenditures as closely as it does the federal budget, and at this point, the agency has not assessed the net effect of the amendment on them, either within the 10-year budget window or for the subsequent decade.

I hope this preliminary analysis is helpful in your consideration of the amendment in the nature of a substitute for H.R. 3962, the Affordable Health Care for America Act. If you have any questions, please contact me or CBO staff. The primary staff contacts for this analysis are Bruce Vavrichek and Jean Hearne.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

Enclosures

cc: Honorable Nancy Pelosi
Speaker
U.S. House of Representatives

[4] For an extensive discussion of this term, see Congressional Budget Office, Letter to the Honorable Max Baucus regarding different measures for analyzing current proposals to reform health care (October 30, 2009).

Honorable Charles B. Rangel
Chairman
Committee on Ways and Means

Honorable Dave Camp
Ranking Member

Honorable Henry A. Waxman
Chairman
Committee on Energy and Commerce

Honorable Joe Barton
Ranking Member

Honorable George Miller
Chairman
Committee on Education and Labor

Honorable John Kline
Senior Republican

Preliminary Analysis of the Insurance Coverage Provisions Contained in Rep. Boehner's Amendment to H.R. 3962

EFFECTS ON INSURANCE COVERAGE /a (Millions of nonelderly people, by calendar year)		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law Coverage /b	Medicaid & CHIP	40	39	39	38	35	34	35	35	35	35
	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup & Other /c	27	26	25	26	28	29	29	29	30	30
	Uninsured /d	50	51	51	51	51	51	52	53	53	54
	TOTAL	267	269	271	273	274	276	277	279	281	282
Change (+/-)	Medicaid/CHIP	0	*	*	*	*	*	*	*	*	*
	Employer	*	1	2	2	2	2	2	2	2	2
	Nongroup/Other /c	*	*	*	*	*	*	*	*	*	*
	Uninsured /d	*	-1	-2	-2	-2	-2	-2	-3	-3	-3
Post-Policy Uninsured Population											
Number of Nonelderly People /d		50	50	49	48	48	49	49	50	51	52
Insured Share of the Nonelderly Population /a											
Including All Residents		81%	81%	82%	82%	82%	82%	82%	82%	82%	82%
Excluding Unauthorized Immigrants		83%	84%	84%	84%	84%	84%	84%	84%	84%	83%

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program; * = fewer than 0.5 million people.

a. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.
b. Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source.
c. Other includes Medicare; the effects of the proposal are almost entirely on nongroup coverage.
d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.

Preliminary Analysis of the Insurance Coverage Provisions Contained in Rep. Boehner's Amendment to H.R. 3962

EFFECTS ON THE FEDERAL DEFICIT / a,b,c (Billions of dollars, by fiscal year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Funding for Reinsurance & High-Risk Pools	0	1	1	1	2	3	4	4	4	4	24
State Innovations Program	0	0	0	17	0	5	6	2	0	1	32
Provisions Affecting Health Savings Accounts	0	0	0	0	0	1	1	1	1	1	5
Gross Cost of Coverage Provisions	0	1	2	19	2	9	10	6	5	6	61
Associated Effects on Tax Revenues /d	0	-1	-3	-4	-4	-6	-6	-7	-7	-7	-46
Associated Effects on Medicaid & CHIP Outlays /e	0	0	-1	-1	-1	-1	-1	-1	-1	-1	-6
NET COST OF COVERAGE PROVISIONS	0	0	-2	14	-3	3	3	-1	-3	-2	8

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program.

a. Does not include federal adminstrative costs subject to appropriation or account for all effects on other federal programs.
b. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit; increases in tax revenues reduce the deficit.
c. Components may not sum to totals because of rounding.
d. Effects are mainly due to changes in taxable compensation resulting from changes in payments for employer-sponsored insurance coverage.
e. Effects are mainly due to changes in Medicaid and CHIP enrollment resulting from the provisions affecting the private health insurance market.

Preliminary Estimate of Direct Spending and Revenue Effects of the Amendment in the Nature of A Substitute to H.R. 3962 offered by Rep. Boehner on Medicare, Medicaid, and Other Provisions
(Billions of dollars, by fiscal year)

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Changes in Direct Spending													
Sec. 113	Administrative Simplification	*	*	-0.1	-0.1	-0.2	-0.3	-0.7	-1.4	-1.5	-1.6	-0.4	-5.9
Sec. 301-310	Effects of Tort Reform on Mandatory Program Spending [a]	0	-0.7	-1.8	-3.2	-4.6	-5.4	-5.9	-6.0	-6.3	-7.0	-10.3	-40.9
Sec. 601	Increased funding to the HHS OIG and HCFAC	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	1.5	3.1
Sec. 603 - 605	Other Medicare and Medicaid program integrity provisions	*	*	*	*	*	*	*	*	*	*	-0.1	-0.3
Sec. 701	Licensure Pathway for Biosimilar Biological Products	0	0	0	*	-0.1	-0.2	-0.5	-0.9	-1.4	-2.0	-0.1	-5.1
Total Changes in Direct Spending		**0.2**	**-0.4**	**-1.6**	**-3.1**	**-4.6**	**-5.7**	**-6.8**	**-8.0**	**-9.0**	**-10.3**	**-9.4**	**-49.1**
Changes in Revenues													
	Effects of Tort Reform	0	0.2	0.6	1.0	1.5	1.7	1.8	1.9	2.1	2.2	3.2	13.0
	Effects of Administrative Simplification	0	-0.2	-0.2	0.1	0.6	1.2	2.0	2.9	3.3	3.4	0.3	13.1
	Effects of Biosimilar Biological Products	0	0	0	*	*	0.1	0.1	0.2	0.2	0.3	*	0.9
Total Changes in Revenues		**0**	*****	*****	**1.1**	**2.1**	**2.9**	**3.9**	**5.0**	**5.6**	**5.9**	**3.5**	**27.0**
Changes in Deficits		**0.2**	**-0.4**	**-2.0**	**-4.2**	**-6.7**	**-8.6**	**-10.7**	**-13.0**	**-14.6**	**-16.3**	**-13.0**	**-76.1**
Memorandum	Non-scoreable savings from HCFAC funding	-0.1	-0.2	-0.4	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.6	-1.8	-4.4

NOTES: * = between $50 million and -$50 million.

HHS = Department of Health and Human Services; OIG = Office of Inspector General; HCFAC = health care fraud and abuse control account

a. Estimate reflects mandatory spending across all federal health programs, and includes Medicare interactions (for Medicare Advantage and Part B premiums).

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

November 19, 2009

Honorable Paul Ryan
Ranking Member
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

This letter responds to questions you have asked about Medicare's payments to physicians and the budgetary effects of H.R. 3961, the Medicare Physicians Payment Reform Act of 2009, as introduced on October 29, 2009. In particular, you inquired about the budgetary impact of a new regulation specifying how payments to physicians should be determined under current law and about the total budgetary impact of enacting both H.R. 3961 and H.R. 3962, the Affordable Health Care for America Act.

The New Rule Governing Medicare's Payments to Physicians

On October 30, 2009, the Centers for Medicare and Medicaid Services promulgated a final rule, "*Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010.*" [1] That rule removes physician-administered (P-A) drugs from the calculation of the sustainable growth rate (SGR) formula, which determines the updates to payment rates for physicians' services. Removal of P-A drugs from the SGR will increase Medicare's spending for fee-for-service physicians' services and the Medicare Advantage (MA) program, as well as the Department of Defense's outlays for the TRICARE program. Because beneficiaries enrolled in Part B of Medicare pay premiums that offset about 25 percent of the costs of their benefits, premium income will rise to offset part of the added costs. On net, the Congressional Budget Office (CBO) estimates that this new rule will increase federal spending by $78 billion over the 2010–2019 period.

The Budgetary Impact of Enacting Both H.R. 3961 and H.R. 3962

Under current law, including the new rule, Medicare's payment rates for physicians' services will be reduced by about 21 percent in January 2010, and CBO estimates those payment rates will be reduced by about 2 percent annually for several subsequent years. H.R. 3961 would increase those payment rates by 1.2 percent in 2010 and restructure the

[1] See http://www.federalregister.gov/OFRUpload/OFRData/2009-26502_PI.pdf. The final rule removed spending for physician-administered drugs from the SGR calculations, specified the Medicare economic index for 2010, and made numerous other changes to the physician fee schedule.

SGR beginning in 2011. Those changes would result in significantly higher payment rates for physicians than those that would result under current law. CBO estimates that enacting H.R. 3961, by itself, would cost $210 billion over the 2010–2019 period.[2]

H.R. 3962, the Affordable Health Care for America Act, would establish a mandate for most legal residents of the United States to obtain health insurance, set up insurance "exchanges" through which certain individuals could receive federal subsidies toward the purchase of such insurance, and make numerous other changes in the health insurance system, in federal health care programs, and in the federal tax code. CBO and the staff of the Joint Committee on Taxation estimate that enacting H.R. 3962, by itself, would reduce federal budget deficits by $109 billion over the 2010–2019 period through its effects on direct spending and revenues.[3]

CBO estimates that enacting both H.R. 3961 and H.R. 3962 would add $89 billion to budget deficits over the 2010–2019 period. That amount is about $12 billion less than the sum of the effects of enacting the bills separately. The $12 billion difference results from two types of interactions. The higher payment rates for physicians' services under H.R. 3961 would increase the net cost of provisions in H.R. 3962 by about $3 billion. However, that difference would be more than offset by the effect of a change under H.R. 3962 in how payment rates for Medicare Advantage plans are set. That change would reduce the effect of the changes made by H.R. 3961 to Medicare's payments for physicians' services in the fee-for-service sector on payment rates for Medicare Advantage plans. As a result, the estimated increase in payments to Medicare Advantage plans would be $15 billion smaller if both bills were enacted than under H.R. 3961 alone.

You also asked about the long-term effects on the federal budget of enacting both bills. A detailed year-by-year projection, like those that CBO prepares for the 10-year budget window, would not be meaningful because the uncertainties involved are simply too great. Among other factors, a wide range of changes could occur—in people's health, in the sources and extent of their insurance coverage, and in the delivery of medical care (such as advances in medical research, technological developments, and changes in physicians' practice patterns)—that are likely to be significant but are very difficult to predict, both under current law and under any proposal.

CBO has therefore developed a rough outlook for the decade following the 10-year budget window. The agency estimates that the two bills together would cost about $32 billion more in 2019 than H.R. 3962 alone and that the combination of the two bills would increase the budget deficit in 2019 by $23 billion relative to current law. Those

[2]See CBO's cost estimate for H.R. 3961 (November 4, 2009) at http://www.cbo.gov/ftpdocs/107xx/doc10704/hr3961.pdf .

[3]See CBO's cost estimate for H.R. 3962 (November 6, 2009) at http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_amendment_update.pdf .

increments would grow during the following decade. As stated in its October 29, 2009, letter to Congressman Charles B. Rangel, "CBO expects that [H.R. 3962] would slightly reduce federal budget deficits in that decade relative to those projected under current law—with a total effect during that decade that is in a broad range between zero and one-quarter percent of GDP [gross domestic product]." If both H.R. 3961 and H.R. 3962 were enacted, CBO expects that federal budget deficits during the decade following the 10-year budget window would *increase* relative to those projected under current law—with a total effect during that decade that is in a broad range between zero and one-quarter percent of GDP.

If you wish further details, CBO would be happy to provide them. The staff contacts for this estimate are Lori Housman and Tom Bradley.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

cc: Honorable John M. Spratt, Jr.
Chairman, Committee on the Budget

Honorable Charles B. Rangel
Chairman, Committee on Ways and Means

Honorable Dave Camp
Ranking Member

Honorable George Miller
Chairman, Committee on Education and Labor

Honorable John Kline
Senior Republican

Honorable Henry A. Waxman
Chairman, Committee on Energy and Commerce

Honorable Joe Barton
Ranking Member

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

December 19, 2009

Honorable Harry Reid
Majority Leader
United States Senate
Washington, DC 20510

Dear Mr. Leader:

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have estimated the direct spending and revenue effects of the Patient Protection and Affordable Care Act (PPACA), Senate Amendment 2786 in the nature of a substitute to H.R. 3590 (as printed in the Congressional Record on November 19, 2009), incorporating the effects of changes proposed in the manager's amendment released on December 19, 2009. This estimate does not include the effects of other amendments adopted during the Senate's consideration of the Patient Protection and Affordable Care Act; it also does not reflect an incremental effect on PPACA from Congressional action on H.R. 3326, the Department of Defense Appropriations Act, 2010, which was cleared on November 19, 2009.[1] Throughout this letter, references to "the legislation" mean the act as originally proposed and incorporating the manager's amendment.

Among other things, the legislation would establish a mandate for most legal residents of the United States to obtain health insurance; set up insurance exchanges through which certain individuals and families could receive federal subsidies to substantially reduce the cost of purchasing that coverage; significantly expand eligibility for Medicaid; substantially reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected under current law); impose an excise tax on insurance plans with relatively high premiums; and make various other changes to the federal tax code, Medicare, Medicaid, and other programs.

CBO and JCT estimate that, on balance, the direct spending and revenue effects of enacting the Patient Protection and Affordable Care Act incorporating the manager's

[1] Section 3112 of the Patient Protection and Affordable Care Act would rescind amounts available in the Medicare Improvement Fund. H.R. 3326, which was cleared by the Senate on December 19, 2009, would reduce the amount in that fund that is available for 2014 by $1.55 billion and increase the amount available for 2015 by $0.55 billion. As a result of those changes, the estimated savings for the PPACA as originally proposed and incorporating the manager's amendment would be reduced by $1 billion over both the 2010–2014 and 2010–2019 periods. That change does not affect the estimated incremental effect of the proposed manager's amendment.

amendment would yield a net reduction in federal deficits of $132 billion over the 2010-2019 period (see Table 1). Approximately $81 billion of that reduction would be on-budget; other effects related to Social Security revenues and spending as well as spending by the U.S. Postal Service are classified as off-budget. CBO has not completed an estimate of the legislation's potential impact on spending that would be subject to future appropriation action.

This estimate incorporates the effects of the manager's amendment, which would make a number of changes to the Patient Protection and Affordable Care Act as originally proposed. The changes with the largest budgetary effects include: expanding eligibility for a small business tax credit; increasing penalties on certain uninsured people; replacing a "public plan" that would be run by the Department of Health and Human Services (HHS) with "multi-state" plans that would be offered under contract with the Office of Personnel Management (OPM); deleting provisions that would increase payment rates for physicians under Medicare; and increasing the payroll tax on higher-income individuals and families. Of the total deficit reduction of $132 billion projected to result from the legislation, the manager's amendment accounts for about $2 billion, and the act as originally proposed accounts for the remaining $130 billion.

CBO and JCT have determined that the legislation contains several intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). The total cost of those mandates to state, local, and tribal governments and the private sector would greatly exceed the thresholds established in UMRA ($69 million and $139 million, respectively, in 2009, adjusted annually for inflation).

CBO and JCT's assessment of the legislation's impact on the federal budget deficit is summarized in Table 1. Table 2 shows federal budgetary cash flows for direct spending and revenues associated with the legislation. Table 3 displays the changes in direct spending and revenues resulting from the provisions in the manager's amendment. Table 4 provides estimates of the resulting changes in the number of nonelderly people in the United States who would have health insurance and presents the primary budgetary effects of the legislation's major provisions related to insurance coverage. Table 5 displays detailed estimates of the costs or savings from other proposed changes (primarily to the Medicare program) that would affect the federal government's direct spending and some aspects of revenues. Detailed estimates of the impact of the tax provisions in Title IX of the legislation are provided by JCT in JCX-61-09 (see www.jct.gov).

This analysis also reviews the main changes included in the manager's amendment, examines the longer-term effects of the legislation on the federal budget, and assesses the effects of the manager's amendment on health insurance premiums.

Table 1. Estimate of the Effects on the Deficit of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
NET CHANGES IN THE DEFICIT FROM INSURANCE COVERAGE PROVISIONS [a,b]												
Effects on the Deficit	2	5	6	3	37	74	109	120	125	133	54	614
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING [c]												
Effects on the Deficit of Changes in Outlays	4	-6	-16	-27	-45	-53	-63	-79	-91	-106	-90	-483
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [d]												
Effects on the Deficit of Changes in Revenues	-1	-6	-10	-30	-27	-32	-35	-38	-41	-42	-75	-264
NET CHANGES IN THE DEFICIT [a]												
Net Increase or Decrease (-) in the Budget Deficit	5	-8	-20	-54	-35	-12	10	3	-7	-16	-111	-132
On-Budget	5	-7	-19	-49	-34	-8	18	13	4	-3	-105	-81
Off-Budget [e]	*	*	*	-5	-1	-4	-8	-10	-11	-13	-6	-52
Memorandum:												
Effects on the Deficit of PPACA as Originally Proposed												
Net Increase or Decrease	2	-14	-28	-58	-38	-11	14	11	1	-8	-136	-130
On-Budget	2	-14	-28	-54	-36	-7	21	20	12	5	-129	-77
Off-Budget [e]	*	*	*	-4	-3	-4	-8	-10	-11	-13	-6	-52
Incremental Effects on the Deficit of Incorporating the Manager's Amendment												
Net Increase or Decrease	3	6	8	5	3	-1	-3	-7	-8	-8	25	-2
On-Budget	3	7	9	5	1	-1	-3	-7	-8	-8	25	-3
Off-Budget [e]	*	*	-1	-1	2	1	*	*	*	*	*	1

Continued

Table 1. Continued.

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation (JCT).

Notes: Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Components may not sum to totals because of rounding; * = between 0.5 billion and -0.5 billion.

PPACA = Patient Protection and Affordable Care Act.

a. Does not include effects on spending subject to future appropriations.

b. Includes excise tax on high-premium insurance plans.

c. These estimates reflect the effects of provisions affecting Medicare, Medicaid, and other federal health programs, and include the effects of interactions between insurance coverage provisions and those programs.

d. The changes in revenues include effects on Social Security revenues, which are classified as off-budget. The 10-year figure of $264 billion includes $250 billion in revenues from tax provisions (estimated by JCT) apart from receipts from the excise tax on high-premium insurance plans and $14 billion in revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by CBO and JCT). (For JCT's estimates, see JCX-61-09.)

e. Off-budget effects include changes in Social Security spending and revenues as well as spending by the U.S. Postal Service.

Estimated Budgetary Impact

According to CBO and JCT's assessment, enacting the Patient Protection and Affordable Care Act with the manager's amendment would result in a net reduction in federal budget deficits of $132 billion over the 2010–2019 period (see Table 1). In the subsequent decade, the collective effect of its provisions would probably be continued reductions in federal budget deficits if all of the provisions continued to be fully implemented. Those estimates are subject to substantial uncertainty.

The estimate includes a projected net cost of $614 billion over 10 years for the proposed expansions in insurance coverage. That net cost itself reflects a gross total of $871 billion in subsidies provided through the exchanges, increased net outlays for Medicaid and the Children's Health Insurance Program (CHIP), and tax credits for small employers; those costs are partly offset by $149 billion in revenues from the excise tax on high-premium insurance plans and $108 billion in net savings from other sources. Over the 2010–2019 period, the net cost of the coverage expansions would be more than offset by the combination of other spending changes that CBO estimates would save $483 billion and other provisions that JCT and CBO estimate would increase federal revenues by $264 billion.[2]

In total, CBO and JCT estimate that the legislation would increase outlays by $366 billion and increase revenues by $498 billion between 2010 and 2019 (see Table 2).

[2] The 10-year figure of $264 billion includes $250 billion in revenues from tax provisions (estimated by JCT) apart from receipts from the excise tax on high-premium insurance plans and $14 billion in revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by CBO and JCT). (For JCT's estimates, see JCX-61-09.)

Table 2. Estimated Changes in Direct Spending and Revenues Resulting From the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN DIRECT SPENDING (OUTLAYS)												
Health Insurance Exchanges												
Premium and Cost Sharing Subsidies	0	0	0	0	13	31	55	69	76	84	13	329
Start-up Costs	*	*	*	*	*	*	0	0	0	0	2	2
Other Related Spending	0	1	2	2	1	*	*	*	*	0	5	5
Subtotal	*	2	2	2	14	32	55	69	76	84	20	336
Reinsurance and Risk Adjustment Payments [a]	0	0	0	0	12	19	21	21	22	24	12	120
Effects of Coverage Provisions on Medicaid and CHIP	*	-2	-3	-3	28	54	75	79	81	87	20	395
Medicare and Other Medicaid and CHIP Provisions												
Reductions in Annual Updates to Medicare FFS Payment Rates	*	-2	-5	-9	-13	-18	-24	-31	-38	-46	-28	-186
Medicare Advantage Rates Based on Plans' Bids	0	-6	-7	-10	-11	-12	-14	-17	-19	-22	-34	-118
Medicare and Medicaid DSH Payments	0	0	*	*	*	-6	-8	-9	-9	-10	*	-43
Other	1	2	-1	-3	-15	-10	-10	-14	-18	-22	-17	-91
Subtotal	1	-6	-13	-22	-39	-47	-57	-72	-84	-100	-79	-438
Other Changes in Direct Spending												
Community Living Assistance Services and Supports	0	-4	-6	-9	-10	-11	-10	-9	-8	-7	-29	-72
Other	4	4	4	4	4	4	2	*	*	-1	20	26
Subtotal	4	1	-2	-5	-6	-7	-7	-8	-8	-7	-9	-47
Total Outlays	5	-6	-16	-27	8	51	87	88	87	87	-35	366
On-budget	5	-6	-16	-27	8	51	87	88	86	86	-36	362
Off-budget	0	*	*	*	*	*	1	1	1	1	*	4

Continued

Table 2. Continued.

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN REVENUES												
Coverage-Related Provisions												
Exchange Premium Credits	0	0	0	0	-4	-9	-17	-22	-24	-26	-4	-102
Reinsurance and Risk Adjustment Collections	0	0	0	0	13	18	21	21	23	25	13	121
Small Employer Tax Credit	-2	-4	-5	-6	-5	-3	-3	-3	-4	-4	-21	-38
Penalty Payments by Employers and Uninsured Individuals	0	0	0	0	2	5	7	9	10	10	2	43
Excise Tax on High-Premium Plans	0	0	0	7	13	17	22	26	30	35	20	149
Associated Effects of Coverage Provisions on Revenues	*	*	-1	-5	-3	3	12	16	18	20	-9	61
Other Provisions												
Fees on Certain Manufacturers and Insurers [b]	2	6	8	10	12	12	12	13	14	14	37	101
Additional Hospital Insurance Tax	0	0	0	13	6	10	13	14	15	15	19	87
Other Revenue Provisions [c]	-1	1	2	7	9	10	10	11	13	13	19	76
Total Revenues	*	2	4	27	44	63	77	85	94	103	76	498
On-budget	-1	1	4	22	42	59	69	75	82	89	69	443
Off-budget	*	*	*	5	1	4	8	11	12	14	7	55
NET IMPACT ON THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES [d]												
Net Change in the Deficit	5	-8	-20	-54	-35	-12	10	3	-7	-16	-111	-132
On-budget	5	-7	-19	-49	-34	-8	18	13	4	-3	-105	-81
Off-budget	*	*	*	-5	-1	-4	-8	-10	-11	-13	-6	-52

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: Does not include effects on spending subject to future appropriation. Components may not sum to totals because of rounding.

* = between $0.5 billion and -$0.5 billion.

CHIP = Children's Health Insurance Program; FFS = Fee-for-service; DSH = Disproportionate Share Hospital.

a. Risk adjustment payments lag revenues shown later in the table by one quarter. Reinsurance payments total $20 billion over the 10-year period.

b. Amounts include fees on manufacturers and importers of branded drugs and certain medical devices as well as fees on health insurance providers.

c. Amounts include $62 billion in increased revenues, as estimated by JCT, for tax provisions other than those broken out separately in the table. In addition, this line includes an increase in revenues of about $14 billion for other provisions shown in Table 5.

d. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Provisions Regarding Insurance Coverage

The legislation would take several steps designed to increase the number of legal U.S. residents who have health insurance. Starting in 2014, the legislation would establish a requirement for such residents to obtain insurance and would in many cases impose a financial penalty on people who did not do so. The bill also would establish new insurance exchanges and would subsidize the purchase of health insurance through those exchanges for individuals and families with income between 133 percent and 400 percent of the federal poverty level (FPL). Policies purchased through the exchanges (or directly from insurers) would have to meet several requirements: In particular, insurers would have to accept all applicants, could not limit coverage for preexisting medical conditions, and could not vary premiums to reflect differences in enrollees' health. The options available in the insurance exchanges would include private health insurance plans and could include two national or multi-state plans operated under contract with OPM.

Starting in 2014, most nonelderly people with income below 133 percent of the FPL would be made eligible for Medicaid. The federal government would pay all of the costs of covering newly eligible enrollees through 2016; in subsequent years, the federal share of spending would vary somewhat from year to year but would average about 90 percent by 2019. (Under current rules, the federal government usually pays about 57 percent, on average, of the costs of Medicaid benefits.) In addition, states would be required to maintain current coverage levels for all Medicaid beneficiaries until the exchanges were fully operational; coverage levels for children under Medicaid and CHIP would have to be maintained through 2019. Beginning in 2014, states would receive higher federal reimbursement for CHIP beneficiaries, increasing from an average of 70 percent to 93 percent. The legislation would also provide states with additional CHIP funding in 2014 and 2015.

The legislation contains a number of other key provisions related to insurance coverage. In general, firms with more than 50 workers that did not offer coverage would have to pay a penalty of $750 for each full-time worker if any of their workers obtained subsidized coverage through the insurance exchanges; that dollar amount would be indexed. As a rule, full-time workers who were offered coverage from their employer would not be eligible to obtain subsidies via the exchanges. However, an exception to that "firewall" would be allowed for workers who had to pay more than a specified percentage of their income for their employer's insurance—9.8 percent in 2014, indexed over time—in which case the employer would be penalized. Under certain circumstances, firms with relatively few employees and relatively low average wages would also be eligible for tax credits to cover up to half of their contributions toward health insurance premiums. Beginning in 2013, insurance policies with relatively high total premiums would be subject to a 40 percent excise tax on the amount by which the premiums exceeded a specified threshold. That threshold would be set initially at $8,500 for single

policies and $23,000 for family policies (with certain exceptions); after 2013, those amounts would be indexed to overall inflation plus 1 percentage point.

Effects of Insurance Coverage Provisions

CBO and JCT estimate that provisions affecting health insurance coverage would result in a net increase in federal deficits of $614 billion over fiscal years 2010 through 2019 (see Table 4). That estimate includes $395 billion in additional net federal outlays for Medicaid and CHIP.[3] It also includes $436 billion in federal subsidies that would be provided to purchase coverage through the new insurance exchanges and related spending.[4] The other main element of the coverage provisions that would increase federal deficits is the tax credit for certain small employers who offer health insurance, which is estimated to cost $40 billion over 10 years. Those costs would be partly offset by receipts or savings, totaling $257 billion over the 10-year budget window, from four sources: net revenues from the excise tax on high-premium insurance plans, totaling $149 billion; penalty payments by uninsured individuals, which would amount to $15 billion; penalty payments by employers whose workers received subsidies via the exchanges, which would total $28 billion; and other budgetary effects, mostly on tax revenues, associated with the expansion of federally subsidized insurance, which would reduce deficits by $65 billion.[5]

By 2019, CBO and JCT estimate, the number of nonelderly people who are uninsured would be reduced by about 31 million, leaving about 23 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under the legislation, the share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 94 percent. Approximately 26 million people would purchase their own coverage through the new insurance exchanges, and there would be roughly 15 million more enrollees in Medicaid and CHIP than is projected under current law. Relative to currently projected levels, the number of people purchasing individual coverage outside the exchanges would decline by about 5 million. Under the legislation, certain employers could allow all of their workers to choose among the plans available in the exchanges, but those enrollees would not be eligible to receive subsidies via the exchanges (and thus are shown in Table 4 as enrollees in employment-based

[3] CBO estimates that state spending on Medicaid and CHIP would increase by about $26 billion over the 2010–2019 period as a result of the provisions affecting coverage reflected in Table 4. That estimate reflects states' flexibility to make programmatic and other budgetary changes to Medicaid and CHIP.

[4] Related spending includes the administrative costs of establishing the exchanges as well as $5 billion for high-risk pools and the net budgetary effects of proposed payments and receipts for reinsurance and risk adjustment.

[5] Changes in the extent of employment-based health insurance affect federal revenues because most payments for that coverage are tax-preferred. If employers increase or decrease the amount of compensation they provide in the form of health insurance (relative to current-law projections), CBO and JCT assume that offsetting changes will occur in wages and other forms of compensation—which are generally taxable—to hold total compensation roughly the same. Such effects also arise with respect to specific elements of the proposal (such as the tax credits for small employers), and those effects are included within the estimates for those elements.

coverage rather than as exchange enrollees). Approximately 5 million people would obtain coverage in that way in 2019, bringing the total number of people enrolled in exchange plans to about 30 million in that year.

The number of people obtaining coverage through their employer would be about 4 million lower in 2019 under the legislation, CBO and JCT estimate. The net change in employment-based coverage is the result of several flows, which can be illustrated using the estimates for 2019:

- About 6 million people would be covered by an employment-based plan under the proposal who would not be covered by one under current law (largely because the mandate for individuals to be insured would increase workers' demand for coverage through their employers).

- Between 8 million and 9 million other people who would be covered by an employment-based plan under current law would not have an offer of such coverage under the proposal. Firms that would choose not to offer coverage as a result of the proposal would tend to be smaller employers and employers that predominantly employ lower-wage workers—people who would be eligible for subsidies through the exchanges—although some workers who would not have employment-based coverage because of the proposal would not be eligible for such subsidies. Whether those changes in coverage would represent the dropping of existing coverage or a lack of new offers of coverage is difficult to determine.

- In addition, between 1 million and 2 million people who could be covered by their employer's plan (or a plan offered to a family member) would instead obtain coverage in the exchanges, either because the employer's offer would be deemed unaffordable and they would therefore be eligible to receive subsidies in the exchanges, or because the "firewall" for those with an offer of employer coverage would be imperfectly enforced. (Those people are counted as enrollees in the exchanges.)

The proposal would call on OPM to contract for two national or multi-state health insurance plans—one of which would have to be nonprofit—that would be offered through the insurance exchanges. Whether insurers would be interested in offering such plans is unclear, and establishing a nationwide plan comprising only nonprofit insurers might be particularly difficult. Even if such plans were arranged, the insurers offering them would probably have participated in the insurance exchanges anyway, so the inclusion of this provision did not have a significant effect on the estimates of federal costs or enrollment in the exchanges.

Provisions Affecting Medicare, Medicaid, and Other Programs

Other components of the legislation would alter spending under Medicare, Medicaid, and other federal programs. The legislation would make numerous changes to payment rates and payment rules in those programs (the budgetary effects of which are summarized in Table 1 and detailed in Table 5). In total, CBO estimates that enacting those provisions would reduce net direct spending by $483 billion over the 2010–2019 period.[6] The provisions that would result in the largest budget savings include these:

- Permanent reductions in the annual updates to Medicare's payment rates for most services in the fee-for-service sector (other than physicians' services), yielding budgetary savings of $186 billion over 10 years. (That calculation excludes interactions between those provisions and others—namely, the effects of those changes on payments to Medicare Advantage plans and collections of Part B premiums.)

- Setting payment rates in the Medicare Advantage program on the basis of the average of the bids submitted by Medicare Advantage plans in each market, yielding savings of an estimated $118 billion (before interactions) over the 2010–2019 period.

- Reducing Medicaid and Medicare payments to hospitals that serve a large number of low-income patients, known as disproportionate share hospitals (DSH), by about $43 billion—composed of roughly $19 billion from Medicaid and $24 billion from Medicare DSH payments.

The legislation also would establish an Independent Payment Advisory Board, which would be required, under certain circumstances, to recommend changes to the Medicare program to limit the rate of growth in that program's spending. Those recommendations would go into effect automatically unless blocked by subsequent legislative action. Such recommendations would be required if the Chief Actuary for the Medicare program projected that the program's spending per beneficiary would grow more rapidly than a measure of inflation (the average of the growth rates of the consumer price index for medical services and the overall index for all urban consumers). The provision would place a number of limitations on the actions available to the board, including a prohibition against modifying eligibility or benefits, so its recommendations probably would focus on:

- Reductions in subsidies for non-Medicare benefits offered by Medicare Advantage plans; and

[6] In addition, the effects of certain provisions affecting Medicare, Medicaid, and other programs would increase federal revenues by approximately $14 billion over the 2010–2019 period.

- Changes to payment rates or methodologies for services furnished in the fee-for-service sector by providers other than hospitals, physicians, hospices, and suppliers of durable medical equipment that is offered through competitive bidding.[7]

The board would develop its first set of recommendations during 2013 for implementation in 2015. CBO expects that the board would be fairly effective at meeting the savings targets during the 2015–2019 period. As a result, CBO estimates that—given all of the reductions that would result from other provisions—this arrangement would reduce Medicare spending by an additional $28 billion over that period. That estimate represents the expected value of the 10-year savings from the arrangement, reflecting CBO's judgment that most, but not all, of the targeted savings would be achieved through this process. The board would also be required to make recommendations regarding changes to nonfederal health care programs that would slow the growth of national health expenditures. Those recommendations would be non-binding.

The legislation includes a number of other provisions with a significant budgetary effect. They include the following:

- Community Living Assistance Services and Supports (CLASS) provisions, which would establish a voluntary federal program for long-term care insurance. Active workers could purchase coverage, usually through their employer. Premiums would be set to cover the full cost of the program as measured on an actuarial basis. However, the program's cash flows would show net receipts for a number of years, followed by net outlays in subsequent decades. In particular, the program would pay out far less in benefits than it would receive in premiums over the 10-year budget window, reducing deficits by about $72 billion over that period, including about $2 billion in savings to Medicaid.

- Requirements that the Secretary of HHS adopt and regularly update standards for electronic administrative transactions that enable electronic funds transfers, claims management processes, and verification of eligibility, among other administrative tasks. These provisions would result in about $11 billion in federal savings in Medicaid and reduced subsidies paid through the insurance exchanges. In addition, these standards would result in an increase in revenues of about $8 billion as an indirect effect of reducing the cost of private health insurance plans.

[7] The proposal would authorize the board to recommend changes that would affect hospitals and hospices beginning in 2020.

- A mandatory appropriation of $15 billion to establish a Prevention and Public Health Fund. CBO estimates that outlays of those funds would total about $13 billion over the 2010–2019 period.

- Mandatory funding of $10 billion for community health centers and the National Health Service Corps. CBO estimates that outlays of those funds would total about $10 billion over the 2010–2019 period.

- An abbreviated approval pathway for biosimilar biological products (biological products that are highly similar to or interchangeable with their brand-name counterparts), which would reduce direct spending by an estimated $7 billion over the 2010–2019 period.

Effect of the Legislation on Discretionary Costs

CBO has not completed an estimate of the discretionary costs that would be associated with the legislation. Such costs would include those arising from the effects of the legislation on a variety of federal programs and agencies as well as from a number of new and existing programs subject to future appropriations.

The federal agencies that would be responsible for implementing the provisions of the legislation are funded through the appropriation process; sufficient appropriations would be essential for them to implement this legislation in the time frame it specifies. Major costs for programs subject to future appropriations would include these:

- Costs to the Internal Revenue Service of implementing the eligibility determination, documentation, and verification processes for premium and cost sharing credits. Those costs would probably be between $5 billion and $10 billion over 10 years.

- Costs to HHS (especially the Centers for Medicare and Medicaid Services) and OPM of implementing the changes in Medicare, Medicaid, and CHIP as well as certain reforms to the private insurance market. Those costs would probably be at least $5 billion to $10 billion over 10 years. (The administrative costs of establishing and operating the exchanges are reflected in Table 1.)

- Costs of a number of grant programs and other changes in the legislation. CBO has not completed a review of those provisions.

Because those costs depend on future appropriations, they are not counted for enforcement of Congressional “pay-as-you-go” procedures and are not included in Table 1.

Changes Made in the Patient Protection and Affordable Care Act by the Manager's Amendment

On November 18, 2009, CBO transmitted an analysis by CBO and JCT of the legislation as originally proposed. The estimates provided here differ from the ones in that analysis because they incorporate the effects of the manager's amendment. Relative to the provisions included in the PPACA as originally proposed, key examples of the changes that would be made by the manager's amendment are as follows:

- The tax credit for small businesses would be made available to firms paying somewhat higher average wages, and it would first take effect in 2010 rather than 2011.

- The penalty for not having insurance would be the greater of a flat dollar amount per person or a percentage of the individual's income, which would increase the amount of penalties collected.

- The provision establishing a public plan that would be run by HHS was replaced with a provision for multi-state plans that would be offered under contract with OPM.

- Certain workers would have the option of obtaining tax-free vouchers from their employers equal in value to the contributions their employers would make to their health insurance plans. The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. (CBO and JCT estimate that about 100,000 workers would take advantage of that option.)

- Several provisions regulating insurers were added, including a requirement for an insurer to provide rebates if its share of premiums going to administrative costs exceeds specified levels and a general prohibition on imposing annual limits on the amount of benefits that would be covered.

- Additional federal funding for CHIP would be provided to states in 2014 and 2015.

- A provision that would increase Medicare's payment rates for physicians' services by 0.5 percent for 2010 was eliminated. Instead, the 21 percent reduction in those payment rates that is scheduled to occur in 2010 under current law would take effect.

- The measure of Medicare spending that would be used to set savings targets for the Independent Payment Advisory Board was modified.

- The increment to the Hospital Insurance portion of the payroll tax rate for individuals with income above $200,000 and for families with income above $250,000 was raised from 0.5 percent to 0.9 percent.

- The 5 percent excise tax on cosmetic surgery was eliminated, and a 10 percent excise tax on indoor tanning services was added.

- Community health centers and the National Health Service Corps would receive an additional $10 billion in mandatory funding.

- Revisions to and extensions of the Indian Health Care Improvement Act were added.

Table 3. Estimate of the Incremental Effects on the Deficit of Incorporating the Manager's Amendment to the Patient Protection and Affordable Care Act, as Originally Proposed

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN DIRECT SPENDING												
Change in Outlays	-7	-1	4	3	4	6	4	-1	-1	-2	3	10
On-Budget	-7	-1	4	3	4	6	4	-1	-1	-2	3	10
Off-Budget	0	0	*	*	*	*	*	*	*	*	*	*
CHANGES IN REVENUES												
Change in Revenues	-9	-8	-4	-1	1	7	7	7	7	6	-22	12
On-Budget	-10	-8	-5	-2	3	8	7	7	7	6	-22	13
Off-Budget	*	*	1	1	-2	-1	*	*	*	*	*	-1
NET IMPACT ON THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES [a]												
Net Change in the Deficit	3	6	8	5	3	-1	-3	-7	-8	-8	25	-2
On-Budget	3	7	9	5	1	-1	-3	-7	-8	-8	25	-3
Off-Budget	*	*	-1	-1	2	1	*	*	*	*	*	1

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: Does not include effects on spending subject to future appropriation. Components may not sum to totals because of rounding.

* = between $0.5 billion and -$0.5 billion.

a. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

After this cost estimate was released, CBO discovered an error in its analysis of the longer-term effects of direct spending (described on pages 15 to 19) under the manager's amendment to the Patient Protection and Affordable Care Act. A correction was provided in a separate letter on December 20, 2009.

Relative to the savings projected for the original proposal, the manager's amendment would reduce the deficit by another $2 billion over 10 years (see Table 3). During this period, the amendment would increase direct spending by about $10 billion and increase revenues by about $12 billion.

The increase in funding for CHIP would raise enrollment and spending in CHIP for several years, with partially offsetting reductions in other sources of coverage. Expanding the small business tax credit would increase the gross cost of the coverage expansion by about $13 billion. Increasing the penalty for not having insurance would increase penalty collections by about $7 billion on net. Several other provisions of the manager's amendment also would affect enrollment and spending in Medicaid, CHIP, and the exchanges. By 2019, the changes related to insurance coverage would slightly increase enrollment in employment-based plans and the exchanges, and they would slightly reduce the number of uninsured people and the number of people enrolled in Medicaid. CBO and JCT estimate that the gross cost of the proposed expansions in insurance coverage would be roughly $23 billion higher as a result of the manager's amendment than they would be under the act as originally proposed ($871 billion compared with $848 billion). The net cost of the proposed insurance expansions would be about $15 billion higher than under the PPACA as originally proposed.

Other provisions included in the manager's amendment would increase federal revenues by about $26 billion (mostly from the change in the payroll tax) and would reduce the savings in Medicare, Medicaid, and other direct spending by about $8 billion on net.

Effects of the Legislation Beyond the First 10 Years

Although CBO does not generally provide cost estimates beyond the 10-year budget projection period (2010 through 2019 currently), Senate rules require some information about the budgetary impact of legislation in subsequent decades, and many Members have requested CBO analyses of the long-term budgetary impact of broad changes in the nation's health care and health insurance systems. A detailed year-by-year projection for years beyond 2019, like those that CBO prepares for the 10-year budget window, would not be meaningful because the uncertainties involved are simply too great. Among other factors, a wide range of changes could occur—in people's health, in the sources and extent of their insurance coverage, and in the delivery of medical care (such as advances in medical research, technological developments, and changes in physicians' practice patterns)—that are likely to be significant but are very difficult to predict, both under current law and under any proposal.

Effects on the Deficit. CBO has developed a rough outlook for the decade following the 10-year budget window by grouping the elements of the legislation into broad categories and assessing the rate at which the budgetary impact of each of those broad categories is likely to increase over time. The categories are as follows:

- The gross cost of the coverage expansions, consisting of exchange subsidies, the net costs of expanded eligibility for Medicaid, and tax credits for employers: Those provisions have an estimated cost of $199 billion in 2019, and that cost is growing at about 8 percent per year toward the end of the 10-year budget window. As a rough approximation, CBO assumes continued growth at about that rate during the following decade.

- The excise tax on high-premium insurance plans: JCT estimates that the provision would generate about $35 billion in additional revenues in 2019 and expects that receipts would grow by roughly 10 percent to 15 percent per year in the following decade.

- Other taxes and other effects of coverage provisions on revenues: Increased revenues from those provisions are estimated to total $74 billion in 2019 and are growing at about 7 percent per year toward the end of the budget window. As a rough approximation, CBO assumes continued growth at about that rate during the following decade.

- Changes to the Medicare program and changes to Medicaid and CHIP other than those associated directly with expanded insurance coverage: Savings from those provisions are estimated to total $106 billion in 2019, and CBO expects that, in combination, they would increase by nearly 15 percent per year in the next decade.

All told, the legislation incorporating the manager's amendment would reduce the federal deficit by $16 billion in 2019, CBO and JCT estimate. In the decade after 2019, the gross cost of the coverage expansion would probably exceed 1 percent of gross domestic product (GDP), but the added revenues and cost savings would probably be greater. Consequently, CBO expects that the legislation, if enacted, would reduce federal budget deficits over the ensuing decade relative to those projected under current law—with a total effect during that decade that is in a broad range around one-half percent of GDP. The imprecision of that calculation reflects the even greater degree of uncertainty that attends to it, compared with CBO's 10-year budget estimates. The expected reduction in deficits would represent a small share of the total deficits that would be likely to arise in that decade under current policies.[8]

Relative to the legislation as originally proposed, the expected reduction in deficits during the 2020–2029 period is larger for the legislation incorporating the manager's amendment. Most of that difference arises because the manager's amendment would lower the threshold for Medicare spending growth that would trigger recommendations for spending reductions by the Independent Payment Advisory Board. Such

[8] See Congressional Budget Office, *The Long-Term Budget Outlook* (June 2009).

recommendations would be required, in the legislation as originally proposed, if projected growth in Medicare spending per beneficiary exceeded the rate of increase in national health expenditures per capita—and in the legislation incorporating the manager's amendment, if it exceeded the average of the growth rates of the consumer price index for medical services and the overall index for all urban consumers. Because other elements of the proposal would sharply reduce the growth rate of Medicare spending in the next two decades relative to growth in the past two decades—from roughly 4 percent to roughly 2 percent on an inflation-adjusted per-beneficiary basis—CBO expects that the full amount of targeted savings would become more difficult to achieve over time. Even so, this element of the manager's amendment would probably augment the reduction in Medicare spending under the proposal significantly in the decade beyond the 10-year budget window.

As noted earlier, the CLASS program included in the bill would generate net receipts for the government in the initial years when total premiums would exceed total benefit payments, but it would eventually lead to net outlays when benefits exceed premiums. As a result, the program would reduce deficits by $72 billion during the 10-year budget window and would reduce them by a smaller amount in the ensuing decade (an amount that is included in the calculations described in the preceding paragraphs). In the decade following 2029, the CLASS program would begin to increase budget deficits. However, the magnitude of the increase would be fairly small compared with the effects of the bill's other provisions, so the CLASS program does not substantially alter CBO's assessment of the longer-term effects of the legislation.

CBO has not extrapolated estimates further into the future, because the uncertainties surrounding them are magnified even more. However, in view of the projected net savings during the decade following the 10-year budget window, CBO anticipates that the legislation would probably continue to reduce budget deficits relative to those under current law in subsequent decades, assuming that all of its provisions would continue to be fully implemented. Pursuant to section 311 of S. Con. Res. 70, CBO estimates that enacting the legislation would not cause a net increase in deficits in excess of $5 billion in any of the four 10-year periods beginning after 2019.

Other Measures. Many Members have expressed interest in the effects of reform proposals on various other measures of spending on health care. One such measure is the "federal budgetary commitment to health care," a term that CBO uses to describe the sum of net federal outlays for health programs and tax preferences for health care—providing a broad measure of the resources committed by the federal government that includes both its spending for health care and the subsidies for health care that are conveyed through reductions in federal taxes (for example, through the exclusion of payments for employment-based health insurance from income and payroll taxes).[9]

[9] For additional discussion of this term, see Congressional Budget Office, letter to the Honorable Max Baucus regarding different measures for analyzing current proposals to reform health care (October 30, 2009).

Under the legislation, federal outlays for health care would increase during the 2010–2019 period, as would the federal budgetary commitment to health care. The net increase in that commitment would be about $200 billion over that 10-year period, driven primarily by the gross cost of the coverage expansions (including increases in both outlays and tax credits). That cost would be partly offset by reductions in the federal commitment from changes to net spending for Medicare, Medicaid, CHIP, and other federal health programs; revenues generated by the excise tax on high-premium insurance plans; and changes to existing law regarding tax preferences for health care and effects of other provisions on tax expenditures for health care. Under the legislation as originally proposed, the net increase in the federal budgetary commitment to health care during the next 10 years was estimated to be about $160 billion. The difference between those figures largely reflects the difference in the gross cost of the coverage expansions.

In subsequent years, the effects of the proposal that would tend to decrease the federal budgetary commitment to health care would grow faster than those that would increase it. As a result, CBO expects that the proposal would generate a reduction in the federal budgetary commitment to health care during the decade following the 10-year budget window. By comparison, CBO expected that the legislation as originally proposed would have no significant effect on that commitment during the 2020-2029 period; most of the difference in CBO's assessment arises because the manager's amendment would lower the threshold for Medicare spending growth that would trigger recommendations for spending reductions by the Independent Payment Advisory Board. The range of uncertainty surrounding these assessments is quite wide.

Members have also requested information about the effect of proposals on national health expenditures (NHE). CBO does not analyze NHE as closely as it does the federal budget, however, and at this point the agency has not assessed the net effect of the current legislation on NHE, either within the 10-year budget window or for the subsequent decade.

Key Considerations. These longer-term calculations assume that the provisions are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation. For example, the sustainable growth rate (SGR) mechanism governing Medicare's payments to physicians has frequently been modified (either through legislation or administrative action) to avoid reductions in those payments, and legislation to do so again is currently under consideration in the Congress.

The legislation would maintain and put into effect a number of procedures that might be difficult to sustain over a long period of time. Under current law and under the proposal, payment rates for physicians' services in Medicare would be reduced by about 21 percent in 2010 and then decline further in subsequent years. At the same time, the legislation includes a number of provisions that would constrain payment rates for other providers of

Medicare services. In particular, increases in payment rates for many providers would be held below the rate of inflation (in expectation of ongoing productivity improvements in the delivery of health care). The projected longer-term savings for the legislation also assume that the Independent Payment Advisory Board is fairly effective in reducing costs beyond the reductions that would be achieved by other aspects of the legislation.

Based on the extrapolation described above, CBO expects that Medicare spending under the legislation would increase at an average annual rate of roughly 6 percent during the next two decades—well below the roughly 8 percent annual growth rate of the past two decades (excluding the effect of establishing the Medicare prescription drug benefit). Adjusting for inflation, Medicare spending per beneficiary under the legislation would increase at an average annual rate of less than 2 percent during the next two decades—about half of the roughly 4 percent annual growth rate of the past two decades. It is unclear whether such a reduction in the growth rate could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or would reduce access to care or diminish the quality of care.

The long-term budgetary impact could be quite different if key provisions of the legislation were ultimately changed or not fully implemented. If those changes arose from future legislation, CBO would estimate their costs when that legislation was being considered by the Congress.

Effects on Health Insurance Premiums

On November 30, CBO released an analysis prepared by CBO and JCT of the expected impact on average premiums for health insurance in different markets of the legislation as originally proposed.[10] Although CBO and JCT have not updated the estimates provided in that letter, the effects on premiums of the legislation incorporating the manager's amendment would probably be quite similar. Replacing the provisions for a public plan run by HHS with provisions for a multi-state plan under contract with OPM is unlikely to have much effect on average insurance premiums because the existence of that public plan would not substantially change the average premiums that would be paid in the exchanges.[11] The provisions contained in the manager's amendment to regulate the share of premiums devoted to administrative costs would tend to lower premiums slightly, and the provisions prohibiting the imposition of annual limits on coverage would tend to raise premiums slightly.

[10] For further description, see Congressional Budget Office, letter to the Honorable Evan Bayh providing an analysis of health insurance premiums under the Patient Protection and Affordable Care Act (November 30, 2009).

[11] The presence of the public plan had a more noticeable effect on CBO's estimates of federal subsidies because it was expected to exert some downward pressure on the premiums of the lower-cost plans to which those subsidies would be tied.

Private-Sector and Intergovernmental Impact
CBO and JCT have determined that the legislation contains private-sector and intergovernmental mandates as defined in the Unfunded Mandates Reform Act.

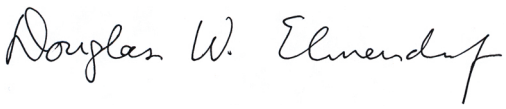
The total cost of mandates imposed on the private sector, as estimated by CBO and JCT, would greatly exceed the threshold established in UMRA for private entities ($139 million in 2009, adjusted annually for inflation)—as was the case for the legislation as originally proposed. The most costly mandates would be the new requirements regarding health insurance coverage that apply to the private sector. The legislation would require individuals to obtain acceptable health insurance coverage, as defined in the legislation. The legislation also would penalize medium-sized and large employers that did not offer health insurance to their employees if any of their workers obtained subsidized coverage through the insurance exchanges. The legislation would impose a number of mandates, including requirements on issuers of health insurance, new standards governing health information, and nutrition labeling requirements.

CBO estimates that the total cost of intergovernmental mandates would greatly exceed the annual threshold established in UMRA for state, local, and tribal entities ($69 million in 2009, adjusted annually for inflation)—as was the case for the legislation as originally proposed. The provisions of the legislation that would penalize those entities—if they did not offer health insurance to their employees and any of their workers obtained subsidized coverage through the insurance exchanges—account for most of the mandate costs. In addition, the legislation would preempt state and local laws that conflict with or are in addition to new federal standards established by the legislation. Those preemptions would limit the application of state and local laws, but CBO estimates that they would not impose significant costs.

As conditions of federal assistance (and thus not mandates as defined in UMRA), the legislation would require state and local governments to comply with “maintenance of effort” provisions associated with high-risk insurance pools. New requirements in the Medicaid program also would result in an increase in state spending. However, because states have significant flexibility to make programmatic adjustments in their Medicaid programs to accommodate changes, the new requirements would not be intergovernmental mandates as defined in UMRA.

I hope this analysis is helpful for the Senate's deliberations. If you have any questions, please contact me or CBO staff. The primary staff contacts for this analysis are Philip Ellis and Holly Harvey.

Sincerely,



Douglas W. Elmendorf
Director

Enclosures

cc: Honorable Mitch McConnell
Republican Leader

Honorable Max Baucus
Chairman
Committee on Finance

Honorable Chuck Grassley
Ranking Member

Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor, and Pensions

Honorable Michael B. Enzi
Ranking Member

Honorable Kent Conrad
Chairman
Committee on the Budget

Honorable Judd Gregg
Ranking Member

TABLE 4. Estimated Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act as Proposed, Incorporating the Manager's Amendment

EFFECTS ON INSURANCE COVERAGE /a (Millions of nonelderly people, by calendar year)		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law Coverage /b	Medicaid & CHIP	40	39	39	38	35	34	35	35	35	35
	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup & Other /c	27	26	25	26	28	29	29	29	30	30
	Uninsured /d	50	51	51	51	51	51	52	53	53	54
	TOTAL	267	269	271	273	274	276	277	279	281	282
Change (+/-)	Medicaid & CHIP	*	-1	-2	-2	8	13	16	15	15	15
	Employer	*	2	2	2	2	-1	-4	-4	-4	-4
	Nongroup & Other /c	*	*	*	*	-2	-3	-5	-5	-5	-5
	Exchanges	0	0	0	0	8	14	23	24	25	26
	Uninsured /d	*	-1	-1	-1	-16	-23	-29	-30	-30	-31
Post-Policy Uninsured Population											
Number of Nonelderly People /d		50	50	50	49	34	28	22	22	23	23
Insured Share of the Nonelderly Population /a											
Including All Residents		81%	81%	82%	82%	88%	90%	92%	92%	92%	92%
Excluding Unauthorized Immigrants		83%	83%	83%	84%	90%	92%	94%	94%	94%	94%
Memo: Exchange Enrollees and Subsidies											
Number w/ Unaffordable Offer from Employer /e						*	1	1	1	1	1
Number of Unsubsidized Exchange Enrollees						2	3	5	5	6	6
Average Exchange Subsidy per Subsidized Enrollee							$4,700	$4,800	$5,000	$5,300	$5,600

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program; * = fewer than 0.5 million people.

a. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.
b. Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source.
c. Other, which includes Medicare, accounts for about half of current-law coverage in this category; the effects of the proposal are almost entirely on nongroup coverage.
d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.
e. Workers who would have to pay more than a specified share of their income (9.8 percent in 2014) for employment-based coverage could receive subsidies via an exchange.

