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

Douglas W. Elmendorf, Director

October 7, 2009

Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr. Chairman,

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have completed a preliminary analysis of the Chairman's mark for the America's Healthy Future Act of 2009, incorporating the amendments that have been adopted to date by the Committee on Finance. That analysis reflects the specifications posted on the committee's Web site on October 2, 2009, corrections posted on October 5, and additional clarifications provided by the staff of the committee through October 6. CBO and JCT's analysis is preliminary in large part because the Chairman's mark, as amended, has not yet been embodied in legislative language.

Among other things, the Chairman's mark, as amended, 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 Medicaid and Medicare programs and the federal tax code.

CBO and JCT's preliminary assessment of the proposal's impact on the federal budget deficit is summarized below. The enclosures with this letter 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 proposal's major provisions related to insurance coverage, display detailed estimates of the cost or savings from

other proposed changes (primarily to the Medicare program) that would affect the federal government's direct spending, and describe the major additional corrections and clarifications provided by the committee staff.

Estimated Budgetary Impact of the Amended Chairman's Mark
According to CBO and JCT's assessment, enacting the Chairman's mark, as amended, would result in a net reduction in federal budget deficits of $81 billion over the 2010–2019 period (see Table 1). The estimate includes a projected net cost of $518 billion over 10 years for the proposed expansions in insurance coverage. That net cost itself reflects a gross total of $829 billion in credits and 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 $201 billion in revenues from the excise tax on high-premium insurance plans and $110 billion in net savings from other sources. The net cost of the coverage expansions would be more than offset by the combination of other spending changes that CBO estimates would save $404 billion over the 10 years and other provisions that JCT and CBO estimate would increase federal revenues by $196 billion over the same period.[1] In subsequent years, the collective effect of those provisions would probably be continued reductions in federal budget deficits. Those estimates are all subject to substantial uncertainty.

Specifications Regarding Insurance Coverage
The amended mark would take several steps designed to increase the number of legal U.S. residents who have health insurance. Starting in July 2013, the proposal 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 proposal also would establish new insurance exchanges and would subsidize the purchase of health insurance through those exchanges for individuals and families with income between 100 percent and 400 percent of the federal poverty level (FPL).

[1] The $196 billion figure includes $180 billion in additional revenues (estimated by JCT) apart from receipts from the excise tax on high-premium insurance plans and $16 billion in additional revenues from certain Medicare and Medicaid provisions (estimated by JCT and CBO).

TABLE 1. PRELIMINARY ESTIMATE OF THE EFFECTS ON THE DEFICIT OF THE CHAIRMAN'S MARK, AS AMENDED, FOR THE AMERICA'S HEALTHY FUTURE ACT OF 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	*	3	5	-7	30	78	96	101	104	107	32	518
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING [b]												
Effects on the Deficit of Changes in Outlays	9	-1	-11	-21	-42	-47	-55	-66	-78	-93	-65	-404
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [c]												
Effects on the Deficit of Changes in Revenues [d]	-11	-13	-15	-19	-20	-21	-22	-23	-25	-26	-78	-196
NET CHANGES IN THE DEFICIT [a]												
Net Increase or Decrease (-) in the Budget Deficit	-2	-11	-20	-47	-32	10	20	13	1	-12	-111	-81
On-Budget	-2	-11	-20	-41	-24	20	31	26	16	6	-98	*
Off-Budget [e]	*	*	*	-6	-8	-9	-11	-13	-16	-18	-13	-81

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

Notes: This estimate reflects the specifications posted on the Senate Finance Committee's Web site on October 2, 2009, corrections posted on October 5, and additional clarifications provided by the staff of the committee through October 6.

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 that are classified as off-budget.

d. The 10-year figure of $196 billion includes $180 billion in additional revenues (estimated by JCT) apart from receipts from the excise tax on high-premium insurance plans and $16 billion in additional revenues from certain Medicare and Medicaid provisions (estimated by JCT and CBO).

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

Policies purchased through the exchanges (or directly from insurers) would have to meet several requirements: In particular, insurers would have to accept all applicants, could not limit coverage for preexisting medical conditions, and could not vary premiums to reflect differences in enrollees' health. The proposal 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.

