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

Douglas W. Elmendorf, Director

November 18, 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, an amendment in the nature of a substitute to H.R. 3590, as proposed in the Senate on November 18, 2009. 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 would yield a net reduction in federal deficits of $130 billion over the 2010-2019 period (see Table 1). Approximately $77 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 all of the legislation's potential impact on spending that would be subject to future appropriation action.

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 below. Table 2 shows federal budgetary cash flows for direct spending and revenues associated with the legislation. Tables 3 and 4 provide estimates

of the resulting changes in the number of nonelderly people in the United States who would have health insurance, present the primary budgetary effects of the legislation's major provisions related to insurance coverage, and display 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 legislation's tax provisions are provided by JCT in JCX-55-09 (see www.jct.gov).

This analysis also examines the longer-term effects of the legislation on the federal budget and reviews the main reasons why this estimate differs from the analysis CBO released on October 7, 2009, for the America's Healthy Future Act of 2009, incorporating amendments adopted by the Committee on Finance.

Estimated Budgetary Impact

According to CBO and JCT's assessment, enacting the Patient Protection and Affordable Care Act would result in a net reduction in federal budget deficits of $130 billion over the 2010–2019 period (see Table 1). In the subsequent decade, the collective effect of its provisions would probably be small 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 $599 billion over 10 years for the proposed expansions in insurance coverage. That net cost itself reflects a gross total of $848 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 $100 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 $491 billion and other provisions that JCT and CBO estimate would increase federal revenues by $238 billion.[1]

In total, CBO and JCT estimate that the legislation would increase outlays by $356 billion and increase revenues by $486 billion between 2010 and 2019 (see Table 2).

[1] The 10-year figure of $238 billion includes $223 billion in revenues from tax provisions (estimated by JCT) apart from receipts from the excise tax on high-premium insurance plans and $15 billion in revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by CBO). (For JCT's estimates, see JCX-55-09.)

Table 1. Estimate of the Effects on the Deficit of the Patient Protection and Affordable Care Act, as Proposed on November 18, 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	*	2	5	3	37	74	106	118	123	130	46	599
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING [b]												
Effects on the Deficit of Changes in Outlays	12	-4	-19	-30	-49	-58	-65	-79	-91	-106	-92	-491
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [c]												
Effects on the Deficit of Changes in Revenues [d]	-9	-12	-13	-31	-26	-27	-28	-29	-31	-32	-91	-238
NET CHANGES IN THE DEFICIT [a]												
Net Increase or Decrease (-) in the Budget Deficit	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

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.

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

d. The 10-year figure of $238 billion includes $223 billion in revenues from tax provisions (estimated by JCT) apart from receipts from the excise tax on high-premium insurance plans and $15 billion in revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by CBO). (For JCT's estimates, see JCX-55-09.)

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

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 also include 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. State governments could elect not to make the public plan available in their state. The legislation also would provide start-up funds to encourage the creation of cooperative insurance plans (co-ops) that could be offered through the exchanges; existing insurers could not be approved as co-ops.

Table 2. Estimated Changes in Direct Spending and Revenues Resulting From the Patient Protection and Affordable Care Act as Proposed on November 18, 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 (OUTLAYS)												
Health Insurance Exchanges												
Premium and Cost Sharing Subsidies	0	0	0	0	15	36	58	71	76	83	15	338
Start-up Costs	*	*	*	*	*	*	0	0	0	0	2	2
Other Related Spending	0	1	2	2	1	1	1	1	*	*	6	9
Subtotal	*	2	2	2	16	37	59	71	77	83	23	349
Reinsurance and Risk Adjustment Payments [1]	0	0	0	0	12	19	20	21	22	24	12	118
Public Health Insurance Plan												
Payments for Benefits and Administration	0	0	0	0	8	14	22	26	28	30	8	129
Collections of Enrollee Premiums, Exchange Subsidies, and Risk Adjustment Payments [2]	0	0	0	0	-9	-15	-23	-27	-29	-31	-9	-134
Start-up Costs	*	*	1	1	*	0	0	0	0	0	2	2
Subtotal	*	*	1	1	*	-1	-1	-1	-1	-1	1	-3
Effects of Coverage Provisions on Medicaid and CHIP	-1	-2	-3	-3	25	48	69	75	80	87	17	374
Medicare and Other Medicaid and CHIP Provisions												
Reductions in Annual Updates to Medicare FFS Payment Rates	*	-2	-5	-9	-14	-20	-26	-32	-39	-47	-30	-192
Medicare Advantage Rates Based on FFS	0	-6	-7	-10	-11	-12	-14	-17	-19	-22	-34	-118
Medicare and Medicaid Payments to DSH Hospitals	0	0	0	0	*	-6	-8	-9	-10	-10	*	-43
Other	8	4	-3	-4	-16	-10	-10	-13	-17	-21	-11	-82
Subtotal	8	-4	-14	-24	-41	-49	-57	-71	-84	-99	-75	-436