TABLE 4. Estimated Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act as Proposed, Incorporating the Manager's Amendment

EFFECTS ON THE FEDERAL DEFICIT / a,b (Billions of dollars, by fiscal year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Medicaid & CHIP Outlays /c	0	-2	-3	-3	28	54	75	79	81	87	395
Exchange Subsidies & Related Spending /d	0	2	2	2	17	42	73	90	100	109	436
Small Employer Tax Credits /e	2	4	5	6	5	4	3	3	4	4	40
Gross Cost of Coverage Provisions	2	4	5	6	50	99	151	172	184	199	871
Penalty Payments by Uninsured Individuals	0	0	0	0	0	-1	-2	-4	-4	-4	-15
Penalty Payments by Employers /e	0	0	0	0	-2	-4	-5	-5	-6	-6	-28
Excise Tax on High-Premium Insurance Plans /e	0	0	0	-7	-13	-17	-22	-26	-30	-35	-149
Other Effects on Tax Revenues and Outlays /f	0	1	1	5	2	-3	-13	-17	-19	-22	-65
NET COST OF COVERAGE PROVISIONS	**2**	**5**	**6**	**3**	**37**	**74**	**109**	**120**	**125**	**133**	**614**

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program.

a. Does not include several billion dollars in federal administrative costs that would be subject to appropriation.
b. Components may not sum to totals because of rounding; positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
c. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2010-2019 period would increase by about $26 billion as a result of the coverage provisions.
d. Includes $5 billion in spending for high-risk pools and the net budgetary effects of proposed collections and payments for reinsurance and risk adjustment.
e. The effects on the deficit of this provision include the associated effects of changes in taxable compensation on tax revenues.
f. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about $3 billion over the 2010-2019 period, and that the coverage provisions would have negligible effects on outlays for other federal programs.

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Changes in Direct Spending Outlays													
TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS													
Subtitle A—Immediate Improvements in Health Care Coverage for All Americans													
1001	Amendments to the Public Health Service Act	Included in estimate for expanding health insurance coverage.											
1002	Helping Consumers Receive Quality Accountable Coverage	*	*	*	0	0	0	0	0	0	0	*	*
Subtitle B—Immediate Assistance to Preserve and Expand Coverage													
1101	Temporary High Risk Health Insurance Pool	Included in estimate for expanding health insurance coverage.											
1102	Reinsurance for Early Retirees	3.0	2.0	0	0	0	0	0	0	0	0	5.0	5.0
1103	Immediate Assistance to Consumers in Identifying Affordable Coverage Options	Included in estimate for expanding health insurance coverage.											
1104	Administrative Simplification												
	Effects on Medicaid spending	*	*	-0.1	-0.1	-0.2	-0.4	-0.8	-1.7	-1.8	-2.0	-0.4	-7.1
	Effects on exchange subsidies	0	0	0	0	-0.1	-0.3	-0.6	-1.0	-1.2	-1.2	-0.1	-4.3
Subtitle C—Effective Coverage for All Americans		Included in estimate for expanding health insurance coverage.											
Subtitle D—Available Coverage for All Americans		Included in estimate for expanding health insurance coverage.											
Subtitle E—Affordable Coverage for All Americans		Included in estimate for expanding health insurance coverage.											
Subtitle F—Shared Responsibility for Health Care		Included in estimate for expanding health insurance coverage.											
Subtitle G—Miscellaneous Provisions													
1556	Equity for Certain Eligible Survivors	*	*	*	*	*	*	*	*	*	*	*	*
	Sections 1551-1555 and 1557-1562	Included in estimate for expanding health insurance coverage.											

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
TITLE II—ROLE OF PUBLIC PROGRAMS													
Subtitle A—Improved Access to Medicaid													
2001	Medicaid Coverage for the Lowest Income Populations	Included in estimate for expanding health insurance coverage.											
2002	Income Eligibility for Nonelderly Determined Using Modified Gross Income	Included in estimate for expanding health insurance coverage.											
2003	Requirement to Offer Premium Assistance for Employer-Sponsored Insurance	Included in estimate for expanding health insurance coverage.											
2004	Medicaid Coverage for Former Foster Care Children	Included in estimate for expanding health insurance coverage.											
2005	Payments to Territories	0	0.1	0.1	0.1	0.7	0.7	0.8	0.8	0.9	1.0	1.0	5.3
2006	Special Adjustment to FMAP Determination for Certain States Recovering from a Major Disaster	0	0.1	0	0	0	0	0	0	0	0	0.1	0.1
2007	Medicaid Improvement Fund Rescission	0	0	0	0	-0.1	-0.2	-0.2	-0.2	-0.2	0	-0.1	-0.7
Subtitle B—Enhanced Support for the Children's Health Insurance Program													
2101	Additional Federal Financial Participation for CHIP	Included in estimate for expanding health insurance coverage.											
2102	Technical Corrections	0	0	0	0	0.1	*	*	0	0	0	0.1	0.1
Subtitle C—Medicaid and CHIP Enrollment Simplification		Included in estimate for expanding health insurance coverage.											
Subtitle D—Improvements to Medicaid Services													
2301	Coverage for Freestanding Birth Center Services	*	*	*	*	*	*	*	*	*	*	*	*
2302	Concurrent Care for Children	*	*	*	*	*	*	*	*	*	*	0.1	0.2
2303	State Eligibility Option for Family Planning Services	0	0	0	0	0	0	0	0	0	0	0	0
2304	Clarification of Definition of Medical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle E—New Options for States to Provide Long-Term Services and Supports													
2401	Community First Choice Option	0	0.1	0.2	0.3	0.7	0.8	0.9	1.1	1.2	1.5	1.3	6.9
2402	Removal of Barriers to Providing Home and Community-Based Services	0	0.1	0.1	0.1	0.2	0.3	0.3	0.4	0.4	0.4	0.5	2.3
2403	Money Follows the Person Rebalancing Demonstration	0	0	0	*	0.1	0.2	0.3	0.4	0.3	0.3	0.2	1.7
2404	Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment	0	0	0	0	0.2	0.3	0.3	0.3	0.3	0.2	0.2	1.5
2405	Expand State Aging and Disability Resource Centers	*	*	*	*	*	*	*	*	0	0	*	0.1
2406	Sense of the Senate Regarding Long-Term Care	0	0	0	0	0	0	0	0	0	0	0	0
	Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes	0	*	0.1	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.6	1.6

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Subtitle F—Medicaid Prescription Drug Coverage	-0.8	-2.6	-3.2	-3.3	-3.7	-4.1	-4.7	-5.0	-5.3	-5.7	-13.5	-38.4
Subtitle G—Medicaid Disproportionate Share Hospital Payments	0	0	*	*	*	-2.8	-3.7	-3.9	-4.0	-4.1	*	-18.5
Subtitle H—Improved Coordination for Dual Eligible Beneficiaries												
2601 5-Year Period for Demonstration Projects	0	0	0	0	0	0	0	0	0	0	0	0
2602 Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle I—Improving the Quality of Medicaid for Patients and Providers												
2701 Adult Health Quality Measures	*	*	*	0.1	0.1	*	*	*	*	0	0.2	0.3
2702 Payment Adjustment for Health Care-Acquired Conditions	0	0	*	*	*	*	*	*	*	*	*	*
2703 State Option to Provide Health Homes for Enrollees With Chronic Conditions	0	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.7
2704 Demonstration Project to Evaluate Integrated Care Around a Hospitalization	0	0	0	0	0	0	0	0	0	0	0	0
2705 Medicaid Global Payment System Demonstration Project	0	0	0	0	0	0	0	0	0	0	0	0
2706 Pediatric Accountable Care Organization Demonstration Project	0	0	0	0	0	0	0	0	0	0	0	0
2707 Medicaid Emergency Psychiatric Demonstration Project	0	*	*	*	*	*	0	0	0	0	0.1	0.1
Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)	*	*	0	0	0	0	0	0	0	0	*	*
Subtitle K—Protections for American Indians and Alaska Natives												
2901 Special Rules Relating to Indians												
No Cost Sharing for Indians with Income at or Below 300 Percent of Poverty Enrolled in Coverage Through a State Exchange	Included in estimate for expanding health insurance coverage.											
Payer of Last Resort and Express-Lane Option	0	0	0	0	0	0	0	0	0	0	0	0
2902 Elimination of Sunset for Payment for Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics	0	*	*	*	*	*	*	*	*	*	0.1	0.2
Indian Health Improvement Act	*	*	*	*	*	*	*	*	*	*	*	*

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
SUBTITLE F—MATERNAL AND CHILD HEALTH SERVICES													
2951	Maternal, Infant, and Early Childhood Home Visiting Programs	*	0.1	0.3	0.4	0.4	0.2	0.1	*	0	0	1.2	1.5
2952	Support, Education, and Research for Postpartum Depression	0	0	0	0	0	0	0	0	0	0	0	0
2953	Personal Responsibility Education	*	*	0.1	0.1	0.1	0.1	*	*	*	0	0.3	0.4
2954	Restoration of Funding for Abstinence Education	*	*	*	*	*	*	*	*	*	0	0.1	0.1
2955	Inclusion of Information About The Importance of Having a Health-Care Power of Attorney in Transition Planning for Children Aging Out of Foster Care and Independent Living Programs	0	0	0	0	0	0	0	0	0	0	0	0
	Support for Pregnant and Parenting Teens and Women	*	*	*	*	*	*	*	*	*	*	0.1	0.2
TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE													
Subtitle A—Transforming the Health Care Delivery System													
PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM													
3001	Hospital Value-Based Purchasing Program	0	0	0	0	0	0	0	0	0	0	0	0
3002	Improvements to the Physician Quality Reporting System												
	Physicians' Services	0	0	0.2	0.2	0.2	0.3	-0.1	-0.2	-0.2	-0.2	0.6	0.3
	PPO Stabilization Fund	0	0	0	0	-0.1	*	0	0	0	0	-0.1	-0.2
3003	Improvements to the Physician Feedback Program	0	0	0	0	0	0	0	0	0	0	0	0
3004	Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs	0	0	0	0	*	*	*	*	*	*	*	-0.2
3005	Quality Reporting for PPS-Exempt Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
3006	Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies	0	0	0	0	0	0	0	0	0	0	0	0
3007	Value-based Payment Modifier Under the Physician Fee Schedule	0	0	0	0	0	0	0	0	0	0	0	0
3008	Payment Adjustment for Conditions Acquired in Hospitals	0	0	0	0	0	-0.3	-0.3	-0.3	-0.3	-0.3	0	-1.5
PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY													
3011	National Strategy	0	0	0	0	0	0	0	0	0	0	0	0
3012	Interagency Working Group on Health Care Quality	0	0	0	0	0	0	0	0	0	0	0	0
3013	Quality Measure Development	0	0	0	0	0	0	0	0	0	0	0	0
3014	Quality Measurement	*	*	*	*	*	*	0	0	0	0	0.1	0.1
3015	Data Collection; Public Reporting	0	0	0	0	0	0	0	0	0	0	0	0
	Interaction of Quality-Measure Development/Endorsement Provisions \	0	0	0	0	*	*	*	*	*	*	*	*

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS													
3021	Establishment of Center for Medicare and Medicaid Innovation	*	0.1	0.2	0.2	0.2	0.2	*	-0.3	-0.7	-1.2	0.7	-1.3
3022	Medicare Shared Savings Program	*	*	*	-0.1	-0.3	-0.6	-0.7	-0.9	-1.0	-1.2	-0.5	-4.9
3023	National Pilot Program on Payment Bundling	0	0	0	*	*	*	*	*	*	*	*	*
3024	Independence at Home Demonstration Program	*	*	*	*	*	*	0	0	0	0	*	*
3025	Hospital Readmissions Reduction Program	0	0	0	-0.1	-0.3	-1.1	-1.3	-1.3	-1.4	-1.5	-0.5	-7.1
3026	Community-Based Care Transitions Program	0	*	0.1	0.1	0.1	0.1	0.1	0	0	0	0.3	0.5
3027	Extension of Gainsharing Demonstration	*	*	*	*	*	0	0	0	0	0	*	*
Subtitle B—Improving Medicare for Patients and Providers													
PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES													
3101	Increase in the Physician Payment Update	0	0	0	0	0	0	0	0	0	0	0	0
3102	Extension of the Work Geographic Index Floor and Revisions to the Practice Expense Geographic Adjustment	0.7	0.9	0.3	0	0	0	0	0	0	0	1.8	1.8
3103	Extension of Exceptions Process for Medicare Therapy Caps	0.6	0.2	0	0	0	0	0	0	0	0	0.8	0.8
3104	Extension of Payment for Technical Component of Certain Physician Pathology Services	0.1	*	0	0	0	0	0	0	0	0	0.1	0.1
3105	Extension of Ambulance Add-Ons	0.1	*	0	0	0	0	0	0	0	0	0.1	0.1
3106	Extension of Certain Payment Rules for Long-Term Care Hospital Services and of Moratorium on the Establishment of Certain Hospitals and Facilities	0	0.1	0.1	*	0	0	0	0	0	0	0.2	0.2
3107	Extension of Physician Fee Schedule Mental Health Add-On	*	*	0	0	0	0	0	0	0	0	*	*
3108	Permitting Physician Assistants to Order Post-Hospital Extended Care Services	*	*	*	*	*	*	*	*	*	*	*	*
3109	Exemption of Certain Pharmacies From Accreditation Requirements	0	0	0	0	0	0	0	0	0	0	0	0
3110	Part B Special Enrollment Period for Disabled TRICARE Beneficiaries	*	*	*	*	*	*	*	*	*	*	*	*
3111	Payment for Bone Density Tests	0.1	0.1	*	0	0	0	0	0	0	0	0.1	0.1
3112	Revision to the Medicare Improvement Fund	0	0	0	0	-16.7	-5.6	0	0	0	0	-16.7	-22.3
3113	Treatment of Certain Complex Diagnostic Laboratory Tests	0	*	*	*	0	0	0	0	0	0	0.1	0.1
3114	Improved Access for Certified-Midwife Services	0	*	*	*	*	*	*	*	*	*	*	*

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

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PART II—RURAL PROTECTIONS													
3121	Extension of Outpatient Hold Harmless Provision	0.1	*	0	0	0	0	0	0	0	0	0.2	0.2
3122	Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas	*	*	0	0	0	0	0	0	0	0	*	*
3123	Extension of the Rural Community Hospital Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0
3124	Extension of the Medicare-Dependent Hospital Program	0	0	*	*	0	0	0	0	0	0	*	*
3125	Payment Adjustment for Low-Volume Hospitals	0	0.1	0.2	*	0	0	0	0	0	0	0.3	0.3
3126	Demonstration Project on Community Health Integration Models in Certain Rural Counties	0	0	0	0	0	0	0	0	0	0	0	0
3127	MedPAC Study on Adequacy of Medicare Payments for Health Care Providers Serving in Rural Areas	0	0	0	0	0	0	0	0	0	0	0	0
3128	Technical Correction Related to Critical Access Hospital Services	0	0	0	0	0	0	0	0	0	0	0	0
3129	Medicare Rural Hospital Flexibility Program	0	0	0	0	0	0	0	0	0	0	0	0
PART III—IMPROVING PAYMENT ACCURACY													
3131	Payment Adjustments for Home Health Care (includes effect of section 3401)	-0.1	-0.5	-0.8	-1.1	-1.8	-3.2	-5.2	-7.4	-9.0	-10.3	-4.3	-39.4
3132	Hospice Reform	0	*	*	*	*	*	*	*	*	*	*	-0.1
3133	Medicare Disproportionate Share Hospital Payments	0	0	0	0	0	-3.6	-4.4	-5.6	-5.0	-5.8	0	-24.4
3134	Misvalued Codes Under the Physician Fee Schedule	0	0	0	0	0	0	0	0	0	0	0	0
3135	Modification of Equipment Utilization Factor for Advanced Imaging Services	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-1.1	-3.0
3136	Revision of Payment for Power-Driven Wheelchairs	0	-0.4	-0.1	*	*	*	*	-0.1	-0.1	-0.1	-0.6	-0.8
3137	Hospital Wage Index Improvement	0.2	*	0	0	0	0	0	0	0	0	0.3	0.3
3138	Treatment of Certain Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
3139	Payment for Biosimilar Biological Products	Included in estimate for title VII, subtitle A.											
3140	Medicare Hospice Concurrent Care Demonstration Program	0	0	*	*	*	*	0	0	0	0	*	*
3141	Application of Budget Neutrality on a National Basis in the Calculation of the Medicare Hospital Wage Index Floor	0	0	0	0	0	0	0	0	0	0	0	0
3142	HHS Study on Urban Medicare-Dependent Hospitals	0	0	0	0	0	0	0	0	0	0	0	0

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Subtitle C—Provisions Relating to Part C													
3201	Medicare Advantage Payment	0	-6.2	-6.7	-10.4	-11.1	-12.4	-14.0	-16.8	-19.0	-21.6	-34.4	-118.1
3202	Benefit Protection and Simplification	0	0	0	0	0	0	0	0	0	0	0	0
3203	Application of Coding Intensity Adjustment During Payment Transition for Medicare Advantage	0	-0.6	-0.8	-0.5	0	0	0	0	0	0	-1.9	-1.9
3204	Simplification of Annual Beneficiary Election Periods	*	*	*	*	*	*	*	*	*	*	*	*
3205	Extension for Specialized Medicare Advantage Plans for Special Needs Individuals	0	0.2	0.2	0.2	0.1	0.1	*	*	*	*	0.7	0.9
3206	Extension of Reasonable Cost Contracts	0	*	*	*	0	0	0	0	0	0	*	*
3207	Technical Correction to MA Private Fee-for-Service Plans	0	*	*	*	*	*	*	*	*	*	0.1	0.1
3208	Making Senior Housing Facility Demonstration Permanent	Included in estimate for section 3205.											
3209	Authority to Deny Plan Bids	Included in estimate for section 3201.											
3210	Development of New Standards for Certain Medigap Plans	0	0	0	0	0	*	*	*	*	*	0	-0.1
Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans													
3301	Medicare Coverage Gap Discount Program	0	2.5	1.9	1.4	1.6	1.8	2.2	2.4	2.5	3.2	7.4	19.5
3302	Improvement in Determination of Medicare Part D Low-Income Benchmark Premium	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.7
3303	Voluntary de Minimis Policy for Subsidy Eligible Individuals Under Prescription Drug Plans and MA–PD Plans	0	*	*	*	*	*	*	0.1	0.1	0.1	0.1	0.4
3304	Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance	0	*	*	*	*	*	*	*	*	*	0.1	0.2
3305	Improved Information for Subsidy Eligible Individuals Reassigned to Prescription Drug Plans and MA–PD Plans	0	0	0	0	0	0	0	0	0	0	0	0
3306	Funding Outreach and Assistance for Low-Income Programs	*	*	*	0	0	0	0	0	0	0	*	*
3307	Formulary Requirements With Respect to Certain Categories or Classes of Drugs	0	0	0	0	0	0	0	0	0	0	0	0
3308	Part D Premiums for High-Income Beneficiaries	0	-0.4	-0.5	-0.7	-0.9	-1.1	-1.3	-1.6	-2.0	-2.4	-2.4	-10.7
3309	Elimination of Cost Sharing for Certain Dual-Eligible Individuals	0	0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	1.1
3310	Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-Term Care Facilities	0	0	-0.1	-0.3	-0.5	-0.8	-1.0	-1.0	-0.9	-1.1	-1.0	-5.7
3311	Prescription Drug Plan Complaint System	0	0	0	0	0	0	0	0	0	0	0	0
3312	Uniform Exceptions and Appeals Process	0	0	0	0	0	0	0	0	0	0	0	0
3313	Office of the Inspector General Studies and Reports	0	0	0	0	0	0	0	0	0	0	0	0
3314	Including Costs Incurred by AIDS Drug Assistance Programs and Indian Health Service in Providing Prescription Drugs Toward the Annual Out-of-Pocket Threshold Under Part D	0	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
3315	Immediate Reduction in Coverage Gap in 2010	Included in estimate for section 3301.											
	Part D Medication Therapy Management Programs	0	0	0	0	0	0	0	0	0	0	0	0

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

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Subtitle E—Ensuring Medicare Sustainability													
3401	Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates that do not Already Incorporate Such Improvements (effect of productivity adjustment for home health services included in estimate for section 3131)	-0.2	-1.1	-3.9	-7.4	-11.2	-15.0	-19.1	-23.8	-29.3	-36.0	-23.7	-147.0
3402	Temporary Adjustment to the Calculation of Part B Premiums	0	-1.3	-1.9	-1.9	-2.5	-2.6	-2.8	-3.2	-4.0	-4.9	-7.5	-25.0
3403	Independent Medicare Advisory Board	0	0	*	*	*	-1.5	-4.0	-5.6	-7.7	-9.4	*	-28.2
Subtitle F—Health Care Quality Improvements		0	0	0	0	0	0	0	0	0	0	0	0
	Medicare Coverage For Individuals Exposed To Environmental Health Hazards	*	*	*	*	*	*	*	*	*	*	0.1	0.3
	Protections for Frontier States	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.8	2.0
	Delay Implementation of RUG-IV	0	0	0	0	0	0	0	0	0	0	0	0
	Pilot Testing of Pay-for-Performance	0	0	0	0	0	0	0	0	0	0	0	0
	Methodology to Assess Health Plan Value	0	0	0	0	0	0	0	0	0	0	0	0
	Modernizing CMS Computer and Data Systems	0	0	0	0	0	0	0	0	0	0	0	0
	Public Reporting of Performance Information	0	0	0	0	0	0	0	0	0	0	0	0
	Medicare Data	0	0	0	0	0	0	0	0	0	0	0	0
	Community-Based Collaborative Care Networks	0	0	0	0	0	0	0	0	0	0	0	0
	Report On Access To High-Quality Dialysis Services	0	0	0	0	0	0	0	0	0	0	0	0

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TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH													
SUBTITLE A—MODERNIZING DISEASE PREVENTION AND PUBLIC HEALTH SYSTEMS													
4002	Prevention and Public Health Fund	0.1	0.6	0.8	1.0	1.3	1.6	1.8	1.9	2.0	2.0	3.7	12.9
	Sections 4001, 4003, 4004	0	0	0	0	0	0	0	0	0	0	0	0
SUBTITLE B—INCREASING ACCESS TO CLINICAL PREVENTIVE SERVICES													
4101	School-Based Health Centers	0	*	*	*	*	*	0	0	0	0	0.1	0.1
4102	Oral Healthcare Prevention Activities	0	0	0	0	0	0	0	0	0	0	0	0
4103	Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan	0.2	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.5	1.6	3.7
4104	Removal of Barriers to Preventive Services in Medicare	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
4105	Evidence-Based Coverage of Preventive Services in Medicare	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.7
4106	Improving Access to Preventive Services for Eligible Adults in Medicaid	0	0	0	*	*	*	*	*	*	*	*	0.1
4107	Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid	0	0	0	*	*	*	*	*	*	*	*	-0.1
4108	Incentives for Prevention of Chronic Diseases in Medicaid	0	*	0.1	*	*	0	0	0	0	0	0.1	0.1
SUBTITLE C—CREATING HEALTHIER COMMUNITIES													
4201	Community Transformation Grants	0	0	0	0	0	0	0	0	0	0	0	0
4202	Healthy Aging, Living Well; Evaluation of Community-Based Prevention and Wellness Programs in Medicare	*	*	*	0	0	0	0	0	0	0	0.1	0.1
4203	Removing Barriers and Improving Access to Wellness for Individuals With Disabilities	0	0	0	0	0	0	0	0	0	0	0	0
4204	Immunizations	*	0	0	0	0	0	0	0	0	0	*	*
4205	Nutrition Labeling at Chain Restaurants	0	0	0	0	0	0	0	0	0	0	0	0
4206	Demonstration Project Concerning Individualized Wellness Plan	0	0	0	0	0	0	0	0	0	0	0	0
4207	Reasonable Break Time for Nursing Mothers	0	0	0	0	0	0	0	0	0	0	0	0

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SUBTITLE D—SUPPORT FOR PREVENTION AND PUBLIC HEALTH INNOVATION													
4301	Research On Optimizing The Delivery of Public Health Services	0	0	0	0	0	0	0	0	0	0	0	0
4302	Understanding Health Disparities: Data Collection and Analysis	0	0.1	0.1	0.1	0	0	0	0	0	0	0.2	0.2
4303	CDC and Employer-Based Wellness Programs	0	0	0	0	0	0	0	0	0	0	0	0
4304	Epidemiology-Laboratory Capacity Grants	0	0	0	0	0	0	0	0	0	0	0	0
4305	Advancing Research and Treatment for Pain-Care Management	0	0	0	0	0	0	0	0	0	0	0	0
4306	Funding for Childhood Obesity Demonstration Project	*	*	*	*	*	0	0	0	0	0	*	*
	Better Diabetes Care	0	0	0	0	0	0	0	0	0	0	0	0
	Grants for Workplace Wellness	0	0	0	0	0	0	0	0	0	0	0	0
	Cures Acceleration Network	0	0	0	0	0	0	0	0	0	0	0	0
	Centers of Excellence for Depression	0	0	0	0	0	0	0	0	0	0	0	0
	Programs Relating to Congenital Heart Disease	0	0	0	0	0	0	0	0	0	0	0	0
	Automated Defibrillation	0	0	0	0	0	0	0	0	0	0	0	0
	Young Women's Breast Health	0	0	0	0	0	0	0	0	0	0	0	0
SUBTITLE E—MISCELLANEOUS PROVISIONS		0	0	0	0	0	0	0	0	0	0	0	0
TITLE V—HEALTH CARE WORKFORCE													
Subtitle A—Purpose and Definitions		0	0	0	0	0	0	0	0	0	0	0	0
Subtitle B—Innovations in the Health Care Workforce		0	0	0	0	0	0	0	0	0	0	0	0
	Alaska Task Force	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle C—Increasing the Supply of the Health Care Workforce		0	0	0	0	0	0	0	0	0	0	0	0
Subtitle D—Enhancing Health Care Workforce Education and Training													
	Sections 5301-5314	0	0	0	0	0	0	0	0	0	0	0	0
5315	United States Public Health Sciences Track	Included in estimate for section 4002.											
	Community Health Workforce	0	0	0	0	0	0	0	0	0	0	0	0
	Physician Assistant Education Programs	0	0	0	0	0	0	0	0	0	0	0	0
	Family Nurse Practitioner Training Programs	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle E—Supporting the Existing Health Care Workforce		0	0	0	0	0	0	0	0	0	0	0	0
	Residents	0	0	0	0	0	0	0	0	0	0	0	0

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Subtitle F—Strengthening Primary Care and Other Workforce Improvements													
5501	Expanding Access to Primary Care Services and General Surgery Services	0	0.4	0.6	0.7	0.7	0.8	0.3	0	0	0	2.5	3.5
5502	Medicare Federally Qualified Health Centers	0	*	*	*	*	0.1	0.1	0.1	0.1	0.1	*	0.4
5503-5506	Medicare Graduate Medical Education Policies	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.4	1.2
5507	Demonstration Projects to Address Health Professions Workforce Needs; Extension of Family-To-Family Health Information Centers	*	0.1	0.1	0.1	0.1	0.1	*	*	0	0	0.4	0.4
5508	Increasing Teaching Capacity	0	*	*	*	*	*	*	*	*	*	0.2	0.2
5509	Graduate Nurse Education Demonstration Program	0	0	*	0.1	0.1	0.1	*	0	0	0	0.1	0.2
Subtitle G—Improving Access to Health Care Services		0	0	0	0	0	0	0	0	0	0	0	0
	Funding for Community Health Centers and the National Health Service Corps	0	0.5	1.8	1.4	1.7	2.6	1.5	0.2	*	0	5.5	9.8
	State Grants to Providers	0	0	0	0	0	0	0	0	0	0	0	0
	Medical Training in Underserved Communities	0	0	0	0	0	0	0	0	0	0	0	0
	Preventive Medicine and Public Health Training Program	0	0	0	0	0	0	0	0	0	0	0	0
	Scholarship and Loan Program	0	0	0	0	0	0	0	0	0	0	0	0
	Infrastructure to Expand Access to Care	0	0.1	*	*	0	0	0	0	0	0	0.1	0.1
	Demonstration Program to Provide Access to Affordable Care	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle H—General Provisions		0	0	0	0	0	0	0	0	0	0	0	0

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TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY												
Subtitle A—Physician Ownership and Other Transparency												
6001 Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals	*	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5
6002 Transparency Reports and Reporting of Physician Ownership or Investment Interests	0	0	0	0	0	0	0	0	0	0	0	0
6003 Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services	0	0	0	0	0	0	0	0	0	0	0	0
6004 Prescription Drug Sample Transparency	0	0	0	0	0	0	0	0	0	0	0	0
6005 Pharmacy Benefit Managers Transparency Requirements	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle B—Nursing Home Transparency and Improvement	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle C—Nationwide Program for National and State Background Checks on Direct	*	*	*	0	0	0	0	0	0	0	0.1	0.1
Subtitle D—Patient-Centered Outcomes Research												
6301 Patient-Centered Outcomes Research												
Medicare	0	0	*	*	*	*	*	*	-0.1	-0.2	0.1	-0.3
Non-Medicare	*	*	0.1	0.1	0.2	0.3	0.4	0.4	0.4	0.5	0.4	2.5
6302 Federal Coordinating Council for Comparative Effectiveness Research	0	0	0	0	0	0	0	0	0	0	0	0

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Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions													
6401	Provider Screening and Other Enrollment Requirements	*	*	*	*	*	*	*	*	*	*	*	-0.2
6402	Medicare and Medicaid Program Integrity Provisions	*	-0.2	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-1.3	-3.2
6403	Elimination of Duplication Between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank	0	0	0	0	0	0	0	0	0	0	0	0
6404	Maximum Period for Submission of Medicare Claims	0	0	0	0	0	0	0	0	0	0	0	0
6405	Physicians Who Order Items or Services Required to Be Medicare-Enrolled Physicians or Eligible Professionals	*	*	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.2	-0.4
6406	Requirement for Physicians to Provide Documentation on Referrals to Programs At High Risk of Waste and Abuse	0	0	0	0	0	0	0	0	0	0	0	0
6407	Face to Face Encounter With Patient Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment Under Medicare	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.3	-1.0
6408	Enhanced Penalties	0	0	0	0	0	0	0	0	0	0	0	0
6409	Medicare Self-Referral Disclosure Protocol	0	0	0	0	0	0	0	0	0	0	0	0
6410	Adjustments to the Medicare Competitive Acquisition Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	*	*	*	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-1.4
6411	Expansion of the Recovery Audit Contractor Program	0	*	*	*	*	*	*	*	*	*	*	*
	Health Care Fraud Enforcement	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle F—Additional Medicaid Program Integrity Provisions													
6501	Termination of Provider Participation Under Medicaid if Terminated Under Medicare or Other State Plan	0	0	0	0	0	0	0	0	0	0	0	0
6502	Medicaid Exclusion From Participation Relating to Certain Ownership, Control, and Management Affiliations	0	0	0	0	0	0	0	0	0	0	0	0
6503	Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicaid	0	0	0	0	0	0	0	0	0	0	0	0
6504	Requirement to Report Expanded Set of Data Elements Under MMIS to Detect Fraud and Abuse	0	0	0	0	0	0	0	0	0	0	0	0
6505	Prohibition on Payments to Institutions or Entities Located Outside of the United States	0	0	0	0	0	0	0	0	0	0	0	0
6506	Overpayments	0.1	*	*	*	*	*	*	*	*	*	0.1	0.1
6507	Mandatory State Use of National Correct Coding Initiative	0	*	*	*	*	*	*	*	*	*	-0.1	-0.3
6508	General Effective Date	0	0	0	0	0	0	0	0	0	0	0	0

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Subtitle G—Additional Program Integrity Provisions	0	0	0	0	0	0	0	0	0	0	0	0
State Demonstration Programs: Alternatives to Tort Litigation	0	0	0	0	0	0	0	0	0	0	0	0
Liability Coverage in Free Clinics	0	*	*	*	*	*	*	*	*	*	*	0.1
FDA Labeling Changes	*	*	*	*	*	*	*	*	*	*	*	-0.1
Subtitle H—Elder Justice Act	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle I—Sense of the Senate Regarding Medical Malpractice	0	0	0	0	0	0	0	0	0	0	0	0
TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES												
Subtitle A—Biologics Price Competition and Innovation	0	0	0	*	-0.1	-0.4	-0.7	-1.2	-1.9	-2.7	-0.1	-7.1
Subtitle B—More Affordable Medicines for Children and Underserved Communities												
7101 Expanded Participation in 340B Program	Included in estimate for section 2501.											
7102 Improvements to 340B Program Integrity	0	0	0	0	0	0	0	0	0	0	0	0
7103 GAO Study on Improving the 340B Program	0	0	0	0	0	0	0	0	0	0	0	0
TITLE VIII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS	0	-3.7	-6.4	-8.7	-9.9	-11.2	-9.6	-8.6	-7.5	-6.8	-28.7	-72.5
TITLE IX—REVENUE PROVISIONS	Estimates provided by the Joint Committee on Taxation in a Separate Table											
INTERACTIONS												
Medicare Advantage Interactions	0	1.0	-0.5	-1.1	-1.9	-2.0	-2.4	-2.8	-3.0	-4.0	-2.5	-16.6
Premium Interactions	0	0.1	0.5	1.1	6.1	4.1	3.8	4.8	5.7	6.7	7.9	32.8
Implementation of Medicare Changes	*	*	*	*	*	*	*	*	*	*	*	0.1
Medicare Part D Interactions with Medicare Advantage Provisions	0	0.1	0.1	0.3	0.3	0.4	0.4	0.4	0.4	0.5	0.8	3.0
Medicare Part B Interactions with Medicare Part D Provisions	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.9
Medicaid Interactions with Medicare Part D Provisions	*	*	*	*	*	0.1	0.1	0.1	0.1	0.2	0.1	0.6
Medicare Interaction with 340B	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5
TRICARE Interaction	*	*	-0.1	-0.2	-0.2	-0.3	-0.5	-0.6	-0.8	-0.9	-0.4	-3.5
FEHB Interaction (on-budget)	0	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.4	0.4	1.8
FEHB Interaction (off-budget)	0	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.4	1.0
Total, Changes in Unified-Budget Direct Spending	**4.3**	**-6.1**	**-15.9**	**-26.9**	**-45.5**	**-53.3**	**-63.3**	**-79.0**	**-91.1**	**-106.3**	**-90.0**	**-483.1**

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Changes in Revenues												
Transitional Reinsurance - Collections for Early Retirees	0	0	0	0	1.5	1.5	0.8	0	0	0	1.5	3.8
Fraud, Waste, and Abuse (on-budget)	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.9
Effect of Administrative Simplification on Revenues [a]	-0.1	-0.2	-0.2	*	0.5	0.9	1.3	1.9	2.0	2.0	*	8.1
Effect on Revenues of Changes in Health Insurance Premiums as a Result of Comparative Effectiveness Research, Changes in the Medicaid Drug Program, Biosimilar Biological Products, and FDA Labeling												
Income and Medicare payroll taxes (on-budget)	*	*	*	*	*	0.1	0.1	0.2	0.3	0.3	0.1	1.0
Social Security payroll taxes (off-budget)	*	*	*	*	*	*	0.1	0.1	0.1	0.2	*	0.5
Total, Changes in Unified-Budget Revenues	**-0.1**	**-0.1**	**-0.1**	**0.2**	**2.1**	**2.6**	**2.4**	**2.2**	**2.5**	**2.6**	**2.0**	**14.2**
Changes in Unified-Budget Deficits	**4.4**	**-6.0**	**-15.8**	**-27.1**	**-47.5**	**-55.8**	**-65.6**	**-81.2**	**-93.6**	**-108.9**	**-92.1**	**-497.3**
Memorandum:												
Non-scoreable Effects												
Savings from increased HCFAC spending	0	*	*	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4	-0.3	-1.6
Expansion of the Recovery Audit Contractor (RAC) Program in Medicaid	0	*	*	*	*	*	*	*	-0.1	-0.1	-0.1	-0.3

NOTES: * = between -$50 million and $50 million.
AIDS = Acquired Immune-Deficiency Syndrome; CDC = Center for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; FMAP = federal medical assistance percentage; FDA = Food and Drug Administration; GAO = Government Accountability Office; HCFAC = Health Care Fraud and Abuse Control; HHS = Department of Health and Human Services; MA = Medicare Advantage; MA-PD = Medicare Advantage prescription drug plan; MedPAC = Medicare Payment Advisory Commission; MMIS = Medicaid Management Information System; PPO = preferred provider organization; PPS = prospective payment system; RUG-IV = Resource Utilization Group, version four.

[a] Includes both on- and off-budget revenues.

JOINT COMMITTEE ON TAXATION
December 19, 2009
JCX-61-09

ESTIMATED REVENUE EFFECTS OF THE MANAGER'S AMENDMENT TO THE REVENUE PROVISIONS CONTAINED IN THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT" [1]

Fiscal Years 2010 - 2019

[Billions of Dollars]

Provision	Effective	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
Revenue Offset Provisions													
1. 40% excise tax on health coverage in excess of $8,500/$23,000 indexed for inflation by CPI-U plus 1% and increased thresholds for over age 55 retirees or certain high-risk professions; levied at insurer level; employer aggregates and issues information return for insurers indicating amount subject to the excise tax; nondeductible; high 17 state transition relief [2]	tyba 12/31/12	---	---	---	7.1	13.0	17.0	21.6	25.8	29.9	34.6	20.1	148.9
2. Employer W-2 reporting of value of health benefits	tyba 12/31/10	*Negligible Revenue Effect*											
3. Conform the definition of medical expenses for health savings accounts, Archer MSAs, health flexible spending arrangements, and health reimbursement arrangements to the definition of the itemized deduction for medical expenses (excluding over-the-counter medicines prescribed by a physician) [2]	tyba 12/31/10	---	0.4	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	2.1	5.0
4. Increase the penalty for nonqualified health savings account distributions to 20%	dma 12/31/10	---	[3]	[3]	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.2	1.3
5. Limit health flexible spending arrangements in cafeteria plans to $2,500, indexed to CPI-U after 2011 [2] [4]	tyba 12/31/10	---	0.6	0.9	1.6	1.9	1.8	1.7	1.7	1.6	1.5	5.0	13.3
6. Require information reporting on payments to corporations	pma 12/31/11	---	---	0.4	3.3	2.0	2.1	2.2	2.3	2.4	2.5	5.6	17.1
7. Additional requirements for section 501(c)(3) hospitals	tyba DOE	*Negligible Revenue Effect*											
8. Impose $2.3 billion annual fee on manufacturers and importers of branded drugs	[5]	2.0	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	11.0	22.2

Provision	Effective	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
9. Impose annual fee on manufacturers and importers of certain medical devices ($2 billion per year for 2011 through 2017; and $3 billion per year thereafter)	[6]	---	1.8	2.0	2.0	2.0	2.0	2.0	2.0	2.8	2.9	7.6	19.2
10. Impose annual fee on health insurance providers ($2 billion for 2011, $4 billion for 2012, $7 billion for 2013, and $9 billion per year for 2014 through 2016, $10 billion thereafter, with certain exceptions)	[7]	---	1.6	3.3	5.8	7.6	7.8	7.8	8.5	8.6	8.6	18.3	59.6
11. Study and report of effect on veterans health care	DOE	*No Revenue Effect*											
12. Eliminate deduction for expenses allocable to Medicare Part D subsidy	tyba 12/31/10	---	0.3	0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.8	1.9	5.4
13. Raise 7.5% AGI floor on medical expenses deduction to 10%; AGI floor for individuals age 65 and older (and their spouses) remains at 7.5% through 2016	tyba 12/31/12	---	---	---	0.4	1.5	1.6	1.7	2.5	3.7	3.9	2.0	15.2
14. $500,000 deduction limitation on taxable year remuneration to officers, employees, directors, and service providers of covered health insurance providers	[8]	---	---	---	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
15. Raise the hospital insurance tax on wages and self-employment income in excess of $200,000 ($250,000 joint) by 0.9 percentage points, unindexed [2]	tyba 12/31/12	---	---	---	13.3	6.0	10.4	13.1	14.1	14.7	15.2	19.3	86.8
16. Modification of section 833 treatment of certain health organizations	tyba 12/31/09	[3]	0.1	0.1	[3]	[3]	[3]	[3]	[3]	[3]	[3]	0.2	0.4
17. Impose 10% excise tax on indoor tanning services	spo/a 7/1/10	[9]	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	1.0	2.7
Total of Revenue Offset Provisions		**2.0**	**7.2**	**10.2**	**37.3**	**37.9**	**46.6**	**54.1**	**61.0**	**67.9**	**73.5**	**94.5**	**397.7**
Other Provisions													
1. Provide income exclusion for specified Indian tribe health benefits	[10]	---	[9]	[9]	[9]	[9]	[9]	[9]	[9]	[9]	[9]	[9]	[9]
2. Simple cafeteria plan nondiscrimination safe harbor for certain small employers	tyba 12/31/10	*Negligible Revenue Effect*											
3. Qualifying therapeutic discovery project credit (sunset 12/31/10)	[11]	-0.4	-0.2	-0.1	-0.1	[9]	[9]	---	---	---	---	-0.9	-0.9
4. Exclusion for assistance provided to participants in state student loan repayment programs for certain health professionals	tyba 12/31/08	[9]	[9]	[9]	[9]	[9]	[9]	[9]	[9]	[9]	[9]	[9]	-0.1

Provision	Effective	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
5. Make the adoption credit refundable; increase qualifying expenses threshold, and extend the adoption credit through 2011	tyba 12/31/09	-0.2	-0.6	-0.5	[3]	---	---	---	---	---	---	-1.2	-1.2
Total of Other Provisions		**-0.6**	**-0.8**	**-0.6**	**-0.1**	**[9]**	**[9]**	**[9]**	**[9]**	**[9]**	**[9]**	**-2.1**	**-2.2**
Revenue-Related Provision - Impose Fee on Insured and Self-Insured Health Plans; Patient-Centered Outcomes Research Trust Fund	**[12]**	**---**	**---**	**---**	**0.1**	**0.3**	**0.3**	**0.4**	**0.4**	**0.5**	**0.7**	**0.4**	**2.6**
NET TOTAL		**1.4**	**6.4**	**9.6**	**37.3**	**38.2**	**46.9**	**54.5**	**61.4**	**68.4**	**74.2**	**92.8**	**398.1**

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding.

Legend for "Effective" column:

dma = distributions made after pma = payments made after tyba = taxable years beginning after

DOE = date of enactment spo/a = services performed on or after

[1] Details of estimates of tax provisions included in Title I are reported in the forthcoming letter from the Congressional Budget Office to the Honorable Harry Reid, Senate Majority Leader, regarding the budgetary effects of the "Patient Protection and Affordable Care Act" and incorporating the effects of the Managers' Amendment.

[2] Estimate includes the following off-budget effects:

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
40% excise tax on health coverage	---	---	---	1.5	2.7	3.5	4.5	5.4	6.3	7.5	4.2	31.3
Conform the definition of medical expenses	---	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.6	1.4
Limit health flexible spending arrangements	---	0.1	0.2	0.4	0.5	0.5	0.5	0.4	0.4	0.4	1.2	3.3
0.9 percentage point increase to hospital insurance tax	---	---	---	3.0	-1.5	-0.7	-0.1	-0.1	-0.2	-0.3	1.5	[3]

[3] Gain of less than $50 million.

[4] Estimate includes interaction with the high premium excise tax.

[5] Effective for calendar years beginning after December 31, 2009; fee is allocated based on market share of branded prescription drug sales for calendar years beginning after December 31, 2008.

[6] Effective for calendar years beginning after December 31, 2010; fee is allocated based on market share of certain medical device sales for calendar years beginning after December 31, 2009.

[7] Effective for calendar years beginning after December 31, 2010; fee is allocated based on market share of net premiums written for any United States health risk for calendar years beginning after December 31, 2009.

[8] Effective for remuneration paid in taxable years beginning after 2012 with respect to services performed after 2009.

[9] Loss of less than $50 million.

[10] Effective for health benefits and coverage provided after the date of enactment.

[11] Effective for amounts paid or incurred after December 31, 2008, in taxable years beginning after December 31, 2008.

[12] Effective for each policy plan year ending after September 30, 2012, but does not apply to policy years ending after September 31, 2019.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

December 20, 2009

Honorable Harry Reid
Majority Leader
United States Senate
Washington, DC 20510

Dear Mr. Leader:

The Congressional Budget Office (CBO) has discovered an error in the cost estimate released on December 19, 2009, related to the longer-term effects on direct spending of the manager's amendment to the Patient Protection and Affordable Care Act (PPACA), Senate Amendment 2786 in the nature of a substitute to H.R. 3590 (as printed in the Congressional Record on November 19, 2009).

Correcting that error has no impact on the estimated effects of the legislation during the 2010–2019 period. However, the correction reduces the degree to which the legislation would lower federal deficits in the decade after 2019.

The legislation would establish an Independent Payment Advisory Board, which would be required, under certain circumstances, to recommend changes to the Medicare program to limit the rate of growth in that program's spending. Those recommendations would go into effect automatically unless blocked by subsequent legislative action. In its original estimate, CBO wrote that: "Such recommendations would be required if the Chief Actuary for the Medicare program projected that the program's spending per beneficiary would grow more rapidly than a measure of inflation (the average of the growth rates of the consumer price index for medical services and the overall index for all urban consumers)." That statement is correct for fiscal years 2015 through 2019. After 2019, however, the threshold for Medicare spending growth that would trigger recommendations for spending reductions would be higher—specifically, the rate of increase in gross domestic product (GDP) per capita plus 1 percentage point.

With this corrected reading, savings from changes to the Medicare program (along with other changes to direct spending that are not associated directly with expanded insurance coverage) would increase at a rate that is between 10 percent and 15 percent per year during the 2020–2029 period, compared with a growth rate of nearly 15 percent reported in the initial estimate. The long-run budgetary effects of the other broad categories of the legislation are unchanged from the initial estimate. All told, CBO expects that the legislation, if enacted, would reduce federal budget deficits over the decade after 2019

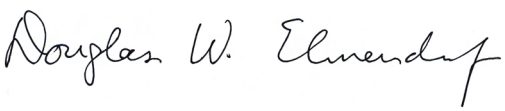
relative to those projected under current law—with a total effect during that decade that is in a broad range between one-quarter percent and one-half percent of GDP. In comparison, the extrapolations in the initial estimate implied a reduction in deficits in the 2020–2029 period that would be in a broad range around one-half percent of GDP. The imprecision of these calculations reflects the even greater degree of uncertainty that attends to them, compared with CBO's 10-year budget estimates. The expected reduction in deficits would represent a small share of the total deficits that would be likely to arise in that decade under current policies.

Relative to the legislation as originally proposed, the expected reduction in deficits during the 2020–2029 period remains somewhat larger for the legislation incorporating the manager's amendment. It also remains that case that most of that difference arises because the manager's amendment would lower the threshold for Medicare spending growth that would trigger recommendations for spending reductions by the Independent Payment Advisory Board. Such recommendations would be required, in the legislation as originally proposed, if projected growth in Medicare spending per beneficiary exceeded the rate of increase in national health expenditures per capita—and in the legislation incorporating the manager's amendment, if it exceeded the rate of increase in GDP plus 1 percentage point.

Based on this extrapolation, CBO expects that Medicare spending under the legislation would increase at an average annual rate of roughly 6 percent during the next two decades—well below the roughly 8 percent annual growth rate of the past two decades (excluding the effect of establishing the Medicare prescription drug benefit). Adjusting for inflation, Medicare spending per beneficiary under the legislation would increase at an average annual rate of roughly 2 percent during the next two decades—well below the roughly 4 percent annual growth rate of the past two decades. It is unclear whether such a reduction in the growth rate could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or would reduce access to care or diminish the quality of care.

I apologize for any confusion created by this error. If you have any questions, please contact me.

Sincerely,



Douglas W. Elmendorf
Director

Enclosures

cc: Honorable Mitch McConnell
Republican Leader

Honorable Max Baucus
Chairman
Committee on Finance

Honorable Chuck Grassley
Ranking Member

Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor, and Pensions

Honorable Michael B. Enzi
Ranking Member

Honorable Kent Conrad
Chairman
Committee on the Budget

Honorable Judd Gregg
Ranking Member

Premiums and Subsidies

In the course of the deliberations over health care legislation, policymakers sought information about the impact that different proposals would have on health insurance premiums—whether for coverage obtained through an employer (the predominant form of private insurance coverage in the United States) or for policies purchased in the individual insurance market and in the proposed health insurance exchanges. To respond to that interest, CBO provided the following analyses:

1. A detailed analysis of estimated health insurance premiums for the year 2016 under PPACA as it was originally introduced, which was conveyed in a letter to Senator Evan Bayh on November 30, 2009.

2. A one-page summary of estimated average premiums in 2009 and 2016 under the law as it existed prior to enactment of PPACA, for purposes of comparison with estimated premiums under proposed legislation (dated December 5, 2009).

3. An analysis of premiums for the "bronze" level of coverage specified by PPACA as passed by the Senate, which was conveyed in a letter to Senator Olympia Snowe on January 11, 2010. (Under PPACA, the bronze level of coverage will pay 60 percent of enrollees' costs for covered medical services, on average; people will generally have to purchase coverage at the bronze level or higher in order to avoid paying a penalty for being uninsured, and larger employers will generally have to offer at least that level of coverage in order to avoid penalties.)

CBO did not formally update its analysis of premium effects for subsequent versions of the legislation but concluded that the impacts were not likely to differ substantially from the estimates issued in November 2009.

Many of the proposals considered by the Congress in 2009 would have established new federal subsidies for coverage purchased by individuals and families through health insurance exchanges. Those subsidies were often designed to limit the share of income that enrollees would have to pay in premiums for a specified insurance plan, usually applying a sliding scale so that the share of income would depend on enrollees' income relative to the federal poverty level. In addition, subsidies were often proposed to cover some of the cost sharing of lower-income enrollees in order to increase the actuarial value of their coverage. CBO provided analyses of several proposals along those dimensions, including these:

4. A one-page table summarizing CBO's estimates of average premiums and subsidy payments under a proposal considered by the Senate Finance Committee (dated October 9, 2009).

5. A letter to House Ways and Means Committee Chairman Charles B. Rangel, dated November 2, 2009, analyzing subsidies and payments at different income levels under H.R. 3962, which was being considered by the House of Representatives at that time.

6. A letter to Senate Majority Leader Harry Reid, dated November 20, 2009, analyzing subsidies and payments at different income levels under PPACA as it was originally introduced.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

November 30, 2009

Honorable Evan Bayh
United States Senate
Washington, DC 20510

Dear Senator:

The attachment to this letter responds to your request—and the interest expressed by many other Members—for an analysis of how proposals being considered by the Congress to change the health care and health insurance systems would affect premiums paid for health insurance in various markets. Specifically, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation have analyzed how health insurance premiums might be affected by enactment of the Patient Protection and Affordable Care Act, as proposed by Senator Reid on November 18, 2009.

I hope this information is helpful to you. If you have any further questions, please contact me or the CBO staff. The primary staff contact for this analysis is Philip Ellis.

Sincerely,

Douglas W. Elmendorf

Attachment

cc: Honorable Harry Reid
Majority Leader

Honorable Mitch McConnell
Republican Leader

Congressional Budget Office

An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act

November 30, 2009

There is great interest in how proposals being considered by the Congress to change the health care and health insurance systems would affect premiums paid for health insurance in various markets. Consequently, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have analyzed how those premiums might be affected by the Patient Protection and Affordable Care Act, an amendment in the nature of a substitute to H.R. 3590, as proposed by Senator Reid on November 18, 2009. The analysis looks separately at the effects on premiums for coverage purchased individually, coverage purchased by small employers, and coverage provided by large employers.

Key Elements of the Proposed Legislation

The proposal includes many provisions that would affect insurance premiums:

- New policies purchased from insurers individually (in the "nongroup" market) or purchased by small employers would have to meet several new requirements starting in 2014. Policies would have to cover a specified set of services and to have an "actuarial value" of at least 60 percent (meaning that the plan would, on average, pay that share of the costs of providing covered services to a representative set of enrollees). In addition, insurers would have to accept all applicants during an annual open-enrollment period, and insurers could not limit coverage for preexisting medical conditions. Moreover, premiums could not vary to reflect differences in enrollees' health or use of services and could vary on the basis of an enrollee's age only to a limited degree.

- A less extensive set of changes would be implemented more quickly and would continue in effect after 2013. Among other changes, health insurance plans: could not impose lifetime limits on the total amount of services covered; could rescind coverage only for certain reasons; would have to cover certain preventive services with no cost sharing; and would have to allow unmarried dependents to be covered under their parents' policies up to age 26. Those changes would also apply to new coverage provided by large employers, including firms that "self-insure"—meaning that the firm, rather than an insurer, bears the financial risk of providing coverage.

However, current policies that had been purchased in any of those markets or that were offered by self-insured firms would be exempt from all of those changes if they were maintained continuously—that is, policies held since the date of enactment of the legislation would be "grandfathered."

In addition, the proposal would: establish a mandate for most legal residents of the United States to obtain health insurance; set up insurance "exchanges" through which certain individuals and families could receive federal subsidies to substantially reduce the amount they would pay to purchase that coverage; make a public insurance plan available through those exchanges in certain states; penalize certain individuals if they did not obtain insurance coverage and penalize certain employers if their workers received subsidies through the exchanges; provide tax credits to certain small employers that offer coverage to their workers; significantly expand eligibility for Medicaid; substantially reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected under current law); levy an excise tax on insurance plans with relatively high premiums; impose fees on insurers and on manufacturers and importers of certain drugs and medical devices; and make various other changes to the federal tax code and to Medicare, Medicaid, and other federal programs. Each of those components of the legislation has the potential to affect the premiums that are charged for insurance, directly or indirectly; some would increase premiums, and others would decrease them.

Overview of the Analysis

In general, the premium for a health insurance policy equals the average amount that an insurer expects to pay for services covered under the plan plus a loading factor that reflects the insurer's administrative expenses and overhead (including any taxes or fees paid to the government) and profits (for private plans). An insurer's costs for covered services reflect the scope of benefits that are covered, the plan's cost-sharing requirements, the enrollees' health status and tendency to use medical services, the rates at which providers are paid, and the degree of benefit management the insurer uses to restrain spending. Although the factors affecting premiums are complex and interrelated—and thus can be difficult to disentangle—this analysis groups the effects of the proposal on premiums into three broad categories:

- Differences in the amount of insurance coverage purchased,
- Differences in the price of a given amount of insurance coverage for a given group of enrollees, and
- Differences in the types of people who obtain coverage in each insurance market.

CBO and JCT estimated the effect of the legislation on premiums in three broad insurance markets—nongroup, small group, and large group—as well as the

contributions to the changes in premiums from each of those three sources of change. Several aspects of the analysis bear emphasis:

- The analysis focuses on the effects of the legislation on the average premium *per person*—that is, per covered life, including dependents covered by family policies. That approach provides an integrated measure of the impact on premiums for single coverage and family coverage, and those effects are expressed as percentage changes in average premiums. The analysis also summarizes the effects of the proposal on the dollar cost of the average premium *per policy* (rather than per insured person) and presents those effects separately for individual and family policies in each market.[1]

- Many individuals and families would experience changes in premiums that differed from the changes in average premiums in their insurance market.[2] As explained below, some provisions of the legislation would tend to decrease or increase the premiums paid by all insurance enrollees, while other provisions would tend to increase the premiums paid by healthier enrollees relative to those paid by less healthy enrollees or would tend to increase the premiums paid by younger enrollees relative to those paid by older enrollees. As a result, some individuals and families within each market would see changes in premiums that would be larger or smaller than, or be in the opposite direction of, the estimated average changes.