Starting in 2014, nonelderly people with income below 133 percent of the FPL would generally be made eligible for Medicaid; the federal government would pay a share of the costs of covering newly eligible enrollees that varies 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 children under Medicaid and CHIP 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 $33 billion over the 2010–2019 period as a result of the specifications affecting coverage. That estimate reflects states' flexibility to make programmatic and other budgetary changes to Medicaid and CHIP.

The amended proposal contains a number of other key provisions. Although it would not explicitly require employers to offer health insurance, firms with more than 50 workers that did not offer coverage would be subject to a penalty for full-time workers who obtained subsidized coverage through the insurance exchanges. 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—10 percent in 2013, indexed over time—in which case the employer could also 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. In general, that threshold would be set initially at $8,000 for single policies and $21,000 for

family policies (although a number of exceptions would apply); after 2013, those amounts would be indexed to overall inflation plus 1 percentage point.

On a preliminary basis, CBO and JCT estimate that the proposal's specifications affecting health insurance coverage would result in a net increase in federal deficits of $518 billion over fiscal years 2010 through 2019. That estimate primarily reflects $345 billion in additional federal outlays for Medicaid and CHIP and $461 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 $23 billion over 10 years. Those costs would be partly offset by receipts or savings, totaling $311 billion over the 10-year budget window, from four sources: net revenues from the excise tax on high-premium insurance plans, totaling $201 billion; penalty payments by uninsured individuals, which would amount to $4 billion; penalty payments by employers whose workers received subsidies via the exchanges, which would total $23 billion; and other budgetary effects, mostly on tax revenues, associated with the expansion of federally subsidized insurance, which would reduce deficits by $83 billion.[3]

By 2019, CBO and JCT estimate, the number of nonelderly people who are uninsured would be reduced by about 29 million, leaving about 25 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under the proposal, the share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 94 percent. Roughly 23 million people would purchase their own coverage through the new insurance exchanges, and there would

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[2] The subsidies reflect the administrative costs of establishing and operating the exchanges. Related spending accounts for $5 billion for high-risk pools, about $3 billion for insurance co-ops, and the net budgetary effects of proposed reinsurance fees and payments.

[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 estimate for those elements.

be roughly 14 million more enrollees in Medicaid and CHIP than is projected under current law.[4] Relative to currently projected levels, the number of people either purchasing individual coverage outside the exchanges or obtaining coverage through employers would decline by several million.

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 specifications, they seem 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, about $3 billion would be spent over the 2010–2019 period.

Specifications Affecting Medicare and Medicaid
Other components of the proposal would alter spending under Medicare, Medicaid, CHIP, and other federal health programs. The proposal would make numerous changes to payment rates and payment rules in those programs (the budgetary effects of which are shown in Table 1 and detailed in the enclosed table). In total, CBO estimates that enacting those provisions would reduce direct spending by $404 billion over the 2010–2019 period.[5] 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 $162 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.)

[4] Under the proposal, certain employers could allow all of their workers to choose among the plans available in the exchanges, but those enrollees would not be eligible to receive subsidies via the exchanges (and thus are shown in the enclosed table as enrollees in employment-based coverage rather than as exchange enrollees). CBO and JCT estimate that approximately 4 million people would obtain coverage in that way in 2019, bringing the total number of people enrolled in exchange plans to about 27 million in that year.

[5] In addition, the Medicare and Medicaid provisions would increase federal revenues by approximately $16 billion over the 2010–2019 period.

- 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 $117 billion (before interactions) over the 2010–2019 period.

- Reducing Medicare and Medicaid payments to hospitals that serve a large number of low-income patients, known as disproportionate share (DSH) hospitals, by almost $45 billion—composed of roughly $22 billion each from Medicaid and Medicare DSH payments.

The proposal also would establish a Medicare Commission, 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 2018, 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). The proposal would not set a target for spending in 2019; after 2019, recommendations would be required if projected growth exceeded the rate of increase in gross domestic product (GDP) per capita plus 1 percentage point. The proposal would place a number of limitations on the actions available to the commission, 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;

- Reductions in subsidies of premiums charged by Part D 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.[6]

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[6] The proposal would authorize the Medicare Commission to recommend changes that would affect hospitals and hospices beginning in 2020.

The commission 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 $22 billion over the 2015–2019 period.

