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

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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

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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
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.

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