- The analysis examines the effects of the proposal in 2016 in order to indicate the impact that it would have once its provisions were fully implemented. To focus on permanent elements of the legislation, however, the estimates exclude the effect of the reinsurance that would be provided for new nongroup plans between 2014 and 2016 only (which would be funded by an assessment on insurers).

- The analysis focuses on the effects of the legislation on total health insurance premiums that would be charged to individuals or employers before accounting for premium subsidies or the small business tax credit. The analysis also reports the effects of the legislation on the amounts the purchasers would ultimately have to pay, after accounting for those two forms of assistance. However, even when examining unsubsidized

[1] In some cases, the translation from premiums per person to premiums per policy is complex. To the extent that proposals change the average number of enrollees in a family policy, the premium per person in family coverage could increase even as the premium per policy decreased (for example, if fewer children were covered); conversely, the average premium per person could decrease even as the premium per policy increased (for example, if more children were covered).

[2] Consistent with CBO and JCT's earlier estimate of the coverage and budgetary effects of the insurance coverage provisions in this proposal, this analysis addresses coverage of the nonelderly resident population.

premiums, the analysis incorporates the effects of those subsidies (as well as existing tax preferences) on the number and types of people who would obtain coverage in each market, because those effects would have an important impact on the total premiums charged.

- The analysis does not incorporate potential effects of the proposal on the level or growth rate of spending for health care that might stem from increased demand for services brought about by the insurance expansion or from the development and dissemination of less costly ways to deliver care that would be encouraged by the proposal. The impact of such "spillover" effects on health care spending and health insurance premiums is difficult to quantify precisely, but the effect on premiums in 2016 would probably be small.

This analysis contains several sections. The next section summarizes the findings. The following three sections describe the estimated effects of the legislation on total premiums paid to insurers through its effects on the amount of insurance coverage obtained, the price of a given amount of insurance coverage for a given group of enrollees, and the type of people who obtain coverage. A subsequent section analyzes the effect of the proposal on the net cost of obtaining insurance, taking into account both the subsidies that would be available to individuals for insurance purchased through the exchanges and the tax credits that would be provided to small businesses. The penultimate section discusses the effects of the excise tax on insurance policies with relatively high premiums (the effects of which are accounted for separately because they would apply only to a portion of the market for employment-based insurance in 2016). A final section briefly discusses some potential effects of the proposal that are not included in the quantitative analysis.

Summary of Findings

The effects of the proposal on premiums would differ across insurance markets (see Table 1). The largest effects would be seen in the nongroup market, which would grow in size under the proposal but would still account for only 17 percent of the overall insurance market in 2016. The effects on premiums would be much smaller in the small group and large group markets, which would make up 13 percent and 70 percent of the total insurance market, respectively.

Nongroup Policies

CBO and JCT estimate that the average premium per person covered (including dependents) for new nongroup policies would be about 10 percent to 13 percent higher in 2016 than the average premium for nongroup coverage in that same year under current law. About half of those enrollees would receive government subsidies that would reduce their costs well below the premiums that would be charged for such policies under current law.

Table 1.

Effect of Senate Proposal on Average Premiums for Health Insurance in 2016

	Percentage, by Market		
	Nongroup[a]	Small Group[b]	Large Group[c]
Distribution of Nonelderly Population Insured in These Markets Under Proposal	17	13	70
Differences in Average Premiums Relative to Current Law Due to:			
Difference in Amount of Insurance Coverage	+27 to +30	0 to +3	Negligible
Difference in Price of a Given Amount of Insurance Coverage for a Given Group of Enrollees	-7 to -10	-1 to -4	Negligible
Difference in Types of People with Insurance Coverage	-7 to -10	-1 to +2	0 to -3
Total Difference Before Accounting for Subsidies	+10 to +13	+1 to -2	0 to -3
Effect of Subsidies in Nongroup and Small Group Markets			
Share of People Receiving Subsidies[d]	57	12	n.a.
For People Receiving Subsidies, Difference in Average Premiums Paid After Accounting for Subsidies	-56 to -59	-8 to -11	n.a.
Effect of Excise Tax on High-Premium Plans Sponsored by Employers			
Share of People Who Would Have High-Premium Plans Under Current Law	n.a.	19	
For People Who Would Have High-Premium Plans Under Current Law, Difference in Average Premiums Paid[e]	n.a.	-9 to -12	
Memorandum			
Number of People Covered Under Proposal (Millions)	32	25	134

Source: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: n.a. = not applicable.

a. The nongroup market includes people purchasing coverage individually either in the proposed insurance exchanges or in the individual insurance market outside the insurance exchanges.

b. The small group market includes people covered in plans sponsored by firms with 50 or fewer employees.

c. The large group market includes people covered in plans sponsored by firms with more than 50 employees.

d. Premium subsidies in the nongroup market are those available through the exchanges. Premium subsidies in the small group market are those stemming from the small business tax credit.

e. The effect of the tax includes both the increase in premiums for policies with premiums remaining above the excise tax threshold and the reduction in premiums for those choosing plans with lower premiums.

That difference in unsubsidized premiums is the net effect of three changes:

- Average premiums would be 27 percent to 30 percent higher because a greater amount of coverage would be obtained. In particular, the average insurance policy in this market would cover a substantially larger share of enrollees' costs for health care (on average) and a slightly wider range of benefits. Those expansions would reflect both the minimum level of coverage (and related requirements) specified in the proposal and people's decisions to purchase more extensive coverage in response to the structure of subsidies.

- Average premiums would be 7 percent to 10 percent lower because of a net reduction in costs that insurers incurred to deliver the same amount of insurance coverage to the same group of enrollees. Most of that net reduction would stem from the changes in the rules governing the nongroup market.

- Average premiums would be 7 percent to 10 percent lower because of a shift in the types of people obtaining coverage. Most of that change would stem from an influx of enrollees with below-average spending for health care, who would purchase coverage because of the new subsidies to be provided and the individual mandate to be imposed.[3]

Average premiums per policy in the nongroup market in 2016 would be roughly $5,800 for single policies and $15,200 for family policies under the proposal, compared with roughly $5,500 for single policies and $13,100 for family policies under current law.[4] The weighted average of the differences in those amounts equals the change of 10 percent to 13 percent in the average premium *per person* summarized above, but the percentage increase in the average premium *per policy* for family policies is larger and that for single policies is smaller because the average number of people covered per family policy is estimated to increase under the proposal. The effects on the premiums paid by some individuals and families could vary significantly from the average effects on premiums.

Those figures indicate what enrollees would pay, on average, not accounting for the new federal subsidies. The majority of nongroup enrollees (about 57 percent) would receive subsidies via the new insurance exchanges, and those subsidies, on average, would cover nearly two-thirds of the total premium, CBO and JCT

[3] Although the effects of each factor should be multiplied rather than added in order to generate the total effect on premiums, there are also interactions among the three factors that make the sum of the individual effects roughly equal to the total effect. The ranges shown for the likely effects of each factor and for the likely overall effect on premiums were chosen to reflect the uncertainties involved in the estimates; however, the actual effects could fall outside of those ranges.

[4] Because of an error, the figures for average nongroup premiums in 2016 under current law that were reported in CBO's September 22, 2009, letter to Senator Baucus on this subject (which had been reported as being about $6,000 for single coverage and about $11,000 for family coverage) were not correct.

estimate. Thus, the amount that subsidized enrollees would pay for nongroup coverage would be roughly 56 percent to 59 percent lower, on average, than the nongroup premiums charged under current law. Among nongroup enrollees who would *not* receive new subsidies, average premiums would increase by somewhat less than the 10 percent to 13 percent difference for the nongroup market as a whole because some factors discussed below would have different effects for those enrollees than for those receiving subsidies.

The amount of subsidy received would depend on the enrollee's income relative to the federal poverty level (FPL) according to a specified schedule (see Table 2, appended).[5] Under the proposal, the subsidy levels in each market would be tied to the premium of the second cheapest plan providing the "silver" level of coverage (that is, paying 70 percent of enrollees' covered health care costs, on average). CBO and JCT have estimated that, in 2016, the average premium nationwide for those "reference plans" would be about $5,200 for single coverage and about $14,100 for family coverage. The difference between those figures and the average nongroup premiums under the proposal that are cited above ($5,800 and $15,200, respectively) reflects the expectation that many people would opt for a plan that was more expensive than the reference plan, to obtain either a higher amount of coverage or other valued features (such as a broader network of providers or less tightly managed benefits).

Employment-Based Coverage

The legislation would have much smaller effects on premiums for employment-based coverage, which would account for about five-sixths of the total health insurance market. In the small group market, which is defined in this analysis as consisting of employers with 50 or fewer workers, CBO and JCT estimate that the change in the average premium per person resulting from the legislation could range from an increase of 1 percent to a reduction of 2 percent in 2016 (relative to current law).[6] In the large group market, which is defined here as consisting of employers with more than 50 workers, the legislation would yield an average premium per person that is zero to 3 percent lower in 2016 (relative to current law). Those overall effects reflect the net impact of many relatively small changes, some of which would tend to increase premiums and some of which would tend to reduce them (as shown in Table 1).[7]

[5] Table 2 reproduces the table included in Congressional Budget Office, letter to the Honorable Harry Reid providing an analysis of subsidies and payments at different income levels under the Patient Protection and Affordable Care Act (November 20, 2009).

[6] Under the proposal, the small group market in 2016 would be defined to include firms with 100 or fewer employees, but the threshold for the exemption from the penalties imposed on employers would be set at 50 full-time employees. Because the proposal would have similar effects on premiums for large and small employers, reclassifying firms with 51 to 100 workers as small employers for purposes of this analysis would probably have little effect on the overall results, though the factors affecting premiums for those firms would be somewhat different.

[7] Because the aggregate amount of premiums for employment-based plans is large, even small percentage changes can have noticeable effects on the federal budget through their effects on the amount of compensation excluded from taxation because of the tax preference that applies to those premiums.

By CBO and JCT's estimate, the average premium per policy in the small group market would be in the vicinity of $7,800 for single policies and $19,200 for family policies under the proposal, compared with about $7,800 and $19,300 under current law. In the large group market, average premiums would be roughly $7,300 for single policies and $20,100 for family policies under the proposal, compared with about $7,400 and $20,300 under current law.[8] As in the nongroup market, the effects on the premiums paid by some people for coverage provided through their employer could vary significantly from the average effects on premiums, particularly in the small group market.

Those figures do not include the effects of the small business tax credit on the cost of purchasing insurance. A relatively small share (about 12 percent) of people with coverage in the small group market would benefit from that credit in 2016. For those people, the cost of insurance under the proposal would be about 8 percent to 11 percent lower, on average, compared with that cost under current law.

The reductions in premiums described above also exclude the effects of the excise tax on high-premium insurance policies offered through employers, which would have a significant impact on premiums for the affected workers but which would affect only a portion of the market in 2016.[9] Specifically, an estimated 19 percent of workers with employment-based coverage would be affected by the excise tax in that year. Those individuals who kept their high-premium policies would pay a higher premium than under current law, with the difference in premiums roughly equal to the amount of the tax. However, CBO and JCT estimate that most people would avoid the cost of the excise tax by enrolling in plans that had lower premiums; those reductions would result from choosing plans that either pay a smaller share of covered health care costs (which would reduce premiums directly as well as indirectly by leading to less use of covered medical services), manage benefits more tightly, or cover fewer services.[10] On balance, the average premium among the affected workers would be about 9 percent to 12 percent less than under current law. Those figures incorporate the other effects on premiums for employment-based plans that were summarized above.

[8] Those calculations also reflect an expectation that a large share of enrollees in employment-based plans would be in grandfathered plans throughout the 2010–2019 period.

[9] Beginning in 2013, insurance policies with relatively high premiums would be subject to a 40 percent excise tax on the amount by which the premiums exceeded a specified threshold. That threshold would be set initially at $8,500 for single policies and $23,000 for family policies (with certain exceptions); after 2013, those amounts would be indexed to overall inflation plus 1 percentage point.

[10] CBO and JCT assume that, if employers reduce the amount of compensation they provide in the form of health insurance (relative to current-law projections), offsetting changes will occur in other forms of compensation, which are generally taxable.

Uncertainty Surrounding These Estimates

The analysis presented here reflects the cost estimate for the legislation that CBO and JCT provided on November 18. The same substantial degree of uncertainty that surrounds CBO and JCT's estimates of the impact that the proposal would have on insurance coverage rates and the federal budget also accompanies this analysis of the proposal's effects on premiums. Some components of those effects are relatively straightforward to estimate, such as the effect of imposing specific fees or the effect of a change in the amount of coverage purchased because of requirements for minimum coverage; however, estimating effects that depend heavily on how enrollees, insurers, employers, or other key actors would respond—to such things as the changes in the market rules for nongroup policies or the excise tax on high-premium policies—involve greater uncertainty. The projections of average premiums in each market under current law are also uncertain.

Differences in the Amount of Coverage Purchased

One key factor contributing to the differences in average insurance premiums under the proposal is differences in the average amount of coverage purchased. Those differences reflect differences in both the *scope* of insurance coverage—the benefits or services that are included—and in the *share of costs* for covered services paid by the insurer—known as the actuarial value. With other factors held equal, insurance policies that cover more benefits or services or have a higher actuarial value (by requiring smaller copayments or deductibles) have higher premiums, while policies that cover fewer benefits or services or specify larger copayments or deductibles have lower premiums.

The main elements of the legislation that would affect the amount of coverage purchased are the requirement that all new policies in the nongroup and small group markets cover at least a minimum specified set of benefits; the requirement that such policies have a certain minimum actuarial value; and the design of the federal subsidies, which would encourage many enrollees in the exchanges to join plans with an actuarial value above the required minimum. (The excise tax on high-premium plans would also affect the amount of coverage purchased; the impact of that tax is discussed in a separate section of this analysis.) Those provisions would have a much greater effect on premiums in the nongroup market than in the small group market, and they would have no measurable effect on premiums in the large group market.

Specifically, because of the greater actuarial value and broader scope of benefits that would be covered by new nongroup policies sold under the legislation, the average premium per person for those policies would be an estimated 27 percent to 30 percent higher than the average premium for nongroup policies under current law (with other factors held constant). The increase in actuarial value would push the average premium per person about 18 percent to 21 percent above its level under current law, before the increase in enrollees' use of medical care resulting from lower cost sharing is considered; that induced increase, along with

the greater scope of benefits, would account for the remainder of the overall difference.

In the small group market, the greater actuarial value and broader scope of benefits provided for in the legislation would increase the average premium per person by about zero to 3 percent (leaving aside the effect of the excise tax on high premium plans, which is discussed separately, and holding other factors constant). Those requirements would have no noticeable effect on premiums in the large group market (again, excluding the effect of the high-premium excise tax).

A Broader Scope of Benefits Would Increase Nongroup Premiums

Under the legislation, new nongroup policies would cover a broader scope of benefits than are projected to be covered by such policies, on average, under current law. In particular, the legislation would require all new nongroup policies to cover a specified set of "essential health benefits," which would be further delineated by the Secretary of Health and Human Services (HHS) and would be required to match the scope of benefits provided by typical employment-based plans. As a result, new nongroup policies would cover certain services that are often not covered by nongroup policies under current law, such as maternity care, prescription drugs, and mental health and substance abuse treatment. Moreover, nongroup insurers would be prohibited from denying coverage for preexisting conditions, so premiums would have to increase to cover the resulting costs.

An additional consideration relates to state-mandated benefits. Under the proposal, states that mandated coverage of benefits beyond those required by the new federal rules would have to pay any costs of subsidizing those additional benefits. CBO and JCT assumed that, to the extent that states continued to mandate such benefits, they would make the resulting payments directly to insurers—so those costs would not be reflected in the premiums that enrollees observed when shopping for insurance in the exchanges. The reduction in premiums (relative to those under current law) resulting from this provision would be relatively small because many benefits that states mandate are already provided by typical employment-based plans and thus would be included in the "essential health benefits" that the proposal would require nongroup policies to cover.[11]

The legislation would further require that policies sold in the small group market cover the same minimum set of benefits as those sold in the nongroup market. That requirement would have relatively little effect on premiums in the small group market, however, because most policies sold in that market already cover those services and would continue to cover them under current law. Further, small group policies that are maintained continuously would be grandfathered under the proposal.

[11] For an additional discussion of the average incremental cost of state-mandated benefits, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), p. 61.

A Greater Actuarial Value Would Increase Nongroup Premiums

Under the legislation, new nongroup policies purchased after 2013 would have a substantially greater actuarial value, on average, than nongroup policies purchased under current law. Policies sold in the nongroup market are expected to have an average actuarial value of about 60 percent under current law, and new nongroup policies would be required to have an actuarial value of at least 60 percent (the level specified for the "bronze" plan) under the proposal. However, federal premium subsidies would be tied to a "reference premium" equal to the premium of the second lowest cost "silver" plan, which would have an actuarial value of 70 percent, and plans would also be available with actuarial values of 80 percent ("gold" plan) and 90 percent ("platinum" plan).[12]

People who received premium subsidies would be able to buy a plan whose premium exceeded the reference premium, although they would have to pay the entire additional cost of that more expensive plan. With the expected enrollment choices of people with subsidies and people without subsidies taken into account, the average actuarial value of nongroup policies purchased is estimated to be roughly 72 percent. The increases in actuarial value relative to that under current law would increase the premiums for those policies, because the policies would cover a greater proportion of their enrollees' spending on medical care. Of course, the increases in actuarial value would also reduce enrollees' expected out-of-pocket spending on copayments and deductibles, particularly for enrollees who used more medical services than average. The reduced cost sharing would lead to greater use of medical services, which would tend to push premiums up further.[13]

Among nongroup enrollees who would not receive new subsidies, the average actuarial value of their coverage would not differ as sharply from the average for the nongroup market under current law. Some would choose to enroll in a "young invincibles" plan to be offered under the proposal; that plan would have relatively high deductibles and a relatively low actuarial value (estimated to be less than 50 percent), and the premium would be correspondingly low. (That plan would generally not be attractive to individuals who could receive premium subsidies for more extensive coverage.) Moreover, if they wanted to, current policyholders in the nongroup market would be allowed to keep their policy with no changes, and the premiums for those policies would probably not differ substantially from current-law levels. But because of relatively high turnover in that market (as well as the incentives for many enrollees to purchase a new policy in order to obtain

[12] Enrollees with income below 200 percent of the FPL would receive subsidies for cost sharing to increase the overall actuarial value of their coverage to either 80 percent or 90 percent. However, the plan in which they enrolled would have a premium that reflects an actuarial value of 70 percent, and that premium was used in the calculation of the average premium under the proposal.

[13] The increase in spending for health care that would arise when uninsured people gained coverage is accounted for separately; see the discussion below. For a discussion of the impact that cost sharing has on spending for health care and related considerations, see Congressional Budget Office, *Key Issues,* pp. 61–62, 71–76, and 110–112.

subsidies), CBO and JCT estimate that relatively few nongroup policies would remain grandfathered by 2016.

Effects on Premiums for Employment-Based Plans Would be Much Smaller The legislation would impose the same minimum actuarial value for new policies in the small group market as in the nongroup market. That requirement would have a much smaller effect on premiums in the small group market, however, because the great majority of policies sold in that market under current law have an actuarial value of more than 60 percent. Essentially all large group plans have an actuarial value above 60 percent, so the effect on premiums in that market would be negligible. In sum, the greater actuarial value and broader scope of benefits in the legislation would increase the average premium per person in the small group market by about zero to 3 percent (with other factors held constant). Those requirements would have no significant effect on premiums in the large group market.

Differences in the Price of a Given Amount of Coverage for a Given Population

A second broad category of differences in premiums encompasses factors that reflect an "apples-to-apples" comparison of the average price of providing equivalent insurance coverage for an equivalent population under the legislation and under current law.[14] The main provisions of the legislation that fall into this category are the new rules for the insurance market, including the establishment of exchanges and availability of a public plan through those exchanges, which would reduce insurers' administrative costs and increase slightly the degree of competition among insurers, and several new fees that would be imposed on the health sector, which would tend to raise insurance premiums.[15]

Some observers have argued that private insurance premiums would also be affected by changes in the extent of "cost shifting"—a process in which lower rates paid to providers for some patients (such as uninsured people or enrollees in government insurance programs) lead to higher payments for others (such as privately insured individuals). However, the effect of the proposal on premiums through changes in cost shifting seems likely to be quite small because the proposal has opposing effects on different potential sources of cost shifting, and

[14] In this description, "equivalent coverage" means policies that have the same scope of benefits and cost-sharing requirements. The benefits received by enrollees in plans with equivalent coverage also depend on factors such as the benefit management being used and the size and composition of the provider network.

[15] The effect of the excise tax on health insurance plans with relatively high premiums is discussed separately, below. Also, to focus on permanent elements of the legislation, this analysis does not include the effect of the reinsurance that would be provided for new nongroup plans between 2014 and 2016 only. Those payments would be financed by a fee levied on all private insurers, so the effects would differ by market but the overall impact on premiums would be modest.

the total amount of cost shifting in the current health care system appears to be modest relative to the overall cost of health insurance.

CBO and JCT estimate that the elements of the legislation that would change the price of providing a given amount of coverage for a given population would, on net, reduce the average premium per person for nongroup coverage in 2016 by about 7 percent to 10 percent relative to the amount under current law. Those elements of the legislation would reduce the average premium per person in the small group market by about 1 percent to 4 percent and would not have a measurable impact on premiums in the large group market.

New Market Rules Would Reduce Administrative Costs

Compared with plans that would be available in the nongroup market under current law, nongroup policies under the proposal would have lower administrative costs, largely because of the new market rules:[16]

- The influx of new enrollees in response to the individual mandate and new subsidies—combined with the creation of new insurance exchanges—would create larger purchasing pools that would achieve some economies of scale.

- Administrative costs would be reduced by provisions that require some standardization of benefits—for example, by limiting variation in the types of policies that could be offered and prohibiting "riders" to insurance policies (which are amendments to a policy's terms, such as coverage exclusions for preexisting conditions); insurers incur administrative costs to implement those exclusions.

- Administrative costs would be reduced slightly by the general prohibition on medical underwriting, which is the practice of varying premiums or coverage terms to reflect the applicant's health status; nongroup insurers incur some administrative costs to implement underwriting.

- Partly offsetting those reductions in administrative costs would be a surcharge that exchange plans would have to pay under the proposal to cover the operating costs of the exchanges.

In the small group market, some employers would purchase coverage for their workers through the exchanges.[17] Such policies would have lower administrative costs, on average, than the policies those firms would buy under current law,

[16] Those market rules would also affect premiums by changing the scope of coverage provided and the types of people who obtain coverage, as discussed in other sections.

[17] In 2016, states would have to give all employers with 100 or fewer employees the option to purchase coverage through the exchanges. States could give larger employers that option starting in 2017. However, CBO and JCT expect that few large firms would take that option if offered because their administrative costs would generally be lower than those of nongroup policies that would be available in the exchanges.

particularly for very small firms.[18] The primary sources of administrative cost savings for small employers would be the economies of scale and relative standardization of benefits in the exchanges noted above; currently, the use of exclusions for preexisting conditions is rare in the small group market, so the rules affecting coverage of those conditions would have only a small effect on administrative costs in that market.

In addition, the administrative simplification provisions of the legislation would require the Secretary of HHS to adopt and regularly update standards for electronic administrative transactions such as electronic funds transfers, claims management processes, and eligibility verification. In CBO and JCT's estimation, those provisions would reduce administrative costs for insurers and providers, which would result in a modest reduction in premiums in all three broad insurance markets.

Increased Competition Would Slightly Reduce Premiums in the Nongroup Market

The exchanges would enhance competition among insurers in the nongroup market by providing a centralized marketplace in which consumers could compare the premiums of relatively standardized insurance products. The additional competition would slightly reduce average premiums in the exchanges by encouraging consumers to enroll in lower-cost plans and by encouraging plans to keep their premiums low in order to attract enrollees. In particular, insurers probably would adopt slightly stronger benefit management procedures to restrain spending or would slightly reduce the rates they pay providers. Those small employers that purchased coverage through the exchanges would see similar reductions in premiums because of the increased competition among plans.

One other feature of the proposal would also put a modicum of downward pressure on average premiums in the exchanges—namely, the provisions allowing exchange administrators to act as "prudent purchasers" when reviewing and approving the proposed premiums of potential insurers.[19] Although the administrators' authority would be limited, evidence from the implementation of an exchange system in Massachusetts suggests that the existence of such authority would tend to reduce premiums slightly.

CBO and JCT's analysis of exchange premiums has also taken into account the availability of a public plan through those exchanges in some states. Premiums for the public plan as structured under the proposal would typically be somewhat

[18] Among small employers, administrative costs decline as a share of premiums as the size of the firm increases. Thus, the smallest employers would be most likely to see lower administrative costs for policies in the exchanges than what they would be charged under current law.

[19] Specifically, the legislation would require insurers seeking to participate in the exchanges to submit a justification for any premium increase prior to implementing it; the legislation also would give exchanges the authority to take that information into consideration when determining whether to make a plan available through the exchanges.

higher than the average premiums of private plans offered in the exchanges.[20] By itself, that development would tend to increase average premiums in the exchanges—but a public plan would probably tend to reduce slightly the premiums of the private plans against which it is competing, for two reasons:

- A public plan as structured in the proposal would probably attract a substantial number of enrollees, in part because it would include a broad network of providers and would be likely to engage in only limited management of its health care benefits. (CBO and JCT estimate that total enrollment in the public plan would be about 3 million to 4 million in 2016.) As a result, it would add some competitive pressure in the exchanges in areas that are currently served by a limited number of private insurers, thereby lowering private premiums to a small degree.

- A public plan is also apt to attract enrollees who are less healthy than average (again, because it would include a broad network of providers and would probably engage in limited management of benefits). Although the payments that all plans in the exchanges receive would be adjusted to account for differences in the health of their enrollees, the methods used to make such adjustments are imperfect. As a result, the higher costs of those less healthy enrollees in the public plan would probably be offset partially but not entirely; the rest of the added costs would have to be reflected in the public plan's premiums. Correspondingly, the costs and premiums of competing private plans would, on average, be slightly lower than if no public plan was available.

Those factors would reduce the premiums of private plans in the exchanges to a small degree, but the effect on the average premium in the exchanges would be offset by the higher premium of the public plan itself. On balance, therefore, the provisions regarding a public plan would not have a substantial effect on the average premiums paid in the exchanges.[21]

New Fees Would Increase Premiums Slightly

The legislation would impose several new fees on firms in the health sector. New fees would be imposed on providers of health insurance and on manufacturers and importers of medical devices. Both of those fees would be largely passed through

[20] Under the proposal, the public plan would negotiate payment rates with providers. CBO and JCT anticipate that those rates would be similar to the rates paid by private insurers participating in the exchanges. The public plan would have lower administrative costs than private plans, on average, but would probably engage in less benefit management and attract a less healthy pool of enrollees (the effects of which would be offset only partially by the risk adjustment procedures that would apply to all plans operating in the exchanges). On net, those factors would result in the public plan's premiums being somewhat higher than the average premiums of private plans in the exchanges.

[21] The presence of the public plan would have a more noticeable effect on federal subsidies because it would exert some downward pressure on the premiums of the lower-cost plans to which those subsidies are tied.

to consumers in the form of higher premiums for private coverage. Self-insured plans would be mostly exempt from the fee on health insurance providers, and since large firms are more likely to self-insure, that fee would result in smaller percentage increases in average premiums for large firms than it would for small firms and for nongroup coverage.[22]

The legislation also would impose a fee on manufacturers and importers of brand-name prescription drugs, which would be allocated among firms on the basis of drug sales to government programs. Because that fee would not impose an additional cost for drugs sold in the private market, CBO and JCT estimate that it would not result in measurably higher premiums for private coverage. (The legislation would also impose an excise tax on high-premium insurance policies provided by employers; that tax is discussed separately below because it would affect only a portion of the insurance market.)

Effects Related to Cost Shifting Would Be Minimal

Some observers have predicted that the proposal (and similar initiatives) would affect premiums for private insurance plans by changing the extent of cost shifting. The legislation would have opposing effects on the pressures for cost shifting:

- On the one hand, the legislation would reduce payments to hospitals and certain other providers under Medicare.[23] In addition, it would significantly increase enrollment in Medicaid, which pays providers appreciably lower rates than private insurers do. Those changes could cause premiums for private coverage to increase.

- On the other hand, the legislation would ultimately reduce the uninsured population by more than half, which would sharply reduce the amount of uncompensated or undercompensated care provided to people who lack health insurance. One recent estimate indicates that hospitals provided about $35 billion in such care in 2008—an amount that would grow under current law but would be expected to decline considerably under the legislation.[24] That change could cause premiums for private coverage to decrease.

[22] The fee would be levied on third-party administrators of self-insured plans in proportion to twice their administrative spending, which is substantially less than the total premiums that would be the base for the levy on plans purchased from insurers. Government health insurance plans such as Medicare and Medicaid would be exempt from that fee, but any public plan offered in the exchanges would be subject to it.

[23] The legislation would reduce Medicare payment updates for most services in the fee-for-service sector (other than physicians' services) and reduce Medicare and Medicaid payments to hospitals that serve large numbers of low-income patients, known as "disproportionate share" (DSH) hospitals.

[24] Recent evidence indicates that physicians collectively provide much smaller amounts of uncompensated or undercompensated care than hospitals. See Jonathan Gruber and David Rodriguez, "How Much Uncompensated care Do Doctors Provide?" *Journal of Health Economics*, vol. 26 (2007), pp. 1151–1169.

The net effect of those opposing pressures would depend on their relative magnitude and also on the degree to which costs are shifted. CBO expects that the magnitude of those opposing pressures would be about the same. Moreover, CBO's assessment of the evidence is that a small amount of cost shifting occurs but that it is not as widespread or extensive as is commonly assumed. The fact that private insurers pay providers higher rates, on average, than Medicare and Medicaid is not evidence that cost shifting occurs. For cost shifting to occur, a *decline* in the rates paid by some payers would have to lead to an *increase* in the rates paid by others; thus, for cost shifting from reductions in rates paid by Medicare to occur, providers would have to have initially been charging private insurers lower rates than they could have. Well-designed studies have found that a relatively small share of the changes in payment rates for government programs is passed on to private payment rates, and the impact of changes in uncompensated care is likely to be similar.[25] Overall, therefore, CBO's assessment is that the legislation would have minimal effects on private-sector premiums via cost shifting.

Differences in the Types of People Who Obtain Coverage in Different Insurance Markets

The third broad factor that would affect average insurance premiums is differences in the types of people who obtain coverage in different insurance markets. If more people who are relatively healthy or relatively disinclined to use medical care participate in a given insurance market, then the average spending on medical services provided in that market will be lower, and the average premium in that market will be lower, with other factors held equal; conversely, if more people who are relatively unhealthy or are relatively inclined to use medical care participate in a given insurance market, the average spending on medical services and the average premium for that market will be higher, all else equal. Thus, a shift of less healthy people from one insurance market to another will tend to lower premiums in the "source" market and raise them in the "destination" market. Likewise, the number and types of people who would be uninsured under current law but would become insured under the proposal—and the effects of gaining coverage on their use of health care—would affect the average premiums charged in the markets in which they buy insurance.

Overall, CBO and JCT estimate that an influx of new enrollees into the nongroup market would yield an average premium per person in that market that is 7 percent to 10 percent lower than the average premium projected under current law. Changes in the types of people covered in the small group and large group markets would have much smaller effects on premiums, yielding a change in the small group market that could range from a decrease of 1 percent to an increase of 2 percent, and a decrease in the large group market of zero to 3 percent.

[25] For a more extensive discussion of cost shifting, see Congressional Budget Office, *Key Issues*, pp. 112–116.

Key Characteristics of the Insured and Uninsured Under Current Law

To assess the likely medical spending of prospective new enrollees in different insurance markets, it is useful to review some key characteristics of the insured and uninsured populations under current law. CBO and JCT's assessment of those characteristics is based on data from representative surveys of the U.S. population that examine people's health insurance coverage, health status, and use of health care.[26] This discussion addresses the projected distribution of the population in 2016, using as a reference point the 162 million people expected to be covered by employment-based insurance in that year under current law.

About 14 million people are expected to be covered by nongroup policies in 2016 under current law. Enrollees in nongroup coverage would be about 3 years older, on average, than enrollees in employment-based insurance—which would tend to raise their use of medical care—but would be slightly healthier, on average, at any given age—which would tend to lower their use of care. On balance, the average spending on medical care of nongroup enrollees would be somewhat greater than that of enrollees in employment-based insurance if they were enrolled in insurance plans with the same amount and structure of coverage.

By contrast, the 52 million people who are expected to be uninsured under current law in 2016 would be about 2 years younger, on average, than the population covered by employment-based plans and thus would be about 5 years younger than nongroup enrollees, on average. At any given age, the average health of the uninsured population would be somewhat worse than the average health of people with nongroup insurance. A large share of the uninsured population, however, would not be eligible to obtain subsidized coverage via the exchanges; instead, those with income below 133 percent of the FPL would generally be eligible for free coverage through Medicaid. That low-income group is relatively unhealthy, and once they are removed from the comparison, the disparity in health between the remaining uninsured population and current-law enrollees in the nongroup market essentially disappears. Therefore, considering only their age and their health status and holding other factors constant, the expected use of medical care by uninsured people who would be eligible for subsidized coverage in the exchanges would be less than that of current nongroup enrollees.

One other factor that would not be the same—and that would tend to accentuate this projected difference in utilization—is how much medical care the uninsured would use once they did gain coverage: They would tend to consume less medical care than current nongroup enrollees, even after adjusting for their age and health. CBO's review of relevant studies concluded that insuring the currently uninsured under a typical employment-based plan would generate an increase of 25 percent to 60 percent in their average utilization of care. (That average increase in utilization and spending would arise even though some newly insured people

[26] For additional information on the data sources used and the methodology involved, see Congressional Budget Office, *CBO's Health Insurance Simulation Model: A Technical Description*, Background Paper (October 2007).

would avoid expensive treatments by getting care sooner, before their illness progressed, or would receive services in a less expensive setting.) Despite that substantial increase in utilization, their use of care would still be below that of people with similar characteristics who are currently insured.[27] That remaining difference in average utilization probably reflects various differences between the insured and uninsured aside from differences in their age and health status, and the effect of obtaining insurance could be much larger for some people and much smaller for others.

A Limited Amount of Adverse Selection Would Occur in New Nongroup Plans

The preceding discussion examined the types of people who would receive coverage in different markets under current law or would be eligible to receive coverage in different markets under the proposal. However, the effects of the proposal on the types of enrollees in each market would depend ultimately on who *chose* to receive coverage in those markets—with the most significant changes coming in the nongroup market.

Under current laws governing the nongroup market, insurers in most states do not have to accept all applicants, may vary premiums widely to reflect differences in enrollees' health status and age, and may exclude coverage of preexisting medical conditions. By themselves, the proposal's provisions changing those rules would make nongroup coverage more attractive to people who are older and who expect to be heavier users of medical care and less attractive to people who are younger and expect to use less medical care. Therefore, in the absence of other changes to the insurance market, people who are older and more likely to use medical care would be more likely to enroll in nongroup plans—a phenomenon known as adverse selection. Such selection would tend to increase premiums in the exchanges relative to nongroup premiums under current law.

However, several other provisions of the proposal would tend to mitigate that adverse selection:

- The legislation would establish an annual open enrollment period for new nongroup policies similar to that typically used by employers, which would limit opportunities for people who are healthy to wait until an illness or other health problem arose before enrolling.

- The substantial premium subsidies available in the exchanges would encourage the enrollment of a broad range of people. For people whose

[27] CBO estimates that the uninsured currently use about 60 percent as much medical care as insured people, taking into account differences between the groups in their average age and health status. Providing all of the uninsured with health insurance coverage equivalent to a typical employment-based plan would thus be estimated to increase their demand for medical services to a level that is between 75 percent and 95 percent of the level of similar people who are currently insured (corresponding to an increase of 25 percent and 60 percent, respectively). For additional discussion of these estimates, see Congressional Budget Office, *Key Issues,* pp. 71–76.

income was below 200 percent of the FPL, those subsidies would average around 80 percent.

- The requirement that people have insurance would also encourage a broad range of people to take up coverage in the exchanges. CBO and JCT expect that some people would obtain coverage because of the penalties that would be levied for not complying with the mandate (which would be $750 per adult and $375 per child in 2016) and that others would obtain coverage simply because of the existence of a mandate; those expectations are based in part on people's compliance with other types of mandates.[28]

- The premiums that most nongroup enrollees pay would be determined on the basis of their income, so higher premiums resulting from adverse selection would not translate into higher amounts paid by those enrollees (though federal subsidy payments would have to rise to make up the difference). That arrangement would dampen the chances that a cycle of rising premiums and declining enrollment would ensue.

- During the 2014–2016 period, as the mandate penalties were being phased in and other provisions were in the initial stages of implementation, the legislation would provide reinsurance payments to insurers that ended up with particularly high-cost enrollees. That reinsurance system (funded by an assessment on all insurers) would also limit the impact of adverse selection on insurance premiums.

On balance, CBO and JCT expect that some adverse selection into nongroup plans would arise, especially among people who received relatively small subsidies. However, the extent of such adverse selection is likely to be limited, and many nongroup enrollees would be in fairly good health.

The Characteristics of Enrollees in Nongroup Plans Would Be Substantially Different Than Those Under Current Law

CBO and JCT estimate that about 32 million people would obtain coverage in the nongroup market in 2016 under the proposal, consisting of about 23 million who would obtain coverage through the insurance exchanges and about 9 million who would obtain coverage outside the exchanges. Relative to the situation under current law, with about 14 million people buying nongroup coverage, the different mix of enrollees would yield average premiums per person in that market that are about 7 percent to 10 percent lower. Some people who would enroll in nongroup coverage under the proposal would be uninsured under current law, some would have employment-based coverage, and some would have nongroup coverage under current law as well. To estimate how the different mix of enrollees in the nongroup market would affect premiums, it is useful to examine enrollment patterns and expected medical costs for each of those three groups.

[28] For a discussion of compliance with mandates, see Congressional Budget Office, *Key Issues*, pp. 48–54.

First, CBO and JCT estimate that about a third of the nongroup enrollees estimated under the proposal in 2016 would be uninsured under current law. As discussed above, the pool of people who would be eligible for the exchanges and would otherwise be uninsured would be—relative to those who have nongroup coverage under current law—younger, roughly as healthy at any given age, and likely to use less medical care (given their age and health status). At the same time, the adverse selection discussed above means that the members of that pool who would choose to purchase coverage would be less healthy, on average, than all of the members of the pool together, particularly among those who would receive limited subsidies. On balance, CBO and JCT estimate that the enrollees who would be uninsured under current law would use significantly less medical care, on average, than individuals enrolled in nongroup coverage under current law (with other factors held constant).[29]

Second, CBO and JCT estimate that about a fifth of nongroup enrollees under the proposal in 2016 would have employment-based coverage under current law. Most of those people would not have an offer of employment-based coverage under the proposal; others would have such an offer but it would be deemed unaffordable, so they would be eligible to obtain subsidies through the exchanges. On average, those enrollees would be older and in poorer health than nongroup enrollees under current law, because the proposal's changes in the nongroup market would make that market more appealing to those types of people. The inflow of those people into the nongroup market would thus tend to increase average medical spending and average premiums per person in that market to some degree.

Third, CBO and JCT estimate that nearly half of the people enrolling in nongroup coverage under the proposal would have nongroup coverage under current law as well. Holding other factors constant, those enrollees would obviously not change average medical spending or premiums in the nongroup market relative to the levels under current law.

In the comparison of nongroup premiums under the proposal with those under current law, the differences discussed in this section would vary considerably among people. In general, the proposal would tend to increase premiums for people who are young and relatively healthy and decrease premiums for those who are older and relatively unhealthy. However, to fully evaluate the implications of the proposal for different types of people, it is necessary to include the effects of the subsidies that are discussed below.

[29] People who report that they are in either fair or poor health tend to use much more health care than the average person, and otherwise uninsured people in fair or poor health would be more likely to enroll in nongroup coverage. Even so, they would constitute less than 10 percent of the otherwise uninsured group enrolling in nongroup coverage.

The Characteristics of Enrollees in Employment-Based Plans Would Be Slightly Different Under the Proposal

CBO and JCT estimate that changes in the characteristics of people with insurance in the small group market would yield a change in the average premiums per person in that market that could range from a decrease of 1 percent to an increase of 2 percent. That difference would be the net effect of three principal factors:

- Under the legislation, new insurance policies sold in the small group market would be subject to the same rating rules as policies sold in the nongroup market. In particular, insurers in the small group market could not vary premiums to reflect the health of firms' workers. That change would reduce premiums for small firms whose employees are in relatively poor health—leading some of those firms that would not offer insurance under current law to do so under the proposal—and increase premiums for small firms whose employees are in relatively good health—leading some of those firms who would offer coverage under current law not to do so under the proposal. Consequently, the people covered in the small group market would be in somewhat worse health, on average, under the proposal than under current law, which would tend to increase average premiums in that market.[30]

- The individual mandate included in the proposal would induce some uninsured workers who would decline the coverage offered by their employers under current law to purchase such coverage. That change would reduce average premiums by a modest amount, because the people who would become insured would be in better health, on average, than their coworkers who would purchase insurance under current law.

- The individual mandate (and the small business tax credit) would also increase slightly the percentage of small firms that offer coverage. Those firms are likely to have healthier workers, on average, than small firms that would offer coverage under current law, largely reflecting the relative youth of workers at firms that would not offer coverage under current law compared with workers at firms that would. Consequently, their inclusion in the small group market would reduce average premiums in that market by a small amount.

[30] That effect would be muted by the proposal's grandfathering provisions, which would allow insurers to continue to set premiums according to current rules as long as an employer's policy was continuously maintained; however, that option would also be most attractive to employers with relatively healthy workers and least attractive to employers with relatively unhealthy workers. The increased attractiveness of the nongroup market for older and less healthy workers would also temper the effect of the new rating rules on average premiums in the small group market, because some of those workers would shift from employment-based to nongroup coverage.

In contrast, CBO and JCT estimate that changes in the characteristics of people with insurance in the large group market would reduce average premiums per person in that market by about zero to 3 percent. One factor that would contribute to that difference is the shift of some less healthy workers to the nongroup market, as noted above. Another factor is the individual mandate, which would encourage younger and relatively healthy workers who might otherwise not enroll in their employers' plans to do so. Other factors that would slightly increase coverage of relatively healthy individuals under large group plans are the provisions of the legislation that would require large employers to automatically enroll new employees in an insurance plan and to offer coverage for unmarried dependents up to age 26. The proposal's restrictions on variation in premiums would have minimal effect on premiums in the large group market; many large firms self-insure and thus would not be affected by those changes, and firms that might be adversely affected could be grandfathered and thus avoid the restrictions.

Effects of the Proposed Exchange Subsidies and Small Business Tax Credit

Under the proposal, the government would subsidize the purchase of nongroup insurance through the exchanges for individuals and families with income between 133 percent and 400 percent of the FPL, and it would provide tax credits to certain small businesses that obtained health insurance for their employees. Although the preceding analysis accounted for the effects of those subsidies on the number and types of people who would obtain coverage and on the amount of coverage that enrollees would obtain, the direct effect of the subsidies on enrollees' payments for coverage were not included in the figures presented above because the objective there was to assess the impact of the legislation on the average premiums *paid to insurers*. This section builds on the earlier calculations by quantifying how the exchange subsidies and tax credits would directly affect the average premiums *paid by individuals and families* who would receive that government assistance.

Premium subsidies in the exchanges would be tied to the premium of the second cheapest silver plan (which would have an actuarial value of 70 percent). The national average premium for that reference plan in 2016 is estimated to be about $5,200 for single coverage and about $14,100 for family coverage (see Table 2). The national average premium for all nongroup plans would be higher—about $5,800 for single coverage and about $15,200 for family coverage—because many people would buy more expensive plans.

Under the proposal, the maximum share of income that enrollees would have to pay for the reference plan would vary depending on their income relative to the FPL, as follows:

- For enrollees with income below 133 percent of the FPL, the maximum share of income paid for that plan would be 2.0 percent in 2014; for enrollees with income between 133 percent and 300 percent of the FPL,

that maximum share of income would vary linearly from about 4 percent of income to 9.8 percent of income in 2014; and for enrollees with income between 300 percent and 400 percent of the FPL, that maximum share of income would equal 9.8 percent.

- After 2014, those income-based caps would all be indexed so that the share of the premiums that enrollees (in each income band) paid would be maintained over time. As a result, the income-based caps would gradually become higher over time; for 2016, they are estimated to range from about 2.1 percent to about 10.2 percent.

- Enrollees with income below 200 percent of the FPL would also be given cost-sharing subsidies to raise the actuarial value of their coverage to specified levels: 90 percent for those with income below 150 percent of the FPL, and 80 percent for those with income between 150 percent and 200 percent of the FPL.

- Enrollees with income above 400 percent of the FPL would not be eligible for exchange subsidies, and enrollees with income below that level whose premiums for the reference plan turned out to be less than their income-based cap also would not receive subsidies.

CBO and JCT estimated that roughly 23 million people would purchase their own coverage through the exchanges in 2016 and that roughly 5 million of those people would not receive exchange subsidies.[31] Therefore, of the 32 million people who would have nongroup coverage in 2016 under the proposal (including those purchased inside and outside the exchanges), about 18 million, or 57 percent, would receive exchange subsidies. For the people who received subsidies, those subsidies would, on average, cover nearly two-thirds of the premiums for their policies in 2016. Putting together the subsidies and the higher level of premiums paid to insurers yields a net reduction in average premiums paid by individuals and families in the nongroup market—for those receiving subsidies—of 56 percent to 59 percent relative to the amounts paid under current law. People in lower income ranges would generally experience greater reductions in premiums paid, and people in higher income ranges who receive subsidies would experience smaller reductions or net increases in premiums paid.

The government would also provide some subsidies for the purchase of health insurance in the form of tax credits to small firms. Under certain circumstances, firms with relatively few employees and relatively low average wages would be eligible for tax credits to cover up to half of their contributions toward insurance premiums. Of the people who would receive small group coverage in 2016 under the proposal, roughly 12 percent would benefit from those credits, CBO and JCT estimate. For the people who would benefit from those credits, the credits would

[31] See Congressional Budget Office, cost estimate for the amendment in the nature of a substitute to H.R. 3590, the Patient Protection and Affordable Care Act (November 18, 2009), Table 3.

tend to reduce the net cost of insurance to workers relative to the premiums paid to insurers by a little less than 10 percent, on average, in 2016. In the small group market, the other factors that were the focus of earlier sections of this analysis would cause premiums paid to insurers to change by an amount that could range from an increase of 1 percent to a reduction of 2 percent (compared to current law). Putting together the tax credits and the change in premiums paid to insurers yields a net reduction in the cost of insurance to workers in the small group market—for those benefiting from tax credits—of 8 percent to 11 percent relative to that under current law.

Effects of the Excise Tax on High-Premium Insurance Plans

The legislation would impose an excise tax on employment-based policies whose total premium (including the amounts paid by both the employer and the employee) exceeded a specified threshold. The tax on such policies would be 40 percent of the amount by which the premium exceeded the threshold. In general, that threshold would be set at $8,500 for single policies and $23,000 for family policies in 2013 (the first year in which the tax would be levied), although a number of temporary and permanent exceptions would apply. After 2013, those dollar amounts would be indexed to overall inflation plus 1 percentage point.

CBO and JCT estimate that, under current law, about 19 percent of employment-based policies would have premiums that exceeded the threshold in 2016. (Because health insurance premiums under current law are projected to increase more rapidly than the threshold, the percentage of policies with premiums under current law that would exceed the threshold would increase over time.) For policies whose premiums remained above the threshold, the tax would probably be passed through as a roughly corresponding increase in premiums. However, most employers would probably respond to the tax by offering policies with premiums at or below the threshold; CBO and JCT expect that the majority of the affected workers would enroll in one of those plans with lower premiums. Plans could achieve lower premiums through some combination of greater cost sharing (which would lower premiums directly and also lower them indirectly by leading to less use of medical services), more stringent benefit management, or coverage of fewer services.

Thus, people who remained in high-premium plans would pay higher premiums under the excise tax than under current law, and people who shifted to lower-premium plans would pay lower premiums under the excise tax than under current law—with other factors held constant. On net, CBO and JCT estimate that the excise tax and the resulting behavioral changes, incorporating the changes in premiums for employer-sponsored insurance that were discussed earlier in this analysis, would reduce average premiums among the 19 percent of policies affected by the tax by about 9 percent to 12 percent in 2016.

Other Potential Effects on Premiums

The proposal could have some broader or longer-term effects on the level or growth rate of health care spending and health insurance premiums. Such effects could arise from several sources, some of which would tend to raise premiums relative to the figures cited above, and others of which would tend to lower them. The uncertainties involved in assessing the magnitude of those effects are especially great. However, in CBO and JCT's judgment, those effects are unlikely to be large—especially by 2016, which is the focus of this analysis.

On the one hand, research by Amy Finkelstein suggests that expanded insurance coverage could have broader effects on the use of health care services than are captured by focusing on changes for the previously uninsured.[32] Examining trends in hospital spending, she found that the substantial increase in demand for medical services generated by the introduction of Medicare in 1965 accelerated the dissemination of new medical procedures more broadly and could account for about half of the overall increase in hospital spending for the population as a whole that occurred in subsequent years.

By that logic, the expansion of insurance coverage to millions of nonelderly people under this proposal could generate a larger increase in health care spending—and thereby health insurance premiums—than estimated here. However, several factors temper that conclusion. For one, the quantitative effect would presumably be smaller than that caused by Medicare because nonelderly people use less health care, on average, than elderly people. Moreover, Medicare initially paid hospitals on the basis of their incurred costs—an approach that gave hospitals little incentive to control those costs. The increase in hospital spending that resulted from Medicare's creation could well have been smaller under a less generous payment system or in an era of more tightly managed care. In particular, roughly half of the increase in insurance coverage generated by this proposal would come from expanded enrollment in Medicaid, which pays relatively low rates to providers. Incentives for cost control would also be greater in the proposed exchanges, because exchange enrollees would have to pay the full additional cost of joining a more expensive insurance plan. Regardless, any effects of expanded insurance coverage on the dissemination of new medical procedures would unfold slowly and would have little effect on health care and health insurance premiums by 2016.

On the other hand, the proposal includes numerous provisions that would encourage the development and dissemination of less costly ways to deliver appropriate medical services, either directly or indirectly. Examples of those provisions include the excise tax on high-premium insurance plans; the creation of a new Medicare advisory board that might limit the growth rate of Medicare

[32] See Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," *Quarterly Journal of Economics*, vol. 122, no. 1 (February 2007), pp. 1–37. For additional discussion of this study, see Congressional Budget Office, *Key Issues*, p. 111.

spending; and certain changes in Medicare's payment methods as well as new pilot and demonstration projects regarding other changes in payment methods (such as penalties for hospital readmissions that are deemed avoidable and incentives to coordinate patients' care). The changes in Medicare's payment methods could "spill over" to the private sector and decrease spending for health care relative to currently projected levels. However, the effects of those initiatives on Medicare's spending are uncertain and would probably be small in 2016 relative to the program's total spending, so any spillover to private insurance at that point would probably be small as well. In addition, the excise tax on high-premium plans would apply to a small share of plans in 2016, so its effects on the cost and efficiency of health care would also probably be small at that point.

All of those considerations serve to emphasize the considerable uncertainty that surrounds any estimate of the impact of any proposal that would make substantial changes in the health insurance or health care sectors, given the size and the complexity of those sectors. That uncertainty applies to the estimated effects of proposals on the federal budget and insurance coverage rates, as well as to their impact on premiums.

TABLE 2. Analysis of Exchange Subsidies and Enrollee Payments in 2016 Under the Patient Protection and Affordable Care Act

11/20/2009

Estimate for "Reference Plan" in 2016 -- 2nd Lowest-Cost "Silver" Plan

	Actuarial Value	Average Premium	Avg. Cost Sharing
Single Policy	70%	$5,200	$1,900
Family Policy	70%	$14,100	$5,000

Single Person

Income Relative to the FPL	*Premium Cap as a Share of Income /a*	*Middle of Income Range /b,c*	*Enrollee Premium for Low-Cost "Silver" Plan*	*Premium Subsidy (share of premium)*	*Average Cost-Sharing Subsidy*	*Average Net Cost Sharing*	*Enrollee Premium + Avg. Cost Sharing*	
							Dollars	*Percent of Income*
100-150% /d	2.1% - 4.7%	$ 14,700	$ 300	94%	$ 1,100	$ 800	$ 1,100	7%
150-200%	4.7% - 6.5%	$ 20,600	$ 1,200	77%	$ 600	$ 1,300	$ 2,500	12%
200-250%	6.5% - 8.4%	$ 26,500	$ 2,000	62%	$ -	$ 1,900	$ 3,900	15%
250-300%	8.4% - 10.2%	$ 32,400	$ 3,000	42%	$ -	$ 1,900	$ 4,900	15%
300-350%	10.2%	$ 38,300	$ 3,900	25%	$ -	$ 1,900	$ 5,800	15%
350-400%	10.2%	$ 44,200	$ 4,500	13%	$ -	$ 1,900	$ 6,400	14%
400-450%	n.a.	$ 50,100	$ 5,200	0%	$ -	$ 1,900	$ 7,100	14%

Family of Four

Income Relative to the FPL	*Premium Cap as a Share of Income /a*	*Middle of Income Range /b,c*	*Enrollee Premium for Low-Cost "Silver" Plan*	*Premium Subsidy (share of premium)*	*Average Cost-Sharing Subsidy*	*Average Net Cost Sharing*	*Enrollee Premium + Avg. Cost Sharing*	
							Dollars	*Percent of Income*
100-150% /d	2.1% - 4.7%	$ 30,000	$ 600	96%	$ 3,300	$ 1,700	$ 2,300	8%
150-200%	4.7% - 6.5%	$ 42,000	$ 2,400	83%	$ 1,800	$ 3,200	$ 5,600	13%
200-250%	6.5% - 8.4%	$ 54,000	$ 4,000	72%	$ -	$ 5,000	$ 9,000	17%
250-300%	8.4% - 10.2%	$ 66,000	$ 6,100	57%	$ -	$ 5,000	$ 11,100	17%
300-350%	10.2%	$ 78,000	$ 7,900	44%	$ -	$ 5,000	$ 12,900	17%
350-400%	10.2%	$ 90,100	$ 9,200	35%	$ -	$ 5,000	$ 14,200	16%
400-450%	n.a.	$ 102,100	$ 14,100	0%	$ -	$ 5,000	$ 19,100	19%

Source: Congressional Budget Office and the Staff of the Joint Committee on Taxation.

Notes: All dollars figures have been rounded to the nearest $100; n.a. = not applicable; FPL = federal poverty level.

a) In 2014, the income-based caps would range from about 4% at 133% of the FPL to 9.8% at 300% of the FPL, and that 9.8% cap would extend to 400% of the FPL; in subsequent years, those caps would be indexed.

b) In 2016, the FPL is projected to equal about $11,800 for a single person and about $24,000 for a family of four.

c) Subsidies would be based on enrollees' household income, as defined in the bill.

d) Under the bill, people with income below 133% of the FPL would generally be eligible for Medicaid and thus ineligible for exchange subsidies; the premium cap in 2014 for those with income below 133% of the FPL would be 2% of income.