"Failsafe" Budgeting Mechanism
An amendment adopted by the committee would require that, beginning in 2012, the Director of the Office of Management and Budget (OMB) certify annually whether or not the provisions of the legislation are projected to increase the budget deficit in the coming year. If the Director determined that they were projected to increase the deficit, he or she would be required to notify the Congress, and exchange subsidies would be automatically adjusted to avoid the estimated increase in the deficit for that year.

The estimates presented in this preliminary analysis do not incorporate the potential effects of using this proposed failsafe mechanism, although CBO and JCT estimate that the amended mark would increase the deficit in fiscal years 2015 through 2018. Many of the budgetary effects of this proposal would appear as part of larger aggregates in the budget and would not be readily observable. Consequently, its overall budgetary impact could not be identified, and OMB's estimating assumptions and procedures would determine whether and how this failsafe procedure was implemented. It is therefore difficult to predict whether the proposed failsafe mechanism would result in a budget-neutral impact in each year. If the mechanism was implemented to reduce exchange subsidy rates in some years, it would probably result in significant reductions to the dollar volume of such subsidies and associated reductions in coverage. Under CBO and JCT's estimates of the deficit impact for the proposal, the failsafe provisions would require a reduction in exchange subsidies averaging about 15 percent during the years 2015 through 2018.

Important Caveats Regarding This Preliminary Analysis
There are a number of key reasons why the preliminary analysis that is provided in this letter and the enclosures does not constitute a final cost estimate for the proposal:

- The Chairman's mark, as amended, has not yet been converted into legislative language. The review of such language could lead to

significant changes in the estimates of the proposal's effects on the federal budget and insurance coverage.

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

- Federal spending that would be funded by future appropriations is not reflected in these estimates. For example, implementation costs for operations of the Internal Revenue Service and the Centers for Medicare and Medicaid Services are not included. Those discretionary costs could total several billion dollars over the 10-year period, but CBO has not yet completed an estimate of the appropriations that would be necessary. (In contrast, administrative costs for establishing and operating the exchanges, largely funded through a premium surcharge, are included in Table 1.)

CBO's Previous Estimate
On September 16, 2009, CBO transmitted a preliminary analysis of specifications for the Chairman's mark as provided by staff of the Finance Committee. Those earlier estimates differ from the estimates provided here for two primary reasons:

First, the proposal has been changed in a number of significant ways. For example, the subsidies that would be provided through the insurance exchanges were made larger, the penalties for not having insurance were reduced, and more people would be exempt from those penalties. Furthermore, the provisions of the excise tax on high-premium insurance plans were changed in ways that would reduce the amount of revenues collected. In addition, states would now be required to maintain current coverage levels for children under Medicaid and CHIP through 2019. Although CBO and JCT were able to provide estimates for many amendments, the agencies are not in a position to assess the impact of

individual policy changes now that they have been combined in the amended mark.

Second, CBO and JCT have made some technical refinements in their estimating procedures, including a revised assessment of the impact of the proposed changes on premiums for employer-sponsored health insurance and the resulting effects on tax revenues.

Effects of the Proposal Beyond the First 10 Years

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

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

- The gross cost of the coverage expansions, consisting of exchange subsidies, the net costs of expanded eligibility for Medicaid, and tax credits for employers: Those provisions have an estimated cost of $180 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 $46 billion in additional revenues in 2019 and that receipts would grow by roughly 10 percent to 15 percent per year in the following decade.

- Other taxes and the effects of coverage provisions on revenues: Increased revenues from those provisions are estimated to total about $52 billion in 2019 and are growing at about 10 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 $93 billion in 2019, and CBO projects that, in combination, they will increase by 10 percent to 15 percent per year in the next decade.

All told, the proposal would reduce the federal deficit by $12 billion in 2019, CBO and JCT estimate. After that, the added revenues and cost savings are projected to grow more rapidly than the cost of the coverage expansion. Consequently, CBO expects that the proposal, 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 between one-quarter percent and 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.

Many Members have expressed interest in the effects of reform proposals on various other measures of spending on health care. Under the Chairman's proposal, the projected effects on the federal budget deficit also represent the change in the federal government's overall commitment of resources to health care because essentially all of the spending and tax elements contained in the proposal are related to health care. Thus, the proposal would reduce the federal budgetary commitment to health care, relative to that under current law, during the decade following the 10-year budget window. 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

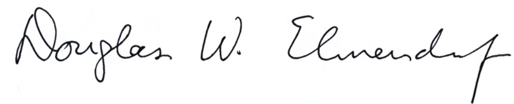
agency has not assessed the net effect of the current proposal on NHE, either within the 10-year budget window or for the subsequent decade.

