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

Keith Hall, Director

August 24, 2017

Honorable Tom MacArthur
U.S. House of Representatives
Washington, DC 20515

Re: Questions About CBO's Objectivity and the Agency's Estimates of the Effects of the American Health Care Act

Dear Congressman:

Thank you for meeting with me on July 12 to talk about the Congressional Budget Office's processes for ensuring the integrity of its work, as well as questions you posed about the agency's analysis of the effects of the American Health Care Act (AHCA).[1] This letter provides additional details about the issues we discussed.

Steps to Keep CBO's Work Objective, Impartial, and Nonpartisan

During our conversation, we discussed steps that CBO takes to ensure that its work is objective, impartial, and nonpartisan. Allow me to elaborate on our conversation:

- When approaching budgetary and economic questions and cost estimates, the agency's analysts—who have a detailed understanding of federal programs and the tax code—carefully read the relevant research literature and extensively examine data collected and reported by the government's statistical agencies and private organizations. The analysts seek out information from people with diverse perspectives on the issues. The agency encourages open discussion of the analytic issues.

[1] Congressional Budget Office, cost estimate for H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives (May 24, 2017), www.cbo.gov/publication/52752.

- The agency enforces strict rules to limit its employees' political activities and to prevent its employees from having financial conflicts of interest.

- The agency applies a rigorous review process to its analysis. All of its reports and estimates are reviewed by people at different levels in the organization, and, typically, the analytic reports are also reviewed by outside experts who specialize in the issues at hand.

- The agency consults with numerous outside experts who represent a variety of perspectives. The experts include professors, analysts at think tanks, representatives of industry groups and professional societies, other private-sector experts, and people working for federal agencies and for state and local governments.

- As part of that effort, the agency holds regular meetings with its Panel of Economic Advisers and Panel of Health Advisers, which consist of experts with a wide variety of backgrounds and specialized knowledge, who are selected to represent a range of views. When considering their advice, CBO also considers whether panel members are engaged in substantial political activity or have significant financial interests that might influence, or that might reasonably appear to influence, their perspective on the issues at hand. Advisers' disclosure reports are available to the public.

- The agency strives to explain the basis of its findings so that outside analysts can understand the results and question the methodologies used.

- Finally, CBO makes no policy recommendations, because choices about public policy inevitably involve value judgments that the agency does not and should not make.

In addition to those processes and policies, I can report that all of the people at CBO are tasked with maintaining a culture of objectivity, impartiality, and nonpartisanship. Employees prize those attributes that bolster the integrity of their analysis, and their interactions continually reinforce the culture.

Estimates of People Insured

You asked about the benchmark to which the AHCA was compared and how the percentage of people insured today relates to CBO's estimates of the number under the AHCA and under that benchmark over the next decade.

In general, CBO analyzes the potential effects of legislation by comparing what would occur under the legislation to its projections over the next 10 years of what would occur under its baseline, which generally follows current law. For health insurance coverage, the construction of the baseline starts with data on recent experience and projects how rates of coverage and sources of insurance would change federal costs as a result of alterations in people's incomes and net costs for various insurance options—accounting for market prices, eligibility for subsidies, and subsidy amounts.

After consulting with the budget committees, CBO and the staff of the Joint Committee on Taxation (JCT) measured the costs and savings in the estimate for the AHCA relative to CBO's March 2016 baseline projections, with adjustments for legislation that was enacted after that baseline was produced. That approach is not unusual: The budgetary effects of reconciliation legislation are typically estimated relative to the baseline that underlies the budget resolution that specified the reconciliation instructions and that was the basis for the deficit reduction goals stated in the resolution. The agencies used the March 2016 baseline for cost estimates for all pieces of legislation related to the budget reconciliation process for 2017, including that for the AHCA. That approach allows for consistent comparisons among related proposals.

In the March 2016 baseline, CBO and JCT projected that the share of people with health insurance would be 90 percent in 2016 and throughout the following decade. As measured in the National Health Interview Survey, conducted by the U.S. Census Bureau, the share turned out to be 90 percent in 2016. Under the AHCA, CBO and JCT projected, the share would fall to 83 percent in 2020, 82 percent in 2021 through 2025, and 81 percent in 2026.

You also asked how CBO's estimates of the effects of the AHCA accounted for data on the actual number of participants in the marketplaces established by the Affordable Care Act (ACA).

In the March 2016 baseline, 10 million people were estimated to be purchasing subsidized insurance through the marketplaces in 2016, and 2 million people were estimated to be purchasing unsubsidized insurance, for a total of 12 million. Actual average enrollment per month during 2016 was 8 million subsidized people and 2 million unsubsidized people, for a total of 10 million.

CBO regularly updates its budget projections and estimating methodology to reflect recent developments and new data. CBO's most recent baseline projections were completed in late January 2017, after the budget resolution for 2017 was adopted. The agencies have not had time to undertake a follow-on analysis of the effects of the AHCA under that baseline. In the projections published in January 2017, the direct spending and revenue effects of the ACA's insurance coverage provisions and the total number of people projected to be uninsured were similar to the estimates in the March 2016 baseline, but the number of people projected to purchase subsidized coverage in the marketplaces was smaller, and the average subsidy per person was larger. If the AHCA was evaluated relative to the January 2017 baseline rather than the March 2016 baseline, it is unclear how different categories of insurance would be affected and whether the budgetary effects would differ noticeably.