December 5, 2009

Estimated Average Premiums Under Current Law

Recently, the CBO and JCT staff released an analysis of average premiums for health insurance under the Patient Protection and Affordable Care Act, as introduced; that analysis compared estimates of average premiums in 2016 under the proposal to those that would prevail under current law. Since then, CBO has received several requests for our estimates of average premiums in 2009. By market and type of coverage, those averages (and the corresponding averages for 2016 under current law) are as follows:

Market	Coverage Type	Average Premiums Under Current Law	
		2009	2016
NONGROUP (for individually purchased policies)	Single	$3,800	$5,500
	Family	$9,000	$13,100
SMALL GROUP (for firms with 50 or fewer employees)	Single	$5,400	$7,800
	Family	$13,300	$19,300
LARGE GROUP (for firms with more than 50 employees)	Single	$5,100	$7,400
	Family	$13,900	$20,300

The estimates for current premiums in the nongroup market are largely based on data from the Medical Expenditure Panel Survey. The estimates for current employment-based premiums are comparable to survey data on those premiums from the Kaiser Family Foundation.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

January 11, 2010

Honorable Olympia Snowe
United States Senate
Washington, DC 20510

Dear Senator:

In late November, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) released an analysis of average premiums for health insurance under the Patient Protection and Affordable Care Act (PPACA) as introduced.[1] That analysis compared the estimates of average premiums in 2016 under the proposal to those that would prevail under current law and distinguished the effects among the markets for individually purchased (nongroup) coverage, for small-group coverage, and for large-group coverage.

This letter responds to your request for additional information about expected premiums under that proposal for policies that would meet the minimum requirements necessary to avoid paying a penalty for not having insurance. As a rule, individuals would be required to have a policy covering the "essential benefits" specified in the legislation and having an actuarial value of at least 60 percent in order to avoid such a penalty. (A plan's actuarial value is the share of costs for covered services that it would pay, on average, with a broadly representative group of people enrolled.) That minimum level of coverage is designated as a "Bronze" plan.

Several caveats apply to this analysis of Bronze premiums. First, it draws on the calculations of premiums that were done for the PPACA as originally introduced; as indicated in CBO's cost estimate for the PPACA incorporating the manager's amendment, the effects of the Senate-passed legislation on premiums are likely to be quite similar to those estimates but may not be identical.[2] Second, CBO has not analyzed premiums for Bronze

[1] Congressional Budget Office, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act," attachment to a letter to the Honorable Evan Bayh (November 30, 2009).

[2] Congressional Budget Office, cost estimate for the Patient Protection and Affordable Care Act, incorporating the manager's amendment (December 19, 2009).

plans as closely as the overall average of premiums discussed in that earlier analysis—in part because, under the proposal, federal subsidies would be tied to the premiums of "Silver" plans (which would cover the same benefits but would have an actuarial value of 70 percent). In particular, the figures for Bronze premiums presented below reflect an assumption that the average age, family characteristics, and other factors associated with health care costs of enrollees in Bronze plans would be similar to those of enrollees in Silver plans (or that any impact on premiums of differences in those characteristics would be effectively offset by the risk-adjustment system and other such mechanisms that would be established under the proposal). Third, these figures do not reflect any subsidies provided by the government for the purchase of insurance (either currently or under the proposal). Finally, as in the previous analysis of premiums, the figures presented here represent national averages; premiums for specific individuals would differ on the basis of their age, average spending on health care in their area of the country, and the specific plan they chose.

Overall, CBO estimates that premiums for Bronze plans purchased individually in 2016 would probably average between $4,500 and $5,000 for single policies and between $12,000 and $12,500 for family policies. For comparison, the previous analysis of the PPACA as introduced found that average premiums among all types of plans in 2016 would be about $5,800 for single policies and about $15,200 for family policies. Average premiums for Bronze plans would be lower than average premiums for all plans because the actuarial value of Bronze plans would be 60 percent, compared with an estimated average actuarial value for all individually purchased plans of roughly 72 percent. That lower actuarial value would reduce premiums for Bronze plans directly, because the policy would pay for a smaller share of enrollees' costs for covered services, and indirectly, because enrollees would use slightly fewer or less-expensive services when faced with the higher cost-sharing requirements included in Bronze plans.

You also asked about the premiums that small employers would have to pay for the Bronze level of coverage. Under the legislation, small employers would be allowed to purchase coverage for their employees through the new insurance exchanges. More generally, the premiums that insurers charged to small employers for new policies, whether or not they were purchased through the exchanges, would be subject to the same rules on pricing that applied in the exchanges and would also be subject to risk adjustment (to offset the effects that having sicker-than-average or healthier-than-average enrollees would have on a plan's premiums). Even so, the premiums for coverage purchased by a small employer would depend on the ages of the workers and dependents covered by the policy. If those employees had the same characteristics as the average individual

purchaser of Bronze plans, then the premiums for the employer's Bronze plan would be equivalent to the figures cited above.

In general, however, small employers would provide plans with a greater amount of coverage than Bronze plans, as they do under current law. The average premiums in 2016 for plans provided by small employers cited in the recent analysis by CBO and JCT—about $7,800 for single policies and $19,200 for family policies—differ from the amounts cited above for individual Bronze policies primarily because the average actuarial value of coverage purchased by small employers would be substantially higher than the Bronze level (about 85 percent, CBO estimates, rather than 60 percent). The premiums for specific employers could deviate significantly from those averages for various reasons.

I hope this information is helpful to you. If you have any further questions, please contact me or the CBO staff. The primary staff contact for this analysis is Philip Ellis.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

cc: Honorable Harry Reid
Majority Leader

Honorable Mitch McConnell
Republican Leader

Analysis of Exchange Subsidies and Enrollee Payments in 2016 10/9/2009
Senate Finance Committee Chairman's Mark as Amended

Estimates for Second-Lowest-Cost "Silver" Plan

	Actuarial Value	Average Premium	Avg. Cost Sharing
Single Policy	70%	$5,000	$1,700
Family Policy	70%	$14,700	$5,100

Single Person

Income Relative to the FPL	*Premium Cap as a Share of Income / a,b*	*Middle of Income Range / c,d*	*Enrollee Premium for Low-Cost "Silver" Plan*	*Premium Subsidy (share of premium)*	*Average Cost-Sharing Subsidy*	*Average Net Cost Sharing*	*Enrollee Premium + Avg. Cost Sharing*	
							Dollars	*Percent of Income*
100-150%	2.1% - 4.8%	$ 14,700	$ 500	90%	$ 1,200	$ 500	$ 1,000	7%
150-200%	4.8% - 7.5%	$ 20,600	$ 1,300	74%	$ 700	$ 1,000	$ 2,300	11%
200-250%	7.5% - 10.1%	$ 26,500	$ 2,300	54%	$ -	$ 1,700	$ 4,000	15%
250-300%	10.1% - 12.8%	$ 32,400	$ 3,700	26%	$ -	$ 1,700	$ 5,400	17%
300-350%	12.8%	$ 38,300	$ 4,900	2%	$ -	$ 1,700	$ 6,600	17%
350-400%	12.8%	$ 44,200	$ 5,000	0%	$ -	$ 1,700	$ 6,700	15%
400-450%	n.a.	$ 50,100	$ 5,000	0%	$ -	$ 1,700	$ 6,700	13%

Family of Four

Income Relative to the FPL	*Premium Cap as a Share of Income / a,b*	*Middle of Income Range / c,d*	*Enrollee Premium for Low-Cost "Silver" Plan*	*Premium Subsidy (share of premium)*	*Average Cost-Sharing Subsidy*	*Average Net Cost Sharing*	*Enrollee Premium + Avg. Cost Sharing*	
							Dollars	*Percent of Income*
100-150%	2.1% - 4.8%	$ 30,000	$ 1,000	93%	$ 3,600	$ 1,500	$ 2,500	8%
150-200%	4.8% - 7.5%	$ 42,000	$ 2,600	82%	$ 1,900	$ 3,200	$ 5,800	14%
200-250%	7.5% - 10.1%	$ 54,000	$ 4,800	67%	$ -	$ 5,100	$ 9,900	18%
250-300%	10.1% - 12.8%	$ 66,000	$ 7,600	48%	$ -	$ 5,100	$ 12,700	19%
300-350%	12.8%	$ 78,000	$ 10,000	32%	$ -	$ 5,100	$ 15,100	19%
350-400%	12.8%	$ 90,100	$ 11,500	22%	$ -	$ 5,100	$ 16,600	18%
400-450%	n.a.	$ 102,100	$ 14,700	0%	$ -	$ 5,100	$ 19,800	19%

Source: Congressional Budget Office and the Staff of the Joint Committee on Taxation.

NOTES: All dollar figures have been rounded to the nearest $100; n.a. = not applicable; FPL = federal poverty level.

a) In 2013, the income caps would range from 2% to 12%; in subsequent years those caps would be indexed.
b) In 2016, people would be exempt from the mandate penalty if they had to pay more than 8.5 percent of their income for insurance.
c) In 2016, the FPL is projected to equal about $11,800 for a single person and about $24,000 for a family of four.
d) Under the proposal, subsidies would generally be based on income data from enrollees' tax returns.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

November 2, 2009

Honorable Charles B. Rangel
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This letter responds to questions about the subsidies that enrollees would receive for premiums and cost sharing and the amounts that they would have to pay, on average, if they purchased a relatively low cost plan in the new insurance exchanges to be established under H.R. 3962, the Affordable Health Care for America Act, as introduced in the House of Representatives on October 29, 2009. The analysis reflects the preliminary analysis of that bill that the Congressional Budget Office (CBO), in conjunction with the staff of the Joint Committee on Taxation (JCT), released last week.

Subsidies and Payments at Different Income Levels Under H.R. 3962

The enclosed table focuses on enrollees who purchase a "reference" plan (the premiums for which equal the average of the three lowest-cost "basic" plans, as defined in the bill), because federal subsidies would be tied to that average. Such a plan would have an actuarial value of 70 percent, which represents the average share of costs for covered benefits that would be paid by the plan. Although premiums under H.R. 3962 would vary by geographic area to reflect differences in average spending for health care and would also vary by age, the table shows the approximate national average for that lower-cost reference plan—about $5,300 for single policies and about $15,000 for family policies in 2016. Enrollees could purchase a more expensive plan or more extensive coverage for an additional, unsubsidized premium—and CBO anticipates that many enrollees would do that, so the average premiums actually paid in the exchanges would be higher (although average cost-sharing amounts could be lower than those shown in the table). The figures are presented for 2016 in order to illustrate the likely situation after the proposed changes in insurance markets were fully implemented. (A downside of that approach is that the figures are harder to compare with those observed in 2009.)

Under the House bill, the maximum share of income that enrollees would have to pay for the reference plan in 2013 would range from 1.5 percent for those with income less than or equal to 133 percent of the federal poverty level (FPL) to 12 percent for those with income equal to 400 percent of the FPL. (People with income below 150 percent of the FPL, however, would generally be eligible for Medicaid and thus ineligible for subsidies within the exchanges.) After 2013, those income-based caps would all be indexed so that the share of the premiums that enrollees (in each income band) paid would be maintained over time. As a result, the income-based caps would gradually become higher over time; for example, they are estimated to range from about 1.6 percent to about 12.8 percent in 2016. Enrollees with income below 350 percent

of the FPL would also be given cost-sharing subsidies to raise the actuarial value of their coverage to specified levels—ranging from 97 percent for those with income below 150 percent of the FPL to 72 percent for those with income between 300 percent and 350 percent of the FPL.

To illustrate the effects of those features, the table shows the amounts of income that would correspond to the midpoint of each FPL band, the resulting premiums that single individuals and families of four would have to pay for a reference plan if their income equaled that midpoint, and the share of their income that would be represented by the sum of the enrollee premiums and the average cost-sharing amount at that midpoint. For instance, a single person with income of $26,500 in 2016 (225 percent of the FPL) would pay a premium of about $1,900 (after getting a premium subsidy of 64 percent) and could expect to pay another $900 in cost sharing (net of federal subsidies); thus, the average payment by such a person for the premium and cost sharing combined is projected to be $2,800, or about 11 percent of income. A family of four with income of about $54,000 (also 225 percent of the FPL in 2016) could expect to pay about the same share of its income for premiums and cost sharing. (Because use of health care in a given year varies widely, many people would pay less in cost sharing than the average, but some would pay more—subject to the limits on out-of-pocket costs that are specified in the bill.)

Comparison with Premiums Under the Proposal Approved by the Senate Finance Committee

The estimated average premiums and average cost-sharing amounts for the reference plan shown at the top of the table—before any subsidies are applied—are slightly higher than the premiums for the comparable plan shown in a similar table that CBO released on October 9 for the health care reform proposal introduced by the Chairman of the Senate Committee on Finance, as amended by the committee. (That table represented an update to a table enclosed in a letter to Chairman Baucus on September 22 that addressed the earlier Chairman's mark.) In the proposal approved by the Finance Committee, the reference plan would be the second cheapest plan available in an area providing the "silver" level of benefits, which also would have a required actuarial value of 70 percent. Because the reference plans in both proposals would cover the same range of benefits and have the same extent of coverage (actuarial value), the difference in premiums cannot be attributed to a difference in coverage. Instead, the difference is the net result of a number of other provisions of each proposal and primarily reflects higher average health care costs projected for enrollees in the exchanges under the House bill than for enrollees in the exchanges under the Finance Committee's proposal.

Why would exchange enrollees under the House bill be slightly less healthy, on average, than exchange enrollees under the Finance Committee's proposal? One reason is that the House bill offers greater subsidies for cost sharing, which would be more valuable to people with health problems and thus would tend to attract a less healthy mix of enrollees. The House bill also restricts more sharply the extent to which premiums can vary by age, which would make the exchanges less attractive to younger people (who tend to have lower health care costs) and more attractive to older people (who tend to have higher health care costs). Some other differences in the proposals also tend to generate a slightly less healthy pool of exchange enrollees under the House bill.

Yet, there are other factors working to counterbalance those effects and to limit the difference in exchange premiums between the two proposals. For example, the House bill would finance the operations of the insurance exchanges through mandatory appropriations rather than a surcharge on the plans offered in the exchanges; it would also include a public plan that CBO estimates would place some downward pressure on the premiums of private plans operating in the exchanges. In addition, under the Finance Committee's proposal, less extensive premium subsidies and more extensive exemptions from the penalties for lacking insurance would weaken the incentives for healthier people to purchase insurance and thus would make for a less healthy pool of enrollees in that proposal, partly offsetting the factors noted above. On balance, however, CBO projects that the average premiums and cost-sharing payments for enrollees in the exchanges under the House bill would be slightly higher than those for enrollees in the exchanges under the Finance Committee's proposal.

I hope this analysis is helpful for your deliberations. If you have any questions, please contact me or CBO staff. The primary staff contact for this analysis is Philip Ellis.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

Enclosures

cc: Honorable Dave Camp
Ranking Member

Identical letters sent to the Honorable George Miller, the Honorable Henry A. Waxman, the Honorable John D. Dingell, and the Honorable Max Baucus.

Analysis of Exchange Subsidies and Enrollee Payments in 2016 11/2/2009
Under H.R. 3962, the Affordable Health Care for America Act

Estimate for "Reference Plan" in 2016 -- Average of 3 Lowest-Cost Basic Plans

	Actuarial Value	Average Premium	Avg. Cost Sharing
Single Policy	70%	$5,300	$2,000
Family Policy	70%	$15,000	$5,500

Single Person

Income Relative to the FPL	*Premium Cap as a Share of Income /a*	*Middle of Income Range /b,c*	*Enrollee Premium in Reference Plan*	*Premium Subsidy (share of premium)*	*Average Cost-Sharing Subsidy*	*Average Net Cost Sharing*	*Enrollee Premium + Avg. Cost Sharing*	
							Dollars	*Percent of Income*
100-150% /d	1.6% - 3.2%	$ 14,700	$ 200	96%	$ 1,600	$ 400	$ 600	4%
150-200%	3.2% - 5.9%	$ 20,600	$ 900	83%	$ 1,400	$ 600	$ 1,500	7%
200-250%	5.9% - 8.5%	$ 26,500	$ 1,900	64%	$ 1,100	$ 900	$ 2,800	11%
250-300%	8.5% - 10.7%	$ 32,400	$ 3,100	42%	$ 700	$ 1,300	$ 4,400	14%
300-350%	10.7% - 11.7%	$ 38,300	$ 4,300	19%	$ 200	$ 1,800	$ 6,100	16%
350-400%	11.7% - 12.8%	$ 44,200	$ 5,300	0%	$ -	$ 2,000	$ 7,300	17%
400+%	n.a.	$ 50,100	$ 5,300	0%	$ -	$ 2,000	$ 7,300	15%

Family of Four

Income Relative to the FPL	*Premium Cap as a Share of Income /a*	*Middle of Income Range /b,c*	*Enrollee Premium in Reference Plan*	*Premium Subsidy (share of premium)*	*Average Cost-Sharing Subsidy*	*Average Net Cost Sharing*	*Enrollee Premium + Avg. Cost Sharing*	
							Dollars	*Percent of Income*
100-150% /d	1.6% - 3.2%	$ 30,000	$ 500	97%	$ 4,900	$ 600	$ 1,100	4%
150-200%	3.2% - 5.9%	$ 42,000	$ 1,900	87%	$ 4,300	$ 1,200	$ 3,100	7%
200-250%	5.9% - 8.5%	$ 54,000	$ 3,900	74%	$ 3,200	$ 2,300	$ 6,200	11%
250-300%	8.5% - 10.7%	$ 66,000	$ 6,300	58%	$ 1,800	$ 3,700	$ 10,000	15%
300-350%	10.7% - 11.7%	$ 78,000	$ 8,800	41%	$ 500	$ 5,000	$ 13,800	18%
350-400%	11.7% - 12.8%	$ 90,100	$ 11,100	26%	$ -	$ 5,500	$ 16,600	18%
400-450%	n.a.	$ 102,100	$ 15,000	0%	$ -	$ 5,500	$ 20,500	20%

Source: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: All dollars figures have been rounded to the nearest $100; n.a. = not applicable; FPL = federal poverty level.

a) In 2013, the income-based caps would range from 1.5% to 12% according to a specified schedule; in subsequent years they would be indexed.
b) In 2016, the FPL is projected to equal about $11,800 for a single person and about $24,000 for a family of four.
c) Under the bill, subsidies would be based on enrollees' adjusted gross income.
d) Under the bill, people with income below 150% of the FPL would generally be eligible for Medicaid and thus ineligible for exchange subsidies.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

November 20, 2009

Honorable Harry Reid
Majority Leader
United States Senate
Washington, DC 20510

Dear Mr. Leader:

This letter responds to questions about the subsidies that enrollees would receive for premiums and cost sharing and the amounts that they would have to pay, on average, if they purchased a relatively low cost plan in the new insurance exchanges to be established under the Patient Protection and Affordable Care Act, as proposed on November 18, 2009. The analysis reflects the estimate of that bill that the Congressional Budget Office (CBO), in conjunction with the staff of the Joint Committee on Taxation (JCT), released on that date.

Subsidies and Payments at Different Income Levels Under the Patient Protection and Affordable Care Act

The enclosed table focuses on enrollees who purchase a "reference" plan—the second lowest cost "silver" plan, as defined in the bill—because federal subsidies would be tied to the premium for it. Such a plan would have an actuarial value of 70 percent, which represents the average share of costs for covered benefits that would be paid by the plan. Although premiums under the bill would vary by geographic area to reflect differences in average spending for health care and would also vary by age, the table shows the approximate national average for that lower-cost reference plan: about $5,200 for single policies and about $14,100 for family policies in 2016. Enrollees could purchase a more expensive plan or more extensive coverage for an additional, unsubsidized premium—and CBO anticipates that many enrollees would do that, so the average premiums actually paid in the exchanges would be higher (although average cost-sharing amounts could be lower than those shown in the table). The figures are presented for 2016 in order to illustrate the likely situation after the proposed changes in insurance markets were fully implemented.[1] A downside of that approach is that the figures are harder to compare with those observed in 2009.

Under the bill, the maximum share of income that enrollees would have to pay for the reference plan would vary depending on their income relative to the federal poverty level (FPL). For enrollees with income below 133 percent of the FPL, the maximum share of income paid for that

[1] The bill includes a reinsurance program that would operate from 2014 through 2016, financed by a fee on insurers. Because that program is temporary, its effects on premiums in 2016 have not been reflected in the attached table in order to provide a more accurate assessment of the bill's impact once it is fully implemented.

plan would be 2 percent in 2014.[2] For enrollees with income between 133 percent and 300 percent of the FPL, that maximum share of income would vary linearly from about 4 percent of income to 9.8 percent of income in 2014. For enrollees with income between 300 percent and 400 percent of the FPL, that maximum share of income would equal 9.8 percent. After 2014, those income-based caps would all be indexed so that the share of the premiums that enrollees (in each income band) paid would be maintained over time. As a result, the income-based caps would gradually become higher over time; for example, they are estimated to range from about 2.1 percent to about 10.2 percent in 2016. Enrollees with income below 200 percent of the FPL would also be given cost-sharing subsidies to raise the actuarial value of their coverage to specified levels: 90 percent for those with income below 150 percent of the FPL and 80 percent for those with income between 150 percent and 200 percent of the FPL.

To illustrate the effects of those features, the table shows the amounts of income that would correspond to the midpoint of each FPL band, the resulting premiums that single individuals and families of four would have to pay for a reference plan if their income equaled that midpoint, and the share of their income that would be represented by the sum of the enrollee premiums and the average cost-sharing amount at that midpoint. For instance, a single person with income of $26,500 in 2016 (225 percent of the FPL) would pay a premium of about $2,000 for the reference plan (after getting a premium subsidy of 62 percent) and could expect to pay another $1,900 in cost sharing; thus, the average payment by such a person for the premium and cost sharing combined is projected to be $3,900, or about 15 percent of their income. A family of four with income of about $54,000 (also 225 percent of the FPL in 2016) could expect to pay about 17 percent of its income for premiums and cost sharing for the reference plan. (Because use of health care in a given year varies widely, many people would pay less in cost sharing than the average, but some would pay more—subject to the limits on out-of-pocket costs that are specified in the bill.)

Comparison with Premiums Under the Proposal Approved by the Senate Finance Committee

The estimated average premiums and average cost-sharing amounts for the reference plan shown at the top of the table—before any subsidies are applied—differ somewhat from those shown in a similar table that CBO released on October 9 for the health care reform proposal that was ultimately approved by the Senate Finance Committee. Those differences primarily reflect differences between the proposals, including differences in the types of people who would enroll in single and family plans as a result of their disparate provisions. Key differences that affect premiums include the following:

- Under the proposal approved by the Senate Finance Committee, premiums for exchange plans would include the costs of covering all state-mandated benefits. Under the proposal now being considered by the Senate, however, states would have to pay those costs for any benefits that are not included in the list of "essential health benefits" specified in the bill (which would be further delineated by the Secretary of Health and Human Services).

[2] People with income below 133 percent of the FPL would generally be eligible for Medicaid and thus ineligible for subsidies within the exchanges.

Consequently, CBO has excluded from its calculation of premiums the estimated costs that states would have to pay.

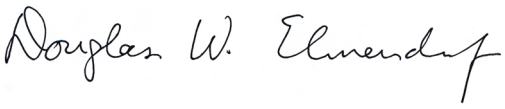
- CBO estimates that the availability of a "public plan" in some states under the current proposal would put some downward pressure on the premiums of private plans offered in the exchanges in those states, and thus would affect the premium for the reference plan.[3]

- The proposals also differ in the extent to which they would allow premiums in the exchanges to vary by age. CBO estimates that the tighter age bands in the current proposal would make older people more likely to seek coverage through the exchanges but would discourage some younger people from enrolling in that coverage—which would raise the average premium in the exchanges, particularly for single coverage.

More generally, the factors that affect insurance premiums are complex, and the resulting amounts reflect an interaction of many forces—so caution should be exercised when interpreting differences in those premiums. CBO expects to provide a broader analysis of premiums under the Patient Protection and Affordable Care Act in the near future.

I hope this analysis is helpful for your deliberations. If you have any questions, please contact me or CBO staff. The primary staff contact for this analysis is Philip Ellis.

Sincerely,



Douglas W. Elmendorf
Director

Enclosure

cc: Honorable Mitch McConnell
Republican Leader

[3] For additional discussion of this effect, see Congressional Budget Office, letter to the Honorable Michael B. Enzi providing supplemental information on potential effects of the Affordable Health Choices Act (September 10, 2009).

Analysis of Exchange Subsidies and Enrollee Payments in 2016 Under the Patient Protection and Affordable Care Act

11/20/2009

Estimate for "Reference Plan" in 2016 -- 2nd Lowest-Cost "Silver" Plan

	Actuarial Value	Average Premium	Avg. Cost Sharing
Single Policy	70%	$5,200	$1,900
Family Policy	70%	$14,100	$5,000

Single Person

Income Relative to the FPL	*Premium Cap as a Share of Income /a*	*Middle of Income Range /b,c*	*Enrollee Premium for Low-Cost "Silver" Plan*	*Premium Subsidy (share of premium)*	*Average Cost-Sharing Subsidy*	*Average Net Cost Sharing*	*Enrollee Premium + Avg. Cost Sharing*	
							Dollars	*Percent of Income*
100-150% /d	2.1% - 4.7%	$ 14,700	$ 300	94%	$ 1,100	$ 800	$ 1,100	7%
150-200%	4.7% - 6.5%	$ 20,600	$ 1,200	77%	$ 600	$ 1,300	$ 2,500	12%
200-250%	6.5% - 8.4%	$ 26,500	$ 2,000	62%	$ -	$ 1,900	$ 3,900	15%
250-300%	8.4% - 10.2%	$ 32,400	$ 3,000	42%	$ -	$ 1,900	$ 4,900	15%
300-350%	10.2%	$ 38,300	$ 3,900	25%	$ -	$ 1,900	$ 5,800	15%
350-400%	10.2%	$ 44,200	$ 4,500	13%	$ -	$ 1,900	$ 6,400	14%
400-450%	n.a.	$ 50,100	$ 5,200	0%	$ -	$ 1,900	$ 7,100	14%

Family of Four

Income Relative to the FPL	*Premium Cap as a Share of Income /a*	*Middle of Income Range /b,c*	*Enrollee Premium for Low-Cost "Silver" Plan*	*Premium Subsidy (share of premium)*	*Average Cost-Sharing Subsidy*	*Average Net Cost Sharing*	*Enrollee Premium + Avg. Cost Sharing*	
							Dollars	*Percent of Income*
100-150% /d	2.1% - 4.7%	$ 30,000	$ 600	96%	$ 3,300	$ 1,700	$ 2,300	8%
150-200%	4.7% - 6.5%	$ 42,000	$ 2,400	83%	$ 1,800	$ 3,200	$ 5,600	13%
200-250%	6.5% - 8.4%	$ 54,000	$ 4,000	72%	$ -	$ 5,000	$ 9,000	17%
250-300%	8.4% - 10.2%	$ 66,000	$ 6,100	57%	$ -	$ 5,000	$ 11,100	17%
300-350%	10.2%	$ 78,000	$ 7,900	44%	$ -	$ 5,000	$ 12,900	17%
350-400%	10.2%	$ 90,100	$ 9,200	35%	$ -	$ 5,000	$ 14,200	16%
400-450%	n.a.	$ 102,100	$ 14,100	0%	$ -	$ 5,000	$ 19,100	19%

Source: Congressional Budget Office and the Staff of the Joint Committee on Taxation.

Notes: All dollars figures have been rounded to the nearest $100; n.a. = not applicable; FPL = federal poverty level.

a) In 2014, the income-based caps would range from about 4% at 133% of the FPL to 9.8% at 300% of the FPL, and that 9.8% cap would extend to 400% of the FPL; in subsequent years, those caps would be indexed.

b) In 2016, the FPL is projected to equal about $11,800 for a single person and about $24,000 for a family of four.

c) Subsidies would be based on enrollees' household income, as defined in the bill.

d) Under the bill, people with income below 133% of the FPL would generally be eligible for Medicaid and thus ineligible for exchange subsidies; the premium cap in 2014 for those with income below 133% of the FPL would be 2% of income.

Federal Budgetary Issues

During the debate over health care legislation, a number of questions arose concerning how to account for and reflect the impact of proposals on the federal budget. CBO produced several analyses examining those issues, including these:

1. An issue brief regarding the budgetary treatment of proposals to change the health insurance system, which was released on May 27, 2009. That brief addressed the issue of what payments for health insurance should be reflected in the federal budget—and, in particular, what sorts of federal regulations would, in combination with a mandate to purchase coverage, mean that premiums paid by enrollees to private insurers should be treated as part of the federal budget because they had been made essentially governmental activities.

2. A letter to Senate Finance Committee Chairman Max Baucus, dated October 30, 2009, primarily assessing the impact of proposals on the "federal budgetary commitment to health care"—that is, their effects both on federal spending for health care and on the reductions in revenues that stem from preferential treatment in the tax code for health insurance.

3. A two-page analysis, dated December 13, 2009, of the budgetary treatment of proposals to regulate health insurers' medical loss ratios—that is, the share of premium dollars that are spent for health care services (as opposed to administrative costs or profits). In particular, the analysis considered the circumstances under which such regulations, when combined with an individual mandate to purchase insurance, would so limit the flexibility of insurers as to warrant including premium payments in the federal budget.

4. A letter to Senator Jeff Sessions, dated January 22, 2010, addressing the effects of reductions in spending on Medicare on both the federal budget deficit and the status of Medicare's trust funds.

ECONOMIC AND BUDGET ISSUE BRIEF
CBO
A series of issue summaries from the Congressional Budget Office
MAY 27, 2009

The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System

The Congress is currently considering various approaches for instituting major changes in the nation's system of health insurance. Some of those proposals would significantly expand the federal government's role in that system, thus raising the question of how such changes might be reflected in the federal budget. This brief describes the approach that the Congressional Budget Office (CBO) will take in judging the appropriate budgetary treatment.[1]

In determining the budgetary treatment of a new program, CBO considers how similar existing programs appear in the budget and how the basic principles that underlie federal budgeting may apply. The most straightforward situation is one in which money flows through a federal agency or some entity acting on behalf of a federal agency. In those cases, the cash flows generally appear in the federal budget. But the major changes being contemplated for the nation's health insurance market are quite different from existing federal programs. Many of those changes would involve a mix of governmental activities and private transactions that have some similarities to other programs but are also different in significant ways. In addition, the scope of the changes and the amounts of money involved are substantial; even if there was a clear parallel in an existing but much smaller program, the budgetary treatment of health care legislation would nevertheless merit careful consideration.

In making decisions about budgetary accounting, experts often refer to the 1967 *Report of the President's Commission on Budget Concepts.* That report stated, "To work well, the governmental budget process should encompass the full scope of the programs and transactions that are within the Federal sector and not subject to the economic disciplines of the marketplace." The commission recommended that "the budget should, as a general rule, be comprehensive of the full range of Federal activities." As the commission noted, however, "the boundaries of the federal establishment are sometimes difficult to draw."

Common Features of Emerging Proposals

Many of the proposals under consideration share some or all of the following features:

- A mandate on all (or most) individuals to have health insurance coverage providing some specified minimum level of benefits.
- A "play-or-pay" requirement, whereby some or all firms would have to either offer health insurance to their employees or make a payment to the federal government.
- New subsidies and expanded eligibility for the existing Medicaid program to make coverage more affordable for some individuals and families.
- New "exchanges" through which individuals and, in some cases, small employers could purchase health insurance. In some proposals, exchanges are envisioned as private online clearinghouses similar to Orbitz or e-health (perhaps authorized or regulated by a federal agency). Under others, they would be much more like governmental entities in that they would be responsible for administering subsidies; for collecting payments for premiums and conveying those funds to insurers; for negotiating with insurers over the benefits offered and the prices charged; and for performing other oversight responsibilities.

1. The Congressional Budget Office will estimate the budgetary impact of legislation as it is being considered by the Congress. If legislation is enacted into law, the Administration's Office of Management and Budget will ultimately determine how its effects will be reflected in the federal budget.

- The establishment of a "public plan" (defined in various ways) to be offered through the exchanges alongside private plans.

- A federal health board with some responsibility for the oversight of—or decisionmaking about—the required level of benefits or coverage or the operations of the exchanges. At this time, the extent of responsibility that such a board might have for the health insurance market is unclear.

The Budgetary Treatment of Various Types of Proposed Cash Transactions of the Government

Some of the budgetary judgments related to current proposals appear to be relatively straightforward in that they clearly involve cash transactions of the federal government or of other entities acting on behalf of the government. Such transactions include the provision of subsidies for some people and businesses; the income and expenditures of a public health insurance plan; the government's receipts from "play-or-pay" requirements and from penalties imposed on individuals who fail to comply with a health insurance mandate; and "risk adjustment" transactions of the government that shift funds from insurers with lower-risk enrollees to those with higher-risk enrollees.

Subsidies for Some People and Small Firms

Subsidies for the purchase of health insurance would, under some proposals, be delivered to some people and small firms as tax credits; under others, they would be payments made through insurance exchanges or other agencies to insurance carriers. Either way, such subsidies would be direct costs to the federal government and should be reflected in the federal budget—like, for example, outlays for Medicaid and the effects on revenues and outlays from the earned income tax credit.

Expenditures and Income of a Public Plan

Some proposals would require the federal government—or in some cases, the insurance exchanges—to establish a new "public" insurance product to be offered through the exchanges. In many cases, a public plan would compete directly with private plans sold through the exchanges and could be held to similar rules prescribing covered benefits and pricing of those plans. Unlike privately offered plans, however, the public plan's initial start-up costs might be covered by the federal government, and in some cases, the rates that it paid providers would be linked to the payment rates of existing public programs. Under some proposals, the public plan would be directly administered by the agency overseeing its establishment, and under others, the overseeing agency would be authorized to use a third-party administrator.

In CBO's view, the budgetary treatment of a public plan would depend critically on who bore the financial risk. If the federal government stood behind the plan financially, then its expenditures should be considered federal outlays and the payments collected for premiums should be considered as either federal revenues or as offsets to outlays (see the discussion below regarding how that choice would be made). That approach would be consistent with the treatment of expenditures for Medicare, which is one potential model for a public plan. Even if such a plan was administered by a third party, the budgetary treatment of the public plan would be the same as long as the government was backing it financially—because the third party would be acting as an agent of the federal government.

Payments to the Government Under "Play-or-Pay" Requirements or for Noncompliance with the Mandate

Under some proposals, firms would be required to make payments to the federal government if they chose not to offer health insurance to their employees, and individuals who did not comply with the requirement to obtain insurance would have to pay a penalty. Such payments would be equivalent to a tax or a fine, and the government's receipts should be recorded in the budget as federal revenues.

Risk Adjustment Transactions of the Government

Under some proposals, the government would make additional payments to plans that attracted relatively unhealthy people, drawing those funds from plans with relatively healthy enrollees. Those "risk adjustment" transactions, aimed at improving the functioning of the insurance market and enhancing the availability of private insurance for high-risk individuals, would redistribute funds to the former plans financed by what would essentially be a tax on the latter. Those cash flows should appear in the federal budget.

The Budgetary Treatment of a Federal Mandate

The imposition of a federal mandate requiring individuals to have a certain minimum amount of health insurance coverage raises more complex issues of budgetary treatment. In considering those issues, CBO first addressed two basic questions:

- Can cash transactions between private entities—in which the funds do not pass through the U.S. Treasury—be reflected in the federal budget?
- Does the existence of a federal mandate, by itself, justify inclusion in the budget of the private-sector costs of the mandated activity?

Can Cash Transactions Between Private Entities Be Reflected in the Federal Budget?

The answer is clearly "yes" when a private entity is acting as an agent of the federal government in carrying out a federal program under the government's direction. For example, the Coal Industry Retiree Health Benefits Program is included in the federal budget, even though its funds do not pass through the Treasury. That program guarantees lifetime health benefits for certain miners and their dependents, and coal companies are required by law to pay health insurance premiums to two privately managed trust funds on behalf of those miners. Even though the benefit plans are nominally private and the federal government plays no role in selecting their trustees, the receipts and spending appear in the federal budget because federal law requires the payment of premiums and determines the use of the money.

Another example is the Universal Service Fund. Federal law requires providers of telecommunications services to make payments to that fund, which is administered by the Universal Service Administrative Company (USAC), a not-for-profit corporation whose board members are nominated by various affected parties and approved by the Chairman of the Federal Communications Commission. Those funds are used to subsidize telecommunications services for high-cost areas, low-income consumers, rural health care providers, schools, and libraries. The payments to the USAC and its disbursements are included in the federal budget because those payments are essentially federal taxes and its disbursements are federal subsidies.

In both cases, a nominally private entity is acting as an agent of the government in carrying out a federal program, and the budget shows the income and expenditures associated with that program.

Does the Existence of a Federal Mandate, by Itself, Justify Inclusion in the Budget of the Private-Sector Costs of the Mandated Activity?

CBO concludes that the answer to that question is "no." The federal government imposes a variety of mandates on private entities. For example, there are federal requirements regarding minimum wages, occupational safety and health, the treatment of persons with disabilities, food and drug safety, the fuel efficiency of automobiles, and environmental impacts. Many of those laws impose substantial costs on businesses, and some directly affect employees' compensation, but the budget includes none of their costs. State and local governments impose mandates on businesses and on individuals as well, including requirements related to automobile insurance and auto safety inspections, the installation of smoke detectors, and the use of child car seats and bicycle helmets. The associated costs are not included in government budgets.

Some proposals under consideration would require all U.S. citizens or legal residents to have a certain minimum amount of health insurance. Existing mandates, like those cited above, are not so broad and do not affect as many people as would a mandate to buy health insurance, which might be legally avoided only by leaving the country. But the fact that one can avoid a mandate imposed on businesses by closing down a business, or a mandate to buy auto insurance by not owning a car, does not distinguish those mandates—as a matter of budgetary principle—from a broader mandate imposed on all citizens. CBO therefore concludes that a national requirement for individuals to buy health insurance would not, by itself, justify including the costs of that insurance in the federal budget and that other factors, in addition to the existence of a mandate, should be considered in making that determination.[2]

What are those factors? To the extent that firms or individuals would be purchasing insurance from the govern-

2. Regardless of whether CBO concluded that the private costs of purchasing insurance should be included in the federal budget, CBO's cost estimates for legislation would include an analysis of the costs of carrying out a mandate, as required under the Unfunded Mandates Reform Act.

ment or via some entities acting on behalf of the government, the cash flows to and from the government (or such entities) should appear in the budget. But the budgetary treatment of purchases of insurance from private companies is more complicated. At its root, the key consideration is whether the proposal would be making health insurance an essentially governmental program, tightly controlled by the federal government with little choice available to those who offer and buy health insurance—or whether the system would provide significant flexibility in terms of the types, prices, and number of private-sector sellers of insurance available to people.

In CBO's view, the former—a governmental program—belongs in the federal budget (including all premiums paid by individuals and firms to private insurers), but the latter—a largely private-sector system—does not. An example of the latter is the automobile insurance market. There is an active private market for automobile insurance; even though states require the purchase of specified minimum amounts of some types of coverage, automobile owners generally have many choices of how much coverage to acquire, which insurer to use, and what price to pay.

Although the appropriate budgetary treatment for the two approaches differs starkly, there is no well-defined dividing line between the two concepts. Rather, proposals may fall at various points along the broad spectrum between the two extremes, and characterizing a proposal as being in one category or the other can be challenging. In assessing where, along the spectrum, a particular proposal falls, CBO will consider a number of criteria, including these:

- Is the consumer likely to be able to choose among *a number of insurance plans* with differing degrees of comprehensiveness?
- If there are plans with different levels of coverage, will they cover a *broad enough range* to offer consumers a meaningful choice?
- Is the consumer likely to be able to choose among *several different insurance companies* competing on price? (The particular role of a public plan in that determination is discussed below.)

The extent to which a proposal would constrain individuals' choices regarding coverage levels can itself be difficult to measure, but the actuarial values from which individuals would be allowed to select provide a useful metric. (An insurance policy's actuarial value is the percentage of expected health claims for covered services that an insurance plan will pay.)[3] Estimates of the actuarial value of employment-based health plans vary, but typical plans appear to have an actuarial value that is between 80 percent and 95 percent, reflecting in part the favorable tax treatment afforded to such plans. Policies purchased in the individual insurance market generally have a lower actuarial value. The actuarial value of Medicare's benefits, if offered to a nonelderly population, has been estimated at roughly 75 percent.[4]

CBO will assess whether a proposal would tightly control the private insurance market by examining, among other characteristics, the number and range of allowed benefit levels in terms of their actuarial values. A proposal that would limit insurance plans to one or two specific levels of benefits, for example, would be offering consumers little choice. Setting a very high minimum actuarial value (termed the "minimum creditable coverage") would limit the range of consumers' choices, as would setting a narrow range for actuarial values—if, for example, plans had to have an actuarial value of at least 85 percent but not more than 90 percent. CBO will deem proposals that set minimum creditable coverage at more than 80 percent to be too constraining to offer consumers substantial choice.

In sum, the existence of a mandate, by itself, is not sufficient cause to bring transactions between private-sector entities into the federal budget. Similarly, the existence of a tightly regulated but still voluntary activity is also insufficient to bring such transactions into the budget. (Medigap policies, which are supplemental private health insurance policies to fill the gaps in Medicare coverage, are an example of the latter.) In CBO's view, a combination of the two—a mandate and tight federal control over how that mandate can be met—is necessary and sufficient to

3. For a more detailed explanation of actuarial values and how they are calculated, see Congressional Budget Office, *Key Issues In Analyzing Major Health Insurance Proposals* (December 2008), pp. 64–65.

4. Chris L. Peterson, *Setting and Valuing Health Insurance Benefits,* R40491 (Congressional Research Service, April 6, 2009). For additional discussion of the actuarial value of Medicare's benefits, see Congressional Budget Office, *Key Issues In Analyzing Major Health Insurance Proposals* (December 2008), p. 92.

justify recording the affected private-sector transactions in the federal budget.

Under that criterion, different segments of the health insurance market could be treated differently in the budget if they were regulated differently. For example, in conjunction with a mandate to purchase insurance, a tightly regulated market for individual or small-group coverage could be accompanied by a much less constrained market for other forms of employer-sponsored insurance; if so, purchases of individual or small-group policies might be included in the budget, whereas other employers' purchases of insurance might not be.

The Budgetary Treatment of Insurance Exchanges

Many of the proposals under consideration would establish some sort of insurance "exchanges." Under some proposals, those exchanges would essentially be private clearinghouses. Under others, exchanges would collect payments from individuals and perhaps from employers, and would then pay premiums to participating plans. Exchanges might be operated by or under the aegis of the federal government, or they might be operated by states or groups of states.

The question arises as to whether payments by individuals and employers that pass through exchanges should be considered receipts of the federal government and premiums paid through exchanges to insurance companies as outlays of the government. (Alternatively, those transactions could be considered private transactions that should not be reflected in the federal budget.) In CBO's view, the answer partly depends on whether individuals and firms would direct their payments *to exchanges* that in turn would pay insurers, or whether individuals and firms would make their payments via the exchanges *to the insurers themselves.* In the former case, the answer would also depend on whether the exchanges were considered to be federal entities (either federal agencies or nonfederal parties acting as agents of the federal government) or not.

If payments were made to and by exchanges, and if the exchanges were effectively federal entities, then the payments should be included in the federal budget. However, if the payments were made directly from individuals and firms to insurance companies via exchanges, or if the payments were made to and by the exchanges but the exchanges were not federal entities, then the payments should not be included in the budget (unless other criteria would justify their inclusion in the budget).

Exchanges that would be federally operated or administered by third parties acting as agents of the federal government would be deemed federal. For example, if proposals specified in detail the duties of exchanges, the kinds of products that could be offered through them, and their oversight responsibilities, then CBO would conclude that the exchanges should be treated as federal even when operated by other parties. If, instead, proposals delegated the determination of such specifications to a federally established board, the exchanges would still be operating as arms of the federal government. Although state agencies cannot be required to serve as agents of the federal government, under some plans states could choose to assume those responsibilities, and CBO would treat them according to these same criteria.

In contrast, if proposals call for exchanges that would simply be clearinghouses to facilitate the purchase of insurance from a variety of private insurers—serving as a marketplace for health insurance plans but not regulating that market themselves—then CBO would not view the exchanges as federal agencies. In such cases, the treatment of the cash flows would depend on whether that portion of the system was inherently governmental—that is, whether there was a mandate on individuals to purchase insurance and how tightly constraining that mandate was, as discussed earlier.[5]

The availability of a public plan through an exchange raises an additional set of issues about whether consumers who purchase coverage through that mechanism would have a meaningful set of choices available to them. Specifically, if a public plan dominated an exchange-based market, then that component of the health insurance system would, in practice, be largely governmental. In that case, all of the transactions of the exchange should properly be considered part of the budget—and premium collections should be recorded as revenues, for reasons discussed below—even if the number and range of benefit levels available through the exchange remained broad. The nature of the competition between a public plan and

5. In general, if exchanges are deemed to be federal, their operating costs should be included in the federal budget.

Table 1.

The Budgetary Treatment of Various Aspects of Health Insurance Proposals

	Individual Mandate; Health Insurance Is Largely Governmental (Tightly Constrained)	Health Insurance Is Largely Private (Loosely Constrained)
Subsidies	In budget (Outlays or revenue losses)	In budget (Outlays or revenue losses)
Play-or-Pay Payments	In budget (Revenues)	In budget (Revenues)
Individual Mandate Penalties	In budget (Revenues)	In budget (Revenues)
Risk Adjustment Transactions	In budget (Revenues and outlays)	In budget (Revenues and outlays)
Transactions of Public Plans	In budget (Revenues and outlays)	In budget (Net outlays)
Premiums Paid Directly to Insurers	In budget (Revenues and outlays)	Not in budget
Premiums Paid for Employer-Sponsored Insurance	In budget (Revenues and outlays)	Not in budget
Premiums Paid to Exchanges		
Exchanges are governmental	In budget (Revenues and outlays)	In budget (Net outlays)
Exchanges are not governmental	In budget (Revenues and outlays)	Not in budget

Source: Congressional Budget Office.

Note: Different segments of the health insurance market could be treated differently in the budget if they are regulated differently.

private plans would probably vary geographically, but if the share of individuals purchasing coverage through exchanges who were projected to enroll in a public plan approached or exceeded two-thirds nationwide, CBO would consider the exchange system to be essentially governmental.

Should Income from Premiums Be Considered Federal Revenues or Offsets to Federal Spending?

If payments of health insurance premiums should be recorded in the federal budget, then another question arises: How should such collections be classified in the budget? Money collected by the federal government and recorded in the budget can be classified as either governmental receipts (typically called revenues or receipts) or as offsets to spending (that is, amounts deducted from outlays to yield net outlays). For the most part, revenues are collections from the public that result from the exercise of the government's sovereign power to tax or otherwise compel payment. Offsets to outlays, by contrast, are typically businesslike transactions with the public (that is, payments from the public in exchange for goods or services); depending on whether the collections are credited to specific spending accounts, they may be labeled either "offsetting receipts" or "offsetting collections." For example, premiums for Parts B and D of Medicare that are paid through withholding from Social Security benefits; income from the sale of timber, minerals, power, and postage stamps; and customs and passport fees are all currently classified as offsetting receipts or collections.

If income from premiums was counted as federal revenues and an equal amount of expenditures was counted as outlays, there would be no effect on the federal deficit—but the total size of the budget would be greater, indicating a greater scope of sovereign governmental activity. In contrast, if income from premiums was counted as an offset to outlays and was matched by an equal amount of outlays, federal revenues would not be affected and net outlays would not change, indicating that the new activity was primarily businesslike or market-oriented.

In CBO's view, a requirement that individuals purchase health insurance combined with tight federal constraints on the market for such insurance or a dominant role for a public plan would constitute a fundamentally govern-

mental system, reflecting the exercise of the government's sovereign power. In those situations, premiums appearing in the budget—for a public plan or for insurance purchased through exchanges or in the private market—should be recorded as federal revenues. That determination could apply either to the health insurance market as a whole or to just a portion of it (for example, the market for individual or small-group insurance).

In contrast, if there was no mandate or if a mandate was imposed in conjunction with an active, loosely restricted private market for health insurance, premiums appearing in the budget—for a public plan or for insurance purchased through exchanges operated by the government—would be associated with businesslike transactions and should be recorded as offsets to outlays.

Conclusion

The bullets below and the table on the facing page summarize CBO's judgments about the appropriate budgetary treatment of various aspects of current proposals to change the U.S. health insurance system:

- Premium income—for a public plan (or plans) and for insurance purchased through exchanges or in the private market—should be classified as federal *revenues* if there is an individual mandate and tight government control of the insurance market. The corresponding expenditures should also be recorded as outlays in the budget. Similarly, if there is an individual mandate and a dominant public plan available to some segments of the insurance market, premiums and outlays for those segments of the market should appear in the budget, and the premium income should be classified as revenues.

- Premium income should be classified as an offset on the *outlay* side of the budget—and the corresponding spending counted as outlays—if:

  - Premiums are collected for a public plan but there is no mandate, or

  - There is an individual mandate in conjunction with an active, loosely restricted private market, and premiums are collected for a public plan or by governmental exchanges.

- Outlays for premiums and income from the receipt of those premiums should not appear in the federal budget if:

  - There is no mandate and no public plan, or

  - There is an individual mandate and an active, loosely restricted private market, and if premiums are paid through nongovernmental exchanges or directly to insurers.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

October 30, 2009

Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Current proposals to reform the health care and health insurance systems would affect the federal budget and the nation's spending for health care in many ways, and those effects can be summarized using a variety of different measures. This letter aims to clarify the measures being used by the Congressional Budget Office (CBO) in its analysis of such proposals—in particular, the effects of proposals on federal budget deficits and on the magnitude of the federal budgetary commitment to health care. As concrete examples, the letter discusses the preliminary analyses recently completed by CBO and the staff of the Joint Committee on Taxation (JCT) of the proposal put forward by the Chairman of the Senate Committee on Finance, as amended by the committee, and of H.R. 3962, the Affordable Health Care for America Act, which was introduced yesterday in the House of Representatives.[1]

The effects of health care reform proposals on the federal budget and national spending for health care are only some of the criteria that might be used in evaluating such proposals. Their impact on the market for health insurance, sources of insurance coverage, the cost of insurance before and after accounting for subsidies, the number of people with health insurance, the organization and delivery of health care, the quality and cost-effectiveness of health care, and many other factors are likely to weigh on policymakers as they make decisions about proposals. Although CBO has analyzed a number of those issues, this letter—in response to questions the agency has received—addresses only the impact on the federal budget.

[1] See Congressional Budget Office, letter to the Honorable Max Baucus providing a preliminary analysis of the Chairman's mark for the America's Healthy Future Act, as amended (October 7, 2009), and letter to the Honorable Charles B. Rangel providing a preliminary analysis of H.R. 3962 (October 29, 2009).

Effects on Federal Budget Deficits

CBO and JCT's analysis of a health care reform proposal focuses on its net impact on federal budget deficits during the 10-year budget window from 2010 through 2019. This "bottom line" reflects all of the effects of a proposal on spending and revenues, regardless of whether or how they are related to the provision of health care. For example, if an increase in spending on health programs was fully offset by the imposition of a new tax that was related to health care, or by cuts in federal spending unrelated to health care, the net impact of the proposal on deficits would be zero in either case. CBO and JCT estimated that the proposal approved by the Committee on Finance would result in a net reduction in federal budget deficits of $81 billion over the 2010–2019 period, and that H.R. 3962 would result in a net reduction in federal budget deficits of $104 billion over the same period.

The analyses of those proposals also included an assessment of their long-term effect on budget deficits, as requested by many Members. However, detailed year-by-year projections, like those that CBO prepares for the 10-year budget window, would not have been meaningful because the uncertainties involved are simply too great. CBO therefore developed an approach for providing a rough outlook for the decade following the 10-year budget window; that approach involved grouping the elements of each proposal into broad categories, assessing the rate at which the budgetary impact of each of those broad categories is likely to increase over time, and summing those impacts.

For the decade following 2019, CBO concluded that the proposal approved by the Senate Committee on Finance would reduce federal budget deficits relative to those projected under current law—with a total effect during that decade that is in a broad range between one-quarter and one-half percent of gross domestic product (GDP). For that same decade, CBO concluded that H.R. 3962 would slightly reduce federal budget deficits relative to those projected under current law—with a total effect during that decade that is in a broad range between zero and one-quarter percent of GDP. The imprecision of those calculations reflects the even greater degree of uncertainty that attends to them compared with CBO's 10-year budget estimates, and the effects of each proposal could fall outside of those ranges.

Following CBO's standard procedures for estimating the costs of legislation, those longer-term projections assumed that the proposals were enacted and remained unchanged throughout the next two decades, which is often not the case for major legislation. (For example, the sustainable growth rate mechanism governing Medicare's payments to physicians has frequently been modified to avoid reductions in those payments, and legislation to do the same again is currently being discussed in the Congress.) These proposals would put into effect (or leave in effect) a number of procedures that might be difficult to maintain over a long period of time. In particular, they would allow Medicare's payment rates for physicians' services to drop sharply for

much of the coming decade, and they aim to achieve substantial long-term savings through constraints on the payment rates for other providers of Medicare services.

Effects on the Federal Budgetary Commitment to Health Care

CBO's letters providing preliminary analyses of the proposal approved by the Senate Committee on Finance and H.R. 3962 also addressed the effects of the proposals on "the federal budgetary commitment to health care." CBO used that phrase in a letter earlier this year to describe the sum of net federal outlays for health programs and tax preferences for health care.[2] The letter noted that this sum would be greater than $1 trillion in fiscal year 2009: Net federal outlays for Medicare and Medicaid would be about $700 billion; tax preferences for health care—commonly called tax expenditures—would amount to more than $250 billion (primarily through the exclusion of premiums for employment-based health insurance from income and payroll taxes); and the federal government would also pay for veterans' health care, public health initiatives, and other health programs.[3]

CBO has used this measure because some Members have expressed interest in the federal government's overall role in the financing of health care—both under current law and under alternative reform proposals. (Whether the federal role should be expanded, contracted, or held the same is a policy choice, and CBO, as always, makes no policy recommendations.) Federal outlays for health programs are not an adequate gauge of that overall role because tax expenditures for health care are substantial under current law and because new tax credits to help purchase health insurance are a significant part of some reform proposals. Similarly, federal tax expenditures for health care do not, by themselves, capture this overall role because federal spending on health care is also substantial under current law and because such spending would increase significantly under some reform proposals. By including both the federal government's spending for health care and the subsidies for health care that are conveyed through reductions in federal taxes, the "federal budgetary commitment to health care" represents a broad measure of the resources allocated by the federal government in this area—and a measure that is independent of the extent to which outlays or tax provisions are used to channel those resources.