These projections assume that the proposals 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. The projected savings for the proposal reflect the cumulative impact of a number of specifications that would constrain payment rates for providers of Medicare services. In particular, the proposal would increase payment rates for physicians' services for 2010, but those rates would be reduced by about 25 percent for 2011 and then remain at current-law levels (that is, as specified under the SGR) for subsequent years. Under the proposal, increases in payment rates for many other 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 proposal also assume that the Medicare Commission is relatively effective in reducing costs—beyond the reductions that would be achieved by other aspects of the proposal—to meet the targets specified in the legislation. The long-term budgetary impact could be quite different if those provisions 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.)

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 proposal would probably continue to reduce budget deficits relative to those under current law in subsequent decades. Therefore, pursuant to section 311 of S. Con. Res. 70, CBO estimates that enacting the proposal would not cause a net increase in deficits in excess of $5 billion in any of the four 10-year periods beginning after 2019.

I hope this preliminary analysis is helpful for the committee's deliberations. If you have any questions, please contact me or CBO staff. The primary staff contacts for this analysis are Philip Ellis, who can be reached at 226-2666, and Holly Harvey, who can be reached at 226-2800.

Sincerely,



Douglas W. Elmendorf
Director

Enclosures

cc: Honorable Chuck Grassley
Ranking Member

Preliminary Analysis of the Insurance Coverage Provisions Contained in the Amended Chairman's Mark

EFFECTS ON INSURANCE COVERAGE /a (Millions of nonelderly people, by calendar year)		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law	Medicaid/CHIP	40	39	39	38	35	34	35	35	35	35
Coverage /b	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup	13	12	12	12	13	14	14	14	14	15
	Other /c	14	14	14	14	14	15	15	15	15	16
	Uninsured /d	50	51	51	51	51	51	52	53	53	54
	TOTAL	267	269	271	273	274	276	277	279	281	282
Change (+/-)	Medicaid/CHIP	*	-2	-2	-1	6	10	13	13	14	14
	Employer	*	2	2	3	4	*	-2	-2	-3	-3
	Nongroup/Other /c	*	*	*	*	-3	-4	-4	-4	-5	-5
	Exchanges	0	0	0	4	15	22	21	22	23	23
	Uninsured /d	*	-1	-1	-6	-22	-27	-28	-29	-29	-29
Post-Policy Uninsured Population											
Number of Nonelderly People /d		51	50	50	45	28	24	24	24	24	25
Insured Share of the Nonelderly Population /a											
Including All Residents		81%	81%	81%	84%	90%	91%	91%	91%	91%	91%
Excluding Unauthorized Immigrants		83%	83%	83%	85%	92%	94%	94%	94%	94%	94%
Memo: Exchange Enrollees and Subsidies											
Number w/ Unaffordable Offer from Employer /e					*	*1*	*1*	*1*	*1*	*2*	*2*
Number of Unsubsidized Exchange Enrollees					*1*	*3*	*5*	*5*	*5*	*5*	*5*
Average Exchange Subsidy per Subsidized Enrollee							*$4,600*	*$4,800*	*$5,000*	*$5,200*	*$5,500*

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

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

a. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.
b. Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source.
c. Includes Medicare and other sources; the effects of the proposal are almost entirely on nongroup coverage.
d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.
e. Workers who would have to pay more than a specified share of their income (10 percent in 2013) for employment-based coverage could receive subsidies via an exchange.