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Table 2. Continued.

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Other Changes in Direct Spending												
Community Living Assistance Services and Supports	0	-4	-6	-9	-10	-11	-10	-9	-8	-7	-29	-72
Other	3	3	2	2	3	3	3	3	3	2	13	26
Subtotal	3	*	-5	-7	-7	-9	-7	-6	-5	-4	-16	-46
Total Outlays	12	-5	-19	-30	4	45	83	89	88	89	-38	356
On-budget	12	-5	-19	-30	4	45	83	88	87	88	-38	352
Off-budget	0	*	*	*	*	*	1	1	1	1	*	4
CHANGES IN REVENUES												
Coverage-Related Provisions												
Exchange Premium Credits	0	0	0	0	-4	-11	-18	-22	-23	-25	-4	-103
Reinsurance and Risk Adjustment Collections	0	0	0	0	13	18	20	21	22	25	13	119
Small Employer Tax Credit	0	-2	-3	-4	-4	-2	-2	-2	-3	-3	-12	-24
Penalty Payments by Employers and Uninsured Individuals	0	0	0	0	2	5	6	7	8	8	2	36
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	-2	-5	-3	3	14	19	22	24	-11	70
Other Provisions												
Fees on Certain Manufacturers and Insurers [3]	9	10	10	10	10	10	10	10	10	10	51	102
Additional Hospital Insurance Tax	0	0	0	13	6	6	7	7	8	8	18	54
Other Revenue Provisions [4]	*	2	3	7	10	11	11	12	13	14	22	82
Total Revenues	9	9	8	28	43	56	70	78	87	97	98	486
On-budget	9	9	9	24	40	52	61	68	75	83	91	430
Off-budget	*	*	*	4	3	5	8	11	12	14	7	56
NET IMPACT ON THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES [5]												
Net Change in the Deficit	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	*	*	*	-4	-3	-4	-8	-10	-11	-13	-6	-52

Continued

Table 2. Continued.

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.

1. Risk adjustment payments over the 10-year period include about $13 billion in payments to the public health insurance plan and about $85 billion in payments to other plans; risk adjustment outlays lag revenues shown later in the table by one quarter. Reinsurance payments total $20 billion over the 10-year period.

2. Premiums include amounts to cover amortized repayment of start-up funds, as well as to maintain the contingency reserve.

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

4. Amounts include $68 billion in increased revenues, as estimated by JCT, for tax provisions other than those not broken out separately in the table. In addition, this line includes an increase in revenues of about $15 billion for other provisions shown in Table 4.

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

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 share of federal spending would vary somewhat from year to year but ultimately would average about 90 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 all Medicaid beneficiaries until the exchanges were fully operational; coverage levels for children under Medicaid and CHIP would need 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. CBO estimates that state spending on Medicaid would increase by about $25 billion over the 2010–2019 period as a result of the provisions affecting coverage reflected in Table 3. That estimate reflects states' flexibility to make programmatic and other budgetary changes to Medicaid and CHIP.