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[2] See Congressional Budget Office, "Health Care Reform and the Federal Budget," attachment to a letter to the Honorable Kent Conrad and the Honorable Judd Gregg (June 16, 2009).

[3] Net federal outlays for Medicare include both spending and offsetting receipts for that program. The latter consist of: premiums for Part A (which are paid only by individuals who, on the basis of their work history or the work history of a spouse, are not entitled to coverage); premiums for Part B (which cover about 25 percent of the cost of Part B); premiums for Part D that are withheld from Social Security benefits (but not premiums that enrollees pay directly to their Part D plans); Part D payments by states (based on the costs that were transferred from Medicaid to Medicare when Part D was established); and amounts paid to providers and subsequently recovered.

Proposal Approved by the Senate Committee on Finance. How would the proposal approved by the Senate Finance Committee affect the federal budgetary commitment to health care? (The attached table provides a summary for the 2010–2019 period.) In assessing that proposal, CBO reported that the gross cost of the coverage expansions (including increases in both outlays and tax expenditures) would be about $829 billion during the 10-year budget window. That figure includes the credits and subsidies provided through new insurance exchanges, increased net outlays for Medicaid and the Children's Health Insurance Program (CHIP), and tax credits for small employers.[4] The proposal also includes the following other significant changes to federal policies that would tend to offset that cost and thereby reduce its effect on the sum of net federal outlays and tax preferences for health care:

- Reductions in net spending for Medicare, Medicaid, CHIP, and other federal health programs other than the changes associated directly with expanded insurance coverage (roughly $404 billion);[5]

- Revenues generated by the excise tax on high-premium insurance plans, which is effectively a reduction in existing tax expenditures for health insurance premiums (roughly $201 billion); and

- Changes to existing law regarding tax expenditures for health care and effects of other provisions on those tax expenditures (roughly $138 billion).[6]

Accounting for all of those changes, CBO and JCT's estimates imply that the proposal would increase the federal budgetary commitment to health care by about $85 billion over the 2010–2019 period.

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[4] Under the Finance Committee's proposal, many of the subsidies for insurance coverage would be provided in the form of refundable tax credits. To the extent that those credits would reduce enrollees' tax liability, they would represent tax expenditures; any amounts in excess of that liability (that is, the portion that is refundable) would be treated as outlays for budgetary purposes. JCT has indicated that roughly three-quarters of the total amount of credits under this plan would be outlays.

[5] The reductions in net spending for those programs could themselves be divided into provisions that would increase spending (and thus the federal budgetary commitment to health care) and provisions that would decrease spending (and thus that commitment). However, even some individual provisions of the proposal have elements that raise costs and elements that lower costs. Tabulating all of the aspects of the proposal that would, in isolation, increase federal outlays would be complicated and would require somewhat arbitrary judgments about how to allocate interactions among different elements of individual provisions and interactions among provisions.

[6] That figure is the sum of roughly $86 billion (the revenue component of the line labeled "Other Effects on Tax Revenues and Outlays" in the table "Preliminary Analysis of the Insurance Coverage Provisions" enclosed with the October 7 letter to the Honorable Max Baucus); roughly $41 billion (the sum of provisions related to tax expenditures for health care estimated by JCT and shown in JCX-41-09); and roughly $12 billion (the sum of provisions labeled "Effect on Revenues of Changes in Health Insurance Premiums" on page 8 of the table "Preliminary Estimate for Title I, Subtitle F, Through Title V of the Chairman's Mark, as Amended" enclosed with the October 7 letter to the Honorable Max Baucus).

The proposal includes still other provisions that would not affect the government's outlays or tax expenditures for health care—and thus not affect the federal budgetary commitment to health care—but that would reduce budget deficits by about $167 billion over the next 10 years. Most of that amount would result from penalty payments by employers and uninsured individuals and from new fees imposed on providers of health insurance and on manufacturers and importers of brand-name drugs and certain medical devices. Although those types of revenues are related to health care, they do not represent tax preferences for health care and therefore do not affect the federal budgetary commitment to health care as CBO uses the term; rather, they are means of paying for an expanded commitment. Putting together the roughly $85 billion increase in the budgetary commitment to health care and the roughly $167 billion in deficit reduction from other provisions yields an estimated net reduction of roughly $81 billion in budget deficits between 2010 and 2019, as noted above.

By CBO's estimate, the Finance Committee's proposal would increase the federal budgetary commitment to health care by about $11 billion in 2019; but in subsequent years, the effects of the proposal that would tend to reduce that commitment would grow faster than those that would increase it. As a result, the net increase in the government's commitment to health care near the end of the 10-year budget window would turn into a net decrease during the subsequent decade, when the proposal would reduce the sum of net federal outlays and tax expenditures for health care (relative to the amounts anticipated under current law). CBO's October 7 letter describing the preliminary analysis of the proposal approved by the Committee on Finance presented that conclusion about the longer-term impact along with CBO's overall assessment of the proposal's effects on budget deficits during that decade.

The approach taken here to categorizing and displaying the effects of provisions in the Finance Committee's proposal differs from the presentation used in CBO and JCT's preliminary analysis of October 7. In that earlier analysis, the agencies grouped the provisions directly related to the expansions of insurance coverage, the provisions making other changes to direct spending (primarily to the Medicare program), and the provisions generating other changes in revenues. That approach seemed useful in describing the overall contours of the proposal; however, it did not separate the aspects of the proposal affecting federal expenditures and tax expenditures for health care from the aspects of the proposal making other changes in federal policy, which is the objective of this letter. Of course, the way in which the budgetary effects of various provisions are combined and displayed has no effect on the estimated net impact of the proposal on budget deficits.

H.R. 3962. In assessing the bill introduced yesterday in the House, CBO reported that the gross cost of the coverage expansions (including increases in both outlays and tax expenditures) would be about $1,055 billion during the 2010–2019 period. As with the

proposal approved by the Senate Finance Committee, that figure includes the subsidies provided through new insurance exchanges, increased net outlays for Medicaid and CHIP, and tax credits for small employers. The bill also includes the following other significant changes to federal policies that would tend to offset that cost and thereby reduce the effect of the proposal on the sum of net federal outlays and tax expenditures for health care:

- Reductions in net spending for Medicare, Medicaid, CHIP, and other federal health programs other than the changes associated directly with expanded insurance coverage (about $426 billion); and

- Changes to existing law regarding tax expenditures for health care and effects of other provisions on those tax expenditures (roughly $32 billion).[7]

Accounting for all of those changes, CBO and JCT's estimates indicate that H.R. 3962 would increase the federal budgetary commitment to health care by about $598 billion over the 2010–2019 period (see the attached table).

The proposal would nevertheless reduce budget deficits over the next 10 years because it includes other provisions that would not affect the government's outlays or tax expenditures for health care—and thus would not affect the federal budgetary commitment to health care—but that would diminish deficits by about $701 billion. Most of that amount would result from an income tax surcharge on high-income individuals, from penalty payments by employers and uninsured individuals, and from other revenue provisions. Although some of those revenues are related to health care, they do not represent tax preferences for health care, so CBO treats them instead as means of paying for an expanded federal budgetary commitment to health care. In combination, the increase of about $598 billion in the budgetary commitment to health care and the deficit reduction of about $701 billion from other provisions yield the estimated net reduction of about $104 billion in budget deficits between 2010 and 2019 noted above.

By CBO's estimate, H.R. 3962 would increase the federal budgetary commitment to health care by about $104 billion in 2019. The legislation would also increase the federal budgetary commitment to health care (relative to that under current law) in the decade after 2019, as explained in CBO's October 29 letter describing the preliminary analysis of the bill.

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[7] That figure is the sum of -$4 billion (the revenue component of the line labeled "Other Effects on Tax Revenues and Outlays" in Table 2, "Preliminary Analysis of the Insurance Coverage Provisions," in the October 29 letter to the Honorable Charles B. Rangel); $21 billion (the sum of provisions related to tax expenditures for health care estimated by JCT and shown in JCX-43-09); and $14 billion (all but the first provision on page 10 of Table 3, "Preliminary Estimate of the Effects on Direct Spending and Revenues of Divisions B, C, and D and Sections 111, 115, and 346 of H.R. 3962," in the October 29 letter to the Honorable Charles B. Rangel).

"Bending the Curve"

The question often arises: How does CBO evaluate whether health care reform proposals "bend the curve"? But that question raises another one: Which curve? Several cost trends are of interest to policymakers, and even though they are related, proposals might not have the same effects on each one. One such curve is the federal budget deficit as a whole, and another is the federal budgetary commitment to health care. A third is the trajectory of national health expenditures (NHE), and a fourth might be the premiums charged for health insurance.

Moreover, what does it mean to "bend the curve"? If a proposal makes the expected budget deficit 20 years from now smaller than it is expected to be without any policy changes, then the deficit curve is clearly being bent downward, on average, during the next 20 years; that is, the average growth rate of the deficit during those two decades would be lower. On the other hand, if the expected deficit is larger, then the deficit curve is being bent upward, and the average growth rate of the deficit in that period would be higher. Would that slower or faster growth rate continue indefinitely? That sort of extrapolation might seem natural, but it may not be appropriate. Distinguishing between a series of shifts in the level of the deficit and permanent changes in the growth rate of the deficit is difficult. Although CBO can provide a rough indication of a proposal's effect on the level of the budget deficit 20 years ahead, the agency does not have an analytic basis for projecting the proposal's effect on the growth rate of the deficit at that point, much less for evaluating whether that growth rate will continue in future years. Those same considerations apply to the agency's analysis of the federal budgetary commitment to health care. Therefore, CBO has concluded that it is more appropriate to talk about whether proposals would "lower" or "raise" the curve of the federal budget deficit or budgetary commitment to health care 10 to 20 years from now than to discuss those proposals' effects on the shape of the curve in that time period or the level or slope of the curve beyond that period.

Major proposals to reform health care would affect not only the federal budget but also spending for health care by individuals, firms, and other levels of government. A broad measure encompassing those effects would be the impact on total national health expenditures. However, CBO does not analyze NHE as closely as it does the federal budget, and at this point CBO has not assessed the net effect of health care reform proposals on those expenditures, either within the 10-year budget window or for the subsequent decade.[8] That is, CBO has not evaluated whether reform proposals would lower or raise—or bend down or up—the "curve" of national health expenditures.

[8] Projections of NHE are produced annually by the Office of the Actuary in the Centers for Medicare & Medicaid Services.

Finally, the question of what impact proposals might have on health insurance premiums is also of considerable interest. CBO intends to address that issue in the near future.

I hope this discussion is helpful in your consideration of proposals for broad changes in the nation's health care and health insurance systems.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

Enclosure

cc: Honorable Chuck Grassley
Ranking Member

Honorable Kent Conrad
Chairman
Committee on the Budget

Honorable Judd Gregg
Ranking Member

Identical letters sent to the Honorable Tom Harkin, the Honorable George Miller, the Honorable Henry A. Waxman, and the Honorable Charles B. Rangel.

CBO'S ESTIMATE OF THE CHANGE IN THE FEDERAL GOVERNMENT'S BUDGETARY COMMITMENT TO HEALTH CARE UNDER TWO PROPOSALS, FISCAL YEARS 2010-2019
(Billions of dollars)

	Senate Finance Committee's Proposal [a]	H.R. 3962 [b]
Changes in the Federal Budgetary Commitment to Health Care		
Gross Cost of Expanded Insurance Coverage	829	1,055
Changes in Net Spending for Medicare, Medicaid, and Other Programs	-404	-426
Changes in Revenues from Tax on High-Premium Insurance Plans	-201	0
Other Changes in Existing Tax Expenditures	-138	-32
Net Change in the Federal Budgetary Commitment to Health Care	**85**	**598**
Other Budgetary Effects		
Penalty Payments by Firms and Individuals	-27	-167
Revenues from Other Changes to Tax Law	-139	-536
Miscellaneous Other Budgetary Effects	-1	2
Net Impact on Federal Budget Deficits	**-81**	**-104**

Source: Congressional Budget Office.

a. The Chairman's mark for the America's Healthy Future Act, as amended by the Senate Committee on Finance.

b. The Affordable Health Care for America Act, as introduced on October 29, 2009.

Notes: Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Components may not sum to totals because of rounding.

For further details, see Congressional Budget Office, letter to the Honorable Max Baucus providing a preliminary analysis of the Chairman's mark for the America's Healthy Future Act, as amended (October 7, 2009), and letter to the Honorable Charles B. Rangel providing a preliminary analysis of H.R. 3962 (October 29, 2009).

Budgetary Treatment of Proposals to Regulate Medical Loss Ratios

CBO has been asked to review a proposal that would require health insurers to provide rebates to enrollees to the extent that their medical loss ratios are less than 90 percent. (A medical loss ratio, or MLR, is the proportion of premium dollars that an insurer spends on health care; it is commonly calculated as the amount of claims incurred plus changes in reserves as a fraction of premiums earned.) In particular, CBO has been asked to assess whether adding such a requirement to the provisions of the Patient Protection and Affordable Care Act (PPACA) put forward by Senator Reid (as an amendment to H.R. 3590) would change its judgment as to how various types of health insurance transactions that would occur under that legislation should be reflected in the federal budget.

In May, CBO released an issue brief entitled *The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System*. That publication identified the primary elements of proposals that CBO thought were relevant to whether purchases of private health insurance should be treated as part of the federal budget. CBO concluded (on page 4) that "at its root, the key consideration is whether the proposal would be making health insurance an essentially governmental program, tightly controlled by the federal government with little choice available to those who offer and buy health insurance—or whether the system would provide significant flexibility in terms of the types, prices, and number of private-sector sellers of insurance available to people." (Note: CBO estimates the budgetary impact of legislation as it is being considered by the Congress; if legislation is enacted into law, the Administration's Office of Management and Budget ultimately determines how its effects will be reflected in the federal budget.)

The PPACA would make numerous changes to the market for health insurance, including requiring all individuals to purchase health insurance, subsidizing coverage for some individuals, and establishing standards for benefit packages. Taken together, those changes would significantly increase the federal government's role in that market. Nevertheless, CBO concluded that there would remain sufficient flexibility for providers of insurance and sufficient choice for purchasers of insurance that the insurance market as a whole should be considered part of the private sector. Therefore, except for certain transactions that explicitly involve the government, CBO would treat the cash flows associated with the health insurance system (for example, premium and benefit payments) as nongovernmental.

Certain policies governing MLRs, particularly those requiring health plans whose MLR falls below a minimum level to rebate the difference to enrollees, can be a powerful regulatory tool. Insurers operating at MLRs below such a minimum would have a limited number of possible responses. They could change the way they provide health insurance, perhaps by reducing their profits or cutting back on efforts to restrain benefit costs through care management. They could choose to pay the rebates, but if they raised premiums to cover the added costs they would simply have to rebate that increment to premiums later. Alternatively, they could exit the market entirely. Such responses would reduce the types, range of prices, and number of private-sector sellers of health insurance—the very flexibilities described in CBO's issue brief.

In CBO's judgment, an important consideration in whether a specific MLR policy would cause such market effects is the fraction of health insurance issuers for whom the policy would be binding. A policy that affected a majority of issuers would be likely to substantially reduce flexibility in terms of the types, prices, and number of private sellers of health insurance. Taken together with the significant increase in the federal government's role in the insurance market under the PPACA, such a substantial loss in flexibility would lead CBO to conclude that the affected segments of the health insurance market should be considered part of the federal budget. (CBO made similar judgments in its issue brief in assessing the level of required coverage that would, in combination with a mandate to purchase coverage, make the purchase of insurance essentially governmental.)

Setting a precise minimum MLR that would trigger such a determination under the PPACA is difficult, because MLRs fall along a continuum. However, CBO has identified MLRs in the principal segments of the insurance market above which a significant minority of insurers would be affected; if a minimum MLR were set at or below those levels, CBO would not consider purchases of private health insurance to be part of the federal budget. Compared with MLRs anticipated under current law, MLRs under the PPACA would tend to be similar in the large-group market, slightly higher in the small-group market, and noticeably higher in the individual (nongroup) market—for reasons that are discussed in CBO's November 30 analysis of the effect of Senator Reid's proposal on insurance premiums. Taking those differences into account, CBO has determined that setting minimum MLRs under the PPACA at 80 percent or lower for the individual and small-group markets or at 85 percent or lower for the large-group market would not cause CBO to consider transactions in those markets as part of the federal budget.

A proposal to require health insurers to provide rebates to their enrollees to the extent that their medical loss ratios are less than 90 percent would effectively force insurers to achieve a high medical loss ratio. Combining this requirement with the other provisions of the PPACA would greatly restrict flexibility related to the sale and purchase of health insurance. In CBO's view, this further expansion of the federal government's role in the health insurance market would make such insurance an essentially governmental program, so that all payments related to health insurance policies should be recorded as cash flows in the federal budget.

Congressional Budget Office

December 13, 2009

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

January 22, 2010

Honorable Jeff Sessions
United States Senate
Washington, DC 20510

Dear Senator:

This letter responds to questions you posed about the Congressional Budget Office's (CBO's) analysis of the effects of H.R. 3590, the Patient Protection and Affordable Care Act (PPACA), as passed by the Senate on December 24. In particular, you asked for clarification on several issues regarding the effect of the legislation on the Hospital Insurance (HI) trust fund, from which Medicare Part A benefits are paid.

Your questions focused on the budgetary impact of the provisions of PPACA that would extend the solvency of the HI trust fund, presumably either by increasing revenues to or decreasing expenditures from that trust fund. Some specific provisions of PPACA can be identified as having such effects. However, some of those provisions would have effects beyond the HI trust fund (such as provisions addressing Medicare Advantage plans, which are paid for from both the trust fund and the Treasury's general fund), and other provisions in the act would affect the trust fund indirectly through their impact on taxable income. Because of those complexities, this letter does not address the possible impact of removing from the act all of the provisions that would affect the HI trust fund, but, rather, summarizes the net effects of the act as a whole on the trust fund.

Budgetary Impact of the Legislation

On the basis of the economic forecast and technical assumptions in CBO's March 2009 baseline, CBO projected that, under current law, the HI trust fund would be exhausted—that is, the balance of the trust fund would decline to zero—during fiscal year 2017. Enacting PPACA, including the manager's amendment, would reduce net outlays for Part A of Medicare by $245 billion over the 2010–2019 period relative to that baseline, CBO estimates. Enacting that legislation would also increase HI payroll tax receipts by about $113 billion over that period, according to estimates by CBO and the staff of the Joint Committee on Taxation (JCT). Together, those changes in outlays and revenues would diminish budget deficits and add to trust fund balances by $358 billion over that 10-year period. Given those changes in the financial flows of the trust fund, CBO estimates that the HI trust fund would have a positive balance of about $170 billion at the end of fiscal year 2019.

In the December 19, 2009, cost estimate for PPACA, CBO and JCT estimated that the direct spending and revenue effects of enacting PPACA would yield a net reduction in federal deficits of $132 billion over the 2010–2019 period.[1] Thus, the act's effects on the rest of the budget—other than the cash flows of the HI trust fund—would amount to a net *increase* in federal deficits of $226 billion over the same period. Those two aspects of the legislation would have differing effects on debt held by the public: The changes to HI revenues and costs, by themselves, would reduce that debt, while changes in other revenues and costs would increase it.

For the decade beyond 2019, CBO expects that enacting PPACA would reduce federal budget deficits relative to those projected under current law—with a total effect during that decade in a broad range between one-quarter percent and one-half percent of gross domestic product.[2] The legislation would have positive effects on the cash flows of the HI trust fund in that decade that would be larger than its effects on federal budget deficits as a whole. Therefore, leaving aside the cash flows of the HI trust fund, CBO expects that PPACA would yield a net *increase* in budget deficits during the decade beyond 2019.

Trust Fund Accounting

However, the HI trust fund, like other federal trust funds, is essentially an accounting mechanism. In a given year, the sum of specified HI receipts and the interest that is credited on the previous trust fund balance, minus spending for Medicare Part A benefits, represents the surplus (or deficit, if the latter is greater) in the trust fund for that year. Any cash generated when there is an excess of receipts over spending is not retained by the trust fund; rather, it is turned over to the Treasury, which provides government bonds to the trust fund in exchange and uses the cash to finance the government's ongoing activities.

The HI trust fund is part of the federal government, so transactions between the trust fund and the Treasury are intragovernmental and have no net impact on the unified budget or on federal borrowing from the public. From a unified budget perspective, any increase in revenues or decrease in outlays in the HI trust fund represents cash that can be used to finance other government activities without requiring new government borrowing from the public. Similarly, any increase in outlays or decrease in revenues in the HI trust fund in some future year represents

[1] Congressional Budget Office, letter to the Honorable Harry Reid regarding the direct spending and revenue effects of the Patient Protection and Affordable Care Act (December 19, 2009). CBO has not prepared an estimate of the budgetary impact of PPACA as passed by the Senate; the estimates used in this letter apply to the bill as introduced, incorporating the manager's amendment but no other amendments. The relevant figures for the Senate-passed version of the legislation would not differ significantly.

[2] Congressional Budget Office, letter to the Honorable Harry Reid regarding an error in the cost estimate released on December 19 (December 20, 2009).

a draw on the government's cash in that year. Thus, the resources to redeem government bonds in the HI trust fund and thereby pay for Medicare benefits in some future year will have to be generated from taxes, other government income, or government borrowing in that year. The HI trust fund and other trust funds have important legal meaning but little economic or budgetary meaning.

The reductions in projected Part A outlays and increases in projected HI revenues resulting from PPACA would significantly raise balances in the HI trust fund and might suggest that significant additional resources—$358 billion plus additional interest to be credited to the trust fund over time—had been set aside to pay for future Medicare benefits. However, only the additional savings by the government as a whole truly increase the government's ability to pay for future Medicare benefits or other programs, and those would be a much smaller ($132 billion plus interest savings to be achieved over time). Unified budget accounting shows that the majority of the HI trust fund savings under PPACA would be used to pay for other spending and therefore would not enhance the ability of the government to pay for future Medicare benefits.

Impact on Federal Debt

You also asked about the impact of PPACA on gross federal debt. Gross federal debt consists of debt held by the public and debt issued to government accounts. Debt held by the public is the most meaningful measure for assessing the relationship between federal debt and the economy because it represents the amount that the government has borrowed in the financial markets to pay for its operations and activities; such borrowing competes with other participants in credit markets for financial resources. In contrast, debt held by trust funds and other government accounts represents *internal* transactions of the government and thus has no effect on credit markets.

Compared with the effects of current law, enacting PPACA would increase the balance in the HI trust fund at the end of 2019 by somewhat more than $358 billion ($358 billion in increased revenues and reduced outlays, described above, plus interest earnings on the larger balances during the 2009–2019 period). Balances in the HI trust fund are generally held in the form of government debt. Therefore, the HI trust fund would hold more than $358 billion of additional government debt by the end of 2019 compared with its holdings under current law. At the same time, enacting PPACA would reduce debt held by the public at the end of 2019 by somewhat more than $132 billion ($132 billion in increased revenues and reduced direct spending, plus interest savings from the smaller debt during the 10-year period). Therefore, enacting PPACA would increase debt held by government accounts more than it would decrease debt held by the public, and would thus increase gross federal debt.[3] However, that measure of debt conveys

[3] Because interest rates on debt held by the public and debt held by government accounts are not too dissimilar, accounting explicitly for the difference in interest costs between the HI trust fund and the unified government accounts would not affect this qualitative conclusion.

little information about the federal government's future financial burdens and has little economic meaning. In contrast, the effects of legislation on debt held by the public offer a more useful measure of that legislation's impact on the government's financial condition.

I hope this information is useful to you. If you have any questions, please contact me.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

cc: Honorable Harry Reid
Majority Leader

Honorable Mitch McConnell
Republican Leader

Honorable Max Baucus
Chairman
Committee on Finance

Honorable Chuck Grassley
Ranking Member

Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor, and Pensions

Honorable Michael B. Enzi
Ranking Member

Honorable Kent Conrad
Chairman
Committee on the Budget

Honorable Judd Gregg
Ranking Member

Medical Malpractice

One of the issues that arose in the debate over health care legislation was whether to limit payments related to medical malpractice—also known as "tort reform." CBO produced several letters analyzing that issue:

1. A letter to Senator Orrin G. Hatch, dated October 9, 2009, updating CBO's estimates of the impact that certain proposed changes would have on spending for health care and the federal budget.

2. A letter to Senator John D. Rockefeller IV, dated December 10, 2009, addressing questions about how recent studies about medical malpractice had affected CBO's analysis and whether tort reform would have a negative effect on patients' health.

3. A letter to Representative Bruce L. Braley, dated December 29, 2009, addressing many of the same questions as the letter to Senator Rockefeller but also including a discussion of the impact of certain proposals on premiums for malpractice insurance.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

October 9, 2009

Honorable Orrin G. Hatch
United States Senate
Washington, DC 20510

Dear Senator:

This letter responds to your request for an updated analysis of the effects of proposals to limit costs related to medical malpractice ("tort reform"). Tort reform could affect costs for health care both directly and indirectly: directly, by lowering premiums for medical liability insurance; and indirectly, by reducing the use of diagnostic tests and other health care services when providers recommend those services principally to reduce their potential exposure to lawsuits. Because of mixed evidence about whether tort reform affects the utilization of health care services, past analyses by the Congressional Budget Office (CBO) have focused on the impact of tort reform on premiums for malpractice insurance. However, more recent research has provided additional evidence to suggest that lowering the cost of medical malpractice tends to reduce the use of health care services. CBO has updated its estimate of the budgetary effects of proposals for tort reform to reflect that new information.

Background on Tort Reform

Under current law, individuals may pursue civil claims against physicians and other health care providers for alleged torts—breaches of duty that result in personal injury. The system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for losses they incur (including medical costs, lost wages, and pain and suffering) resulting from injuries that occur because of negligence.

Many observers have proposed nationwide curbs on medical malpractice torts. As CBO outlined in its 2008 report *Key Issues in Analyzing Major Health Insurance Proposals*, reforms to the tort system generally fall into one of two categories: caps on the payments that may be made and limits on who may be found liable. Broader reforms, such as the establishment of specialized courts or different standards of evidence, have also been discussed, but they have not featured as prominently in legislative proposals.

Caps on tort awards could take a number of forms. One common proposal would limit awards for noneconomic damages, such as pain and suffering. Other proposals would limit the amount awarded for punitive damages, or the situations in which a plaintiff could receive awards for punitive damages, or both. Still other proposals would cap the contingency fees that claimants' attorneys could collect as a percentage of the total

damages recovered. Additionally, some proposals would allow compensation that plaintiffs received from other sources—including payments from health and life insurance, workers' compensation, and automobile insurance—to be introduced at trials (juries presumably would take that information into account in determining awards); some proposals would also prevent those other sources from receiving any portion of awards for damages.

The two most common ways of imposing limits on liability are to shorten the statute of limitations on malpractice claims and to change the rules regarding joint-and-several liability. The principle of joint-and-several liability allows a claimant to recover the entire amount of a damage award from any one of the parties found to be responsible for an injury, regardless of the party's degree of responsibility for that injury. Replacing joint-and-several liability with a "fair-share" rule would limit each defendant's financial liability to his or her percentage share of responsibility for the injury.

Several times over the past decade, CBO has estimated the effects of legislative tort reform proposals. Typical proposals have included:

- A cap of $250,000 on awards for noneconomic damages;
- A cap on awards for punitive damages of $500,000 or two times the award for economic damages, whichever is greater;
- Modification of the "collateral source" rule to allow evidence of income from such sources as health and life insurance, workers' compensation, and automobile insurance to be introduced at trials or to require that such income be subtracted from awards decided by juries;
- A statute of limitations—one year for adults and three years for children—from the date of discovery of an injury; and
- Replacement of joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury.

The Effect of Tort Reform on Premiums for Medical Liability Insurance

National implementation of a package of proposals similar to the preceding list would reduce total national premiums for medical liability insurance by about 10 percent, CBO now estimates. That figure reflects the fact that many states have already enacted at least some of the proposed reforms. For example, about one-third of the states have implemented caps on noneconomic damages, and about two-thirds have reformed their rules regarding joint-and-several liability.

CBO estimates that the direct costs that providers will incur in 2009 for medical malpractice liability—which consist of malpractice insurance premiums together with settlements, awards, and administrative costs not covered by insurance—will total approximately $35 billion, or about 2 percent of total health care expenditures. Therefore,

lowering premiums for medical liability insurance by 10 percent would reduce total national health care expenditures by about 0.2 percent.

Recent Evidence on the Broader Effects of Tort Reform

On the basis of newly available research, CBO has updated its analysis of the effects of tort reform to include not only direct savings from lower premiums for medical liability insurance but also indirect savings from reduced utilization of health care services. Many analysts surmise that the current medical liability system encourages providers to increase the volume or intensity of the health care services they provide to protect themselves against possible lawsuits. (An example of increasing intensity would be ordering a computerized tomography scan rather than a simple x-ray.) In earlier analyses, CBO did not incorporate such effects in its estimates because research on the impact of tort reform on the use of health care services produced inconsistent results. For example, Kessler and McClellan (1996) and CBO (2006) both observed reductions in Medicare's hospital spending in states that had enacted a cap on noneconomic damages (for the full citations, see the attached list of references); however, those studies also reported *increases* in Medicare's spending for hospitals and for physicians' services in states that had changed their joint-and-several liability rules to fair-share rules.

More recent research has yielded additional evidence that tort reform reduces the use of health care services. Lakdawalla and Seabury (2009) and Baicker, Fisher, and Chandra (2007), using data on hospitals' total expenditures and Medicare's spending for Part A and Part B services, found that reductions in the cost of medical liability lowered health care expenditures.[1] In addition, Avraham, Dafny, and Schanzenbach (2009) found that several types of reform significantly lowered the costs of health plans offered by self-insured employers.

Other recent research seeks to reconcile some earlier results that appeared to be contradictory. Currie and MacLeod (2008) have suggested that certain components of tort reform, such as changes in the rules on joint-and-several liability, create different financial incentives for physicians than do other reform components, such as caps on noneconomic damages. Caps on damages unambiguously reduce financial liability for all providers. Reform of joint-and-several liability rules, however, is likely to increase the financial liability of the providers assigned the greatest share of responsibility in malpractice cases—typically, physicians. Therefore, physicians may reduce the volume and intensity of the services they provide in response to caps on damages, but they may increase volume and intensity in response to reform of joint-and-several liability rules. As a result, the inclusion or exclusion of specific components in a legislative tort reform proposal could affect the proposal's likely impact on health care spending.

The Effects of Tort Reform on Total Health Care Spending and the Federal Budget

CBO now estimates, on the basis of an analysis incorporating the results of recent research, that if a package of proposals such as those described above was enacted, it would reduce total national health care spending by about 0.5 percent (about $11 billion in 2009). That figure is the sum of the direct reduction in spending of 0.2 percent from

[1] Part A of Medicare pays for hospital care and related services; Part B pays for care by physicians and related services.

Table 1.
Effects of Tort Reform on Mandatory Spending and Tax Revenues

(Billions of dollars)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total 2010-2014	Total 2010-2019
Change in Mandatory Spending[a]	0	-0.7	-1.8	-3.2	-4.6	-5.4	-5.9	-6.0	-6.3	-7.0	-10.3	-41.0
Change in Revenues	0	0.2	0.6	1.0	1.5	1.7	1.8	1.9	2.1	2.2	3.2	13.0
Net Effect on the Deficit[b]	0	-0.9	-2.4	-4.2	-6.1	-7.1	-7.7	-7.9	-8.4	-9.2	-13.5	-54.0

Sources: Congressional Budget Office; Joint Committee on Taxation.

a. Includes Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits program. Numbers do not include potential effects on payments made through the Federal Tort Claims Act and effects on other, small mandatory programs.

b. Negative numbers indicate a reduction in the deficit.

lower medical liability premiums, as discussed earlier, and an additional indirect reduction of 0.3 percent from slightly less utilization of health care services. (That reduction is the estimated net effect of the entire package listed earlier, although some components of that package might increase the utilization of physicians' services, as has already been noted.) CBO's estimate takes into account the fact that because many states have already implemented some of the changes in the package, a significant fraction of the potential cost savings has already been realized.

In the case of the federal budget, enactment of such a package of proposals would reduce mandatory spending for Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits program by roughly $41 billion over the next 10 years (see Table 1).[2] That figure includes a larger percentage decline in Medicare's spending than in the other programs' or in national health spending in general, a calculation based on empirical evidence showing that the impact of tort reform on the utilization of health care services is greater for Medicare than for the rest of the health care system. One possible explanation for that disparity is that the bulk of Medicare's spending is on a fee-for-service basis, whereas most private health care spending occurs through plans that manage care to some degree. Such plans limit the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as "defensive" medicine); in that way, plans control costs and keep premiums lower than they otherwise would be. In research reported in 2002, Kessler and McClellan found that when tort reform was introduced, health care spending in regions with relatively more enrollees in managed care plans did not fall as much as it did in regions with relatively fewer enrollees. Presumably, the managed care plans had already eliminated some of the defensive medicine that would otherwise have been diminished by tort reform.

[2] Spending in some discretionary federal programs could also be reduced, but funding for those programs is subject to future appropriation action and is not included in the estimates in Table 1. For example, some savings could be realized if the amounts appropriated to such federal agencies as the Department of Defense and the Department of Veterans Affairs were reduced because of lower health care costs as a result of tort reform. In CBO's estimation, that reduction would be less than $1 billion during the 2010–2019 period. The impact on federal agencies would be proportionally smaller than the impact on the overall health care system because medical malpractice costs are already lower than average for entities covered by the Federal Tort Claims Act.

By reducing spending on health care in the private sector, the package of proposals discussed here would also affect federal revenues. Much private-sector health care is provided through employment-based insurance that represents nontaxable compensation. Lower costs for health care arising from those proposals would lead to higher taxable wages and thereby increase federal tax revenues by an estimated $13 billion over the next 10 years, according to estimates by the staff of the Joint Committee on Taxation (JCT). Combining the effects on both mandatory spending and revenues, a tort reform package of the sort described earlier in this letter would reduce federal budget deficits by roughly $54 billion over the next 10 years. That estimate assumes that a change enacted in 2010 would have an impact that increased over time, achieving its full effect after four years, as providers gradually changed their practice patterns. Of course, the estimated effect of any specific legislative proposal would depend on the details of that proposal.

The Effects of Tort Reform on Health Outcomes

Because medical malpractice laws exist to allow patients to sue for damages that result from negligent health care, imposing limits on that right might be expected to have a negative impact on health outcomes. There is less evidence about the effects of tort reform on people's health, however, than about its effects on health care spending—because many studies of malpractice costs do not examine health outcomes. Some recent research has found that tort reform may adversely affect such outcomes, but other studies have concluded otherwise. Lakdawalla and Seabury (2009) found that a 10 percent reduction in costs related to medical malpractice liability would increase the nation's overall mortality rate by 0.2 percent. However, Kessler and McClellan (1996 and 2002) and Sloan and Shadle (2009) concluded that tort reform generated no significant adverse outcomes for patients' health.

I hope you find this information useful. If you have any further questions, please contact me or my staff. The primary staff contact is Stuart Hagen.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

cc: Honorable Patrick J. Leahy
Chairman
Senate Committee on the Judiciary

Honorable Jeff Sessions
Ranking Member
Senate Committee on the Judiciary

Honorable John Conyers Jr.
Chairman
House Committee on the Judiciary

Honorable Lamar Smith
Ranking Member
House Committee on the Judiciary

Attachment: References

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CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

December 10, 2009

Honorable John D. Rockefeller IV
United States Senate
Washington, DC 20510

Dear Senator:

This letter responds to questions you posed about the Congressional Budget Office's (CBO's) recent analysis of the budgetary effects of proposals to limit costs related to medical malpractice ("tort reform"), as described in a letter to Senator Hatch.[1] In particular, this letter addresses your questions about how recent empirical studies affected CBO's analysis, why CBO's latest estimates of the budgetary effects of tort reform are larger than the agency's previous estimates, and whether tort reform would have a negative impact on patients' health.

In the letter to Senator Hatch, CBO concluded that tort reform would lower costs for health care both directly, by reducing medical malpractice costs, and indirectly, by reducing the use of health care services through changes in the practice patterns of providers; the agency estimated that enacting a package of proposals outlined in that letter would reduce federal budget deficits by about $54 billion during the 2010–2019 period. Previously, the agency had found that tort reform would lower health care costs only by reducing medical malpractice costs, and it had estimated significantly smaller effects of tort reform on the federal budget. In the letter to Senator Hatch, CBO noted that imposing limits on suits for damages resulting from negligent health care might have a negative impact on health outcomes but concluded that the evidence is less clear about the effects of tort reform on health outcomes than it is about the effects on health care costs.

Recent Research Findings

CBO's latest assessment of the effects of tort reform on spending for health care draws on a considerable amount of analysis that the agency has undertaken during the past several years and a stream of recent research studies that have used a

[1] Congressional Budget Office, letter to the Honorable Orrin G. Hatch regarding effects of proposals to limit costs related to medical malpractice (October 9, 2009).

variety of data and empirical techniques.[2] Despite that analysis, estimates of the budgetary effects of tort reform are unavoidably uncertain, as is true for many other issues that CBO studies. In dealing with uncertainty, the agency consistently strives to produce estimates that lie in the middle of the distribution of plausible outcomes based upon available knowledge.

After a careful evaluation of the research relevant to tort reform, along with discussions with members of the agency's Panel of Health Advisers who have particular expertise in this topic, CBO concluded that the weight of empirical evidence now demonstrates a link between tort reform and the use of health care services. The estimates from CBO's own empirical analysis in 2006 implied that implementing the package of tort reforms described in the recent letter to Senator Hatch would reduce the use of health care services and, thereby, health care spending—a finding that was consistent with the results of some studies done by outside researchers.[3] However, the studies available at that time (including CBO's) reported estimates that varied considerably in magnitude and contained some anomalous results, so CBO concluded that there was not sufficient evidence to incorporate in its budget estimates an effect of tort reform on health care utilization. More-recent studies have provided further support for the hypothesis that tort reform would slightly reduce the use of health care, and they have helped to resolve some apparent anomalies in earlier findings.[4]

For example, studies by Lakdawalla and Seabury and by Avraham, Dafny, and Schanzenbach analyzed data that had not been used in previous research and used statistical methods that strengthened the evidence regarding the effects of tort reform on health care utilization and spending. Previous research had generally compared changes in health care spending over time in states that had and had not adopted tort reforms, controlling for other observable differences among states. Lakdawalla and Seabury used an approach that did not rely on comparisons of state tort reforms; they found that a reduction in medical malpractice costs was

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[2] For CBO's earlier analyses, see *The Effects of Tort Reform: Evidence from the States* (June 2004) and *Medical Malpractice Tort Limits and Health Care Spending* (April 2006).

[3] See Daniel Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics,* vol. 111, no. 2 (1996), pp. 354–380; and Daniel Kessler and Mark McClellan, "Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care," *Journal of Public Economics,* vol. 84, no. 2 (2002), pp.175–195.

[4] See Ronen Avraham, Leemore S. Dafny, and Max M. Schanzenbach, *The Impact of Tort Reform on Employer-Sponsored Health Insurance Premiums,* Working Paper No. w15371 (Cambridge, Mass.: National Bureau of Economic Research, September 2009); Katherine Baicker, Elliot S. Fisher, and Amitabh Chandra, "Malpractice Liability Costs and the Practice of Medicine in the Medicare Program," *Health Affairs,* vol. 26, no. 3 (2007), pp. 841–852; Janet Currie and W. Bentley MacLeod, "First Do No Harm? Tort Reform and Birth Outcomes," *Quarterly Journal of Economics,* vol. 123, no. 2 (2008), pp. 795–830; Darius N. Lakdawalla and Seth A. Seabury, *The Welfare Effects of Medical Malpractice Liability,* Working Paper No. w15383 (Cambridge, Mass.: National Bureau of Economic Research, September 2009); and Frank A. Sloan and John H. Shadle, "Is There Empirical Evidence for "Defensive Medicine"? A Reassessment," *Journal of Health Economics,* vol. 28, no. 2 (2009), pp. 481–491.

associated with a reduction in health care spending that exceeded what would arise solely from the direct effect of that reduction in malpractice costs. Avraham, Dafny, and Schanzenbach analyzed the impact of tort reform on health insurance premiums; they found that tort reform was associated with a reduction in premiums for self-insured plans that, again, exceeded what would arise from the direct effect of tort reform on malpractice costs.

In addition, a study by Baicker, Fisher, and Chandra found that use of diagnostic services, especially imaging, showed the largest changes in response to a change in malpractice costs. That result is consistent with a common view that ordering additional diagnostic services is a preferred strategy for reducing exposure to medical malpractice liability. That study reinforced the findings from other studies that tort reform would affect health care utilization by changing the practice patterns of providers. A study by Sloan and Shadle found mixed evidence of an effect of tort reform on health care spending. The authors estimated that certain types of tort reform had no effect on total spending by hospitals, while other types decreased it.

Previous research by CBO and others had found that replacing "joint and several" liability laws with a "fair share" rule appeared to increase health care spending—in contrast with other tort reforms, such as caps on noneconomic damages, which appeared to decrease spending. A study by Currie and MacLeod explained that a fair share rule is unusual among commonly discussed tort reforms because it increases the risk of financial liability perceived by most physicians. In CBO's view, if physicians generally react to greater liability pressure by performing more procedures, then a fair share rule would be expected to increase overall health care utilization and spending.[5] That explanation helped to make sense of previously counterintuitive results and therefore gave CBO greater confidence in those earlier results.

CBO's Updated Estimates of the Budgetary Effects of Tort Reform

In CBO's December 2008 *Budget Options* volume, a common package of tort reform proposals was estimated to decrease spending by about $4 billion and to increase revenues by about $1 billion from 2010 to 2019.[6] In CBO's letter to Senator Hatch, those proposals were estimated to decrease spending by roughly $41 billion and increase revenues by roughly $13 billion over that same period. The latest estimates are substantially larger than the earlier ones for four principal reasons:

[5] Seemingly contrary to that logic, Currie and MacLeod estimated that adopting a fair share rule decreased utilization. However, their analysis focused on a single procedure, births by Caesarean section.

[6] See Congressional Budget Office, *Budget Options, Volume 1: Health Care* (December 2008), pp. 21–22.

- They include a larger estimate of the effect of tort reform on medical malpractice costs;

- They incorporate the effect of a gradual reduction in the utilization of health care services resulting from changes in the practice patterns of providers;

- The estimated effect on federal revenues was substantially smaller in the previous estimate (which reflected only a reduction in malpractice costs) than the estimated effect on revenues in the current estimate (which reflects the combined effects of the reduction in malpractice costs and the change in spending attributable to changes in practice patterns); and

- The reduction in utilization is projected to generate a proportionately larger reduction in federal spending on health care than in other spending on health care.

Tort Reform Would Have a Greater Effect on Malpractice Costs. CBO periodically updates its estimates of the effect of tort reform on malpractice costs as new data on malpractice costs and state laws become available and the agency improves its techniques for modeling the effects of tort reform. CBO currently estimates that the nation's direct costs for medical malpractice—which consist of malpractice insurance premiums and settlements, awards, and administrative costs not covered by insurance—would be reduced by about 10 percent (relative to the amounts under current law) if the common package of tort reforms was implemented nationwide. CBO's previous estimate was that tort reform would lower malpractice costs nationwide by about 6 percent.[7]

Tort Reform Would Also Affect the Utilization of Health Care Services. As described in CBO's letter to Senator Hatch and reiterated above, the agency's estimates of the effects of tort reform now incorporate a slight reduction in the utilization of health care attributable to changes in the practice patterns of providers. The combination of direct savings in malpractice costs and indirect savings in health care services would reduce national health spending in response to the proposed reforms by roughly 0.5 percent, CBO projects. The increase in CBO's estimate of the effects of tort reform on health care spending—arising from both the larger estimated change in malpractice costs and the incorporation of the change in utilization owing to changes in practice patterns—implies a significant increase in the estimated effects of tort reform on both federal tax revenues and federal outlays.

The Effect of Reduced Health Care Spending on Revenues Would Be Greater. On the revenue side, a reduction in spending on health care arising from

[7] See Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, pp. 150–154.

tort reform would shift some compensation from employment-based health insurance (which is excluded from income and payroll taxes) to taxable wages and salaries, thereby increasing tax revenues. That reduction in spending on health care—and the resulting revenue impact—would be the combined effect of three consequences of tort reform: a reduction in malpractice costs; a reduction in the use of health care services; and an increase in the amount of health insurance purchased because of lower insurance prices brought about by the two other factors. In CBO's previous estimate, the second factor on that list was not included, and the induced increase in insurance purchases offset a considerable share of the decrease in spending due to lower malpractice costs; as a result, the net reduction in spending was a good deal smaller than the 0.2 percent figure that represents CBO's current assessment of the effect of tort reform on health care spending due to the reduction in malpractice costs. In CBO's latest estimate, the reduction in spending owing to changes in providers' practice patterns significantly outweighs the induced increase in insurance purchases; as a result, the net reduction in spending incorporating all three factors listed above is 0.5 percent. Thus, the estimated increase in federal tax revenues from tort reform has risen by more than the ratio of 0.5 to 0.2.

Changes in Utilization Would Have a Proportionately Greater Effect on Federal Spending. On the outlay side, the reduction in the utilization of health care services due to changes in practice patterns would have a proportionately larger effect on federal spending for health care than it would have on other spending for health care. The most important reason for the difference is that, according to empirical evidence, utilization of care in Medicare would be reduced more than would utilization of care as a whole. The greater impact in Medicare can probably be explained by two factors. First, the bulk of Medicare services are provided on a fee-for-service basis, whereas most private health care spending occurs through plans that manage the utilization of care to some degree. Such plans may limit the use of services that have marginal benefit to patients to a greater degree than does Medicare, leaving less room for changes in pressures regarding malpractice to affect utilization. Second, when compared with the use of private health care services, the use of services in Medicare is less likely to be influenced by the effects of changes in malpractice costs on the premiums and cost sharing faced by patients.

Effects of Tort Reform on Patients' Health

As you noted in your letter, the potential impact of tort reform on the quality of health care and on health outcomes is an important consideration for policymakers. CBO's letter to Senator Hatch observed that imposing limits on patients' suits involving harm from negligent health care might be expected to have a negative effect on health outcomes. The letter also noted that there is less evidence about the effects of tort reform on people's health than there is about its effects on health care spending, because many studies of malpractice costs have not examined health outcomes.

Among the analyses that have investigated health outcomes, the study by Lakdawalla and Seabury cited earlier reported that lower malpractice costs were associated with an increase in mortality, while the study by Currie and MacLeod found positive impacts on health from reform of joint and several liability and negative impacts from caps on noneconomic damages. Studies by Kessler and McClellan (1996 and 2002) and Sloan and Shadle (2009) found that state tort reforms had no significant effects on health. Thus, the limited evidence currently available about the effects of tort reform on health outcomes is much more mixed than the larger collection of evidence currently available about the effects of tort reform on health care spending.

Those mixed results related to health outcomes may arise, in part, because of the complicated relationship between malpractice claims and medical errors. As CBO discussed in its December 2008 *Key Issues in Analyzing Major Health Insurance Proposals*, an estimated 181,000 severe medical injuries attributable to negligence occurred in U.S. hospitals in 2003.[8] However, the correlation between errors and malpractice claims is weaker than might be supposed. An analysis using data from the state of New York, called the Harvard Medical Practice Study, showed that a majority of hospital patients who suffered injuries because of negligence never filed claims and that a substantial fraction of claims that were filed involved health problems that did not appear to be caused by negligence (as judged by a panel of medical professionals)—although patients who suffered injuries due to negligence were more likely to file claims and to receive higher compensation than patients who did not suffer injuries due to negligence.[9]

Your letter raised the concern that, if tort reform led to worse health outcomes, future health care spending could be higher. CBO's estimates of the likely effects of tort reform are based on research that links changes in malpractice costs to changes in health care spending, including not only the spending changes caused by providers' responses to changes in the medical liability environment but also the spending changes resulting from associated changes in health status. With all of those factors taken into account, the weight of evidence indicates that tort reform would reduce the utilization of health care services and, thereby, spending. Nevertheless, spending might increase for certain patients, providers, or procedures, while decreasing for others.[10] In addition, currently available research

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[8] See Congressional Budget Office, *Key Issues,* pp. 150–154.

[9] See Paul C. Weiler and others, *A Measure of Malpractice: Medical Injury, Malpractice Litigation and Patient Compensation* (Cambridge, Mass.: Harvard University Press, 1993). Similar patterns of results have been documented in subsequent studies, including David M. Studdert and others, "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," *Medical Care,* vol. 38, no. 3 (2000), pp. 250–260; and David M. Studdert and others, "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine,* vol. 354, no. 19 (2006), pp. 2024–2033.

[10] For example, Currie and MacLeod found that the rates at which Caesarean-section deliveries were performed increased when caps on noneconomic damages were implemented.

might not capture the effects that changes in health outcomes due to tort reform could have on health care spending over the long run; hopefully, future research can fill that gap.

I hope you find this information useful. If you have any further questions, please contact me or my staff. The primary staff contact is Stuart Hagen.

Sincerely,

Douglas W. Elmendorf
Director

cc: Honorable Orrin G. Hatch

Honorable Patrick J. Leahy
Chairman
Senate Committee on the Judiciary

Honorable Jeff Sessions
Ranking Member
Senate Committee on the Judiciary

Honorable John Conyers, Jr.
Chairman
House Committee on the Judiciary

Honorable Lamar Smith
Ranking Member
House Committee on the Judiciary

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

December 29, 2009

Honorable Bruce L. Braley
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

This letter responds to questions you posed about the Congressional Budget Office's (CBO's) recent analysis of the budgetary effects of proposals to limit costs related to medical malpractice ("tort reform"), as described in a letter to Senator Hatch.[1] In particular, this letter addresses your questions about factors that affect premiums for medical malpractice insurance, the effects of tort reform on patients' health, how recent empirical studies affected CBO's analysis, and why CBO's latest estimates of the budgetary effects of tort reform are larger than the agency's previous estimates.

In its letter to Senator Hatch, CBO concluded that tort reform would lower costs for health care both directly, by reducing medical malpractice costs—which consist of malpractice insurance premiums and settlements, awards, and legal and administrative costs not covered by insurance—and indirectly, by reducing the use of health care services through changes in the practice patterns of providers. The agency estimated that enacting a package of proposals outlined in that letter would reduce federal budget deficits by about $54 billion during the 2010–2019 period. Previously, the agency had found that tort reform would lower health care costs only by reducing medical malpractice costs, and it had estimated significantly smaller effects of tort reform on the federal budget. In the letter to Senator Hatch, CBO noted that imposing limits on suits for damages resulting from negligent health care might have a negative impact on health outcomes but concluded that the evidence is less clear about the effects of tort reform on health outcomes than it is about the effects on health care costs.

Tort Reform and Malpractice Premiums

When setting premiums for malpractice policies, insurers are likely to take into account a number of factors, including: recent payments for awards and settlements; the anticipated cost of future payments and the amount of uncertainty surrounding them (taking into account the legal environment in which the insurer

[1] Congressional Budget Office, letter to the Honorable Orrin G. Hatch regarding effects of proposals to limit costs related to medical malpractice (October 9, 2009).

operates); the extent of competition in the malpractice insurance market; the expected rate of return on invested premium income; and administrative expenses.[2] Because it often takes several years for a malpractice claim to be settled, a substantial period of time may elapse before insurers find out whether they correctly predicted future payments when setting the premium. If actual payments turn out to be greater than predicted, insurers may increase premiums to cover the shortfall; if actual payments are less than predicted, insurers may decrease premiums to remain competitive in the industry. That characteristic of the market for medical malpractice insurance, along with changes in interest rates, contributes to cyclical increases and decreases in premiums from year to year. The study by Rodwin, Chang, Ozaeta, and Omar that you cited in your letter noted that outcome, and pointed out that although medical malpractice premiums may vary substantially in the short run, over the long run premiums reflect liability costs.[3]

Reflecting that relationship, a number of recent research studies, as well as CBO's own analyses, have found that tort reform lowers medical malpractice premiums.[4] Studies by Thorpe and by Kilgore, Morrissey, and Nelson found that caps on noneconomic damages substantially reduced premiums, while a study by Danzon, Epstein, and Johnson found that both caps on noneconomic damages and changes to "joint and several liability" laws lowered premiums.[5] A study by Born, Viscusi, and Baker showed that tort reforms significantly lowered payments by insurers for awards and settlements and also lowered the gap between actual payments and those predicted by the insurer at the start of the claims process.[6] Both of those effects—lower overall payments and more certainty about future payments—are consistent with reductions in medical malpractice premiums associated with tort reform.

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[2] For a review of the literature, see Faith R. Neale and others, "Dynamics of the Market for Medical Malpractice Insurance," *Journal of Risk and Insurance*, vol. 76, no. 1 (2009), pp. 221–247.

[3] See Marc A. Rodwin, Hak J. Chang, Melissa M. Ozaeta, and Richard J. Omar, "Malpractice Premiums in Massachusetts, A High-Risk State: 1975 to 2005," *Health Affairs*, vol. 27, no. 1 (2008), pp. 835–844.

[4] See Congressional Budget Office, *Medical Malpractice Tort Limits and Health Care Spending* (April 2006).

[5] See Kenneth E. Thorpe, "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms," *Health Affairs*, vol. W4, pp. 20-30; Merideth Kilgore, Michael A. Morrisey, and Leonard J. Nelson, "Tort Law and Medical Malpractice Insurance Premiums," *Inquiry*, vol. 43, no. 3 (2006), pp. 255–270; and Patricia M. Danzon, Andrew J. Epstein, and Scott J. Johnson, "The Crisis in Medical Malpractice Insurance," in Robert E. Litan and Richard Herring, eds., *Brookings-Wharton Papers on Financial Services* (Washington, D.C.: Brookings Institution Press), pp. 55–95.

[6]See Patricia Born, W. Kip Viscusi, and Tom Baker, "The Effects of Tort Reform on Medical Malpractice Insurers' Ultimate Losses," *Journal of Risk and Insurance*, vol. 76, no. 1 (2009), pp. 197–219.

Analyses like those cited above are the best ones for identifying the effects of tort reform on malpractice insurance premiums because they use data for many states and control for the relevant characteristics of states' health care markets that may affect malpractice premiums. Studies that simply observe changes in premiums over time in states that do, and do not, adopt reforms are less suited to isolating the actual effects of tort reform. One reason is that the markets for medical malpractice insurance, physicans' services, and health care more broadly are likely to be different in states that choose to adopt tort reforms and states that do not. Additionally, states may experience other changes in their health care system at the same time tort reforms are implemented. Those analytical challenges are dealt with in the studies on which CBO has based its estimates.

The Effects of Tort Reform on Patients' Health

As you noted in your letter, the potential impact of tort reform on the quality of health care and on health outcomes is an important consideration for policymakers. CBO's letter to Senator Hatch observed that imposing limits on patients' suits involving harm from negligent health care might be expected to have a negative effect on health outcomes. The letter also noted that there is less evidence about the effects of tort reform on people's health than there is about its effects on health care spending, because many studies of malpractice costs have not examined health outcomes.