Preliminary Analysis of the Insurance Coverage Provisions Contained in the Amended Chairman's Mark

EFFECTS ON THE FEDERAL DEFICIT / a,b,c (Billions of dollars, by fiscal year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Medicaid/CHIP Outlays /d	-1	-2	-3	-1	25	44	61	69	74	80	345
Exchange Subsidies & Related Spending /e	1	2	3	7	29	68	80	84	90	98	461
Small Employer Tax Credits /f	0	2	4	3	3	3	2	2	2	2	23
Gross Cost of Coverage Provisions	*	2	4	8	56	115	143	155	166	180	829
Penalty Payments by Uninsured Individuals	0	0	0	0	0	*	-1	-1	-1	-1	-4
Penalty Payments by Employers /f	0	0	0	0	-1	-3	-4	-5	-5	-5	-23
Excise Tax on High Premium Insurance Plans /f	0	0	0	-10	-18	-23	-30	-35	-40	-46	-201
Other Effects on Tax Revenues and Outlays /g	*	1	2	-6	-8	-11	-12	-13	-16	-20	-83
NET COST OF COVERAGE PROVISIONS	*****	**3**	**5**	**-7**	**30**	**78**	**96**	**101**	**104**	**107**	**518**

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

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

a. Does not include several billion dollars in federal administrative costs that would be subject to appropriation.
b. Components may not sum to totals because of rounding; positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
c. Estimates could change based on review of legislative language.
d. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2010-2019 period would increase by about $33 billion as a result of the coverage specifications.
e. Includes $5 billion in spending for high-risk pools, about $3 billion in spending for insurance co-ops, and the net budgetary effects of proposed reinsurance fees and payments.
f. The effects on the deficit of this provision include the associated effects of changes in taxable compensation on tax revenues.
g. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about $3 billion over the 2010-2019 period, and that the coverage provisions would have negligible effects on outlays for other federal programs.

Preliminary Estimate for Title I, Subtitle F, Through Title V of the Chairman's Mark, as Amended, for the America's Healthy Future Act of 2009
Estimates reflect specifications and are subject to revision upon review of legislative language.
By fiscal year, in billions of dollars.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Changes in Direct Spending Outlays												
TITLE I-HEALTH CARE COVERAGE												
SUBTITLE F-TRANSPARENCY AND ACCOUNTABILITY												
Ombudsmen Program	included in estimate for expanding insurance coverage											
Transparency	included in estimate for expanding insurance coverage											
Health Insurance Consumer Assistance Grants	0	0	0	0	0	0	0	0	0	0	0	0
Standardization	included in estimate for expanding insurance coverage											
SUBTITLE G-ROLE OF PUBLIC PROGRAMS												
PART I-MEDICAID COVERAGE FOR THE LOWEST-INCOME POPULATIONS												
Eligibility Standards and Methodologies	included in estimate for expanding insurance coverage											
Medicaid Program Payments	included in estimate for expanding insurance coverage											
Medicaid and Employer-Sponsored Insurance	included in estimate for expanding insurance coverage											
Treatment of the Territories	0	0.1	0.1	0.1	0.7	0.7	0.8	0.8	0.9	1.0	1.0	5.3
Medicaid Improvement Fund	0	0	0	0	-0.1	-0.2	-0.2	-0.2	-0.2	0	-0.1	-0.7
PART II-CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)	included in estimate for expanding insurance coverage											
PART III-IMPROVEMENTS TO MEDICAID												
Enrollment Coordination with the Exchange	included in estimate for expanding insurance coverage											
Presumptive Eligibility	included in estimate for expanding insurance coverage											
Waiver Transparency	0	0	0	0	0	0	0	0	0	0	0	0
PART IV-MEDICAID SERVICES												
Free-Standing Birth Centers	*	*	*	*	*	*	*	*	*	*	*	*
Curative and Palliative Care for Children in Medicaid	*	*	*	*	*	*	*	*	*	*	0.1	0.2
Long-Term Services and Supports												
Aging and Disability Resource Center funding	*	*	*	*	*	*	*	*	0	0	*	0.1
Community first choice option	0	0	0	0	0.1	0.2	0.4	0.9	1.2	0	0.1	2.9
Spousal impoverishment	0	0	0	0	0.2	0.2	0.2	0.3	0.3	0	0.2	1.2
Home- and community-based services	*	0.2	0.2	0.2	0.3	0.4	0.4	0.5	0.6	0.6	1.0	3.4
Money Follows the Person Rebalancing Demonstration	0	0	0	*	0.1	0.2	0.3	0.4	0.3	0.3	0.2	1.7
Family Planning Services	0	0	0	0	0	0	0	0	0	0	0	0
Definition of Medical Assistance	0	*	*	*	*	*	*	*	*	*	*	*
School-Based Health Centers	0.1	0.1	*	*	0	0	0	0	0	0	0.2	0.2
Repayment of Medicaid Overpayment	0.1	*	*	*	*	*	*	*	*	*	0.1	0.1
PART V-MEDICAID PRESCRIPTION DRUG COVERAGE	-0.6	-1.4	-1.7	-1.8	-1.9	-2.0	-2.3	-2.4	-2.5	-2.7	-7.4	-19.4
PART VI-MEDICAID DISPROPORTIONATE SHARE PAYMENTS	0	0	0	*	-2.2	-2.9	-4.1	-4.2	-4.3	-4.5	-2.2	-22.2