The legislation contains a number of other key provisions related to insurance coverage. 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 $599 billion over fiscal years 2010 through 2019 (see Table 3). That estimate primarily reflects $374 billion in additional net federal outlays for Medicaid and CHIP and $447 billion in federal subsidies that would be provided to purchase coverage through the new insurance exchanges and related spending.[2] The other main element of the coverage provisions that would increase federal deficits is the tax credit for small employers who offer health insurance, which is estimated to reduce revenues by $27 billion over 10 years. Those costs would be partly offset by receipts or savings, totaling $249 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 $8 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 $64 billion.[3]

By 2019, CBO and JCT estimate, the number of nonelderly people who are uninsured would be reduced by about 31 million, leaving about 24 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

[2] Related spending includes the administrative costs of establishing the exchanges as well as $5 billion for high-risk pools, about $3 billion for insurance co-ops, and the net budgetary effects of proposed fees and payments for reinsurance and risk adjustment.

[3] 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.

from about 83 percent currently to about 94 percent. About 25 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, and the number obtaining coverage through their employer would also 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 3 as enrollees in employment-based coverage rather than as exchange enrollees). CBO and JCT expect that 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 legislation would require that the premiums for the public plan be set to fully fund expenditures for medical claims, administrative costs, and a contingency reserve. The legislation would provide for start-up funding for the administrative costs associated with establishing the public plan and require that those funds be paid back in amortized amounts over 10 years. The legislation also would provide start-up funding for a contingency reserve in an amount sufficient to cover 90 days of claims. On an annual basis, collections of premiums would exceed benefit payments and administrative costs by the amount needed to cover the start-up costs and to maintain the contingency reserve.

Roughly one out of eight people purchasing coverage through the exchanges would enroll in the public plan, CBO estimates, meaning that total enrollment in that plan would be 3 million to 4 million. That estimate reflects two main components:

- CBO’s assessment is that a public plan paying negotiated rates would attract a broad network of providers but would typically have premiums that were 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 for 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 applicable to all plans operating in the exchanges.)

- CBO’s analysis took into account the probability that some states would opt not to allow the public plan to be offered to their residents. Rather than trying to judge

which states might opt out, CBO applied a probability recognizing that public opinion is divided regarding the desirability of a public plan and that some states might have difficulty enacting legislation to opt out. Overall, CBO's assessment was that about two-thirds of the population would be expected to have a public plan available in their state.

The proposed co-ops had very little effect on the estimates of total enrollment in the exchanges or federal costs because, as they are described in the legislation, they seemed unlikely to establish a significant market presence in many areas of the country or to noticeably affect federal subsidy payments. As a result, CBO estimates that of the $6 billion in federal funds that would be made available to establish such co-ops, about $3 billion would be spent over the 2010–2019 period.

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 4). In total, CBO estimates that enacting those provisions would reduce direct spending by $491 billion over the 2010–2019 period.[4] 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 $192 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 (DSH) hospitals, by about $43 billion—composed of roughly $22 billion from Medicaid and $21 billion from Medicare DSH payments.

[4] In addition, the effects of certain provisions affecting Medicare, Medicaid, and other programs would increase federal revenues by approximately $15 billion over the 2010–2019 period.

The legislation also would establish an Independent Medicare 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. For fiscal years 2015 through 2019, such recommendations would be required if the Medicare trustees 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). After 2019, recommendations would be required if projected growth exceeded the rate of increase in national health expenditures (NHE) per capita. 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

- 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.[5]

The board would develop its first set of recommendations during 2013 for implementation in 2015. CBO estimates that—given all of the reductions that would result from other provisions—this arrangement would reduce Medicare spending by an additional $23 billion over the 2015–2019 period.

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

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

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.

- 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.

- 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 $7 billion over the 2010–2019 period.

Effect of the Legislation on Discretionary Costs

CBO has not completed an estimate of all the discretionary costs that would be associated with the legislation. Total 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 (and especially the Centers for Medicare and Medicaid Services) 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.