Among the analyses that have investigated health outcomes, a recent study by Lakdawalla and Seabury reported that lower malpractice costs were associated with an increase in mortality, while a study by Currie and MacLeod found positive impacts on health from reform of joint and several liability and negative impacts from caps on noneconomic damages.[7] Studies by Kessler and McClellan and by Sloan and Shadle found that state tort reforms had no significant effects on health.[8] Similarly, a study by Baicker, Fisher, and Chandra found that there was no significant association between mortality and malpractice costs.[9] Thus, the limited evidence currently available about the effects of tort reform on health outcomes is much more mixed than the larger collection of evidence currently available about the effects of tort reform on health care spending.

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[7] See Darius N. Lakdawalla and Seth A. Seabury, *The Welfare Effects of Medical Malpractice Liability*, Working Paper No. w15383 (Cambridge, Mass.: National Bureau of Economic Research, September 2009); and Janet Currie and W. Bentley MacLeod, "First Do No Harm? Tort Reform and Birth Outcomes," *Quarterly Journal of Economics*, vol. 123, no. 2 (2008), pp. 795–830.

[8] See Daniel Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics*, vol. 111, no. 2 (1996), pp. 354–380; Daniel Kessler and Mark McClellan, "Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care," *Journal of Public Economics*, vol. 84, no. 2 (2002), pp.175–195; and Frank A. Sloan and John H. Shadle, "Is There Empirical Evidence for "Defensive Medicine"? A Reassessment," *Journal of Health Economics*, vol. 28, no. 2 (2009), pp. 481–491.

[9] See Katherine Baicker, Elliot S. Fisher, and Amitabh Chandra, "Malpractice Liability Costs and the Practice of Medicine in the Medicare Program," *Health Affairs*, vol. 26, no. 3 (2007), pp. 841–852.

Those mixed results related to health outcomes may arise, in part, because of the complicated relationship between malpractice claims and medical errors. As CBO discussed in its December 2008 report *Key Issues in Analyzing Major Health Insurance Proposals*, an estimated 181,000 severe medical injuries attributable to negligence occurred in U.S. hospitals in 2003.[10] However, the correlation between errors and malpractice claims is weaker than might be supposed. An analysis using data from the state of New York, called the Harvard Medical Practice Study, showed that a majority of hospital patients who suffered injuries because of negligence never filed claims and that a substantial fraction of claims that were filed involved health problems that did not appear to be caused by negligence (as judged by a panel of medical professionals)—although patients who suffered injuries due to negligence were more likely to file claims and to receive higher compensation than patients who did not suffer injuries due to negligence.[11]

Recent Research on Tort Reform and Health Care Spending

CBO's latest assessment of the effects of tort reform on spending for health care draws on a considerable amount of analysis that the agency has undertaken during the past several years and a stream of recent research studies that have used a variety of data and empirical techniques.[12] Despite that analysis, estimates of the budgetary effects of tort reform are unavoidably uncertain, as is true for many other issues that CBO studies. In dealing with uncertainty, the agency consistently strives to produce estimates that lie in the middle of the distribution of plausible outcomes based upon available knowledge.

After a careful evaluation of the research relevant to tort reform, along with discussions with members of the agency's Panel of Health Advisers who have particular expertise in this topic, CBO concluded that the weight of empirical evidence now demonstrates a link between tort reform and the use of health care services. The estimates from CBO's own empirical analysis in 2006 implied that implementing the package of tort reforms described in the recent letter to Senator Hatch would reduce the use of health care services and, thereby, health care spending—a finding that was consistent with the results of some studies done by outside researchers.[13] However, the studies available at that time (including

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[10] See Congressional Budget Office, *Key Issues,* pp. 150–154.

[11] See Paul C. Weiler and others, *A Measure of Malpractice: Medical Injury, Malpractice Litigation and Patient Compensation* (Cambridge, Mass.: Harvard University Press, 1993). Similar patterns of results have been documented in subsequent studies, including David M. Studdert and others, "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," *Medical Care,* vol. 38, no. 3 (2000), pp. 250–260; and David M. Studdert and others, "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine*, vol. 354, no. 19 (2006), pp. 2024–2033.

[12] For CBO's earlier analyses, see *The Effects of Tort Reform: Evidence from the States* (June 2004) and *Medical Malpractice Tort Limits and Health Care Spending* (April 2006).

[13] See Kessler and McClellan, "Do Doctors Practice Defensive Medicine?" and "Malpractice Law and Health Care Reform."

CBO's) reported estimates that varied considerably in magnitude and contained some anomalous results, so CBO concluded that there was not sufficient evidence to incorporate in its budget estimates an effect of tort reform on health care utilization. More-recent studies have provided further support for the hypothesis that tort reform would slightly reduce the use of health care, and they have helped to resolve some apparent anomalies in earlier findings.[14]

For example, the study by Lakdawalla and Seabury and one by Avraham, Dafny, and Schanzenbach analyzed data that had not been used in previous research and used statistical methods that strengthened the evidence regarding the effects of tort reform on health care utilization and spending. Previous research had generally compared changes in health care spending over time in states that had and had not adopted tort reforms, controlling for other observable differences among states. Lakdawalla and Seabury used an approach that did not rely on comparisons of state tort reforms; they found that a reduction in medical malpractice costs was associated with a reduction in health care spending that exceeded what would arise solely from the direct effect of that reduction in malpractice costs. Avraham, Dafny, and Schanzenbach analyzed the impact of tort reform on health insurance premiums; they found that tort reform was associated with a reduction in premiums for self-insured plans that, again, exceeded what would arise from the direct effect of tort reform on malpractice costs.

In addition, the study by Baicker, Fisher, and Chandra found that use of diagnostic services, especially imaging, showed the largest changes in response to a change in malpractice costs. That result is consistent with a common view that ordering additional diagnostic services is a preferred strategy for reducing exposure to medical malpractice liability. That study reinforced the findings from other studies that tort reform would affect health care utilization by changing the practice patterns of providers. The study by Sloan and Shadle found mixed evidence of an effect of tort reform on health care spending. The authors estimated that certain types of tort reform had no effect on total spending by hospitals, while other types decreased it.

Previous research by CBO and others had found that replacing joint and several liability laws with a "fair share" rule appeared to increase health care spending—in contrast with other tort reforms, such as caps on noneconomic damages, which appeared to decrease spending. The study by Currie and MacLeod explained that a fair share rule is unusual among commonly discussed tort reforms because it increases the risk of financial liability perceived by most physicians. In CBO's

[14] See Ronen Avraham, Leemore S. Dafny, and Max M. Schanzenbach, *The Impact of Tort Reform on Employer-Sponsored Health Insurance Premiums*, Working Paper No. w15371 (Cambridge, Mass.: National Bureau of Economic Research, September 2009); Baicker, Fisher, and Chandra (2007); Currie and MacLeod (2008); Lakdawalla and Seabury (2009); and Sloan and Shadle (2009).

view, if physicians generally react to greater liability pressure by performing more procedures, then a fair share rule would be expected to increase overall health care utilization and spending.[15] That explanation helped to make sense of previously counterintuitive results and therefore gave CBO greater confidence in those earlier results.

CBO's Updated Estimates of the Budgetary Effects of Tort Reform
In CBO's December 2008 *Budget Options* volume, a common package of tort reform proposals was estimated to decrease spending by about $4 billion and to increase revenues by about $1 billion from 2010 to 2019.[16] In CBO's letter to Senator Hatch, those proposals were estimated to decrease spending by roughly $41 billion and increase revenues by roughly $13 billion over that same period. The latest estimates are substantially larger than the earlier ones for four principal reasons:

- They include a larger estimate of the effect of tort reform on medical malpractice costs;
- They incorporate the effect of a gradual reduction in the utilization of health care services resulting from changes in the practice patterns of providers;
- The estimated effect on federal revenues was substantially smaller in the previous estimate (which reflected only a reduction in malpractice costs) than the estimated effect on revenues in the current estimate (which reflects the combined effects of the reduction in malpractice costs and the change in spending attributable to changes in practice patterns); and
- The reduction in utilization is projected to generate a proportionately larger reduction in federal spending on health care than in other spending on health care.

Tort Reform Would Have a Greater Effect on Malpractice Costs. CBO periodically updates its estimates of the effect of tort reform on malpractice costs as new data on malpractice costs and state laws become available and the agency improves its techniques for modeling the effects of tort reform. CBO currently estimates that the nation's direct costs for medical malpractice—which consist of malpractice insurance premiums and settlements, awards, and legal and administrative costs not covered by insurance—would be reduced by about 10 percent (relative to the amounts under current law) if the common package of

[15] Seemingly contrary to that logic, Currie and MacLeod estimated that adopting a fair share rule decreased utilization. However, their analysis focused on a single procedure, births by Caesarean section.

[16] See Congressional Budget Office, *Budget Options, Volume 1: Health Care* (December 2008), pp. 21–22.

tort reforms was implemented nationwide. CBO's previous estimate was that tort reform would lower malpractice costs nationwide by about 6 percent.[17]

Tort Reform Would Also Affect the Utilization of Health Care Services. As described in CBO's letter to Senator Hatch and reiterated above, the agency's estimates of the effects of tort reform now incorporate a slight reduction in the utilization of health care attributable to changes in the practice patterns of providers. The combination of direct savings in malpractice costs and indirect savings in health care services would reduce national health spending in response to the proposed reforms by roughly 0.5 percent, CBO projects. The increase in CBO's estimate of the effects of tort reform on health care spending—arising from both the larger estimated change in malpractice costs and the incorporation of the change in utilization owing to changes in practice patterns—implies a significant increase in the estimated effects of tort reform on both federal tax revenues and federal outlays.

The Effect of Reduced Health Care Spending on Revenues Would Be Greater. On the revenue side, a reduction in spending on health care arising from tort reform would shift some compensation from employment-based health insurance (which is excluded from income and payroll taxes) to taxable wages and salaries, thereby increasing tax revenues. That reduction in spending on health care—and the resulting revenue impact—would be the combined effect of three consequences of tort reform: a reduction in malpractice costs; a reduction in the use of health care services; and an increase in the amount of health insurance purchased because of lower insurance prices brought about by the two other factors. In CBO's previous estimate, the second factor on that list was not included, and the induced increase in insurance purchases offset a considerable share of the decrease in spending attributable to lower malpractice costs; as a result, the estimated net reduction in spending was a good deal smaller than the 0.2 percent figure that represents CBO's current assessment of the effect of tort reform on health care spending because of the reduction in malpractice costs. In CBO's latest estimate, the reduction in spending owing to changes in providers' practice patterns significantly outweighs the induced increase in insurance purchases; as a result, the net reduction in health care spending incorporating all three factors listed above is 0.5 percent. Thus, the estimated increase in federal tax revenues from tort reform has risen by more than the ratio of 0.5 to 0.2.

Changes in Utilization Would Have a Proportionately Greater Effect on Federal Spending. On the outlay side, the reduction in the utilization of health care services due to changes in practice patterns would have a proportionately larger effect on federal spending for health care than it would have on other spending for health care. The most important reason for the difference is that, according to empirical evidence, utilization of care in Medicare would be reduced

[17] See Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, pp. 150–154.

more than would utilization of care as a whole. The greater impact in Medicare can probably be explained by two factors. First, the bulk of Medicare services are provided on a fee-for-service basis, whereas most private health care spending occurs through plans that manage the utilization of care to some degree. Such plans may limit the use of services that have marginal benefit to patients to a greater degree than does Medicare, leaving less room for changes in pressures regarding malpractice to affect utilization. Second, when compared with the use of private health care services, the use of services in Medicare is less likely to be influenced by the effects of changes in malpractice costs on the premiums and cost sharing faced by patients.

I hope you find this information useful. If you have any further questions, please contact me or my staff. The primary staff contact is Stuart Hagen.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

cc: Honorable Orrin G. Hatch

Honorable John Conyers, Jr.
Chairman
House Committee on the Judiciary

Honorable Lamar Smith
Ranking Member
House Committee on the Judiciary

Honorable Patrick J. Leahy
Chairman
Senate Committee on the Judiciary

Honorable Jeff Sessions
Ranking Member
Senate Committee on the Judiciary

Other Issues

CBO analyzed a variety of other issues related to health care legislation—in some cases, analyzing the opportunities and challenges that are involved in designing large-scale proposals to change the health care and health insurance systems, and in other cases, addressing specific questions that arose during the Congressional debate. The publications included in this volume are the following:

1. CBO testimony that was presented before the Senate Budget Committee on February 10, 2009, about the issues that arise in trying to expand health insurance coverage and control costs for health care.

2. A letter to Senate Budget Committee Chairman Kent Conrad and Ranking Member Judd Gregg on June 16, 2009, discussing the pressures that spending for health care are placing on the federal budget and the key issues that arise in trying to address those pressures.

3. An issue brief discussing the effects that changes to the health insurance system might have on labor markets—including the effects of new penalties and subsidies for employment-based insurance as well as changes in the tax treatment of that coverage—which was released on July 13, 2009. (CBO's analysis of the likely impact of the enacted legislation on labor markets was included in its August 2010 report *The Budget and Economic Outlook: An Update;* see Box 2-1.)

4. A letter to Representative Nathan Deal, dated August 7, 2009, discussing the effects of proposals to expand governmental support for preventive medical care and wellness programs and the challenges involved in reducing federal spending on health care as a result.

5. A letter to Representative George Miller, Chairman of the House Education and Labor Committee, dated November 25, 2009, regarding the budgetary effects of proposals to establish a Community Living Assistance Services and Supports (CLASS) program; under that program, which was included in PPACA, the federal government will offer insurance for long-term care services that is designed to be financed by enrollees' premiums. (An identical letter was sent to Senator Tom Harkin, Chairman of the Senate Health, Education, Labor, and Pensions Committee.)

Congressional Budget Office

Testimony

Statement of
Douglas W. Elmendorf
Director

Expanding Health Insurance Coverage and Controlling Costs for Health Care

before the
Committee on the Budget
United States Senate

February 10, 2009

This document is embargoed until it is delivered at 10:00 a.m. (EST) on Tuesday, February 10, 2009. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Chairman Conrad, Senator Gregg, and Members of the Committee, thank you for inviting me to testify this morning about the opportunities and challenges that the Congress faces in pursuing two major policy goals: (1) expanding health insurance coverage, so that more Americans receive appropriate health care without undue financial burden, and (2) making the health care system more efficient, so that it can continue to improve Americans' health but at a lower cost in both the public and private sectors. Both are complex endeavors in their own right, and interactions and trade-offs between them may arise.

First, with respect to expanding health insurance coverage, my testimony makes the following key points:

- Without changes in policy, a substantial and growing number of people under age 65 will lack health insurance. The Congressional Budget Office (CBO) estimates that the average number of nonelderly people who are uninsured will rise from at least 45 million in 2009 to about 54 million in 2019. That projection is consistent with long-standing trends in coverage and largely reflects the expectation that health care costs and health insurance premiums will continue to rise faster than people's income—making health insurance more difficult to afford.

- Proposals could achieve near-universal health insurance coverage by combining three key features:

  - Mechanisms for pooling risks—both to ensure that people who develop health problems can find affordable coverage and to keep people from waiting until they are sick to sign up for insurance. Options include strengthening the current employment-based system, modifying the market for individually purchased insurance, and establishing a new mechanism such as an insurance exchange.

  - Subsidies to make health insurance less expensive for individuals and families, particularly those with lower income who are most likely to be uninsured today. For reasons of equity and administrative feasibility, however, it is difficult for subsidy systems to avoid "buying out the base"—that is, providing new subsidies to people who already have insurance or would have purchased it anyway.

  - Either an enforceable mandate for individuals to obtain insurance or an effective process to facilitate enrollment in a health plan. An enforceable mandate would generally have a greater effect on coverage rates, but without meaningful subsidies, it could impose a substantial burden on many people—given the cost of health insurance relative to the financial means of most uninsured individuals.

- Certain trade-offs arise in choosing how to design subsidies and mandates. To achieve near-universal coverage through subsidies alone would require that they cover a very large share of the premiums—which is an expensive proposition. But policymakers may also be reluctant to establish the penalties and enforcement mechanisms necessary to make a mandate effective. Other policies that adopted more limited versions of those three features could reduce the number of uninsured people to a lesser extent at a lower budgetary cost.

Second, with respect to controlling costs and improving efficiency—so that we get the best health for the amount we spend as a nation—some key considerations are these:

- Spending on health care has generally grown much faster than the economy as a whole, and that trend has continued for decades. In part, that growth reflects the improving capabilities of medical care—which can confer tremendous benefits by extending and improving lives. Studies attribute the bulk of cost growth to the development of new treatments and other medical technologies, but features of the health care and health insurance systems can influence how rapidly and widely new treatments are adopted.

- The high and rising costs of health care impose an increasing burden on the federal government as well as state governments and the private sector. Under current policies, CBO projects, federal spending on Medicare and Medicaid will increase from about 5 percent of gross domestic product (GDP) in 2009 to more than 6 percent in 2019 and about 12 percent by 2050. Most of that increase will result from growth in per capita costs rather than from the aging of the population. In the private sector, the growth of health care costs has contributed to slow growth in wages because workers must give up other forms of compensation to offset the rising costs of employment-based insurance.

- The available evidence also suggests that a substantial share of spending on health care contributes little if anything to the overall health of the nation, but finding ways to reduce such spending without also affecting services that improve health will be difficult. In many cases, the current system does not create incentives for doctors, hospitals, and other providers of health care—or their patients—to control costs. Significantly reducing the level or slowing the growth of health care spending below current projections would require substantial changes in incentives. Given the central role of medical technology in cost growth, reducing or slowing spending over the long term would probably require decreasing the pace of adopting new treatments and procedures or limiting the breadth of their application.

Third, controlling costs and improving efficiency present many challenges, but there are a number of approaches about which many analysts would probably concur:

- Many analysts would agree that payment systems should move away from a fee-for-service design and should instead provide stronger incentives to control costs, reward value, or both. A number of alternative approaches could be considered—including fixed payments per patient, bonuses based on performance, or penalties for substandard care—but their precise effects are uncertain. Policymakers may thus want to test various options (for example, using demonstration programs in Medicare) to see whether they work as intended or to determine which design features work best. Almost inevitably, though, reducing the amount that is spent on health care will involve some cutbacks or constraints on the number and types of services provided relative to currently projected levels.

- Many analysts would agree that the current tax exclusion for employment-based health insurance—which exempts most payments for such insurance from both income and payroll taxes—dampens incentives for cost control because it is open-ended. Those incentives could be changed by replacing the tax exclusion or restructuring it in ways that would encourage workers to join health plans with higher cost-sharing requirements and tighter management of benefits. (Given stronger incentives, the competition among health plans for enrollees could then determine the optimal mix of payment systems for providers.)

- Many analysts would agree that more information is needed about which treatments work best for which patients and about what quality of care different doctors, hospitals, and other providers deliver. The broad benefits that such information provides suggest a role for the government in funding research on the comparative effectiveness of treatments, in generating measures of quality, and in disseminating the results to doctors and patients. But absent stronger incentives to control costs and improve efficiency, the effect of information alone on spending will generally be limited.

- Many analysts would agree that controlling federal costs over the long term will be very difficult without addressing the underlying forces that are also causing private costs for health care to rise. Private insurers generally have more flexibility than Medicare's administrators to adapt to changing circumstances—a situation that policymakers may want to remedy—but changes made in the Medicare program can also stimulate broader improvements in the health sector.

Fourth, many of the steps that analysts would recommend might not yield substantial budgetary savings or reductions in national spending on health care within a 10-year window—and others might increase federal costs or total spending—for several reasons:

- In some cases, savings may materialize slowly because an initiative is phased in. For example, Medicare could save money by reducing payments to hospitals that have a high rate of avoidable readmissions (for complications following a discharge) but would have to gather information about readmission rates and notify hospitals before such reductions could be implemented. More generally, the process of converting innovative ideas into successful programmatic changes could take several years. Of course, for proposals that would increase the budget deficit, phase-in schedules reduce the amount of the increase that is captured in a 10-year budget window.

- Even if they generate some offsetting savings, initiatives are not costless to implement. For example, expanding the use of disease management services can improve health and may well be cost-effective—that is, the value of the benefits could exceed the costs. But those efforts may still fail to generate net reductions in spending on health care because the number of people receiving the services is generally much larger than the number who would avoid expensive treatments as a result. In other cases, most of the initial costs would be incurred in the first 10 years, but little of the savings would accrue in that period.

- Moreover, the effect on the federal budget of a policy proposal to encourage certain activities often differs from the impact of those activities on total spending for health care. For example, a preventive service could be cost-reducing overall, but if the government began providing that service for free, federal costs would probably increase—largely because many of the payments would cover costs for care that would have been received anyway.

- In some cases, additional steps beyond a proposal are needed for the federal government to capture savings generated by an initiative. For example, requiring that hospitals adopt electronic health records would reduce their costs for treating Medicare patients, but the program's payment rates would have to be reduced in order for the federal government to capture much of those savings.

- Savings from some initiatives may not materialize because incentives to reduce costs are lacking. For example, proposals to establish a "medical home" might have little impact on spending if the primary care physicians who would coordinate care were not given financial incentives to economize on their patients' use of services. Those proposals could increase costs if they simply raised payments to those primary care physicians.

- In some cases, estimating the budgetary effects of a proposal is hampered by limited evidence. Studies generally examine the effects of discrete policy changes but typically do not address what would happen if several changes were made at the same time. Those interaction effects could mean that the savings from combining two or more initiatives will be greater than or less than the sum of their individual effects.

Finally, I offer some observations on the issues that arise when trying to expand coverage and reduce costs at the same time:

- By themselves, steps to substantially expand coverage would probably increase total spending on health care and would generally raise federal costs. Those federal costs would be determined primarily by the number of people receiving subsidies of their premiums and the average amount of the subsidy. Steps that reduced the costs of the health insurance policies would limit the federal costs of providing premium subsidies but could not eliminate those costs.

- An expansion of coverage could be financed in a number of ways. One option is to limit or eliminate the current tax exclusion for employment-based health insurance. The savings from taking such steps would grow steadily because the revenue losses that stem from that exclusion are rising at the same rate as health care costs. The same can generally be said about using reductions in Medicare or Medicaid spending to offset the costs of expanding insurance coverage. Those methods of financing could adversely affect some people's current coverage, however, and other financing options that would either raise revenues or reduce other spending are also available.

On a broad level, many analysts agree about the direction in which policies would have to go in order to make the health care system more cost-effective: Patients and providers both need stronger incentives to control costs as well as more information about the quality and value of the care that is provided. But much less of a consensus exists about crucial details regarding how those changes are made—and similar disagreements arise about how to expand insurance coverage. In part, those disagreements reflect different values or different assessments of the existing evidence, but often they reflect a lack of evidence about the likely impact of making significant changes to the complex system of health insurance and health care.

CBO's Recent Volumes on Health Care

Concerns about the number of people who are uninsured and about the rising costs of health insurance and health care have given rise to proposals that would substantially modify the U.S. health insurance system and that seek to reduce federal or total spending for health care. The complexities of the health insurance and health care systems pose a major challenge for the design of such proposals and inevitably raise

questions about their likely impact. To assist the Congress in its upcoming deliberations, CBO has produced two major reports that address such proposals.

The December 2008 report titled *Key Issues in Analyzing Major Health Insurance Proposals* describes the assumptions that CBO would use in estimating the effects of various elements of such proposals on federal costs, insurance coverage, and other outcomes. It also reviews the evidence upon which those assumptions are based and, if the evidence points to a range of possible effects rather than a precise prediction, the factors that would influence where a proposal falls within the range. The report does not provide a comprehensive analysis of any specific proposal; rather, it identifies and examines many of the critical factors that would affect estimates of a variety of proposals. In particular, it considers the types of issues that would arise in estimating the effects of proposals to:

- Provide tax credits or other types of subsidies to make insurance less expensive to the purchaser;
- Require individuals to purchase health insurance, typically paired with a new system of government subsidies;
- Require firms to offer health insurance to their workers or pay into a fund that subsidizes insurance purchases;
- Replace employment-based coverage with new purchasing arrangements or provide strong incentives for people to shift toward individually purchased coverage; or
- Provide individuals with coverage under, or access to, existing insurance plans such as the Medicare program, either as an additional option or under a "Medicare-for-all" single-payer arrangement.

Wherever possible, the analysis describes in quantitative terms how CBO would estimate the budgetary and other effects of such proposals. In other cases, it describes the components that a proposal would have to specify in order to permit estimation of those effects. The report reflects the current state of CBO's analysis of and judgments about the likely response of individuals, employers, insurers, and providers to changes in the health insurance and health care systems. Certainly, the details of particular policies and the way in which they are combined, as well as new evidence or analysis related to the issues discussed here, could affect CBO's estimates of the effects of large-scale health insurance proposals.

The December 2008 report titled *Budget Options, Volume 1: Health Care,* comprises 115 discrete options to alter federal programs, affect the private health insurance market, or both. It includes many options that would reduce the federal budget deficit and some that would increase it. Although similar to CBO's previous reports on budget options, this volume reflects an extensive and concerted effort to substantially

expand the range of topics and types of proposals considered and includes estimates of many approaches that the agency had not previously analyzed. (Volume 2, containing budget options that are not related to health care, is forthcoming.) The report is organized thematically, rather than by program, and covers the following areas:

- The private health insurance market and the tax treatment of health insurance;
- Changing the availability of health insurance through existing federal programs;
- The quality and efficiency of health care and geographic variation in spending for Medicare;
- Paying for services in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP);
- Premiums and cost sharing in federal health programs;
- Long-term care;
- Health behavior and health promotion; and
- Closing the gap between Medicare's spending and receipts.

The options that were included stem from a variety of sources, including extensive discussions with Congressional staff; reviews of legislative proposals, the President's budget, and academic literature; and analyses conducted by CBO staff, other government agencies, and private groups. Although the number of health-related policy options is significantly greater than in previous *Budget Options* volumes, it is not an exhaustive list. CBO's estimates are sensitive to the precise specifications of each option and could change in the future for a variety of reasons, including changes in economic conditions or other factors that affect projections of baseline spending or the availability of new evidence about an option's likely effects. It should also be noted that the options' effects may not be additive; that is, there could be important interaction effects among options that make their cumulative impact larger or smaller than the sum of the estimates. Some of the options that are particularly complex may be candidates for demonstration projects or pilot programs, which could help resolve the uncertainty about their effects.[1]

The remainder of my testimony largely summarizes the conclusions reached in the *Key Issues* volume. Those conclusions—and the background information and evidence

1. Estimates of the impact on revenues of proposals to change the federal tax code are prepared by the staff of the Joint Committee on Taxation (JCT) and would be incorporated into any formal CBO estimate of a proposal's effects on the federal budget. For its recent reports on health care, CBO consulted with JCT about the behavioral considerations that are incorporated into both agencies' estimates, and JCT prepared the revenue estimates for several of the options.

on which they are based—are also relevant to much of CBO's analysis for the *Budget Options* volume. Although summarizing all 115 options would not be feasible here, my testimony highlights some of the agency's main findings.

Background on Spending and Coverage

Spending on health care and related activities will account for about 18 percent of GDP in 2009—an expected total of $2.6 trillion—and under current law that share is projected to reach 20 percent by 2017. Annual health expenditures per capita are projected to rise from about $8,300 to about $13,000 over that period. Federal spending accounts for about one-third of those totals, and federal outlays for the Medicare and Medicaid programs are projected to grow from about $720 billion in 2009 to about $1.4 trillion in 2019. Over the longer term, rising costs for health care represent the single greatest challenge to balancing the federal budget. (For additional discussion, see the November 2007 CBO report *The Long-Term Outlook for Health Care Spending*.)

The number of people who are uninsured is also expected to increase because health insurance premiums are likely to continue rising much faster than income, which will make insurance more difficult to afford. As noted above, CBO estimates that the average number of nonelderly people who are uninsured will rise from at least 45 million in 2009 to about 54 million in 2019. The estimate for 2009 does not reflect the recent deterioration in economic conditions, which could result in a larger uninsured population, nor does it take into account recently enacted legislation.

Employment-Based Insurance

For several reasons, most nonelderly individuals obtain their insurance through an employer, and employment-based plans now cover about 160 million people, including spouses and dependents. One fundamental reason such plans are popular is that they are subsidized through the tax code—because nearly all payments for employment-based insurance are excluded from taxable compensation and thus are not subject to income and payroll taxes. Another factor is the economies of scale that larger group purchasers enjoy, which reduce the average amount of administrative costs that are embedded in premiums; partly as a result, large employers are more likely than small employers to offer insurance to their workers. Overall, about three-fourths of workers are offered employment-based insurance and are eligible to enroll in it.

Another commonly cited reason for the popularity of employment-based policies is that employers offering coverage usually pay most of the premium—a step they take partly to encourage broad enrollment in those plans, which helps keep average costs stable. Ultimately, however, the costs of those employers' payments are passed on to employees as a group, mainly in the form of lower wages.

Other Sources of Coverage

Other significant sources of coverage for nonelderly people include the individual insurance market and various public programs. Roughly 10 million people are covered by individually purchased plans, which have some advantages for enrollees; for example, they may be portable from job to job, unlike employment-based insurance. Even so, individually purchased policies generally do not receive favorable tax treatment. In most states, premiums may vary to reflect an applicant's age or health status, and applicants with particularly high expected costs are generally denied coverage.

Another major source of coverage is the federal/state Medicaid program and the related but smaller CHIP. Both programs provide free or low-priced coverage for children in low-income families and (to a more limited degree) their parents; Medicaid also covers poor individuals who are blind or disabled. On average, Medicaid and CHIP are expected to cover about 43 million nonelderly people in 2009 (and there are also many people eligible for those programs who have not enrolled in them).[2] Medicare also covers about 7 million people younger than 65 who are disabled or have severe kidney disease.

About 12 million people have insurance coverage from various other sources, including federal health programs for military personnel. The total number of nonelderly people with health insurance at any given point in 2009 is expected to be about 216 million.

Approaches for Reducing the Number of Uninsured People

Concerns about the large number of people who lack health insurance have generated proposals that seek to increase coverage rates substantially or achieve universal or near-universal coverage. Two basic approaches could be used:

- Subsidizing health insurance premiums, either through the tax system or spending programs, which would make insurance less expensive for people who are eligible, or
- Establishing a mandate for health insurance, either by requiring individuals to obtain coverage or by requiring employers to offer health insurance to their workers.

By themselves, premium subsidies or mandates to obtain health insurance would not achieve universal coverage. Those approaches could be combined and could be implemented along with provisions to facilitate enrollment in ways that could achieve near-universal coverage. (Many of the issues and trade-offs that arise in designing such

2. That figure represents average enrollment (rather than the number of people enrolled at any time during the year) and excludes nonelderly individuals living in institutions (such as nursing homes), people living in U.S. territories, and people receiving only limited benefits under Medicaid (such as family planning services).

initiatives are also illustrated by the more incremental options to expand insurance coverage that are examined in the *Budget Options* volume.)

Subsidizing Premiums

Whether new subsidies are delivered through the tax system or a spending program, several common issues arise. Trade-offs exist between the share of the premiums that is subsidized, the number of people who enroll in insurance as a result of the subsidies, and the total costs of the subsidies. As the subsidy rate increases, more people will be inclined to take advantage of them, but the higher subsidy payments will also benefit those who would have decided to obtain insurance anyway. Beyond a certain point, therefore, the cost per newly insured person can grow sharply because a large share of the additional subsidy payments is going to otherwise insured individuals.

To hold down the costs of subsidies, the government could limit eligibility for subsidy payments to individuals who are currently uninsured. That restriction, however, would create incentives for insured individuals to drop their coverage. Some proposals might try to distinguish between people who become uninsured in response to subsidies and those who would have been uninsured in the absence of a government program (for example, by imposing waiting periods for individuals who were previously enrolled in an employment-based plan), but such proposals could be very difficult to administer. In addition, providing benefits only to the uninsured might be viewed as unfair by people with similar income and family responsibilities who purchased health insurance and would therefore be ineligible for the subsidies.

Another approach to limiting costs would target subsidies toward the lower-income groups, who are most likely to be uninsured otherwise, but such approaches can also have unintended consequences that affect the costs of a proposal. If eligibility was limited to people with income below a certain level, then those with income just above the threshold would have strong incentives to work less or hide income in order to qualify for the subsidies or maintain their eligibility. Phasing out subsidies gradually as income rises would reduce those incentives, but it would increase the amount of subsidy payments that go to individuals and families who would have had insurance in any event.

Restructuring the Existing Tax Subsidies. Tax subsidies could be restructured to expand coverage in several ways. For example, the current tax exclusion for employment-based health insurance could be replaced with a deduction or tax credit to offset the costs of insurance, and tax subsidies could be extended to include policies purchased in the individual insurance market. That step would sever the link between employment and tax subsidies for private health insurance and could give similar people the same subsidy whether or not they were offered an employment-based health plan.

Deductions and credits differ, however, in their effectiveness at reaching the uninsured. An income tax deduction might provide limited benefits to low-income

individuals because, like the existing exclusion, its value is less for those in lower tax brackets. In contrast, tax credits can be designed to provide lower- and moderate-income taxpayers with larger benefits than they would receive from tax deductions or exclusions. An important question regarding tax credits—particularly for lower-income people who pay relatively little in income taxes and are also more likely to be uninsured—is whether the credits would be refundable and therefore fully available to individuals with little or no income tax liability.

For the same budgetary costs, a refundable tax credit might be more effective at increasing insurance coverage, both because it can be designed to provide a larger benefit to low-income people than they receive under current law and because those recipients might be more responsive to a given subsidy than are people with higher income. Still, the effect on coverage rates might be limited if people do not receive refundable tax credits before their premium payments are due.

Providing Subsidies Through Spending Programs. The government could seek to increase coverage rates by spending funds to subsidize insurance premiums. New subsidies could be provided implicitly by expanding eligibility for Medicare, Medicaid, or CHIP or explicitly by creating a new program. To hold costs down, benefits could be targeted on the basis of income, assets, family responsibilities, and insurance status. Targeting benefits, however, would require program administrators to certify eligibility and enforce the program's rules, which would affect coverage and the program's costs.

The Effects of Subsidy Proposals. Proposals to subsidize insurance coverage would affect decisions by both employers and individuals. Employers' decisions to offer insurance to their workers reflect the preferences of their workers, the cost of the insurance that they can provide, and the costs of alternative sources of coverage that workers would have. Smaller firms appear to be more sensitive to changes in the cost of insurance than are larger employers. Subsidies that reduce the cost of insurance offered outside the workplace would cause some firms to drop coverage or reduce their contributions. When deciding whether to enroll in employment-based plans, workers would consider the share of the premium that they pay as well as the price and attractiveness of alternatives. The available evidence indicates that a small share of the population would be reluctant to purchase insurance even if subsidies covered nearly all of the costs.

Related Budget Options. Several of the alternatives included in CBO's *Budget Options* volume highlight the potential effects of changing the tax treatment of health insurance. For example, Option 10 would replace the current exclusion from income taxes for employment-based health insurance with a tax deduction that phases out at higher income levels. That option would increase federal revenues by approximately $550 billion through 2018 (as estimated by the staff of the Joint Committee on Taxation). Because that option would increase the effective price of health insurance for higher-income taxpayers, it would, by CBO's estimation, increase the number of

uninsured people by about 1.5 million in 2014 (in part because some employers would decide to stop offering coverage). Those estimates are sensitive to the parameters of the deduction and particularly to the range of income over which the deduction is phased out.

Other examples illustrate the effects on federal costs and coverage that stem from targeting different populations. Allowing low-income young adults to enroll in Medicaid, as described in Option 23, would cover about 1.1 million people in 2014, at a federal cost of about $22 billion over the 2010–2019 period, according to CBO's estimates. Allowing low-income parents with children eligible for Medicaid to enroll in the program, as described in Option 24, would cost about $38 billion over the same period and would expand coverage to about 1.4 million parents and 700,000 children in 2014.

Another approach is illustrated by Option 7, which would create a voucher program to subsidize the purchase of health insurance for households with income below 250 percent of the federal poverty level. Specifically, individuals would receive up to $1,500, and families would receive up to $3,000. According to CBO's estimates, that approach would reduce the net number of uninsured people by about 2.2 million in 2014. Overall, approximately 4 million people would use the voucher, but about 1.7 million of those people would have had coverage in the individual health insurance market or through an employer. In addition, about 100,000 people would become newly uninsured as a result of small employers' electing not to offer coverage because of the new voucher program. The total cost to the federal government of such a voucher program would be about $65 billion over the next decade.

Mandating Coverage

In an effort to increase the number of people who have health insurance or to achieve universal or near-universal coverage, the government could require individuals to obtain health insurance or employers to offer insurance plans. Employer mandates could include a requirement that employers contribute a certain percentage of the premium, which would encourage their workers to purchase coverage. To the extent that the required contributions exceeded the amounts that employers would have paid under current law, offsetting reductions would ultimately be made in wages and other forms of compensation.

The impact of a mandate on the number of people covered by insurance would depend on its scope, the extent of enforcement, and the incentives to comply, as well as the benefits that enrollees received. Individual mandates, for example, could be applied broadly to the entire population of the United States or to a specific group, such as children; employer mandates might vary by the size of the firm. (Option 3 in the *Budget Options* volume is a specific requirement for large employers to offer coverage or pay a fee. Under the provisions of that option, the number of newly insured individuals would be relatively small, only about 300,000.)

Penalties would generally increase individuals' incentives to comply with mandates, but when deciding whether to obtain insurance, people would also consider the likelihood of being caught if they did not comply. Data from the tax system and from other government programs, where overall rates of compliance range from roughly 60 percent to 90 percent, indicate that mandates alone would not achieve universal coverage, largely because some people would still be unwilling or unable to purchase insurance.

Facilitating Enrollment

Simplifying the process of enrolling in health insurance plans or applying for subsidies could yield higher coverage rates and could also increase compliance with a mandate to obtain coverage. One approach would be to enroll eligible individuals in health insurance plans automatically, giving them the option to refuse that coverage or to switch to a different plan. Automatic enrollment has been found to increase participation rates in retirement plans and government benefit programs. It requires the government, an employer, or some other entity to determine the specific plan into which people will be enrolled, however, and those choices may not always be appropriate for everyone.

Factors Affecting Insurance Premiums

Premiums for employment-based plans are expected to average about $5,000 per year for single coverage and about $13,000 per year for family coverage in 2009. Premiums for policies purchased in the individual insurance market are, on average, much lower—about one-third lower for single coverage and one-half lower for family policies. Those differences largely reflect the fact that policies purchased in the individual market generally cover a smaller share of enrollees' health care costs, which also encourages enrollees to use fewer services. An offsetting factor is that average administrative costs are much higher for individually purchased policies. The remainder of the difference in premiums probably arises because people who purchase individual coverage have lower expected costs for health care to begin with.

The federal costs of providing premium subsidies, and the effects of those subsidies on the number of people who are insured, would depend heavily on the premiums charged. Premiums reflect the average cost that any insurer—public or private—incurs, and those costs are a function of several factors:

- The scope of benefits the coverage includes and its cost-sharing requirements,
- The degree of benefit management that is conducted,
- The administrative costs the insurer incurs, and
- The health status of the individuals who enroll.

Insurers' costs also depend on the mechanisms and rates used to pay providers and on other forces affecting the supply of health care services. Proposals could affect many of those factors directly or indirectly. For example, the government might specify a minimum level of benefits that the coverage must provide in order to qualify for a subsidy or fulfill a mandate; such a requirement could have substantial effects on the proposal's costs or its impact on coverage rates.

Design of Benefits, Cost Sharing, and Related Budget Options

Health insurance plans purchased in the private market tend to vary only modestly in the scope of their benefits—with virtually all plans covering hospital care, physicians' services, and prescription drugs—but they vary more substantially in their cost-sharing requirements. A useful summary statistic for comparing plans with different designs is their "actuarial value," which essentially measures the share of health care spending for a given population that each plan would cover. Actuarial values for employment-based plans typically range between 65 percent and 95 percent, with an average value between 80 percent and 85 percent. Cost-sharing requirements for enrollees tend to be greater for policies purchased in the individual insurance market, where actuarial values generally range from 40 percent to 80 percent, with an average value between 55 percent and 60 percent.

Public programs also vary in the extent of the coverage they provide. Medicaid requires only limited cost sharing (reflecting the low income of its enrollees); cost sharing under CHIP may be higher but is capped as a share of family income. Medicare's cost sharing varies substantially by the type of service provided; for example, home health care is free to enrollees, but most hospital admissions incur a deductible of about $1,000. In addition, the program does not cap the out-of-pocket costs that enrollees can incur. Overall, the actuarial value of Medicare's benefits for the nonelderly population is about 15 percent lower than that of a typical employment-based plan. Those considerations would affect CBO's analysis of proposals to expand enrollment in public programs.

In general, the more comprehensive the coverage provided by a health plan, the higher the premium or cost per enrollee. Indeed, an increase in a health plan's actuarial value would also lead enrollees to use more health care services. Reflecting the available evidence, CBO estimates that a 10 percent decrease in the out-of-pocket costs that enrollees have to pay would generally cause their use of health care to increase by about 1 percent to 2 percent. The agency would apply a similar analysis to proposals that included subsidies to reduce the cost-sharing requirements that lower-income enrollees face.

Several budget options examine the effects of changing cost-sharing requirements in the Medicare program. Option 81 would replace the program's current requirements with a unified deductible, a uniform coinsurance rate, and a limit on out-of-pocket costs. That option would reduce federal spending by about $26 billion over 10 years—mostly because of the increase in cost sharing for some services and the resulting

reduction in their use. Option 83 would combine those changes in the Medicare program with limits on the extent to which enrollees could purchase supplemental insurance policies (known as medigap plans) that typically cover all of Medicare's cost-sharing requirements. That option would reduce federal spending by about $73 billion over 10 years—with the added savings emerging because enrollees would be more prudent in their use of care once their medigap plans did not cover all of their cost-sharing requirements. Options 84, 85, and 86 would reduce federal outlays by imposing cost sharing for certain Medicare services that are now free to enrollees, and Option 89 would increase federal outlays by eliminating the gap in coverage (commonly called the doughnut hole) in the design of Medicare's drug benefit. Options 95 through 98 would reduce federal spending by introducing or increasing cost-sharing requirements for health care benefits provided to veterans, military retirees and their dependents, and dependents of active-duty personnel.

Management of Benefits

Another factor affecting health insurance premiums and thus the costs or effects of legislative proposals is the degree of benefit and cost management that insurers apply. Nearly all Americans with private health insurance are enrolled in some type of "managed care" plan, but the extent to which specific management techniques are used varies widely. Common techniques to constrain costs include negotiating lower fees with a network of providers, requiring that certain services be authorized in advance, monitoring the care of hospitalized patients, and varying cost-sharing requirements to encourage the use of less expensive prescription drugs. Overall, CBO estimates, premiums for plans that made extensive use of such management techniques would be 5 percent to 10 percent lower than for plans using minimal management. Conversely, proposals that restricted plans' use of those tools would result in higher health care spending than proposals that did not impose such restrictions.

Administrative Costs

Some proposals would affect the price of health insurance by changing insurers' administrative costs. Some types of administrative costs (such as those for customer service and claims processing) vary in proportion to the number of enrollees in a health plan, but others (such as those for sales and marketing efforts) are more fixed; that is, those costs are similar whether a policy covers 100 enrollees or 100,000. As a result of those economies of scale, the average share of the policy premium that covers administrative costs varies considerably—from about 7 percent for employment-based plans with 1,000 or more enrollees to nearly 30 percent for policies purchased by very small firms (those with fewer than 25 employees) and by individuals.

Some administrative costs would be incurred under any system of health insurance, but proposals that shifted enrollment away from the small-group and individual markets could avoid at least a portion of the added administrative costs per enrollee that are observed in those markets. In general, however, substantial reductions in administrative costs would probably require the role of insurance agents and brokers

in marketing and selling policies to be sharply curtailed and the services they provide to be rendered unnecessary.

Spending by Previously Uninsured People

The impact that the mix of enrollees has on health insurance premiums is also an important consideration, particularly for proposals that would reduce the number of people who are uninsured. The reason is that the use of health care by the previously uninsured will generally increase when they gain coverage. On average, the uninsured currently use about 60 percent as much care as the insured population, CBO estimates, after adjusting for differences in demographic characteristics and health status between the two groups.

On the basis of the research literature and an analysis of survey data, CBO estimates that enrolling all people who are currently uninsured in a typical employment-based plan would increase their use of services by 25 percent to 60 percent; that is, they would use between 75 percent and 95 percent as many services as a similar group of insured people. The remaining gap in the use of services reflects the expectation that, on average, people who are uninsured have a lower propensity to use health care, a tendency that would persist even after they gained coverage. For more incremental increases in coverage rates, CBO would expect that people who chose to enroll in a new program would be more likely to use medical care than those who decided not to enroll.

In addition, recent estimates indicate that about a third of the care that the uninsured receive is either uncompensated or undercompensated—that is, they either pay nothing for it or pay less than the amount that a provider would receive for treating an insured patient. To the extent that such care became compensated under a proposal to expand coverage, health care spending for the uninsured would increase, regardless of whether their use of care also rose.

Proposals Affecting the Choice of an Insurance Plan

The government could affect the options available to individuals when choosing a health insurance plan—and the incentives they face when making that choice—in a number of ways. In particular, proposals could establish or alter regulations governing insurance markets, seek to reveal more fully the relative costs of different health insurance plans, or have the federal government offer new health insurance options.

The effects of proposals on insurance markets would depend on more than the impact they have on the premiums charged or on the share of the premium that enrollees have to pay; those effects would also reflect the market dynamics that arise as individuals shift among coverage options and as policy premiums adjust to those shifts. In particular, the risk that some plans would experience "adverse selection"—that is, that their enrollees will have above-average or higher-than-expected costs for health care—

has important implications for the operation of insurance markets and for proposals that would regulate those markets or introduce new insurance options.

Insurance Market Regulations and Related Budget Options

Proposals could seek to establish or alter regulations governing the range of premiums that insurers may charge or the terms under which individuals and groups purchase coverage. Purchases in the individual insurance market and most policies for small employers are governed primarily by state regulations. Those regulations differ in the extent to which they limit variation in premiums, require insurers to offer coverage to applicants, permit exclusions for preexisting health conditions, or mandate coverage of certain benefits. Roughly 20 percent of applicants for coverage in the individual market have health problems that raise their expected costs for health care substantially, and in most states they may be charged a higher premium or have their application denied; as a result, premiums are correspondingly lower in those states for the majority of applicants.

Proposals might seek to modify the regulation of health insurance markets in order to make insurance more affordable for people with health problems or to give consumers more choices, but those goals might conflict with each other. For example, limiting the extent to which premiums for people in poor health can exceed those for people in better health (as some states currently do) would reduce premiums for those who have higher expected costs for health care, but it would also raise premiums for healthier individuals and thus could reduce their coverage rates. Other proposals might counteract such limits on variations in premiums—for example, by allowing people to buy insurance in other states. That approach would enable younger and relatively healthy individuals living in states with tight limits to purchase a cheaper policy in another state. Older and less healthy residents who continued to purchase individual coverage in the tightly regulated states, however, would probably face higher premiums as a result.

By themselves, changes in the regulation of the small-group and individual insurance markets would generally have modest effects on the federal budget and on the total number of people who are insured. Those budgetary effects would primarily reflect modest shifts into or out of Medicaid, CHIP, or employment-based coverage as those options became more or less attractive relative to coverage in the individual market. Proposals to require insurers to cover all applicants or to guarantee coverage of preexisting health conditions would benefit people whose health care would not be covered otherwise, but insurers would generally raise premiums to reflect the added costs.

Another approach that has attracted attention recently involves so-called high-risk pools. Most states have established such pools to subsidize insurance for people who have high expected medical costs and have either been denied coverage in the individual insurance market or been quoted a very high premium. Overall participation in high-risk pools is limited—there are currently about 200,000 enrollees nationwide—but proposals could seek to expand the use of those pools by providing new federal

subsidies. The costs of such subsidies would depend primarily on the average health care costs of enrollees, the share of those costs covered by the pool, and the number of people who enrolled as a result.

CBO analyzed several specific options related to the regulation of insurance markets in its *Budget Options* volume. For example, Option 2 would allow insurers licensed in one state to sell policies to individuals living in any other state and to be exempt from the regulations of those other states. Under that option, premiums would tend to rise for people with higher expected costs for health care living in states that tightly regulate insurance markets, and premiums would fall correspondingly for low-cost individuals in those states because some of them would find insurance policies with lower premiums sold in other states with looser regulations. As a result, according to CBO's estimates, by 2014 about 600,000 people with relatively low expected health care spending would gain coverage and about 100,000 people with higher expected costs would drop their coverage. In addition, some firms would stop offering health insurance plans altogether, resulting in an additional loss of coverage for about 100,000 employees and their dependents. Those changes in coverage would generate nearly $8 billion in additional federal revenues over 10 years, as some compensation shifted from untaxed health benefits to taxable wages. Among those who were no longer offered employment-based coverage, a small number would enroll in Medicaid causing roughly a $400 million increase in federal outlays over the 2010–2019 period.

Option 6 would require states to use "community rating" of premiums for small employers who purchase coverage from an insurer—meaning that insurers would have to charge all applicants the same per-enrollee premium for a given policy. Under that option, total enrollment in the small-group health insurance market would fall by about 400,000 (or roughly 1 percent of current enrollment) in 2014, reflecting the net effect of both increased enrollment by people with high expected costs and decreased enrollment by people with low expected costs. The budget deficit would be reduced by about $5 billion over the next decade, largely as a result of higher tax revenues. Option 4 would require all states to establish high-risk pools and provide federal subsidies toward enrollees' premiums. Enrollees would be responsible for paying premiums up to 150 percent of the standard rate for people of similar age. That option would increase the deficit by about $16 billion over the 2010–2019 period; on net, about 175,000 individuals who would have been uninsured otherwise would gain insurance coverage in 2014.

Steps to Reveal Relative Costs

Some proposals would seek to restructure the choices that individuals face—and expose more clearly the relative costs of their health insurance options—either by reducing or eliminating the current tax subsidy for employment-based insurance or by encouraging or requiring the establishment of managed competition systems. Both approaches would provide stronger incentives for enrollees to weigh the expected benefits and costs of policies when making decisions about purchasing insurance. As a

result, many enrollees would choose health insurance policies that were less extensive, more tightly managed, or both, compared with the choices made under current law.

The current tax exclusion for the premiums of employment-based health plans provides a subsidy of about 30 percent, on average, if both the income and payroll taxes that are avoided are taken into account. Eliminating that exclusion, or replacing it with a fixed-dollar tax credit or deduction, would effectively require employees to pay a larger share of the added costs of joining a more expensive plan; conversely, employees would capture more of the savings from choosing a cheaper plan. As a result, according to CBO's estimates, people would ultimately select plans with premiums that were between 15 percent and 20 percent lower than the premiums they would pay under current law. Less extensive changes, such as capping the amount that may be excluded at a certain dollar value, would have proportionally smaller effects on average premiums.

The key features of a managed competition system involve a sponsor, such as an employer or government agency, offering a structured choice of health plans and making a fixed-dollar contribution toward the cost of that insurance. Enrollees would thus bear the cost of any difference in premiums across plans. In CBO's estimation, a proposal requiring that approach would yield average premiums for health insurance that were about 5 percent lower than those chosen under current law. Proposals that also adopted other features of managed competition, such as standardization of benefits across plans and adjustments of sponsors' payments to those plans to reflect the health risk of each enrollee, might yield more intense competition among plans and help avoid problems of adverse selection.

Federally Administered Options and Related Budget Options

Under some proposals, the federal government would make available additional options for insurance—for example, by providing access to the private health plans that are offered through the Federal Employees Health Benefits (FEHB) program. The effects of that approach would depend critically on how the premiums for nonfederal enrollees were set. If insurers could charge different premiums to different applicants on the basis of their expected costs for health care, the option would resemble the current small-group and individual markets and thus would have little impact. Alternatively, if new enrollees were all charged the same premium, the FEHB plans would be most attractive to people who expected to have above-average costs for health care. If no subsidies were provided, the total premiums charged to nonfederal enrollees would probably be much higher than those observed in the program today—so the number of new enrollees would probably be limited. Depending on the specific features of such proposals, providing access to FEHB plans might not prove to be financially viable because of adverse selection into those plans.

The government could also design an insurance option based on Medicare that would be made more broadly available, on a voluntary basis, to the nonelderly population. The federal costs per enrollee would depend primarily on the benefits that system pro-

vided; the rates used to pay doctors, hospitals, and other providers of health care; and the extent of any premium subsidies that were offered to enrollees—all of which could differ from Medicare's current design. As for whether such a plan would be more or less costly than a private health insurance plan that provided the same benefits to a representative group of enrollees, the answer would vary geographically. Assuming that Medicare's current rules applied, those costs would be comparable in many urban areas, but in other areas, the cost of the government-run plan would be lower (as is evident in the current program through which Medicare beneficiaries may enroll in a private health plan). At the same time, because Medicare currently provides broad access to doctors and hospitals and employs little benefit management, a Medicare-based option might attract relatively unhealthy enrollees, which could drive up its premiums, federal costs, or both.

Many of the same considerations would arise in designing a single-payer, Medicare-for-all system, but that approach might raise some unique issues as well—and the scale of its impact on federal costs could obviously be much larger if nearly all of the population was covered. Enrollees could be offered a choice of plans under a single-payer system (as happens in Medicare). If, instead, only one design option was offered and all residents were required to enroll in it, then concerns about adverse selection would not arise. That approach could also reduce the administrative costs that doctors and hospitals currently incur when dealing with multiple insurers. The lack of alternatives with which to compare that program, however, could make it more difficult to assess the system's performance. More generally, that approach would raise important questions about the role of the government in managing the delivery of health care.

Under the provisions of Option 27 in the *Budget Options* volume—which would allow individuals and employers to buy into the FEHB program—CBO estimates that about 2.3 million people would enroll in 2014, of whom about 1.3 million would have been uninsured otherwise. The new program would constitute a separate insurance risk pool for nonfederal enrollees, and their premiums would not be the same as those for federal employees. However, premiums would be the same for all nonfederal enrollees within each plan in a particular geographic area and would be structured so that they did not lead to any new outlays by the federal government. The estimate reflects an assessment that the individuals who enrolled in the program would have greater-than-average health risks, which would lead to higher premiums than if the entire eligible population had enrolled in the program. Although considerable uncertainty exists about the financial viability of FEHB plans in such a program, CBO estimated that features such as an annual open-enrollment period, limited exclusions of coverage for preexisting health conditions, and participation by small employers would limit adverse selection and yield a stable pool of enrollees. The buy-in option would increase the deficit by almost $3 billion from 2010 to 2019, reflecting the net effect of reduced revenues (from a shift in employers' compensation to nontaxable health insurance) and reduced outlays from lower enrollment in Medicaid.

Option 18 would establish a Medicare buy-in program for individuals ages 62 to 64. CBO's analysis reflects an assessment that the government could set a premium at a level such that the program was self-financing; that is, the premium would not be subsidized (and a mechanism would be established to ensure that outcome). As with the option to buy into the FEHB program, CBO would expect the buy-in program to attract individuals with higher-than-average health risks. Although the program would be structured so that enrollees paid its full costs through their premiums, federal spending would increase by about $1 billion over 10 years because some people would choose to retire—and thus receive Social Security benefits—earlier than they would have otherwise. In a typical year of the buy-in program, CBO estimates, about 300,000 people would participate, of whom 200,000 would otherwise have purchased individual coverage, 80,000 would have been uninsured, and 20,000 would have remained employed and had employment-based coverage.