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PART VII-DUAL ELIGIBLES												
Waiver Authority for Dual Eligible Demonstrations	0	0	0	0	0	0	0	0	0	0	0	0
Federal Coordinated Health Care Office	0	0	0	0	0	0	0	0	0	0	0	0
PART VIII-MEDICAID QUALITY												
Medicaid Quality Measures	*	*	*	0.1	0.1	*	*	*	*	0	0.2	0.3
Medicaid Reimbursement for Health-Care Acquired Conditions	0	0	*	*	*	*	*	*	*	*	*	*
Medicaid Bundled Payments Demonstration Project	0	0	0	0	0	0	0	0	0	0	0	0
Medicaid Global Payments Demonstration Project	*	*	*	0	0	0	0	0	0	0	0.1	0.1
Medicaid Accountable Care Organizations Demonstration Project	0	0	0	0	0	0	0	0	0	0	0	0
Medicaid Emergency Psychiatric Care Demonstration Project	0	*	*	*	*	*	*	*	0	0	0.1	0.1
PART IX-MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION	*	*	0	0	0	0	0	0	0	0	*	*
PART X-AMERICAN INDIANS AND ALASKA NATIVES												
Premiums and Cost-Sharing	included in estimate for expanding insurance coverage											
Payer of Last Resort	0	0	0	0	0	0	0	0	0	0	0	0
Eligibility Determination	0	0	0	0	0	0	0	0	0	0	0	0
Indian Providers and Medicare Part B	0	*	*	*	*	*	*	*	*	*	0.1	0.2
Other Policies Related to Exchange Coverage	0	0	0	0	0	0	0	0	0	0	0	0
Indian Tribe Health Benefits	included in JCT estimates											
SUBTITLE H-ADDRESSING HEALTH DISPARITIES												
Standardized Collection of Data	0	0.1	0.1	0.1	0	0	0	0	0	0	0.2	0.2
Sufficient Disparities Data	0	0	0	0	0	0	0	0	0	0	0	0
Data Sharing	0	0	0	0	0	0	0	0	0	0	0	0
Privacy and Security	0	0	0	0	0	0	0	0	0	0	0	0
Medical Power of Attorney for Foster Care Children	0	0	0	0	0	0	0	0	0	0	0	0
Therapeutic Foster Care	*	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
SUBTITLE I-MATERNAL, INFANT, AND EARLY CHILDHOOD VISITATION												
Home Visitation Grants Program	*	0.2	0.3	0.4	0.4	0.2	*	*	0	0	1.3	1.5
Support Services for Women Suffering from Postpartum Depression	0	0	0	0	0	0	0	0	0	0	0	0
Elder Justice	0	0	0	0	0	0	0	0	0	0	0	0
VA and TRICARE Protections	0	0	0	0	0	0	0	0	0	0	0	0
Assisted Suicide	0	0	0	0	0	0	0	0	0	0	0	0
Abstinence Education and Personal Responsibility Education for Adulthood Training	*	0.1	0.1	0.1	0.1	0.1	0.1	*	*	0	0.4	0.6