Comparison With CBO and JCT’s Estimate for the Senate Finance Committee’s Proposal

On October 7, 2009, CBO transmitted a preliminary analysis by CBO and JCT of the Chairman’s mark for the America’s Healthy Future Act of 2009, incorporating the amendments adopted by the Finance Committee through that date. The estimates provided here differ from the ones in that analysis for several reasons, primarily involving differences in the provisions of the two proposals. Relative to the provisions included in the Finance Committee’s proposal, prominent examples of such differences are as follows:

- The subsidies that would be provided through the insurance exchanges are larger, and there are provisions regarding a public plan that could be offered in the exchanges.

- The penalties for individuals who do not obtain insurance are phased in more quickly and the exemptions from those penalties are less extensive. The penalties for employers whose workers receive exchange subsidies also differ.

- The start dates for the individual mandate, exchanges, and employer penalties were all moved from July 1, 2013, to January 1, 2014.

- This legislation contains a number of additional provisions, including those establishing the CLASS program and an abbreviated approval pathway for follow-on biologics, and providing increased funding for prevention and public health.

- The thresholds for the excise tax on high-premium insurance plans are higher, and there is a new provision for an additional payroll tax on high-income individuals.

- CBO and JCT have also made some technical changes in their modeling, including changes in how people are expected to respond to the phasing in of a penalty for not having insurance, and in how firms would respond to the penalties they would face.

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 $196 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 $63 billion in 2019 and are growing at about 8 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 10 percent to 15 percent per year in the next decade.

All told, the legislation would reduce the federal deficit by $8 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 bill, 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-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. 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.[6]

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

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

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).[7]

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 $160 billion over 10 years, driven primarily by the $848 billion gross cost of the coverage expansions (including increases in both outlays and tax credits). That cost is partly offset by the following reductions in the federal commitment:

- Changes to net spending for Medicare, Medicaid, CHIP, and other federal health programs other than the changes associated directly with expanded insurance coverage (about $420 billion);

- Revenues generated by the excise tax on high-premium insurance plans, which is effectively a reduction in the existing tax expenditure for health insurance premiums (about $150 billion); and

- Changes to existing law regarding tax preferences for health care and effects of other provisions on tax expenditures for health care (about $120 billion).[8]

CBO expects that, during the decade following the 10-year budget window, the increases and decreases in the federal budgetary commitment to health care stemming from this legislation would roughly balance out, so that there would be no significant change in

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[7] 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).

[8] That figure is the sum of: about $70 billion (the revenue component of the line labeled "Other Effects on Tax Revenues and Outlays" in Table 3); about $40 billion (the sum of provisions related to tax expenditures for health care estimated by JCT and shown in Table JCX-55-09); and about $10 billion (the sum of provisions related to tax expenditures included in the section "Changes in Revenues" on page 15 of Table 4).

that commitment. The range of uncertainty surrounding that assessment is quite wide, and the commitment could turn out to be higher or lower than under current law.

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 put into effect a number of procedures that might be difficult to maintain over a long period of time. Although it would increase payment rates for physicians' services for 2010 relative to those in effect for 2009, those rates would be reduced by about 23 percent for 2011 and then remain at current-law levels (that is, as specified under the SGR) for 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 Medicare Advisory Board is fairly effective in reducing costs—beyond the reductions that would be achieved by other aspects of the bill—to meet the targets specified in the legislation.

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 (excluding the effect of establishing the Medicare prescription drug benefit). Adjusting for inflation, Medicare spending per beneficiary under the bill would increase at an average annual rate of roughly 2 percent during the next two decades—much less than the roughly 4 percent annual growth rate of the past two decades. Whether such a reduction in the growth rate could be achieved through greater efficiencies in the delivery of health care or would reduce access to care or diminish the quality of care is unclear.

The long-term budgetary impact could be quite different if key provisions of the bill 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.

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.

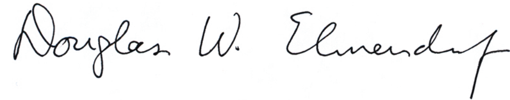
The total cost of mandates imposed on the private sector, as estimated by CBO and JCT, would greatly exceed the threshold established in UMRA for private entities ($139 million in 2009, adjusted annually for inflation). The most costly mandates would be the new requirements regarding health insurance 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). 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