Factors Affecting the Supply and Prices of Health Care Services

The ultimate effects of proposals on the use of and spending for health care depend not only on factors that affect the demand for health care services, such as the number of people who are insured and the scope of their coverage, but also on factors that affect the supply and prices of those services. The various methods used for setting prices and paying for services, and the resulting payment rates, affect the supply of health care services by influencing the decisions that doctors, hospitals, and other providers of care make about how many patients to serve and which treatments their patients will receive. Average payment rates for Medicare, Medicaid, and private insurers also differ, which would affect the budgetary impact of proposals that shifted enrollees—and their costs—from one source of coverage to another. Changes in payment rates for public programs or in the amount of uncompensated care provided to the uninsured could also affect private payment rates.

Payment Methods, Incentives for Providers, and Related Budget Options

Most care provided by physicians in the United States is paid for on a fee-for-service basis, meaning that a separate payment is made for each procedure, each office visit, and each ancillary service (such as a laboratory test). Hospitals are generally paid a fixed amount per admission (a bundled payment to cover all of the services that the hospital provides during a stay) or an amount per day. Such payments may encourage doctors and hospitals to limit their own costs when delivering a given service or bundle, but they can also create an incentive to provide more services or more expensive bundles if the additional payments exceed the added costs.

Other arrangements, such as salaries for doctors or periodic capitation payments (fixed amounts per patient), do not provide financial incentives to deliver additional services. Those approaches raise concerns, however, about providers' incentives to stint on care or avoid treating sicker patients. One study randomly assigned enrollees to different health plans and found that those in an integrated plan (which owns the hospitals used by enrollees and pays providers a salary) used 30 percent fewer services

than enrollees in a fee-for-service plan, but whether those results could be replicated more broadly is unclear.

Proposals could seek to change payment methods either indirectly or directly. They could change the payment methods used by private health plans indirectly by encouraging shifts in enrollment toward plans that have lower-cost payment systems. For public programs, such as Medicare and Medicaid, federal policymakers could directly change payment methods. In either case, making those changes could prove to be very difficult.

Chapter 5 of CBO's *Budget Options* volume examines a number of policies that could change the way that providers are paid and thus the incentives they have. Most of those options focus on Medicare, but other options address Medicaid or the larger health care system. Some options would involve relatively modest changes in payment methods, but others would make more dramatic changes to those methods and thus to incentives for providers. Given the significant uncertainty surrounding the effects of some approaches, a series of pilot projects or demonstration programs might provide valuable insights into how to design new payment systems to achieve lower spending while maintaining or improving the quality of care.

Option 30, for example, would bundle Medicare's payments for hospital and post-acute care. Under the specifications of that option, federal spending would be reduced by about $19 billion over the 2010–2019 period, CBO estimates. That approach would constitute a significant change in the way Medicare pays for post-acute care (which includes services provided by skilled nursing facilities and home health agencies). Medicare would no longer make separate payments for post-acute care services following an acute care inpatient hospital stay. Instead, the unit of payment for acute care provided in hospitals would be redefined and expanded to include post-acute care provided both there and in nonhospital settings. Hospitals would have incentives to reduce the cost of post-acute care for Medicare beneficiaries by lessening its volume and intensity or by contracting with lower-cost providers.

Option 38 illustrates how Medicare could move away from fee-for-service payments to physicians in favor of a blend of capitated and per-service payments. That option would require the Centers for Medicare and Medicaid Services (CMS) to assign each beneficiary who participates in fee-for-service Medicare to a primary care physician. Those physicians would receive approximately three-fourths of their Medicare payments on a per-service basis and approximately one-fourth under a capitated arrangement; they would also receive bonuses or face penalties, depending on the total spending for all Medicare services incurred by their panel of beneficiaries. In response to the incentives created by that payment approach, physicians would probably try to reduce spending among their panel of patients in several ways—for example, by limiting referrals to specialists, increasing their prescribing of generic medications, and reducing hospitalizations for discretionary procedures. According to CBO's estimates, this option would increase payments to physicians and decrease

payments to all other Medicare providers, with a net federal savings of about $5 billion between 2010 and 2019.

Payment Rates and Related Budget Options

The financial incentives created by different payment systems—and the spending amounts they yield—also depend on the level at which payment rates, or prices, are set. Those rates depend partly on the methods that are used to set them. Private-sector payment rates are set by negotiation, reflecting the underlying costs of the services and the relative bargaining power of providers and health plans; in turn, bargaining power depends on factors such as the number of competing providers or provider groups within a local market area. Fee-for-service payment rates in Medicare and Medicaid are generally set administratively. That method poses a number of challenges, including how to determine providers' costs—particularly for services that require substantial training or that become cheaper to provide when they are performed more frequently. Additional issues include how to account for the quality of those services and their value to patients, and what impact rate setting might have on the development of new medical technology.

On average, payment rates under Medicare and Medicaid are lower than private payment rates. Specifically, Medicare's payment rates for physicians in 2006 were nearly 20 percent lower than private rates, on average, and its average payment rates for hospitals were as much as 30 percent lower. As for Medicaid, recent studies indicate that its payment rates for physicians and hospitals were about 40 percent and 35 percent lower, respectively, than private rates. Within Medicare, and probably within Medicaid as well, those differentials vary geographically and tend to be larger in rural areas and smaller in urban areas (where competition among providers is generally greater). Given those differences, proposals that shifted enrollment between private and public plans could have a large impact on payments to providers and on spending for health care. Depending on how providers responded to those changes, enrollees' access to care could be affected.

Chapters 7 and 8 of the *Budget Options* volume examine a wide variety of ways in which payment rates for medical services and supplies could be changed under both the Medicare and Medicaid programs. In particular, Option 55 would reduce (by 1 percentage point) the annual update factor under Medicare for inpatient hospital services; by CBO's estimates, that change would yield $93 billion in savings over 10 years. Option 59 includes several alternatives for increasing payment rates for physicians under Medicare, which (under current law) are scheduled to fall by about 21 percent in 2010 and by about 5 percent annually for several years thereafter. The 10-year cost of those alternatives ranges from $318 billion to $556 billion.

Responses to Changes in Demand or Payment Rates

Changes in payment rates could also have an indirect effect on spending by altering the number of services that providers would be willing to supply. Similarly, the budgetary effects of covering previously uninsured individuals would depend not only on

the resulting increase in their demand for care but also on how that increase affected the supply and prices of services. Because the number of U.S.-trained physicians that will be available to work over the next 10 years is largely fixed, supply adjustments in the short run would have to occur in other areas—which could include changes in the number of hours doctors worked or in their productivity, inflows of foreign-trained physicians, or changes in doctors' fees and patients' waiting times.

Whether and to what extent the supply of physicians and other providers would become constrained also depends on the size of the increase in demand for their services and the amount of time available for adjustments to occur. CBO's analysis indicates that providing the uninsured population with coverage that is similar to a typical employment-based plan would increase total demand for physicians' services and hospital care by between 2 percent and 5 percent. If payment rates rose in response to that increase in demand, the impact on spending could be larger. Spending on behalf of previously uninsured people would also increase to the extent that the uncompensated care they had received became compensated.

Uncompensated Care and Cost Shifting

Another issue that arises when analyzing payment rates is whether relatively low rates for public programs or the costs of providing uncompensated or undercompensated care to the uninsured lead to higher payment rates for private insurers—a process known as cost shifting. To the extent that such cost shifting occurs now, proposals that reduced the uninsured population or that switched enrollees from public to private insurance plans could affect private payment rates and thus alter insurance premiums. For that to occur, however, doctors and hospitals would have to lower the fees they charged private health plans in response to a decline in uncompensated care or an increase in their revenues from insured patients.

Overall, the effect of uncompensated care on private-sector payment rates appears to be limited. According to one recent set of estimates, hospitals provided about $35 billion in uncompensated care in 2008, representing roughly 5 percent of their total revenues.[3] Roughly half of those costs may be offset, however, by payments under Medicare and Medicaid to hospitals that treat a disproportionate share of low-income patients. Estimates of uncompensated care provided by doctors are considerably smaller, amounting to a few billion dollars, so the costs of providing such care do not appear to have a substantial effect on private payment rates for physicians.

Whether and to what extent payments to hospitals under Medicare and Medicaid fall below the costs of treating those patients is more difficult to determine. Recent studies indicate, however, that when payment rates change under those programs, hospitals shift only a small share of the savings or costs to private insurers (the same logic would apply for uncompensated care). Instead, lower payment rates from public programs or

3. Jack Hadley and others, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs,* Web Exclusive (August 25, 2008), pp. W399–W415.

large amounts of uncompensated care may lead hospitals to reduce their costs, possibly by providing care that is less intensive or of lower quality than would have been offered had payments per patient been larger.

Administrative Issues and Effects on Other Programs

The extent to which proposals would affect health insurance coverage or federal budgetary costs, and the timing of those effects, would depend partly on the administrative responsibilities and costs that those proposals entailed and partly on their interactions with other government programs. Other factors would also affect coverage and costs, including the impact of any maintenance-of-effort provisions that might be applied to states or employers and the treatment of various segments of the population, including people who are ineligible for current government health programs and those who—although eligible—are generally difficult to reach and enroll.

Administrative Issues

Proposals could require both federal and state governments to assume new administrative responsibilities and could allocate those responsibilities to new or existing agencies. How well agencies fulfilled new missions—and how long it would take them to do so—would depend on the scope of the new responsibilities and the funding provided. Even with adequate funding, implementing a major initiative might take several years, as illustrated by the experience with the new Medicare drug benefit. One way to ease the implementation of a new federal program would be to build on existing programs; CHIP, for example, was implemented relatively rapidly because it largely built on the existing infrastructure of the state-operated Medicaid program.

Maintenance-of-Effort Requirements

A proposal that created new subsidies for health insurance could lead employers or states to scale back the coverage that they sponsor, particularly if a new federally funded program provided similar or more generous benefits. To prevent such responses or offset their effects on federal spending, proposals could include maintenance-of-effort provisions. Monitoring and enforcing such requirements for private firms would be difficult, however, unless proposals specified effective reporting mechanisms and sufficient penalties for violations.

States' maintenance-of-effort provisions are generally structured in two ways: requiring states to maintain existing programs at historical eligibility or benefit levels (as is done under CHIP), or requiring states to continue spending funds at certain historical or projected levels or to return some of their savings to the federal government (as is done for the Medicare drug benefit). The effectiveness of such requirements would depend on how they were defined, the enforcement mechanisms that were specified, and the incentives for states to comply. The provisions for CHIP and the Medicare drug benefit are examples of effective approaches.

Effects on Other Federal Programs

Proposals could also have unintended effects on eligibility for other federal programs that are not directly related to health care. New subsidies for health insurance might be counted as income or assets when determining eligibility for benefits in means-tested programs (such as the Supplemental Nutrition Assistance Program, formerly known as the Food Stamp program) unless explicitly excluded by law. Proposals that changed the employment-based health insurance system could shift compensation between wages and fringe benefits, thus affecting eligibility for government benefits (including Social Security) or tax credits (such as the earned income tax credit) that are based on cash earnings. Temporary or aggregate adjustments could be made to benefit formulas in order to minimize any adverse effects, but some recipients might still be made worse off.

Treatment of Certain Populations

The treatment of certain populations would present various administrative challenges for proposals to expand coverage. Some individuals, including military personnel and veterans, already receive health benefits from the federal government, and issues might arise regarding the coordination of their current benefits with new federal subsidies. In other cases, federal health programs currently deny benefits to certain populations, such as unauthorized immigrants or prison inmates, and proposals would have to specify whether and how those restrictions would apply to new programs. Other populations, such as the homeless, face challenges enrolling in existing programs, and similar issues might arise in designing new subsidies for health insurance. Those considerations would affect both the costs of proposals and their overall impact on rates of insurance coverage.

Changes in Health Habits and Medical Practices

In addition to any broader changes they make in the health insurance and payment systems, proposals could include specific elements designed to induce individuals to improve their own health or to encourage changes in how diseases are treated. Through a combination of approaches, proposals could try to change the behavior of both patients and providers by:

- Promoting healthy behavior, including measures aimed at reducing rates of obesity and smoking;
- Expanding the use of preventive medical care, which can either impede the development or spread of a disease or detect its presence at an early stage;
- Establishing a "medical home" for each enrollee, typically involving a primary care physician who would coordinate all of his or her care;

- Adopting "disease management" programs that seek to coordinate care for and apply evidence-based treatments to certain diseases, such as diabetes or coronary artery disease;

- Funding research comparing the effectiveness of different treatment options, the results of which could help discourage the use of less clinically effective or less cost-effective treatments;

- Expanding the use of health information technology, such as electronic medical records, which would make it easier to share information about patients' conditions and treatments; and

- Modifying the system for determining and penalizing medical malpractice.

Some of those initiatives could improve individuals' health or enhance the quality of the care that they receive, but it is not clear that they also would reduce overall health care spending or federal costs. In its analysis of such initiatives, CBO considers the available studies that have assessed the particular approaches. In many cases, those studies do not support claims of reductions in health care spending or budgetary savings.

Challenges in Demonstrating Savings

For several reasons, it may be difficult to generate reductions in health care spending from such initiatives. In some cases, the problem is largely one of identifying and targeting the people whose participation would cause health care spending to decline. Broad programs aimed at preventive medical care and disease management could reduce the need for expensive care for a portion of the recipients but could also provide additional services—and incur added costs—for many individuals who would not have needed costly treatments anyway. To generate net reductions in spending, the savings that such interventions generated for people who would have needed expensive care would therefore have to be large enough to offset the costs of serving much larger populations.

A related issue is that many individuals or health plans might already be taking the steps involved (or will in the future) even in the absence of a new requirement or incentive. The effect of any proposal would have to be measured against that trend, and a large share of any subsidies involved might go to people who (or health plans that) would have taken those steps even if there were no requirements or incentives to do so. For example, some doctors and hospitals are already using electronic medical records, and more will adopt that technology in the future under current law, so new subsidy payments would go to many providers who would have purchased such systems anyway, and savings would accrue only for those providers who accelerated their purchases as a result of the subsidy.

In other cases, the effect on health care spending depends crucially on whether doctors and patients have incentives to change the use of health care services. For example, studies may find that a given treatment has fewer clinical benefits or is less cost-effective (meaning that added costs are high relative to the incremental health benefits) for certain types of patients—but those results may not have a substantial effect on the use of that treatment unless the financial incentives facing doctors (through their payments) or patients (through their cost sharing) are aligned with the findings. Similarly, proposals to establish a medical home may have little impact on spending if the primary care physicians who would coordinate care were not given financial incentives to limit their patients' use of other health services.

Other types of initiatives might ultimately yield substantial long-term health benefits but might not generate much savings, at least in the short term. Even if successful, measures to reduce smoking and obesity—two factors linked to the development of chronic and acute health problems—might not have a substantial impact on health care spending for some time. In the long term, spending on diseases caused by poor health habits could decline substantially, but the impact on federal costs would also have to account for people living longer and receiving more in Medicare benefits (for the treatment of other diseases and age-related ailments) as well as other government benefits that are not directly related to health care (including Social Security benefits). Similarly, investments in health information technology might require substantial start-up costs that would be difficult to recapture in the typical 5- and 10-year budgetary time frames used to evaluate legislative proposals.

Demonstrating savings might also be difficult because of data limitations and methodological concerns. For example, studies have found that tort limits, by reducing malpractice awards, cause premiums for malpractice insurance to fall and thus could have a very modest impact on doctors' fees and health care spending. Some observers argue that tort limits would yield larger reductions in that spending because doctors would stop ordering unnecessary tests and taking other steps to reduce the risk of being sued. CBO has not found consistent evidence of such broader effects, but that may reflect the difficulty of disentangling the impact of changes to the medical malpractice system from other factors affecting medical costs.

Related Budget Options

In its *Budget Options* volume, CBO estimated the effect of several approaches aimed at changing health habits or medical practice. For example, Option 106 would impose a new excise tax on sugar-sweetened beverages (equal to 3 cents per 12 ounces of beverage), which would raise about $50 billion in revenues from 2010 to 2019. CBO did not, however, estimate that spending on health care would be reduced under that option. After evaluating the available evidence, CBO could not establish causal links between lower consumption of sugar-sweetened beverages (which would occur under the option) and the use of health care. Studies indicate, for example, that people would offset the reduction in their consumption of such beverages with increases in consumption of other unhealthy foods—so the impact on obesity rates is not clear. In

addition, even though obesity is associated with higher spending on health care, the effect of losing weight on spending for health care is more difficult to determine.

CBO also analyzed the effects of establishing a "medical home" for chronically ill enrollees in the Medicare fee-for-service program (see Option 39). As designed, that option would increase Medicare spending by about $6 billion over 10 years because of the fees provided to practitioners who elected to become medical homes. Alternatively, approaches that would give primary care physicians a financial incentive to limit their patients' use of expensive specialty care—such as the option imposing partial capitation, discussed above—could reduce Medicare spending (depending on the specific features of their design). In the realm of preventive medical care, CBO analyzed the impact of basing Medicare's coverage of such services on evidence about their effectiveness (see Option 110). That option would save nearly $1 billion over 10 years because it would lead the Medicare program to drop coverage for services that are currently covered even though an independent task force has recommended against their use (reflecting evidence that the preventive services are either ineffective or do more harm than good).

Under Option 45, the federal government would fund research that compares the effectiveness of different medical treatments. The results of that research would gradually generate modest changes in medical practice as providers responded to evidence on the effectiveness of alternative treatments, the net effect of which would be to reduce total spending on health care in the United States; the resulting reductions in spending for federal health programs would partly offset the federal costs of conducting that research. Option 8 would impose specific limits on medical malpractice awards; the resulting reduction in premiums for malpractice insurance would yield reductions in the federal budget deficit of nearly $6 billion over 10 years. (CBO did not conclude that the option would have broader effects on the use of health care services.)

Finally, Options 46 through 49 provide various approaches to increase the adoption of health information technology and electronic medical records. Option 46 would create incentives under the Medicare program to adopt that technology; the primary effects on federal outlays would stem from the payment of bonuses for adopting it or the collection of penalties for not doing so. Option 47 would require doctors and hospitals to use electronic health records in order to participate in Medicare. CBO judged that virtually all doctors and hospitals would adopt electronic health records as a result, reducing the federal budget deficit by about $34 billion over 10 years (or by a larger amount if Medicare's payments to doctors and hospitals were also reduced to capture the resulting gains in their productivity).

Effects on Total Health Care Spending, the Scope of the Federal Budget, and the Economy

Proposals that would substantially change the health insurance market could affect total spending on health care, the flow of payments between various sectors of the economy, and the operation of the U.S. economy. CBO will consider those effects in its analyses of major health care proposals.

Effects on Total Spending and the Scope of the Federal Budget

Many health insurance proposals would have an impact on total spending for health care, and some might contain provisions that explicitly limit the level or rate of growth in health care spending; such proposals might impose a global budget or budgetary cap on all or a part of that spending. The effectiveness of such strategies would depend on several factors, including the scope of the global budget, the targets selected for different categories of spending, and the mechanisms used to enforce the caps.

In addition to their overall effects on federal spending and revenues, proposals that made substantial changes to the health insurance system or its financing methods could raise a number of budgetary issues. Such proposals could have substantial effects on the flows of payments among households, employers, and federal and state governments—even if the proposals were budget neutral from a federal perspective. Some proposals might assign the federal government a more active role in the health insurance market; for example, the government could be required to disburse subsidies covering the cost of health insurance, collect health insurance premiums from policyholders, or make payments to insurers. Any of those changes might raise questions regarding who—the government, the insured, or the insurer—would bear financial responsibility for any shortfalls in payments that might occur.

Other proposals might require that individuals or businesses make payments directly to nongovernmental entities. Depending on the specific provisions of such proposals, CBO might judge that payments resulting from federal mandates should be recorded as part of the federal budget even if the funds did not flow through the Treasury. The extent of federal control and compulsion is a critical element in determining budgetary treatment. In general, CBO believes that federally mandated payments—those resulting from the exercise of sovereign power—and the disbursement of those payments should be recorded in the budget as federal transactions.

Effects on the Economy

Proposals that made large-scale changes affecting the provision and financing of health insurance could also have an impact on the broader economy. Because most health insurance is currently provided through employers, proposals could affect labor markets by changing individuals' decisions about whether and how much to work and employers' decisions to hire workers. Such effects could arise in several ways:

- Proposals that decreased the return from an additional hour of work, by imposing new taxes or phasing out subsidies or credits for health insurance as earnings rise, could cause some people to work fewer hours or leave the labor force.

- Proposals that made health insurance less dependent on employment status could induce some people to retire earlier and others to change jobs more often.

- Proposals that treated firms differently on the basis of such characteristics as the number of employees or average wages could affect the allocation of workers among firms.

- Proposals that required employers to provide health insurance could adversely affect the hiring of employees earning at or near the minimum wage, because the total compensation of those workers could exceed their value to the firm.

Some observers have asserted that domestic firms providing health insurance to their workers incur higher costs for compensation than do competitors based in countries where insurance is not employment based and that fundamental changes to the health insurance system could reduce or eliminate that disadvantage. Although U.S. employers may appear to pay most of the costs of their workers' health insurance, economists generally agree that workers ultimately bear those costs. That is, when firms provide health insurance, wages and other forms of compensation are lower (by a corresponding amount) than they otherwise would be. As a result, the costs of providing health insurance to their workers are not a competitive disadvantage for U.S.-based firms.

In addition to their effects on the labor market, proposals could also affect the size of the nation's stock of productive capital, especially through their effects on government budgets. Those effects would depend partly on how the costs of any insurance expansions or other changes were financed. The net effect on the economy of a broad proposal to restructure the health insurance system would, not surprisingly, depend crucially on the details.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

June 16, 2009

Honorable Kent Conrad
Chairman
Committee on the Budget
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In the absence of significant changes in policy, rising costs for health care will cause federal spending to grow much faster than the economy, putting the federal budget on an unsustainable path. This letter responds to your request for information about the features of reform proposals that would affect federal spending on health care over the long term.

As you noted, many experts believe that a substantial share of spending on health care contributes little if anything to the overall health of the nation. Therefore, changes in government policy have the potential to yield large reductions in both national health expenditures and federal health care spending without harming health. Moreover, many experts agree on some general directions in which the government's health policies should move—typically involving changes in the information and incentives that doctors and patients have when making decisions about health care.

However, large reductions in spending will not actually be achieved without fundamental changes in the financing and delivery of health care. The government can spur those changes by transforming payment policies in federal health care programs and by significantly limiting the current tax subsidy for health insurance. Those approaches could directly lower federal spending on health care and indirectly lower private spending on it as well. Yet, many of the specific changes that might ultimately prove most important cannot be foreseen today and could be developed only over time through experimentation and learning. Modest versions of such efforts—which would have the desirable effect of allowing policymakers to gauge their impact—would probably yield only modest results in the short term.

Therefore, one broad long-range approach for reform that has drawn interest recently would combine specific policy actions—to generate near-term savings and provide experience that would lay the groundwork for future savings—with a mechanism or framework to impose ongoing pressure for achieving efficiencies in the delivery of health care. The effectiveness of that path would depend ultimately on the willingness of federal policy to maintain significant and systematic pressure over time and would require tough choices to be made. Without meaningful reforms, the substantial costs of many current proposals to expand federal subsidies for health insurance would be much more likely to worsen the long-run budget outlook than to improve it.

CBO does not provide formal cost estimates beyond the 10-year budget window because the uncertainties are simply too great. However, in evaluating proposals to reform health care, the agency will endeavor to offer a qualitative indication of whether they would be more likely to increase or decrease the budget deficit over the long term.

The attached analysis elaborates on these points. Please contact me at (202) 226-2700 if you have any questions.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

Attachment

Identical letter sent to the Honorable Judd Gregg.

CONGRESSIONAL BUDGET OFFICE

Health Care Reform and the Federal Budget

June 16, 2009

Because the Congress is now considering major legislation affecting health care and health insurance, the possible effects on the federal budget have received significant attention. To elucidate those effects, this analysis examines the budget outlook under current law; the likely budgetary effect of efforts to expand the scope of insurance coverage; the potential for reducing health care spending; the likely impact of specific changes in the health system; and mechanisms for engendering efficiency gains in health care over time.

The Federal Budget Outlook

The federal budget is on an unsustainable path, primarily because of rapidly rising spending on health care. Federal outlays for Medicare and Medicaid have increased from 1 percent of gross domestic product (GDP) in 1970 to more than 5 percent in 2009; and the Congressional Budget Office (CBO) projects that under current policy, they will exceed 6 percent of GDP in 2019 and about 8 percent in 2029. Most of that increase will result from rising costs per capita, rather than from the aging of the population. As a result, the country faces difficult and fundamental trade-offs between limiting the growth of Medicare and Medicaid relative to GDP, accepting a continuing increase in taxes relative to GDP, and reducing other spending relative to GDP, possibly to levels not experienced in this country in more than 40 years.[1]

Moreover, serious fiscal imbalances are not a far-off problem. Under current law, CBO projects, Medicare's Part A trust fund—which pays for inpatient services, post-acute care, and hospice services and receives revenues principally from the payroll tax—will have insufficient funds to pay for all covered services starting in 2017. More broadly, federal debt held by the public is set to jump from 41 percent of GDP at the end of 2008 to more than 60 percent by the end of 2010, the highest level since the mid-1950s. Under CBO's March baseline projection, the debt would fall back below 60 percent of GDP in the second half of the decade, but the baseline assumes that currently scheduled increases in tax rates will be allowed to occur, even though policymakers seem intent on extending at least some of the 2001 and 2003 tax cuts. If those and all other expiring provisions were extended

[1] The rapid growth of Medicare and Medicaid relative to the economy during the past four decades has been, in a sense, "financed" by a significant reduction in defense spending relative to GDP. Meanwhile, federal revenues and nondefense spending on other programs have grown about in line with the economy, on average. However, with health care spending continuing to shoot up and defense spending down to about 4 percent of GDP, the historical pattern cannot be repeated.

and the alternative minimum tax was indexed for inflation, the debt would continue to rise relative to GDP throughout the next decade, reaching 86 percent by 2019. Debt held by the public has not been that high since the years immediately following World War II.

For many observers and policymakers, that grim outlook for the federal budget during the next decade and beyond is an important motivation for crafting health care reform and making other policy choices in a manner that significantly reduces future deficits.

The Potential Impact of Expanding Health Insurance Coverage on the Budget Outlook

The federal government's financing of health care will total more than $1 trillion in 2009, all told. Federal outlays for Medicare and Medicaid are about $700 billion; tax preferences for health care (especially the exclusion of premiums for employment-based health insurance from income and payroll taxes) amount to more than $250 billion; and the federal government also pays for veterans' health care, public health initiatives, and other health programs. Already, those direct and indirect payments for health care account for nearly 60 percent of total health expenditures for the nation.

Many proposals to significantly expand insurance coverage would add to federal costs by providing large subsidies to help lower-income individuals and families purchase insurance. Those proposals would take several years to implement, but it is useful to consider the budgetary implications if they were up and running now so as to compare those costs to existing obligations. Depending on the specific policies selected, the added cost could be on the order of $100 billion. In the absence of specific constraints on growth, the new spending (or revenue losses, if tax credits were used to provide subsidies) would probably increase over time roughly with the underlying costs of health care and, thus, would grow about as fast as spending on other federal health care programs.[2]

From that perspective, a large-scale expansion of insurance coverage would represent a permanent increase of roughly 10 percent in the federal budgetary commitment to health care. Improving the budget outlook therefore would require that other aspects of an initiative on health care reduce the federal resources

[2] Spending growth in some other federal health programs depends on the aging of the population as well as the increase in age-adjusted health care costs. At the same time, the growth rate of spending on insurance subsidies would depend on the design of the programs. If lower-income households' costs for insurance were capped at a fixed share of income, then federal spending would rise faster than health care costs. Alternatively, subsidies for health insurance could be set to increase more slowly than health care costs, although that approach would make insurance more difficult for some households to afford over time. A reasonable assumption would therefore seem to be that, absent structural reforms, costs in all of the federal health programs would grow at roughly the same rate.

devoted to it by more than that amount (or that other federal spending or revenues be adjusted to accomplish the same end).

By themselves, insurance expansions would also cause national spending on health care to increase, in part because insured people generally receive somewhat more medical care than do uninsured people—notwithstanding the fact that some newly insured people would avoid expensive treatments by getting care sooner, before their illness progressed.[3] However, the rise in national spending on health care would be less than the increase for the federal government because some costs that are now paid by others would be shifted to the government (via the subsidies provided by the proposal).

Expanding insurance coverage would make it modestly easier to achieve some other reductions in national and federal spending on health care, but it would not alter the fundamental nature of these challenges. Several issues are relevant:

- Broader insurance coverage might lead to less cost shifting in the health care system, but that effect would probably be relatively small and would not directly produce net savings in national or federal spending on health care.

  If more people had insurance, then the amount of uncompensated care would decline. Some government payments designed to pay for part of that care (such as "disproportionate share" payments to hospitals that treat many poor patients) could be trimmed accordingly. And, to the extent that costs of uncompensated care are currently shifted to private payers, some offsetting savings could arise. However, undoing any current shifts of spending among different payers would not change the growth rate of federal spending beyond the first few years.

  Moreover, uncompensated care is less significant than many people assume. According to one study, hospitals provided about $35 billion in uncompensated care nationwide in 2008—less than 2 percent of national health expenditures—and the estimates are much smaller for other providers.[4] The extent to which such costs are shifted to other payers is also uncertain; well-structured studies have found modest effects.[5] Further, some proposed expansions of insurance coverage would broaden eligibility for Medicaid, which might lead to additional cost shifting given Medicaid's low payments to providers.

[3] See Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 71–76.

[4] Jack Hadley and others, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs,* Web Exclusive (August 25, 2008), pp. W399–W415.

[5] See Congressional Budget Office, *Key Issues,* pp.112–116.

- In terms of the trajectory of spending, policymakers might be more willing to slow the growth in payments to health care providers—and providers might be more willing to accept slower growth—if they were not worried about the possible impact of slower payment growth on access to medical care for uninsured or underinsured people. (That effect could arise if cutbacks in payment rates for insured patients led doctors or hospitals to limit their provision of such care.) But budgetary savings from reducing payments to providers would not occur automatically with broader insurance coverage; they would arise only to the extent that legislation explicitly trimmed payment rates relative to levels under current law.

- Health care providers currently use resources looking for ways to receive payments for treating uninsured people. In addition, insurers currently use resources trying to determine the health of prospective customers and to avoid paying for treatments that address preexisting conditions. Expanded insurance coverage, together with the requirement that insurers provide coverage to all applicants and the elimination of restrictions on preexisting conditions (two features of many current insurance-market reform proposals), would save such resources.

- Currently, a significant share of the population moves in and out of insurance coverage during a year, which complicates efforts to provide effective prevention and wellness services. As discussed later, though, those services are less broadly effective at reducing health care spending than might be expected, and in any event, expansion proposals would not eliminate all of the churning that makes it harder to maintain continuity of care.

- Most expansions of insurance coverage that are under consideration would leave a moderate number of people uninsured, in part because some people would be ineligible for subsidies or would choose not to buy insurance even with large subsidies. Therefore, any current problems arising from the lack of insurance could be reduced but not eliminated.

It also bears emphasizing that if a reform package achieved "budget neutrality" during its first 10 years, budgetary savings in the long run would not be guaranteed—even if the package included initial steps toward transforming the delivery and financing of health care that would gain momentum over time. Different reform plans would have different effects, of course, but two general phenomena could make the long-run budgetary impact less favorable than the short-run impact:

- First, an expansion of insurance coverage would be phased in over time to allow for the creation of new administrative structures such as insurance exchanges. As a result, the cost of an expansion during the 2010–2019 period could be a poor indicator of its ultimate cost.

- Second, savings generated by policy actions outside of the health care system would probably not grow as fast as health care spending. Such would be the case for revenues stemming from the Administration's proposal to limit the tax rate applied to itemized deductions and from proposals to tax sugar-sweetened soda or alcohol, for example.

Some policy options under consideration would yield savings that grew in tandem with health care spending—reducing the level of federal spending on health care but not affecting the measured rate of spending growth after the first few years. For example, the largest savings proposed in the President's budget would arise from a decrease in payments to private health insurance plans operating under the Medicare Advantage program. If enacted, that change would permanently lower the level of Medicare spending, but it would probably not offset a noticeably larger share of the cost of an expansion of insurance coverage in the second 10 years than in the first.

Moreover, any savings in existing federal programs that were used to finance a significant expansion of health insurance would not be available to reduce future budget deficits. In light of the unsustainable path of the federal budget under current law, using savings to finance new programs instead of reducing the deficit would necessitate even stronger policy actions in other areas of the budget.

Potential Savings in Health Care

Given those challenges, a health care reform package would need to incorporate very significant and fundamental changes in health care to truly improve the long-run budget outlook. Of course, projecting the effect of health policy changes into the distant future is very difficult, partly because predicting how the practice of medicine would evolve in the absence of those changes is difficult. Therefore, experts generally focus on ways to reduce the growth of health care spending over the next decade or two rather than over the very long run.

Policy changes that reaped significant savings quickly would lessen the medium-term impact on the deficit that a large-scale expansion of insurance coverage would have and could lay the groundwork for greater savings later. For example, if the growth rate of federal health care spending was trimmed by 1 percent per year during the next 20 years, the savings would roughly match the cost of an expansion of insurance coverage by the end of the decade and would exceed that cost in the next decade.

Significant savings seem possible because the available evidence implies that a substantial share of spending on health care contributes little if anything to the overall health of the nation. Therefore, experts generally agree that changes in government policy have the *potential* to produce substantial savings in both national and federal spending on health care without harming health. However,

turning that potential into *reality* in a sector that accounts for one-sixth of the U.S. economy is likely to be a prolonged and difficult process.

Perhaps the most compelling evidence about the extent of inefficiency in the health sector is that Medicare spending varies widely across different regions of the country, but the variation is not correlated with available measures of the quality of care or health outcomes. Researchers affiliated with the Dartmouth *Atlas of Health Care* have compared the Medicare spending for enrollees across the nation, controlling for demographic characteristics such as age, sex, and race. According to those researchers' calculations, Medicare spending could be reduced by almost 30 percent if outlays in medium- and high-spending regions were reduced to the average level in the lowest-spending decile.[6]

Comparisons of that sort are sensitive to the method of calculation. Some studies have expressed skepticism about the Dartmouth researchers' estimate.[7] CBO's own informal comparison of per capita Medicare spending in metropolitan areas, controlling for both the health status of individuals and the prices of health care inputs, implies that the savings from turning medium- and high-spending areas into low-spending areas might be roughly half of the estimate by the Dartmouth researchers. In addition, much less is known about regional comparisons of spending for and the health of patients outside the Medicare program. Still, most experts conclude that both formal analysis and extensive anecdotal evidence of regional differences in medical care and costs imply that a significant portion of spending on health care is not serving its intended purpose. Moreover, the delivery of health care in low-cost regions is not completely efficient now, so further savings might be achievable even in those areas.

Many experts think that transformational changes in health care financing and delivery could reduce the federal budgetary commitment to health by more than the 10 percent increase that would result from a large-scale expansion of insurance coverage. Achieving substantial and lasting savings, however, would require fundamental changes in the organization and delivery of health care. Examples of efficient care certainly exist today, with many individual health care providers and groups of providers offering both high quality and relatively low cost. Yet applying the methods of those efficient providers throughout the health care system cannot be accomplished through fiat or good intentions. Instead, the government controls two powerful policy levers for encouraging changes in medical practice:

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[6] See John E. Wennberg and others, "Geography and the Debate Over Medicare Reform," *Health Affairs*, Web Exclusive (February 13, 2002), pp.W96–W114.

[7] See, for example, Jack Hadley and others, *Variations in Medical Care Spending per Medicare Beneficiary: The First Stage of an Instrumental Variable Analysis* (report submitted to the Changes in Health Care Financing and Organization Program, Robert Wood Johnson Foundation, May 2006).

- Changes in Medicare could directly affect the efficiency of health care delivered to older and disabled Americans. Changes in payment rules could induce providers to offer higher-quality and lower-cost care (while ensuring that efficiency gains were shared by the government), and changes in the structure of benefits could give program beneficiaries stronger incentives to choose less costly care. Improved efficiency within Medicare is likely to have spillover effects on the efficiency of health care outside of the program.

- Changes in the tax exclusion for employer-sponsored health insurance can affect the efficiency of health care financed by the private sector, by giving workers stronger incentives to seek lower-cost health insurance plans. Those steps could well have spillover effects on Medicare.

Considerable consensus exists among experts about some types of changes that are likely to make the health sector more efficient: move away from a fee-for-service system toward paying providers for value, perhaps through fixed payments per patient, bonuses based on performance, or penalties for substandard care; provide stronger incentives for both providers and patients to control costs, through higher cost-sharing requirements or tighter management of benefits; and facilitate good decisionmaking by providers and patients by equipping them with more information about the effectiveness of different treatments and the quality of care delivered by different providers. Those changes in the flow of money and information would spur and facilitate other changes in the organization and delivery of health care.

Unfortunately, little reliable evidence exists about exactly how to implement those types of changes—especially at the level of specificity required for legislation. A recent letter to the President from a group of stakeholders in the health care industry reveals both the promise and the difficulty of achieving substantial savings through health care reform: Those stakeholders see increased efficiency as a critical goal of their organizations, and they agree that significant savings can be obtained. At the same time, many of the group's proposals offer little detail about the specific changes necessary to achieve those objectives or the obstacles to their making the changes.[8]

Policy Options That Could Produce Budgetary Savings in the Long Run

A number of specific reforms show great promise for reducing federal spending on health care over time without harming people's health. However, at this point,

[8] In particular, many of the proposals could be implemented without legislation, so they would not affect the budgetary scoring of a reform proposal, although they might affect CBO's baseline projections of the costs of federal programs. See Congressional Budget Office, *Response to Questions About Health Care Industry Stakeholders' Proposals*, letter to the Honorable Dave Camp (June 16, 2009).

experts do not know exactly how best to structure those reforms to achieve that goal. They will need to learn through experimentation. In the meantime, any particular approach to implementing such ideas might well yield less savings than hoped for or might raise concerns about the impact on the quality of care and on patients and providers.

CBO has analyzed a number of reform options in its recent publications, including creating so-called accountable care organizations, bundling payments to hospitals and other providers, providing additional information about effective medical treatments, expanding the use of preventive and wellness services and primary care, increasing cost sharing by patients, and modifying the tax treatment of employment-based health insurance.[9] When CBO evaluates policies, the agency aims to reflect the middle of the range of expert opinion about likely outcomes. For any particular policy option, CBO carefully reviews the relevant empirical evidence and examines the incentives that would be created to control costs and the factors that might limit the success of those incentives—as illustrated in the following discussion.[10]

One general point worth emphasizing is that reform options may have different effects on health and on the federal budget. Some policies, such as the increased use of preventive services and the coordination of care, would have clearer positive effects on health than on the federal budget balance. Other policies, such as certain changes in Medicare's payment methods, would have a direct impact on federal spending, but their effect on health outcomes would be less clear. In part, that uncertainty reflects the difficulty of measuring the quality of health care—a situation that is likely to improve but which will take time to do so.

Create Accountable Care Organizations

In Medicare's traditional fee-for-service program, providers have little or no financial incentive to coordinate the care their patients receive across different treatment settings or to be accountable for the costs and quality of that care. One prominent example of a structure that may function better would be accountable care organizations formed by physicians and other health care providers. Under this model, providers would receive bonuses if they held down the total cost of the services their patients received during a year while also meeting requirements for the quality of the care; some versions would also impose penalties on doctors who did not meet those targets.

Proponents contend that such groups would coordinate care more effectively, which would improve patients' health. In addition, the financial incentives would

[9] See Congressional Budget Office, *Budget Options, Volume 1: Health Care* (December 2008) and *Key Issues*.

[10] See, for example, Congressional Budget Office, *An Analysis of the Literature on Disease Management Programs,* letter to the Honorable Don Nickles (October 13, 2004).

reduce the unnecessary use of specialists and expensive tests and procedures. Other initiatives, such as establishing "medical homes" for patients and implementing care coordination or disease management, could also be pursued more easily in this environment. Models of efficient health care today—including the Mayo Clinic, Kaiser Permanente, and Geisinger—are integrated delivery systems, and accountable care organizations have some of the same features.

A current demonstration project in Medicare (known as the Physician Group Practice demonstration) is testing similar approaches for providing care, using some of the integrated health systems noted above. However, the evidence for cost savings is mixed. Moreover, expanding this approach to physicians who are not already in an integrated system and may be reluctant to join one raises further issues. For example, challenges arise when trying to design programs that are voluntary for both enrollees and physicians, because both parties would generally need to expect some gain in order to participate—often at the government's expense. Making such mechanisms mandatory, though, raises understandable concerns.

Given the novelty of these organizations, a number of questions remain unanswered about the structure and environment of them: How tightly would the groups need to be integrated in order to achieve cost savings? How should bonuses and penalties be set? Should payments to providers in the regular fee-for-service system be restrained in order to encourage them to join accountable care organizations? Although many experts agree that this approach should be vigorously pursued, several rounds of successive and significant changes and refinements in Medicare's rules would probably be necessary to yield substantial budgetary savings.

Bundle Payments to Hospitals and Other Providers

A number of experts have proposed bundling Medicare's payments for hospitals and related services. (Payments are referred to as bundled when they cover multiple individual services.) These proposals illustrate a common issue in evaluating the budgetary effects of health care reform: Options that sound alike may have quite different cost consequences if they employ different degrees of aggressiveness in pursuing cost-saving goals.

CBO's *Budget Options* volume included an option that would have hospitals receive a single bundled payment from Medicare for both the hospital services they provide and the care that their patients receive in a post-acute setting in the 30 days following their discharge. Hospitals already receive a fixed payment per admission, but this arrangement would provide hospitals with a new incentive to coordinate the care their patients receive after they are discharged and to economize in the use of post-acute care. The payment amount would be adjusted over time to capture part of the anticipated reduction in costs. CBO estimated that this option would save about $19 billion over the 2010–2019 period.

The Commonwealth Fund also recently analyzed an option for bundling, one considerably more aggressive in reducing spending and altering incentives for providers.[11] Under that option, successively more inclusive bundling would be phased in: Initially, Medicare would bundle together payments for a hospital stay and any readmissions within 30 days; after three years, the bundling would be expanded to include post-acute care services as well; and after three more years, the bundling would also include payments for physicians in the inpatient setting and emergency room. Payment amounts would be reduced immediately upon implementation and then would continue to be restrained over time to reflect anticipated increases in efficiency from coordination among providers. The Commonwealth Fund estimated that this proposal would reduce federal spending by over $200 billion between 2010 and 2020.

Provide Additional Information About Treatments' Effectiveness

Concerns about the limited evidence that is available to determine which treatments are most effective for which patients has generated considerable interest in expanding the supply and use of information that compares the effectiveness of treatment options. (Limited evidence may help explain why the use of certain treatments and the types of care provided vary widely from one area of the country to another.) Many analysts believe that, because of the broad benefits that additional information could provide, the federal government should fund research on the effectiveness of treatments and should help disseminate the results to doctors and patients.[12]

Merely conducting and disseminating additional research is unlikely to have major effects on patterns of clinical practice or health care spending, however. For new research to have a significant impact, providers' financial incentives would need to be aligned with the results. For example, legislation could allow the Medicare program to limit or deny coverage for treatments that were found to be less clinically effective or less cost-effective than other interventions. Alternatively, Medicare could tie its payments to providers to the cost of the most effective treatment, or patients could be required to pay for at least a portion of the additional cost of less effective treatments. In all of these approaches, patients and physicians could still choose the course of treatment they preferred, but Medicare's payments would depend on the broad results of research.

Further challenges in reaping net savings from comparative effectiveness research arise from the cost of the research itself and from the lags in getting research under way, developing results (particularly if they depend on new clinical trials),

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[11] See Stuart Guterman and others, *Reforming Provider Payment: Essential Building Block for Health Reform*, The Commonwealth Fund, Commission on a High Performance Health System (March 2009).

[12] See Congressional Budget Office, *Research on the Comparative Effectiveness of Medical Treatments: Issues and Options for an Expanded Federal Role* (December 2007). In addition to evaluating medical treatments and procedures, such analysis could examine processes for delivering care.

and disseminating the findings. Although those challenges do not undermine experts' support for additional research, they explain why such research might not yield net budgetary savings within a 10-year budget window.

Expand the Use of Preventive and Wellness Services and Primary Care

Many proposals to modify the health insurance system include provisions to expand the use of preventive and wellness services and the use of primary care. Those changes could improve people's health and the quality of care they receive. For example, vaccines can prevent the spread of diseases; screening tests may be able to detect illnesses at earlier and more treatable stages; and greater focus on primary care can foster healthier behavior and better coordination of care.

Although those policies could also lead to less spending on health care, the impact of specific preventive and wellness services on spending varies, depending on the disease being targeted and the population receiving the services. Evidence indicates that some preventive services (such as certain vaccines) reduce costs—that is, the savings for those who avoid getting sick exceed the costs of providing the intervention broadly. However, that outcome is far from universal: One study of the health and economic effects of preventive services found that only 20 percent of the services that were assessed yielded net financial savings.[13]

Several factors make preventive care less broadly effective at reducing health care spending than might be expected. For some preventive services, clinical evidence on effectiveness is lacking: In its 2006 review of such evidence, the U.S. Preventive Services Task Force was neutral toward—neither recommending nor discouraging the use of—approximately 40 percent of the services it reviewed because of a lack of evidence. For other preventive services, clinical evidence shows benefits, but the cost of the intervention for the many people who might receive it would exceed the likely savings for the relative few who would avoid the disease as a result. In addition, a decision by the federal government to subsidize preventive care might shift some costs to the government that would otherwise be borne by the private sector.

A related issue is the ability of the federal government to reduce its spending on health care by fostering healthier behavior and lifestyles. Reducing risk factors for chronic diseases that afflict older Americans can reduce the prevalence of those diseases and thereby the Medicare spending that goes to treat them. However, the overall budgetary effect also depends on the cost to the government of the policies that reduce risk, other health care costs that are incurred by people who live longer, and additional Social Security benefits that are paid to people who live longer. The relative magnitude of those effects varies for different diseases, and research on the topic is limited. One recent study that incorporated the interactions of different medical conditions and the cost of treating them—but did

[13] Joshua T. Cohen and others, "Does Preventive Care Save Money? Health Economics and the Presidential Candidates," *New England Journal of Medicine,* vol. 358, no. 7 (February 14, 2008), pp. 661–663.

not address Social Security outlays or the cost of risk-reducing policies—found that controlling diabetes would increase medical costs and that controlling obesity would reduce costs substantially.[14] Unfortunately, the design and costs of effective programs to reduce obesity are very unclear.

As with prevention, the budgetary impact of greater use of primary care would depend on the combination of increases and decreases in spending occurred. One study of the relationship between Medicare spending and the composition of the workforce of physicians found that, with the total number of physicians held constant, states with more general practitioners had lower spending.[15] Achieving that outcome, however, involves reducing the number of specialists in line with increasing the number of primary care physicians, and the mechanism for accomplishing that change (for example, the appropriate adjustments in payment policies) is unclear. Savings would be less likely if the number of specialists remained the same while the number of primary care physicians increased.

Increase Cost Sharing by Patients

Increasing the cost-sharing obligations that individuals face in government health programs and private insurance would strengthen the incentives for them to use medical care prudently. Research has shown that patients are responsive to the price they pay for many aspects of care.[16] To be sure, the rationale for insurance is to limit patients' out-of-pocket costs, so people with significant health problems or with low income and few assets could not pay a large share of their health costs themselves; cost sharing could be designed to maintain appropriate financial protection while still creating some sensitivity to cost. In addition, maintaining lower cost sharing for certain preventive services, medications to treat chronic conditions, and other care that would reduce future spending (which falls under the rubric of "value-based insurance design") may make sense. Still, ensuring that patients have some financial stake in decisions about treatment methods would lead them to ask their doctors more questions about the effectiveness of different tests and treatments and to make better-informed and more cost-sensitive decisions about their care.

CBO's *Budget Options* volume includes a number of approaches to modifying cost sharing in the Medicare program. One option to increase cost-sharing liabilities for most patients but place an upper cap on a patient's total annual liability was estimated to save $26 billion over 10 years. Making those changes and simultaneously restricting the amount of cost sharing that could be covered by

[14] Dana P. Goldman and others, "The Value of Elderly Disease Prevention," *Forum for Health Economics & Policy*, vol. 9, no. 2 (2006).

[15] Katherine Baicker and Amitabh Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs*, Web Exclusive (April 7, 2004), pp. W184–W197.

[16] See Joseph P. Newhouse and the Insurance Experiment Group, *Free for All: Lessons from the RAND Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993); and Congressional Budget Office, *Key Issues,* pp. 73–74.

individually purchased supplemental (medigap) insurance nearly tripled the estimated amount of budgetary savings. In addition, changing the tax treatment of employment-based health insurance (discussed next) would encourage a higher degree of cost sharing in private insurance, along with other effects.

Modify the Tax Treatment of Employment-Based Health Insurance
Nearly all analysts agree that the current tax treatment of employment-based health insurance—which exempts most payments for such insurance from both income and payroll taxes—dampens incentives for cost control because it is open-ended. Those incentives could be changed by restructuring the tax exclusion to encourage workers to join health plans with lower premiums; those lower premiums would arise through a combination of higher cost-sharing requirements and tighter management of benefits.

CBO's *Budget Options* volume discusses a number of such changes. One option would replace the current tax exclusion with a refundable but more limited tax credit. Another option would limit the amount of health insurance premiums that could be excluded from income and payroll taxes to specific dollar amounts that represented the 75th percentile of premiums paid by or through employers.[17] These approaches would change workers' incentives about how much insurance to purchase and how much care to demand, and they would increase federal revenues by several hundred billion dollars over 10 years.

Imposing Ongoing Pressure to Increase Efficiency in the Health Care System

Vigorous implementation of specific reforms discussed in the preceding section could save money for the federal government in the medium term; they could also lay the groundwork for long-term savings. However, many of the reforms would only reach fruition with substantial changes in how medicine is practiced. Therefore, the largest savings would be reaped slowly, as experts learn more from experience with innovative approaches to financing and delivering care and as payment rules are adjusted to shift behavior further and capture savings for the federal government.

To ensure that *current* legislation puts the federal budget on a more sustainable path will probably require creating a framework for federal health care spending that imposes ongoing pressure to increase efficiency over time—particularly but not exclusively in the case of providers. Such pressure could be imposed in several ways, including reducing Medicare's payment updates automatically to take account of expected productivity gains; reducing Medicare payments in higher-spending areas of the country; giving the Secretary of Health and Human Services broad discretion to change Medicare to produce savings, but imposing an

[17] The dollar amounts in 2010 would be about $17,300 a year for family coverage and about $6,800 a year for individual coverage.

across-the-board reduction in payments to providers if savings are not achieved in other ways; and limiting the growth of Medicare's implicit subsidy of premiums.

Yet for any of those approaches to work over time, the Congress would need to let the legislated changes to payments take effect—even in the face of concerns from providers and patients. If, instead, the Congress ended up relieving the pressure by boosting payments, then the anticipated savings would prove to be illusory. The repeated deferral of the cutbacks in payments to physicians called for by Medicare's sustainable growth rate mechanism is a cautionary example.

Reduce Annual Updates in Medicare's Payments to Reflect Expected Productivity Gains

Under current law, Medicare's fee-for-service payments to caregivers in a variety of facilities (including acute care and long-term care hospitals, outpatient facilities, skilled nursing facilities, and home health agencies) are determined according to preset fee schedules. The basic payment rates are updated annually to reflect changes in the prices of various inputs (such as labor and equipment) that are used to provide medical services. Those prices are measured by market-basket indexes, which combine various price increases into a single update factor for each type of provider. Each index is designed to approximate the changes in costs that providers incur as a result of changes in input prices—under an assumption that the quantity, quality, and mix of those inputs remain constant. To the extent that providers increase their productivity over time—for example, by using fewer inputs or a less expensive mix of inputs to produce the same or greater output—the payment updates overstate the actual increases in costs. Indeed, the Medicare Payment Advisory Commission (MedPAC) often recommends that updates be set equal to changes in market-basket indexes less overall productivity growth in the economy (as long as access to care and other measures meet appropriate standards).

Some experts maintain that increased use of information technology and a new focus on efficiency will yield substantial productivity gains in the health sector.[18] Some of those gains may appear as reductions in the quantity of services and thus yield savings automatically for the government. However, most of the gains are likely to take the form of reduced costs per service, which would cut government spending only if the government cut the prices it pays (and otherwise would end up boosting providers' profit margins).[19] Imposing slower growth in payments would create ongoing pressure on providers to identify and adopt efficiencies; it would also, however, create risks for providers and patients if the efficiency gains were not achieved.

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[18] See, for example, David Cutler, "Health System Modernization Will Reduce the Deficit," (May 11, 2009), available at www.americanprogressaction.org/issues/2009/05/pdf/health_modernization.pdf.

[19] For an illustration of that approach, see Option 54 in CBO's December 2008 *Budget Options* volume.

More generally, reducing payment updates in the fee-for-service Medicare system could also prove to be a powerful mechanism for shifting providers into new payment schemes and organizational arrangements. Anticipated large reductions in payments to physicians under the sustainable growth rate mechanism, for example, could provide an impetus to physicians to join accountable care organizations, where they might receive bonuses for low-cost high-quality care. However, the fact that the Congress has intervened to prevent past cuts in payment rates that the mechanism would have caused makes it less likely that physicians will believe that scheduled future reductions will actually occur.

Reduce Medicare Payments in Higher-Spending Areas

Another tack for applying ongoing pressure to restrain spending would be to reduce Medicare payments, or the growth in those payments, in higher-spending areas of the country. CBO recently examined several variants of this approach in its *Budget Options* volume: reducing Medicare fees for physicians in high-spending areas, reducing Medicare payments across the board in high-spending areas, reducing Medicare's payments to hospitals in areas with a high volume of elective admissions, and imposing a surcharge on cost sharing by Medicare beneficiaries in high-spending areas.

This approach would focus directly on reducing the geographical disparities that currently exist in health care spending, although it would not target specific medical providers or types of services that might be most responsible for the differences in spending. As with reductions in payment updates, this approach would create risks for providers and patients in higher-spending areas if the efficiency gains were not achieved. The overall challenge in reducing the use of care that seems to be wasteful is trying to distinguish that care from necessary care, and that task is made only somewhat easier by focusing attention on geographic areas where wasteful spending is more likely to be occurring.