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TITLE II-PROMOTING DISEASE PREVENTION AND WELLNESS												
SUBTITLE A-MEDICARE												
Risk Assessment, Personalized Prevention Plan, and Wellness Visit	0.2	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.5	0.5	1.6	3.7
Removing Barriers to Preventive Services	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.8
Evidence-Based Coverage of Preventive Services	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.7
Study on Beneficiary Access to Immunizations	0	0	0	0	0	0	0	0	0	0	0	0
Incentives for Healthy Lifestyles	*	*	*	*	*	*	0	0	0	0	0.1	0.1
SUBTITLE B-MEDICAID												
Improving Access to Preventive Services for Eligible Adults	*	*	*	*	*	*	*	*	*	*	*	0.1
Tobacco Cessation	0	0	0	*	*	*	*	*	*	*	*	-0.1
Incentives for Healthy Lifestyles	*	0.1	*	*	0	0	0	0	0	0	0.1	0.1
Medicaid State Plan Option Promoting Health Homes and Integrated Care	*	*	*	*	*	*	*	*	*	*	*	0.1
Appropriations for Childhood Obesity Demonstration Project	*	*	*	*	*	0	0	0	0	0	*	*
SUBTITLE C-WORKPLACE WELLNESS												
Incentives for Participation in Voluntary Wellness Programs	included in estimate for expanding insurance coverage											
TITLE III-IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE												
SUBTITLE A-TRANSFORMING THE HEALTH CARE DELIVERY SYSTEM												
PART I-LINKING PAYMENT TO QUALITY OUTCOMES IN THE MEDICARE PROGRAM												
Hospital Value-Based Purchasing	0	0	0	0	0	0	0	0	0	0	0	0
Physician Quality Reporting Initiative	0	0.1	*	-0.1	-0.1	-0.2	-0.2	-0.1	-0.2	-0.2	-0.1	-0.8
Expansion of Physician Feedback Program	0	0	0	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.1	-0.9
Value-Based Modifier for Physician Payment Formula	0	0	0	0	0	0	0	0	0	0	0	0
Medicare Inpatient Rehabilitation Facility, Long-Term Acute Care Hospital, and Hospice Quality Reporting	0	0	0	0	*	*	*	*	*	*	*	-0.2
Medicare PPS-Exempt Cancer Hospital Quality Reporting	0	0	0	0	0	0	0	0	0	0	0	0
Medicare Home Health Agency and Skilled Nursing Facility Value-Based Purchasing Implementation Plans	0	0	0	0	0	0	0	0	0	0	0	0
Reducing Health-Care Acquired Conditions	0	0	0	0	0	-0.3	-0.3	-0.3	-0.3	-0.3	0	-1.5
PART II-STRENGTHENING THE QUALITY INFRASTRUCTURE												
Quality Infrastructure	*	0.1	0.1	0.1	0.1	*	0	0	0	0	0.2	0.3
Health Information Technology for Free Clinics	0	0	0	0	0	0	0	0	0	0	0	0

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PART III-ENCOURAGING DEVELOPMENT OF THE NEW PATIENT CARE MODELS												
Accountable Care Organizations	0	0	*	-0.1	-0.3	-0.6	-0.7	-0.9	-1.0	-1.2	-0.5	-4.9
CMS Innovation Center												
Funding for Center (including noncovered benefits)	0.1	0.2	0.4	0.6	0.7	0.8	0.9	1.0	1.0	1.0	1.9	6.6
Effect on Medicare spending for benefits	0	-0.1	-0.2	-0.4	-0.5	-0.6	-0.9	-1.3	-1.8	-2.3	-1.1	-8.0
National Pilot Program on Payment Bundling	0	0	0	*	*	*	*	*	*	*	*	*
Reducing Avoidable Hospital Readmissions	0	0	0	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.5	-2.1
Transitional Care Program to Reduce Preventable Readmissions	0	0.1	0.2	0.2	0.1	0	0	0	0	0	0.5	0.5
Extension of Gainsharing Demonstration	*	*	*	*	*	0	0	0	0	0	*	*
Home-Based Chronic Care Management Program	*	*	*	*	*	*	*	*	*	*	*	*
PART IV-STRENGTHENING PRIMARY CARE AND OTHER WORKFORCE IMPROVEMENTS												
Primary Care/General Surgery Bonus	0	0.2	0.3	0.3	0.3	0.3	0.1	0	0	0	1.1	1.6
Graduate Medical Education Provisions	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.4	1.0
Proposal on Development of a National Workforce Strategy	0	0	0	0	0	0	0	0	0	0	0	0
Demonstration Project to Address Health Professions Workforce Needs	*	*	0.1	0.1	0.1	0.1	*	*	*	0	0.3	0.4
Extension of Family-to-Family Health Information Centers	*	*	*	*	*	*	0	0	0	0	*	*
Teaching Health Centers	0	*	*	*	*	*	*	*	*	*	0.2	0.2
Advanced-Practice Nurse Training	0	0.2	0.2	0.2	0.2	0.2	*	0	0	0	0.8	1.0