Estimates of Effects on Premiums

You asked why CBO and JCT did not provide an estimate of the average effect on premiums for people living in states that would obtain waivers from requirements for both essential health benefits (EHBs) and community rating under the AHCA.

The agencies judged that such an estimate would be too imprecise. CBO and JCT developed estimates of premiums for individuals as part of the microsimulation used in the analysis. Among the one-sixth of the population residing in states that would make substantial changes to market regulations, many people would pay low premiums, but some would pay very high premiums. CBO and JCT were uncertain how high those premiums could go, because insurers there might decide to not offer policies with high premiums and their decisions are hard to predict. That uncertainty about insurers' behavior had little effect on the agencies' estimates of the number of people with insurance coverage or on the number of people using tax credits, because the number of people who would pay high premiums was not large. Similarly, it had little effect on the agencies' estimates of spending because the tax credit amounts were not

linked to premiums. However, the very high premiums for those people would have had a substantial effect on the agencies' estimate of average premiums. Thus, uncertainty about how high those premiums could go made the estimate of the average too imprecise.

You also asked for information about how CBO and JCT assessed the effects that waivers available under the AHCA would have on premiums in specific states. However, because a projection of a specific state's actions would be highly uncertain, the agencies' estimates reflect an assessment of the probabilities of different outcomes, without any explicit predictions about which states would make which decisions.

CBO and JCT's estimates incorporate many factors that would influence states' decisions to apply for one or both waivers. In developing their projections of states' behavior, the agencies took into account states' past behavior regarding the nongroup market (including the rules that existed or exist in state law) as well as current market conditions.

Before the ACA was enacted, states varied widely in the types of services and benefits that nongroup insurance plans were required to cover. For example, 18 states mandated the coverage of maternity care in the nongroup market before 2014, and 23 states mandated some mental health benefits.[2] CBO and JCT expect that states that previously mandated fewer benefits would be more likely to apply for a waiver to modify the EHBs.

In addition, states used a variety of approaches to regulate the nongroup market prior to the enactment of the ACA. For example, before the implementation of that law, when community rating became required nationally, 7 states prohibited medical underwriting based on health status, 11 states placed other limits on medical underwriting, and 32 states placed no restrictions on medical underwriting.[3] CBO and JCT expect that states with no restrictions on medical underwriting and fewer regulations governing the nongroup market before 2014 would be more likely to apply for a community-rating waiver.

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[2] Henry J. Kaiser Family Foundation, "State Health Facts (Health Insurance & Managed Care Indicators: Pre-ACA State Mandated Health Insurance Benefits)" (accessed August 15, 2017), http://tinyurl.com/m527l6x.

[3] Henry J. Kaiser Family Foundation, "State Health Facts: Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals)" (accessed August 15, 2017), http://tinyurl.com/m8cehyl.

Current market conditions—such as the number of people likely to enroll in nongroup coverage, insurers' participation, and anticipated premiums in local markets—would also affect states' decisions to apply for waivers. CBO and JCT expect that states with smaller markets, fewer insurers, and higher premiums would be more likely to apply for one or both waivers. States would consider applying at the same time that they would consider how to use funds available through the Patient and State Stability Fund, so those decisions would be intertwined.

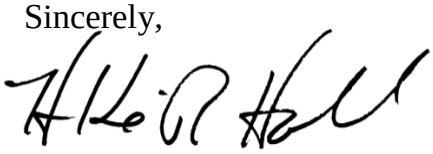
Finally, CBO and JCT expect that the preferences of local insurers, hospitals, and medical providers would also influence states' decisions.

States would face some pressure to modify the EHBs in order to reduce premiums in the nongroup market. At the same time, countervailing pressure would also exist because people who use services or benefits that might be excluded from the EHBs would pay more for them, and providers might be concerned that the share of patients who do not pay their medical bills would increase. Reducing the scope of the EHBs could also segment the nongroup market and potentially contribute to instability.[4]

States would also face some pressure from insurers to apply for a waiver from the community-rating requirement because it would provide them with an additional tool to manage the risk posed by people who wait to enroll in coverage until they face high medical expenses. Market participants' concerns about instability could generate opposing pressure.

I hope that you find this information helpful. If you have any further questions, please contact me.

Sincerely,



Keith Hall
Director

[4] Although the risk-adjustment program that exists under current law would continue to operate and is designed to help stabilize the nongroup market by balancing risks among insurers, it is unclear how effective the program would be if the EHBs were modified because the scope of benefits among plans would probably vary.

cc:

Honorable Diane Black Chairman House Budget Committee	Honorable John Yarmuth Ranking Member House Budget Committee
Honorable Paul Ryan Speaker U.S. House of Representatives	Honorable Nancy Pelosi Democratic Leader U.S. House of Representatives
Honorable Mitch McConnell Majority Leader U.S. Senate	Honorable Charles Schumer Democratic Leader U.S. Senate