Combine Increased Discretion to Change Medicare With a Fallback If Savings Were Not Obtained

Another way to ensure significant savings in Medicare would be to give the Secretary of Health and Human Services, the Administrator of the Centers for Medicare and Medicaid Services, or some governmental entity broad discretion to make changes in Medicare to produce savings—but also to impose an across-the-board reduction in payments to providers if sufficient savings were not achieved in other ways.[20]

Many experts think that broader discretion for the administrators of Medicare would help to encourage innovation and enhance efficiency in any event. However, the fallback reductions in payments to providers would be crucial in

[20] For an illustration of that approach, see Option 114 in CBO's December 2008 *Budget Options* volume.

encouraging providers to accept other changes in the program instead. Moreover, as noted above, this mechanism and others in this section would only be effective in the end if the Congress let the legislated reductions in payments take effect.

Limit the Growth of Medicare's Subsidy of Premiums

One other mechanism for imposing ongoing pressure to achieve efficiencies in Medicare would be to limit the growth of the program's implicit subsidy of premiums. If increases in medical costs beyond some threshold were borne at least partly by Medicare beneficiaries rather than the government, the government's financial burden could be reduced. In addition, beneficiaries would then face strong incentives to make informed, cost-sensitive decisions about their medical care. Such changes could be designed to maintain greater protection for older beneficiaries or beneficiaries with lower income.

ECONOMIC AND BUDGET ISSUE BRIEF
CBO
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Effects of Changes to the Health Insurance System on Labor Markets

In the United States, health insurance coverage is linked to employment in ways that can affect both wages and the demand for certain types of workers. That close linkage can also affect people's decisions to enter the labor force, to work fewer or more hours, to retire, and even to work in one particular job or another.

Changes to the health insurance system could affect labor markets by changing the cost of insurance offered through the workplace and by providing new options for obtaining coverage outside the workplace. For example:

- Requiring employers to offer health insurance—or pay a fee if they do not—is likely to reduce employment, although the effect would probably be small.
- Providing new subsidies for health insurance that decline in value as a person's income rises could discourage some people from working more hours.
- Increasing the availability of health insurance that is not related to employment could lead more people to retire before age 65 or choose not to work at younger ages. But it might also encourage other workers to take jobs that better match their skills, because they would not have to stay in less desirable jobs solely to maintain their health insurance.

The overall impact on labor markets, however, is difficult to predict. Although economic theory and experience provide some guidance as to the effect of specific provisions, large-scale changes to the health insurance system could have more extensive repercussions than have previously been observed and also may involve numerous factors that would interact—affecting labor markets in significant but potentially offsetting ways.

The Current Link Between Employment and Health Insurance

In 2009, at least 150 million people under the age of 65—or about three out of every five nonelderly Americans—are expected to have health insurance that is provided through an employer or other job-related arrangement, such as a plan offered through a labor union. That figure includes active workers, spouses and dependents covered by family policies, and retirees under the age of 65. The cost of that insurance is estimated to be, on average, $5,000 for a single plan and $13,000 for a family plan. For people whose income is at 300 percent of the federal poverty level (about $32,500 for a single person without children and $66,000 for a couple with two children), that cost represents between 15 percent and 20 percent of total income.

One reason employment-based plans are popular is that they are subsidized through the tax code—meaning that nearly all payments for employment-based insurance are excluded from taxable compensation and thus are not subject to income and payroll taxes. Another factor is the economies of scale that larger group purchasers have; such economies reduce the administrative costs embedded in policy premiums. Partly as a result, large employers are more likely than small ones to offer insurance to their workers.[1]

Another commonly cited reason for the popularity of employment-based insurance is that employers offering coverage usually pay a large share of the premiums. According to a survey of firms conducted in 2008, employers contributed 73 percent of the cost of a family

1. As a result of those economies of scale, the average share of the policy premiums that covers administrative costs varies considerably—from about 7 percent for employment-based plans with 1,000 or more enrollees to nearly 30 percent for policies purchased by very small firms (those with fewer than 25 employees) and by individuals.

policy for their workers and 84 percent of the cost of single coverage, on average.[2] Employers make those sizable contributions, in part, to encourage broad participation among their employees, so as to limit the potential for "adverse selection." Otherwise, employers' health plans might disproportionately attract enrollees whose health care costs are above average, causing average insurance premiums to rise to reflect the higher spending per enrollee.

Who Bears the Cost of Employment-Based Health Insurance?

Although employers directly pay most of the costs of their workers' health insurance, the available evidence indicates that active workers—as a group—ultimately bear those costs.[3] Employers' payments for health insurance are one form of compensation, along with wages, pension contributions, and other benefits. Firms decide how much labor to employ on the basis of the total cost of compensation and choose the composition of that compensation on the basis of what their workers generally prefer. Employers who offer to pay for health insurance thus pay less in wages and other forms of compensation than they otherwise would, keeping total compensation about the same.

That relationship between employers' contributions for health insurance and compensation can be difficult to observe. Firms offering health insurance actually tend to pay higher wages, on average, than firms that do not offer it. However, those differences in total compensation reflect such factors as disparities in the skill and productivity of workers, not the employers' failure to pass on the costs of providing insurance.[4]

Health Insurance and the Decision to Work

In the current system, employment-based health insurance offers a number of advantages (including the ones listed above as well as coverage of existing medical conditions) that may be difficult or impossible for workers to obtain by purchasing insurance individually. For that reason, its availability can play an important role in people's decisions to enter or remain in the workforce—especially those nearing retirement, who probably place a greater value on coverage of existing conditions than do their younger counterparts. People who are insured through their employer but are not offered health benefits after retirement have an additional incentive to remain employed until they qualify for Medicare at age 65.

Workers whose health insurance will cover them in retirement tend to retire earlier, on average, than those without such benefits.[5] That conclusion has been reached by a number of studies using different estimating techniques. For example, studies that examined the correlation between health benefits and the probability of retirement, controlling for other factors, found that having health benefits in retirement increased the probability of retirement before age 65 by 30 percent to 80 percent. Studies using other estimating techniques generally found smaller results, and a few found little or no effect.[6] However, the weight of the evidence indicates that retirees' health coverage probably leads to earlier retirement.

The availability of employment-based health insurance may also affect decisions by younger workers to enter or remain in the workforce. If primary earners are not offered family coverage through their employer, other members of their household may enter the workforce to obtain employment-based insurance. Some research indicates that spouses who are not covered under the primary earners' insurance are more likely to be employed than are spouses who are covered through such a plan.[7]

Health Insurance and Choice of Jobs

Some of the same advantages of employment-based health insurance that may keep more people in the labor force

2. Henry J. Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET), *Employer Health Benefits: 2008 Annual Survey* (Washington, D.C.: Kaiser/HRET, September 2008).

3. For a discussion of that evidence, see Jonathan Gruber, "Health Insurance and the Labor Market," in A.J. Culyer and J.P. Newhouse, eds., *Handbook of Health Economics,* vol. 1 (Amsterdam: North Holland, 2006), pp. 645–706.

4. For further discussion of the incidence of employment-based health insurance, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, pp. 4–8.

5. See, for example, Jonathan Gruber and Brigitte C. Madrian, *Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature,* Working Paper No. 8817 (Cambridge, Mass.: National Bureau of Economic Research, March 2002).

6. One reason for the diversity of the results is the difficulty of controlling for other characteristics of workers; people choose their jobs partly on the basis of retirement benefits, and those who prefer early retirement may be more likely to choose a job that offers health coverage in retirement.

7. Gruber and Madrian, *Health Insurance, Labor Supply, and Job Mobility.*

can also cause people to decide to work (or stay) at firms that offer health insurance rather than take a job that better matches their skills and interests but does not offer health insurance. In addition, those who have medical problems (or have family members with medical problems) have an incentive to stay in a job that provides health insurance in order to cover those preexisting conditions, even if more productive opportunities exist elsewhere—a phenomenon known as "job lock." (Those opportunities could include working for a different employer or becoming an entrepreneur.) At the same time, people for whom health benefits have little value—such as those who receive insurance coverage through a spouse's employer—are more likely to take jobs that do not offer health insurance but that instead pay higher cash wages and salaries or provide other desired fringe benefits.

The evidence is mixed regarding the effects of employment-based health insurance on job turnover. Although some empirical studies conclude that workers are less likely to change jobs when faced with the potential loss of health insurance, others report little or no effect.[8] Much of that evidence is difficult to interpret, however, because jobs that provide health insurance generally have other attributes that discourage turnover.

Effects of Changes in the Health Insurance System on Labor Markets

Proposals to change the health insurance system may include many provisions that could affect outcomes in the labor market. Those provisions could impose new requirements on businesses, provide subsidies for individuals or small businesses, or affect the availability and cost of health insurance obtained through the individual market or through new purchasing pools (sometimes called exchanges, gateways, or connectors).

Imposing a Play-or-Pay Requirement on Employers

Some proposals would require employers to either play—that is, contribute toward their workers' cost of health insurance—or pay a fee to the government. Those proposals usually require employers to offer plans that meet certain standards; they also specify a minimum amount for employers' contributions toward those plans.[9] That fee could be a fixed dollar amount paid for each worker who was not offered health insurance; alternatively, it could be set at a percentage of earnings, so that the payment per worker would rise as his or her earnings increased—up to, perhaps, some threshold amount.[10]

Supporters of such play-or-pay requirements generally justify those provisions as a way to ensure that employers pay a portion of their employees' health care costs, referring to those requirements in some cases as "employer responsibility payments." However, if employers who did not offer insurance were required to pay a fee, employees' wages and other forms of compensation would generally decline by the amount of that fee from what they would otherwise have been—just as wages are generally lower (all else being equal) to offset employers' contributions toward health insurance.[11]

Play-or-pay requirements may have another rationale. They may encourage firms that currently offer health insurance plans to retain those plans in the future, despite the incentives created by other aspects of legislative proposals to drop such coverage; as a result, such provisions could reduce the budgetary costs of new subsidy programs. In June 2009, the Congressional Budget Office (CBO) analyzed title 1 of a draft of the Affordable Health Choices Act. That proposal contained generous subsidies for health insurance for families with income up to

8. For a discussion of those studies, see Brigitte C. Madrian, *The U.S. Health Care System and Labor Markets,* Working Paper No. 11980 (Cambridge, Mass.: National Bureau of Economic Research, January 2006), p. 19.

9. In Massachusetts, for example, employers with more than 10 full-time employees must make a "fair and reasonable" contribution to a qualifying health plan or pay an annual fee of up to $295 per full-time worker (roughly 15 cents an hour). The Senate Committee on Health, Education, Labor, and Pensions is considering legislation (the Affordable Health Choices Act) that would require firms to contribute at least 60 percent of the premiums for a qualifying plan or to pay $750 a year (or about 38 cents an hour) for each full-time worker. Different requirements would apply to part-time workers.

10. The House Tri-Committee Health Reform Discussion Draft includes a play-or-pay requirement for firms to contribute at least 72.5 percent toward a worker's premium (65 percent for family coverage) or pay a fee amounting to 8 percent of wages for each worker. For minimum-wage workers, that payroll tax would be roughly equal to 58 cents an hour. The requirements would be prorated for part-time workers.

11. The impact of the fee would be similar to that of employers' contributions for payroll taxes. Most analysts agree that wages and benefits would fall by the amount of an increase in those contributions.

500 percent of the federal poverty level but did not impose any play-or-pay requirements on employers. CBO concluded that the absence of such a play-or-pay requirement or other requirements for employers would have contributed to a noticeable decline in the number of people offered an employment-based plan.[12] A subsequent version of that bill—containing a play-or-pay requirement and a smaller subsidy program—led to a much smaller estimated impact on the amount of coverage provided through employment-based plans.[13]

Although play-or-pay requirements may prevent the erosion of employment-based plans, they are likely to affect the labor market. Because employees largely bear the cost of health insurance or play-or-pay fees in the form of lower wages, the effects of those provisions on employment and hours worked is likely to be relatively minor. However, a play-or-pay requirement could affect the amount of work available for certain categories of workers. In particular, a play-or-pay provision could reduce the hiring of low-wage workers, whose wages could not fall by the full cost of health insurance or a substantial play-or-pay fee if they were close to the minimum wage.[14]

The effect on employment would depend on the specifications of a play-or-pay requirement. Larger play-or-pay fees would tend to have a greater effect on employment; as the fees increased, more workers would be affected because their wages could not easily adjust without bumping into the minimum wage. The structure of the play-or-pay requirement would also matter. In some proposals, for example, the fees imposed on employers would apply only to full-time workers who were not offered health insurance; in others, the fees would apply to all workers but would be lower for part-time or temporary workers. Such limitations would increase incentives for firms to replace full-time employees with more part-time or temporary workers.

The effect of play-or-pay requirements on employment would also depend on the sensitivity of hiring decisions to changes in the minimum levels of compensation (including the minimum wage and the required levels of benefits). The impact of play-or-pay requirements on the employment of low-wage workers would be similar to the effects of raising the minimum wage—and the latter has been studied extensively. Although findings from those studies vary greatly, the weight of the evidence suggests that raising the minimum wage has a negative but small effect on the employment of low-wage workers.[15]

Several studies have used the findings from research on the minimum wage to estimate the effects of play-or-pay requirements on employment. One study estimated that 224,000 workers (or about 0.2 percent of all private-sector full-time workers between the ages of 22 and 65) could become unemployed if firms were required to provide health insurance costing, on average, $2 per hour worked (or roughly $4,000 a year per employee).[16] A second study found a larger effect—a potential loss of 750,000 jobs—from a higher play-or-pay assessment ($3 an hour, or $6,000 a year), but that estimate also included the effect of increasing the minimum wage from $5.15 (the minimum wage in 2004, the year of the study) to $7.25.[17] That study also assumed that play-or-pay requirements applied to part-time workers as well as full-time workers and that hiring decisions were somewhat more sensitive to changes in the minimum wage. Play-or-pay proposals that imposed less hefty assessments would have a smaller effect on employment.

Other researchers have examined Hawaii's experience with an employer mandate. Since 1975, employers in that state have been required to offer health insurance to their full-time workers or pay a penalty.[18] One study of that mandate found that the rate of employment grew faster in

12. Congressional Budget Office, "Preliminary Analysis of Major Provisions Related to Health Insurance Coverage Under the Affordable Health Choices Act," letter to the Honorable Edward M. Kennedy (June 15, 2009).

13. Congressional Budget Office, "Affordable Health Choices Act," letter to the Honorable Edward M. Kennedy (July 2, 2009).

14. The minimum wage is scheduled to increase from $6.55 to $7.25 on July 24, 2009.

15. For a review of that literature, see David Neumark and William L. Wascher, "Minimum Wages and Employment," *Foundations and Trends in Microeconomics*, vol. 3, no. 1-2 (2007), pp. 1–182.

16. Katherine Baicker and Helen Levy, *Employer Health Insurance Mandates and the Risk of Unemployment,* Working Paper No. 13528 (Cambridge, Mass.: National Bureau of Economic Research, October 2007).

17. Richard Burkhauser and Kosali Simon, *Who Gets What from Employer Pay or Play Mandates?* Working Paper No. 13578 (Cambridge, Mass.: National Bureau of Economic Research, 2007).

18. The penalty paid for each day the firm does not offer health insurance to its full-time employees is the greater of $25 or $1 per employee not offered coverage. A firm that fails to provide coverage for more than 30 days may be shut down by the state.

Hawaii than in the rest of the United States after the mandate was instituted, although that result may have been due to factors other than the mandate.[19] Another study did not find any relationship between the mandate and employment levels in Hawaii but observed an increase in the employment of part-time workers—one of the categories of workers who were exempted from the mandate.[20]

Imposing a Surcharge on Employers Whose Workers Receive Health Care Subsidies

Some proposals have considered imposing surcharges on employers whose workers use health care that is subsidized by the government. In Massachusetts, employers can be required to pay a surcharge if employees and their dependents who are not offered a plan use, in total, more than $50,000 worth of care a year from a state-funded pool that was established to finance care for the uninsured. Other variants of surcharge proposals would require employers—even those that offer insurance to their employees—to pay all or a portion of certain health insurance subsidies that their workers received from the government. Supporters of such surcharges often refer to them as "free-rider" penalties. Although the surcharges would be imposed on the firms, workers in those firms would ultimately bear the burden of those fees, just as they would with play-or-pay requirements or premiums for employment-based health insurance.

The differences between the effects of play-or-pay requirements and employer surcharge provisions illustrate some of the trade-offs concerning the size and characteristics of the affected population. Relative to the broader-based play-or-pay requirements, employer surcharges tend to be more targeted, applying only to workers who are not enrolled in their employers' plans and receive government subsidies for insurance obtained elsewhere. Many of those workers, however, are more likely to have earnings at or near the minimum wage, and the size of such surcharges—if based on the actual costs imposed on government programs—could be larger per affected worker than the assessments being considered in many play-or-pay requirements. As a result, the effects of an employer surcharge could be concentrated among workers whose wages could not easily adjust to absorb its full cost; such targeted provisions could therefore have a much larger impact on employment than a substantially smaller play-or-pay fee affecting a broader base of workers. Moreover, the employment loss would be concentrated disproportionately among low-income workers who employers expected would be more likely to obtain subsidies from the government (for example, unmarried individuals who do not receive family coverage through a spouse's job).

At the same time, employer surcharge provisions, which would require government agencies to track subsidies to individuals and then identify which employers to bill, could be more difficult to implement than play-or-pay requirements, and those administrative hurdles might temper the effects of such provisions on employment. Employer surcharge provisions might also create greater uncertainty for firms because their liability would depend on whether workers chose a government-subsidized plan, obtained other coverage, or became uninsured.

Expanding or Creating Individual Subsidies for Health Insurance

Subsidies for health insurance coverage can affect people's decisions about whether and how much to work. A subsidy can be provided through the transfer system (possibly as a voucher) or through the tax system (as an exclusion from income, a tax deduction, or a tax credit). A subsidy represents an increase in income, and some recipients may respond by working fewer hours (and thus offsetting part of the increase in subsidy income with a reduction in wage income).

To limit costs, subsidies are typically phased out as a beneficiary's income rises. Over the phase-out range, a worker receives less compensation for each additional hour worked, because each dollar earned reduces the subsidy. That effect, known as an "implicit tax," can lead people to work fewer hours than they otherwise would, in the same way that income and payroll tax rates do. Most empirical studies conclude that increases in marginal tax rates generally reduce the number of hours worked, particularly among secondary earners (typically, the spouse of the main earner in a family).[21] Higher tax rates also reduce people's incentive to raise their income in other ways,

19. Norman K. Thurston, "Labor Market Effects of Hawaii's Mandatory Employer-Provided Health Insurance," *Industrial and Labor Relations Review,* vol. 51, no. 1 (October 1997), pp. 117–135.

20. Thomas C. Buchmueller, John DiNardo, and Robert G. Valletta, *The Effect of an Employer Health Insurance Mandate on Health Insurance Coverage and the Demand for Labor: Evidence from Hawaii,* Working Paper No. 2009-08 (San Francisco, Calif.: Federal Reserve Bank of San Francisco, April 2009).

21. See Congressional Budget Office, *Labor Supply and Taxes* (January 1996).

such as working harder in the hope of winning raises; accepting new positions or responsibilities with higher compensation; or investing in their future earning capacity through education, training, or other means.[22]

Policymakers face a trade-off in deciding how to phase out subsidies. If subsidies are large and are phased out quickly, the implicit tax rates, and thus the negative impact on work incentives, can be quite high. Implicit tax rates can be reduced by expanding the range over which the subsidy is phased out, but doing so increases the number of people subject to the implicit tax and boosts the total cost of the subsidy. In the extreme, the same subsidy can be granted to everyone, but doing so substantially increases budgetary costs, which might in turn be financed through higher explicit tax rates. Alternatively, a subsidy can be eliminated all at once at a certain income (creating a "cliff" in the relationship of subsidy to income), which eliminates the cost of phasing out the subsidy more gradually but, for people whose potential income is near the cliff, significantly increases the disincentives to work more. People whose income is just below the threshold can respond by not working more hours, and those whose income is just above the threshold may cut their hours of work in order to qualify for the subsidy.

One program that creates work disincentives for its recipients is Medicaid. That program is structured so that eligibility for benefits is completely eliminated at a specified income for most eligibility categories (a cliff).[23] For individuals whose income is close to that threshold, working more and earning a higher income can lead to the loss of Medicaid benefits, creating a disincentive to work more. Proposals that would simply extend Medicaid eligibility to families whose income was slightly higher than allowed under current law would effectively move the cliff—reducing disincentives to work for families at the current threshold but creating new disincentives for families whose income was somewhat higher. One study concluded that a series of increases in the income limit for Medicaid eligibility in the late 1980s and 1990s increased the labor force participation of working-age single mothers by a small but statistically significant amount.[24] Creating new subsidies for health insurance for families above the eligibility thresholds for Medicaid would effectively reduce the size of current cliffs because people would become eligible for the new subsidies at the same time they became ineligible for Medicaid.

New subsidies might be created to cover the costs of private health insurance, and they could be gradually reduced over a specified income range in a variety of ways—with different implications for marginal tax rates and work incentives. Those subsidies could be gradually reduced at a uniform rate, causing implicit marginal tax rates to rise by the same amount for all recipients in the phase-out range. For example, a proposal might provide families whose income was at the federal poverty level (roughly $23,000 for a family of four in 2013, the year in which many proposals would take effect) with fully subsidized health insurance valued at $15,000. That subsidy might be gradually reduced as income increased, and families whose income was above 400 percent of the poverty level ($92,000) might be ineligible for any subsidy. In that case, marginal tax rates would go up by about 22 percentage points for all families whose income was between 100 percent and 400 percent of the poverty level.

An alternative approach would provide subsidies over the same income range but would link eligibility for those subsidies to an "affordability" standard that would limit the amount a family spent on health insurance premiums to a percentage of family income. For example, a family with income at the federal poverty level could be required to pay 1 percent of income but would receive a federal subsidy for the difference between the cost of their health insurance and the family's required contribution. That cap on premiums could be set to rise with income—for example, increasing to 10 percent of income as the family's income rose to 400 percent of the federal poverty level—and implicit marginal tax rates would also increase as income rose. An advantage of raising the cap is that

22. Martin Feldstein, "Effects of Taxes on Economic Behavior," *National Tax Journal*, vol. 61, no. 1 (March 2008), pp. 131–139.

23. Although eligibility for Medicaid varies by state, all states are required to cover pregnant women, children under age 6 whose family income is at or below 133 percent of the federal poverty level, and children who are at least age 6 but not yet 19 and whose family income is up to 100 percent of the federal poverty level. Some factors reduce the severity of the cliff: Eligibility for children can extend to higher income levels than eligibility for parents, so families do not lose all their benefits at once; and transitional medical assistance continues Medicaid eligibility temporarily for people whose earnings have risen to a level that would otherwise make them ineligible.

24. For estimates of the size of the effect on labor supply, see Aaron S. Yelowitz, "The Medicaid Notch, Labor Supply, and Welfare Participation: Evidence from Eligibility Expansions," *Quarterly Journal of Economics,* vol. 110, no. 4 (November 1995), pp. 909–939.

families with income below 200 percent of the poverty level—a group typically in the phase-out range for other income-related transfers and tax credits (such as the earned income tax credit)—would face smaller increases in marginal tax rates than under the approach that phased out subsidies uniformly over a broad income range. A disadvantage of that approach is that it could result in a cliff at the income level at which people were no longer eligible for a subsidy. Thus, a family whose income in 2013 was just over four times the federal poverty level and who paid $15,000 for insurance would pay 16 percent of income, compared with 10 percent if their income was slightly lower. That cliff, however, could be reduced or eliminated by either increasing the premium cap or extending the subsidy to families with slightly higher income.

Capping the Exclusion of Employment-Based Insurance

Some proposals would limit the current tax subsidy for health insurance by reducing the tax exclusion for employment-based health insurance—perhaps by capping the amount of payments that could be excluded from taxable income. Reducing that exclusion would make a larger share of compensation taxable. By itself, that change would reduce after-tax income, encouraging people to work more to make up for their lost earnings. Capping the exclusion would also affect the relative prices of goods: The effective price of health insurance would rise, making other goods relatively less expensive. For example, the price of leisure—a good that people "purchase" with forgone earnings by choosing to work less—would fall relative to the cost of health insurance. In the absence of other changes, an increase in the price of health insurance would tend to boost the consumption of other goods, including leisure. The net effect on labor supply of the reduction in income and the change in relative prices is uncertain and would depend on the details of the proposal.

Giving Preferential Treatment to Small Businesses

Many proposals to change the health insurance system would give small businesses subsidies or other types of preferential treatment. Subsidies based on a firm's size might be intended to help "level the playing field" between large and small firms, whose costs for providing health insurance differ, but they could also create a competitive advantage for small firms. Similarly, proposals that exempted small businesses from play-or-pay requirements, or lowered the assessments imposed on those firms, could favor employment in such firms.

The responses to such incentives could take several forms—some involving actions by workers, some involving actions by firms, and some involving actions by both parties. For example, workers might prefer to take jobs with smaller firms to take advantage of the new subsidies. Similarly, firms might take steps to become smaller (or avoid actions that might expand their workforces). For example, firms could outsource—that is, lay off employees and contract with other, smaller companies for the same services. Alternatively, they could divide themselves into subsidiaries with smaller workforces. One study examined the impact of state regulations governing health insurance plans offered by small groups and found a clustering of firms just under the statutory thresholds (for example, 25 employees) in states with rules that favored small firms, suggesting that some employers might have adjusted their size to take advantage of the preferential treatment of smaller firms.[25]

A firm seeking to reorganize in response to such incentives, however, could face high barriers to that process. It might find that keeping all of its workers within the same entity was more efficient. Employee benefit laws also limit the extent to which firms can treat employees differently across subsidiaries. Certain features of proposals—such as limiting subsidies only to the smallest firms or capping the average wages of workers in eligible firms—might make it more difficult for firms to reorganize or for workers to move to smaller firms. Administering subsidies for small businesses, however, might be challenging, because it would be difficult for government agencies to monitor the size of firms—providing opportunities for some firms to claim subsidies for which they were not eligible.

Enhancing the Individual Insurance Market or Creating Exchanges

Proposals might increase the attractiveness of health insurance coverage that is not provided through employers, even though those proposals might still retain current tax subsidies for employment-based insurance. For example, some proposals would establish exchanges where people could shop for insurance. Insurance obtained through exchanges could provide some of the advantages of employment-based insurance, including lower administrative costs. Another common feature of many proposals

25. Kanika Kapur and others, *Do Small Group Health Insurance Regulations Influence Small Business Growth?* Working Paper No. WR-351-ICJ (Santa Monica, Calif.: Rand Institute for Civil Justice, May 2006).

is the provision of subsidies that would help cover the costs of health insurance purchased through exchanges. Other changes to the insurance market—prohibiting insurers from denying coverage to people because of their preexisting conditions or limiting how much insurers could vary prices with the age or health status of insured individuals—would also make insurance in the exchanges or individual market more affordable for less healthy or older individuals.

By making insurance obtained outside the workplace more attractive, those provisions could cause some people to retire early. In its 2008 report *Budget Options, Volume 1: Health Care*, CBO analyzed an option that would allow people between the ages of 62 and 64 to buy into Medicare coverage. Under that option, participants would pay premiums equal to the average cost of benefits for program participants plus a 5 percent administrative fee. CBO estimated that the number of retired individuals would increase by roughly 20,000 as a consequence. That option, however, did not include subsidies to cover the costs of Medicare premiums or restrictions on how much premiums could vary with the age of enrollees—two features that would increase the attractiveness of the "bridge" coverage.

Increasing the availability of health insurance from sources other than employers could also reduce the participation of some younger workers in the labor force, especially those for whom gaining employer-based insurance is a major motivation for working; however, that effect would probably not be large. The impact on participation would probably be greatest among secondary earners because they tend to be more responsive to changes in the marginal benefit of working than are primary earners. Proposals that increased the availability of health insurance from other sources could also reduce job lock and, potentially, lead to better matches of workers to jobs.

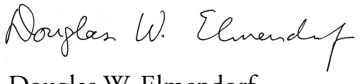
Effects of Changes to the Health Insurance System on International Competitiveness

Some analysts have argued that domestic firms offering health insurance to their workers face higher costs for compensation than do competitors based in countries where insurance is not related to employment and that fundamental changes to the health insurance system could reduce or eliminate that disadvantage. However, such a cost reduction is unlikely to occur, except in the short run, primarily because the costs of fringe benefits are largely borne by workers in the form of lower cash wages. Other economic factors (including tax rates and currency values) are likely to have a larger impact on a nation's competitiveness in the world market.

To be sure, workers' cash compensation might not increase immediately by the full amount of any reduction in employers' payments for health insurance. For that reason, firms that currently contribute toward the costs of their workers' health benefits could temporarily reap some savings in labor costs if changes to the health insurance system resulted in their workers receiving subsidized coverage in some other way. But those firms would experience no permanent change in their competitive status.

In at least one circumstance, firms might find it difficult to adjust wages as health care costs increased or declined. Some firms have commitments to cover the health care costs of their retirees, and those commitments may not be fully funded. Reducing those legacy costs could ease the financial strain on those firms. Stockholders could benefit, but whether lower costs would enhance the firms' competitiveness would depend on how firms used those additional savings. If those retiree benefits were the result of collective bargaining on behalf of both active workers and retirees, active workers might bear the costs of those benefits—but they might also capture any savings resulting from reductions in those costs.

This brief was prepared by Janet Holtzblatt and Benjamin Page. It and other CBO publications are available at the agency's Web site (www.cbo.gov).



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Douglas W. Elmendorf, Director

August 7, 2009

Honorable Nathan Deal
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

This letter responds to the question you asked at a July 16, 2009, committee markup concerning the Congressional Budget Office's (CBO's) analysis of the budgetary effects of proposals to expand governmental support for preventive medical care and wellness services. Specifically, you asked whether the agency's scoring methods reflect potential reductions in federal costs from improvements in health that might result from expanded support for those activities.[1]

Preventive Medical Care

Preventive medical care includes services such as cancer screening, cholesterol management, and vaccines. In making its estimates of the budgetary effects of expanded governmental support for preventive care, CBO takes into account any estimated savings that would result from greater use of such care as well as the estimated costs of that additional care. Although different types of preventive care have different effects on spending, the evidence suggests that for most preventive services, expanded utilization leads to higher, not lower, medical spending overall.

That result may seem counterintuitive. For example, many observers point to cases in which a simple medical test, if given early enough, can reveal a condition that is treatable at a fraction of the cost of treating that same illness after it has progressed. In such cases, an ounce of prevention improves health and reduces spending—for that individual. But when analyzing the effects of preventive care on total spending for health care, it is important to recognize that doctors do not know beforehand which patients are going to develop costly illnesses. To avert one case of acute illness, it is usually necessary to provide preventive care to many patients, most of whom would not have suffered that illness anyway. Even

[1] For additional information on both topics, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 132–139.

when the unit cost of a particular preventive service is low, costs can accumulate quickly when a large number of patients are treated preventively. Judging the overall effect on medical spending requires analysts to calculate not just the savings from the relatively few individuals who would avoid more expensive treatment later, but also the costs for the many who would make greater use of preventive care.[2] As a result, preventive care can have the largest benefits relative to costs when it is targeted at people who are most likely to suffer from a particular medical problem; however, such targeting can be difficult because preventive services are generally provided to patients who have the potential to contract a given disease but have not yet shown symptoms of having it.

Researchers who have examined the effects of preventive care generally find that the added costs of widespread use of preventive services tend to exceed the savings from averted illness. An article published last year in the *New England Journal of Medicine* provides a good summary of the available evidence on how preventive care affects costs.[3] After reviewing hundreds of previous studies of preventive care, the authors report that slightly fewer than 20 percent of the services that were examined save money, while the rest add to costs. Providing a specific example of the benefits and costs of preventive care, another recent study conducted by researchers from the American Diabetes Association, the American Heart Association, and the American Cancer Society estimated the effects of achieving widespread use of several highly recommended preventive measures aimed at cardiovascular disease—such as monitoring blood pressure levels for diabetics and cholesterol levels for individuals at high risk of heart disease and using medications to reduce those levels.[4] The researchers found that those steps would substantially reduce the projected number of heart attacks and strokes that occurred but would also increase total spending on medical care because the ultimate savings would offset only about 10 percent of the costs of the preventive services, on average. Of particular note, that study sought to capture both the costs and benefits of providing preventive care over a 30-year period.

Of course, just because a preventive service adds to total spending does not mean that it is a bad investment. Experts have concluded that a large fraction of preventive care adds to spending but should be deemed "cost-effective," meaning that it provides clinical benefits that justify those added costs: Roughly 60 percent of the preventive services examined in the review cited above have additional

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[2] In the case of screening tests, additional spending may also arise from treatment of newly diagnosed conditions as well as treatment stemming from tests yielding false positive results—that is, results indicating that a disease is present even though it is not.

[3] Joshua T. Cohen, Peter J. Neumann, and Milton C. Weinstein, "Does Preventive Care Save Money? Health Economics and the Presidential Candidates," *New England Journal of Medicine*, vol. 358, no. 7 (February 14, 2008), pp. 661–663.

[4] Richard Kahn and others, "The Impact of Prevention on Reducing the Burden of Cardiovascular Disease," *Circulation,* vol. 118 (July 28, 2008), pp. 576–585.

costs that many in the health care community consider to be reasonable relative to their clinical benefits. Still, providing that preventive care would represent a net use of resources rather than a source of funding for other activities. (About 20 percent of the services reviewed have costs that are large relative to their benefits, and a small fraction actually impair health while adding to costs.)

That pattern is not unique to preventive services. Treatments for existing medical conditions range from those that save money to those that cost money in much the same way that preventive services do: About 20 percent save money, and about 60 percent have costs that many consider reasonable relative to their benefits, according to the study cited above. Thus, not only preventive services but medical services more generally could be evaluated in order to encourage high-value services of both types and discourage low-value ones. (Note that with respect to both preventive care and treatments, the review encompassed only those approaches that had been carefully studied, and not the whole spectrum of each type of service.)

Even if the provision of preventive medical care saves money, potential savings from expanded federal support might be limited depending on how frequently that service is currently provided. Many studies of preventive care compare the costs and benefits of a preventive service with the costs and benefits of doing nothing. In practice, of course, a great deal of preventive medicine is already being performed—examples include periodic screening for colon or breast cancer, the use of cholesterol-lowering drugs that help prevent serious heart disease, and the use of vaccines—and many insurance plans already cover certain preventive services at little or no cost to enrollees.

Consequently, a new government policy to encourage prevention could end up paying for preventive services that many individuals are already receiving—which would add to federal costs but not reduce total future spending on health care. In particular, Medicare already covers preventive services that have been shown to reduce net costs. Moreover, legislation enacted last summer authorizes Medicare to add coverage of preventive services that improve health, including those that also reduce costs. For their part, private insurers are likely to be motivated to cover services that are shown to reduce costs in the short run, so the potential to increase the use of such services among privately insured individuals is especially limited. However, the turnover that occurs as individuals change jobs and switch insurers may discourage insurers from subsidizing preventive care that takes a long time to pay off, because the initial insurers may not be the ones to realize the resulting benefits.

A further consideration affecting the budgetary impact of proposals is that some types of preventive care may increase longevity. Of course, that effect reinforces the desirability of such care, but it also could add to federal spending in the long run: Social Security outlays rise when people live longer, and Medicare outlays may rise because, even if a preventive service lowers a beneficiary's risk of one

illness, a longer lifespan allows for more time to incur other health care expenses associated with age.

In sum, expanded governmental support for preventive medical care would probably improve people's health but would not generally reduce total spending on health care. However, government funding for some specific types of preventive care might lower total spending. In its estimates, CBO seeks to capture the likely future effects on the budget on a case-by-case basis.

Wellness Services

Wellness services include efforts to encourage healthy eating habits and exercise and to discourage bad habits such as smoking. As with preventive care, CBO's estimates of the budgetary effects of expanded governmental support for wellness services endeavor to account for any savings that would result from greater use of those services as well as the costs of those services. However, evidence regarding the effect of wellness services on subsequent spending on health care is limited, and CBO is continuing to evaluate the evidence that does exist.

Where CBO has identified evidence about the effects on future medical spending of broader government policies that encourage better health, the agency tries to include those effects in its analysis. For example, CBO's estimates of the budgetary effects of reduced tobacco use (from a higher excise tax, for example) include a reduction in Medicaid spending because less smoking would result in fewer low-birthweight babies, who have higher costs at birth and afterward.

More generally, however, designing government policies that are effective at inducing people to be healthier is challenging. Even successful efforts might take many years to bear fruit and could involve significant costs. Moreover, many employers already support some wellness services for their employees, and new government efforts to encourage such services could end up paying for services that some individuals are already receiving—which would add to federal costs but not reduce total future spending on health care. As with preventive medicine, the net budgetary effect of government support for wellness services depends on the balance of two factors—the reduction in government spending for people who reduce their future use of medical care and the costs to the government of providing or subsidizing wellness services.

One notable success story in improving health is the large reduction in smoking that has occurred in the United States over the past several decades: The fraction of adults who smoke today is roughly half of what it was in 1965. But public policies that discouraged smoking took decades to develop, implement, and reach fruition. Obesity, which is perhaps the most pressing public health problem facing the country, is probably even more difficult to address. Unlike smoking, which involves a unique substance that is not healthy in any quantity, obesity is the end result of several interacting factors that are not all intrinsically unhealthy. One of those factors is obviously diet, which can be hard to regulate because many foods

are safe to eat in moderation. Another key factor is lack of exercise, a bad habit that—like a poor diet—can be difficult for individuals to change and is particularly difficult for policymakers to influence. Approaches for losing weight reflect those difficulties: A variety of interventions appear to succeed in the short run, but relatively few participants are able to maintain their weight loss for a long period of time. Keeping to a lower weight may require longer-lasting, and potentially more expensive, approaches.

One recent study that analyzed the interactions of different chronic conditions and the costs of treating them—but did not address the costs of avoiding the conditions—found that cutting obesity rates in half would reduce total medical spending by the elderly Medicare population by roughly 10 percent in 2030.[5] However, the study also summarized other researchers' findings that, although better diets and increased physical activity lead to weight loss, "the majority of patients regain the initial weight loss within two to five years, [so] attention has thus focused on more intensive interventions to sustain weight loss." Another recent study estimated that the annual medical burden of obesity is now almost 10 percent of all medical spending and, specifically, that Medicare and Medicaid spending would be about 10 percent lower in the absence of obesity.[6] However, the article also noted, "The extent to which greater use of obesity treatments would reduce spending in either the short or the long run remains unknown. The same is true for prevention. Many successful obesity prevention efforts are likely to be cost-effective … but not cost saving. From a public health perspective, … these interventions may still be worth pursuing."

In an effort to improve health and reduce medical costs, many employers—particularly large employers—offer their workers wellness programs designed to encourage healthy living.[7] Those programs include nutrition and weight loss programs, discounts for gym membership, smoking cessation programs, and other personal health coaching. Although some case studies suggest that certain wellness programs reduce subsequent medical care, little systematic evidence exists. The findings from case studies may not be applicable to programs that would be implemented more broadly, either because the characteristics of the affected people may be different or because employers' adoption of wellness programs has been combined sometimes with other changes in health insurance (such as changes in payments to providers or changes in employees' cost-

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[5] Dana P. Goldman and others, "The Value of Elderly Disease Prevention," *Forum for Health Economics and Policy,* vol. 9, no. 2 (2006), www.bepress.com/fhep/biomedical_research/1/.

[6] Eric A. Finkelstein and others, "Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates," *Health Affairs,* Web Exclusive (2009), pp. w822–w831.

[7] Steven G. Aldana, "Financial Impact of a Comprehensive Multisite Workplace Health Promotion Program," *Preventive Medicine,* vol. 40 (2005), pp. 131–137.

sharing).[8] Identifying the effects of wellness services on health is especially difficult because those effects may not emerge for years: According to a review of the literature in 2001, studies of wellness activities generally follow participants for a few years—long enough to change some risk factors but not usually long enough to generate significant reductions in disease.[9] Because the evidence about such programs continues to evolve, CBO will continue to examine that evidence closely in evaluating specific proposals—the effects of which could depend very importantly on the proposals' design.

Scorekeeping Rules and Procedures

Beyond the substantive factors that can limit the effect of expanded governmental support for preventive medical care and wellness services on future government spending on health care, budget "scorekeeping" rules specify that only certain types of spending effects can be considered for purposes of Congressional budget enforcement. Scorekeeping rules were set forth by the Congress in the conference report for the Balanced Budget Act of 1997 and are updated occasionally upon agreement by the full group of "scorekeepers," a group that consists of the House and Senate Committees on the Budget, the Congressional Budget Office, and the Office of Management and Budget. The purpose of those rules is to ensure consistent budgetary treatment across programs and over time.

Two particular scorekeeping rules could affect provisions that provide funding for preventive care or wellness services. They prohibit counting any changes in mandatory spending as a result of changes in the amount of mandatory funding for administration or program management or in the amount of discretionary appropriations for any activity. (A mandatory spending program is one that does not require annual appropriations—for example, Medicare and Medicaid; discretionary programs are funded each year in an appropriation bill—including, for example, the research programs of the National Institutes of Health.) The rules were adopted in part to avoid situations in which hoped-for, but quite uncertain, savings are used to offset near-term, certain spending increases or revenue decreases in the same legislation.

As a result, even when new prevention and wellness activities funded from discretionary appropriations would, in CBO's judgment, generate eventual savings in Medicare or Medicaid, those savings would not be credited to the appropriation action as part of the budget scorekeeping process. Some legislation would authorize such appropriations, but not provide them, leaving that action for future appropriation bills. Because such legislation would not actually provide funding for prevention or wellness activities, it too could not be credited with

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[8] See, for example, Victoria Colliver, "Preventive Health Plan May Prevent Cost Increases," *San Francisco Chronicle* (February 11, 2007).

[9] Steven G. Aldana, "Financial Impact of Health Promotion Programs: A Comprehensive Review of the Literature," *American Journal of Health Promotion*, vol. 15, no. 5 (May-June 2001), pp. 296–320.

savings in mandatory programs. However, once an appropriation bill becomes law, any estimated savings in Medicare or Medicaid are factored into CBO's baseline projections; consequently, any realized savings in such cases will in fact reduce budget deficits (unless they are used for other purposes).

I hope that you find this information useful. If you have any further questions, please contact me or my staff. The CBO contacts are Jim Baumgardner and Colin Baker.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

cc: Honorable Frank Pallone, Jr.
Chairman
Subcommittee on Health

Honorable Henry A. Waxman
Chairman
Committee on Energy and Commerce

Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

November 25, 2009

Honorable George Miller
Chairman
Committee on Education and Labor
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

In response to several questions that CBO has received, this letter provides additional information on the budgetary effects of proposals to establish the Community Living Assistance Services and Supports (CLASS) Program.

H.R. 3962, the Affordable Health Care for America Act, as passed by the House of Representatives, and the Patient Protection and Affordable Care Act proposed by Senator Reid contain very similar proposals regarding a new federal program for long-term care insurance. Both proposals would establish a voluntary program for such insurance, termed the Community Living Assistance Services and Supports program. The key difference between the two proposals is in the population eligible to enroll: H.R. 3962 would allow both active workers and nonworking spouses to enroll, while the Senate proposal would allow only active workers to participate. For both the House and Senate versions of CLASS, the Congressional Budget Office (CBO) estimates that the cash flows under the new program would generate budgetary savings (that is, a reduction in net federal outlays) for the 2010-2019 period and for the 10 years following 2019, followed by budgetary costs (an increase in net federal outlays) in subsequent decades.[1] Because participation in the program would be voluntary, collections of insurance premiums under CLASS would be recorded as offsetting receipts (a credit against direct spending).

On balance, CBO estimates that the version of CLASS specified in H.R. 3962 would reduce deficits by $102 billion over the 2010-2019 period, while the version contained in the Senate proposal would reduce deficits by $72 billion over that period. The following discussion provides additional information on CBO's estimates for those proposals, including information on their longer-term effects.

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[1] See Congressional Budget Office, cost estimate for H.R. 3962, the Affordable Health Care for America Act (November 20, 2009); and cost estimate for the Patient Protection and Affordable Care Act (November 18, 2009).

Description of the CLASS Proposals

The Community Living Assistance Services and Supports proposals in H.R. 3962 and under consideration in the Senate would each establish a voluntary federal program for long-term care insurance that would be administered by the Secretary of Health and Human Services (HHS). Under both proposals, individuals could purchase coverage that would provide specified future benefits, with premiums set so that the program would be in actuarial balance over 75 years. (Actuarial balance means that expected insurance premiums plus the interest earned on such premium income would equal or exceed the expected cash payments for future benefits and the administrative costs of operating the program.) Premiums would vary only according to the enrollee's age when he or she enters the program. Once enrolled, an individual's premium would generally remain the same for as long as that individual remained in the program. H.R. 3962 would allow active workers and their nonworking spouses to enroll, while the Senate proposal would allow only active workers to participate.

In general, enrollees would have to pay premiums for five years to be vested in the program (that is, eligible to receive benefits in the event they become functionally disabled). Vested enrollees who need assistance performing at least two or three common daily activities such as dressing, bathing, and eating would receive cash benefits to pay for support services in a community setting. Severely impaired enrollees could apply their benefit toward the cost of residential care in a nursing home facility. The benefit would be at least $50 per day (indexed for inflation); the Secretary of HHS would set benefit levels based on the extent of enrollees' impairment. CBO assumed that the Secretary would initially establish an average daily benefit of about $75 (indexed for inflation). That figure includes an average benefit of $50 per day for impaired enrollees living in the community and larger amounts for enrollees who become institutionalized. Benefit payments made through the CLASS program would not be considered as income in determining an enrollee's eligibility for Medicaid.

Both the House and Senate legislation would provide considerable authority to the Secretary to adjust premiums for both current and future enrollees and to reduce benefits to the daily minimum of $50 in order to maintain the solvency of the program.

Budgetary Effects Over the Next 10 Years

CBO's estimates of the CLASS provisions in H.R. 3962 and in the Senate proposal differ because of the treatment of nonworking spouses in the two proposals. CBO estimates that the inclusion of nonworking spouses in the House proposal would increase expected future benefit payments (and would increase premiums correspondingly) because nonworking spouses who enroll in the program would be expected to be less healthy, on average, than active workers, and therefore more likely to become functionally impaired in later years and qualify for benefits.

H.R. 3962. CBO estimates that under the House-passed version of the CLASS program, the average monthly premium in 2011 would be about $146 (premiums for new enrollees would increase with inflation in later years). Expected enrollment in the program would reach slightly more than 10 million people by 2019 (or about 4 percent of the adult population). The estimated premiums are calculated to be adequate for the program to remain solvent for 75 years, taking into account the interest income that would be generated on unspent balances in the program's trust fund. (Because most enrollees would not receive benefits for many years, the fund would accumulate significant balances in the early years of the program.)

Over the 2010-2019 period, CBO estimates that the House-passed version of the CLASS program would reduce federal budget outlays by about $102 billion (see Table 1). This deficit reduction would occur in part because no benefits would be paid out during the first five years the program was in operation. Premium receipts would total about $123 billion over the 10–year period, and benefit payments would amount to $20 billion, CBO estimates. For those 10 years, administrative costs associated with operating the program would be 3 percent of premiums, as specified in the legislation, or about $4 billion. The program would generate about $2 billion in savings (over the 2010-2019 period) in the Medicaid program because, once an individual became eligible to collect benefits under both the CLASS and Medicaid programs, a portion of the CLASS benefit would go toward offsetting Medicaid costs. Medicaid would continue to provide the full array of long-term care benefits—to the extent that the individual was eligible—but the CLASS program would defray some costs that Medicaid would have otherwise paid.

Table 1. Estimated Budgetary Impact of Section 2581 of H.R. 3962, the Affordable Health Care for America Act

	Outlays in Billions of Dollars, by Fiscal Year											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Premiums	0	-5.3	-9.3	-12.6	-14.4	-16.2	-16.0	-16.2	-16.4	-16.5	-41.7	-123.1
Benefit Payments	0	0	0	0	0	0	2.3	4.3	6.1	7.3	0	20.0
Administrative Costs	0	0.2	0.3	0.4	0.4	0.5	0.5	0.5	0.5	0.5	1.3	3.7
Medicaid Savings	0	0	0	0	0	0	-0.3	-0.5	-0.7	-0.8	0	-2.2
Net Outlays	0	-5.2	-9.0	-12.3	-14.0	-15.8	-13.5	-11.9	-10.4	-9.5	-40.5	-101.6

The Senate Proposal. CBO estimates that under the current Senate proposal for CLASS, the average monthly premium in 2011 would be about $123 (premiums for new enrollees would increase with inflation in later years), and enrollment in the program would be slightly less than 10 million people by 2019 (or about 3.5 percent of the adult population). The slightly lower enrollment expected under the Senate proposal stems from the exclusion of nonworking spouses (as would be allowed under H.R. 3962). However, a higher percentage of those eligible would be expected to enroll under the Senate proposal because of the lower estimated premium.

Over the 2010-2019 period, CBO estimates that the Senate version of CLASS would reduce federal outlays by about $72 billion (see Table 2). Premium receipts would total about $88 billion over the 10–year period, and benefit payments would amount to about $14 billion, CBO estimates. For that period, administrative costs associated with operating the program would be 3 percent of premiums, as specified in the legislation, or less than $3 billion. The program would generate almost $2 billion in savings in the Medicaid program over the next 10 years.

Table 2. Estimated Budgetary Impact of Section 8001 of the Patient Protection and Affordable Care Act

	Outlays in Billions of Dollars, by Fiscal Year											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Premiums	0	-3.8	-6.6	-9.0	-10.2	-11.5	-11.4	-11.6	-11.7	-11.8	-29.6	-87.6
Benefit Payments	0	0	0	0	0	0	1.6	3.0	4.3	5.2	0	14.1
Administrative Costs	0	0.1	0.2	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.9	2.6
Medicaid Savings	0	0	0	0	0	0	-0.2	-0.3	-0.5	-0.6	0	-1.6
Net Outlays	0	-3.7	-6.4	-8.7	-9.9	-11.2	-9.6	-8.6	-7.5	-6.8	-28.7	-72.5

Effects Beyond the First 10 Years

Projections of premium receipts and benefit payments beyond the 10-year budget window (2010-2019) are subject to more uncertainty than projections for the first 10 years, and detailed year-by-year projections of those amounts would not be meaningful. Among other factors, a wide range of changes could occur—in people's health and disability status, in the evolution of private long-term care insurance, and in the delivery of medicine—that are likely to be significant but are very difficult to predict, both under current law and under the House and Senate proposals. As a result, CBO is only able to give a broad assessment of the potential budgetary outcomes in future decades, based on the underlying structure of the long-term care proposals.

CBO estimates that both the House and Senate versions of the CLASS program would reduce the federal budget deficit in the second decade following enactment of the legislation (2020-2029), but by smaller amounts than in the initial decade. By the third decade, the sum of benefit payments and administrative costs would probably exceed premium income and savings to the Medicaid program. Therefore, the programs would add to budget deficits in the third decade—and in succeeding decades—by amounts on the order of tens of billions of dollars for each 10-year period. The House-passed version of CLASS, which would reduce the federal budget deficit in the first 10 years by an estimated $30 billion more than would the Senate version, would likewise add somewhat more to the deficits in the third decade and beyond than would the Senate proposal. (That is, the greater participation and poorer health status of enrollees under the House version would lead to larger benefit payments in those later years.)

The CLASS program would add to budget deficits in future decades even though the proposals require the Secretary of HHS to set premiums to ensure the program's solvency for 75 years. Because of the extended time horizon involved in long-term care insurance and the build-up of unspent premium receipts, income from interest on accumulated fund balances would play a large role in financing the program's benefits. Typically, enrollees pay premiums for many years before some of them become disabled and qualify for benefits. Private issuers of long-term care insurance finance benefit payments from their reserve of accumulated premium receipts and the income they derive from investing those premiums. Similarly, the Secretary would invest CLASS program premium receipts in federal securities and would incorporate that expected income into calculations of appropriate premiums to charge. However, trust fund income from investments in federal securities would be an intragovernmental transfer within the federal budget. As a result, from a budget scorekeeping perspective, the CLASS program would inevitably add to future deficits (on a cash basis) by more than it reduces deficits in the near term, even though the premiums would be set to ensure solvency of the program.[2]

Key Caveats. These estimated effects of the CLASS proposals are subject to considerable uncertainty, for several reasons. The budgetary impact would depend importantly on the number of people who would enroll in the program and the health status of those enrollees later in life. That would depend, in turn, on peoples' perceptions about their need for long-term care insurance and their comparison of the premiums they would have to pay in the CLASS program with the value of the future benefits the program would provide. CBO's estimate of the premiums that would be required to ensure the programs' actuarial soundness over 75 years is based on projections of future trends in the prevalence of disabilities and in the ways that care for people with disabilities will be provided. Though some insight can be obtained from the experience of

[2] Because premium income in the early years would reduce the amount that the government has to borrow from the public, interest on the public debt would also be reduced during that period, but that type of effect is not included in the estimates used in the Congressional budget process.

private-market insurance, both of those trends are subject to substantial uncertainty. Moreover, under the CLASS proposals, the Secretary of HHS would be given great latitude in administering the program, which adds to the uncertainty about the program's cash flows because benefit and premium levels could be set at different levels than CBO has estimated and could be adjusted over time in a variety of ways.

The CLASS program could be subject to considerable financial risk in the future if it were unable to attract a sufficiently healthy group of enrollees. Relatively healthy enrollees would ensure that the program's premiums and the interest on those premiums would be adequate to pay for future benefits. However, attracting healthy enrollees could be challenging for several reasons. One reason is that the administrative costs of the program are limited to 3 percent of premiums, which might mean that the Secretary would not have sufficient funds to effectively market the program to a large number of people. A relatively small enrollment would increase the risk of adverse selection and could undermine the long-run stability of the program. (On the other hand, by keeping administrative costs to a minimum, the CLASS program might attract relatively healthy enrollees because the resulting premiums could be lower than the premiums that would be charged for many private policies that have substantially higher administrative costs and devote a share of their premiums to profit.)

Another reason why attracting health enrollees could be a challenge is that the CLASS program would have to enroll all eligible people who apply, making it likely that some enrollees would be people who were unable to obtain coverage in the private market because of their poor health status. To avoid insuring people with a higher-than-average probability of eventually receiving benefits, private insurers employ extensive underwriting of policies sold in the individual market (that is, people are charged different premiums depending on their expected future need for care), and market coverage selectively in the employer market.

The program includes provisions that would allow employers, at their option, to automatically enroll employees in the CLASS program. That feature could help to boost participation in the program and thereby mitigate the risk of adverse selection. However, the proposals would not require employers to auto-enroll their employees, and employees would have the right to opt out of the coverage altogether, reducing the likely effects of auto-enrollment to stimulate participation in the program.

I hope you find this information helpful. If you have any questions, please contact me. The CBO staff contacts are Bruce Vavrichek and Stuart Hagen.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

cc: Honorable John Kline
Senior Republican

Honorable Henry A. Waxman
Chairman
Committee on Energy and Commerce

Honorable Joe Barton
Ranking Member

Honorable Charles B. Rangel
Chairman
Committee on Ways and Means

Honorable Dave Camp
Ranking Member

Honorable John D. Dingell

Identical letter sent to the Honorable Tom Harkin.