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SUBTITLE B-IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS												
PART I-ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES												
Sustainable Growth Rate	7.0	3.9	0	0	0	0	0	0	0	0	10.9	10.9
Extension of Floor on Medicare Work Geographic Adjustment	0.3	0.5	0.2	0	0	0	0	0	0	0	1.1	1.1
Practice Expense Geographic Practice Cost Index	0.2	0.6	0.3	0	0	0	0	0	0	0	1.1	1.1
Misvalued Relative Value Units	0	0	0	0	0	0	0	0	0	0	0	0
Therapy Caps	0.7	0.9	0.2	0	0	0	0	0	0	0	1.8	1.8
Extension of Treatment of Certain Physician Pathology Services	0.1	0.1	*	0	0	0	0	0	0	0	0.2	0.2
Extension of Increased Payments for Ambulance Services	*	*	*	0	0	0	0	0	0	0	0.1	0.1
Extension of Long-Term Care Hospital Provisions	0	0.1	0.1	*	*	*	0	0	0	0	0.2	0.2
Extension of Payment Adjustment for Mental Health Services	*	*	*	0	0	0	0	0	0	0	0.1	0.1
Permit Physician Assistants to Order Post-Hospital Extended Care Services and to Serve Hospice Patients	*	*	*	*	*	*	*	*	*	*	*	*
Medicare Diabetes Self-Management Training	*	*	*	*	*	*	*	*	*	*	*	*
Medicare Improvement Fund	0	0	0	0	-16.7	-5.6	0	0	0	0	-16.7	-22.3
Medicare Part B Special Enrollment Period for Military Retirees	0	0	*	*	*	*	*	*	*	*	*	*
Federally Qualified Health Centers PPS	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.9
Guidelines to Ensure Emergency Room Access	0	0	0	0	0	0	0	0	0	0	0	0
Medicare Payment for Biosimilar Products	0	0	0	0	0	0	0	0	0	0	0	0
Access to Critical Lab Tests	0	*	*	*	0	0	0	0	0	0	0.1	0.1
Report on Payment for New Clinical Lab Tests	0	0	0	0	0	0	0	0	0	0	0	0
PART II-RURAL PROTECTIONS												
Extend Medicare Rural Hospital Flexibility Program	0	0	0	0	0	0	0	0	0	0	0	0
Extend HOPD Hold Harmless for Small Rural Hospitals	*	*	*	0	0	0	0	0	0	0	0.1	0.1
Extend and Expand HOPD Hold Harmless for Sole Community Hospitals	0.1	0.2	*	0	0	0	0	0	0	0	0.3	0.3
Extend Reasonable Cost Payment for Laboratory Services in Small Rural Hospitals	*	*	*	0	0	0	0	0	0	0	*	*
Extend Rural Community Hospital Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0
Extend Medicare Dependent Hospital Program	0	0	*	*	*	0	0	0	0	0	0.1	0.1
Payment Adjustment for Low-Volume Hospitals	0	0.1	0.1	*	0	0	0	0	0	0	0.3	0.3
Demonstration Project on Community Health Integration Models in Certain Rural Counties	0	0	0	0	0	0	0	0	0	0	0	0
Study on Adequacy of Medicare Payments in Rural Areas	0	0	0	0	0	0	0	0	0	0	0	0
Technical Correction Related to Critical Access Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
Payment for Dual-Energy X-Ray Absorptiometry Services	0.1	0.1	*	0	0	0	0	0	0	0	0.1	0.1
Super Rural Ambulance Payments	*	*	*	0	0	0	0	0	0	0	*	*

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PART III-MEDICARE PART D IMPROVEMENTS												
Improving Coverage in the Part D Coverage Gap	0.3	1.3	1.2	1.4	1.6	1.8	2.2	2.3	2.5	3.2	5.7	17.7
Improving the Determination of Part D Low-Income Benchmarks	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.7
Voluntary De Minimis Policy for Low-Income Subsidy Plans	0	*	*	*	*	*	*	0.1	0.1	0.1	0.1	0.4
Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance	0	*	*	*	*	*	*	*	*	*	0.1	0.2
Facilitation of Reassignments of Beneficiaries in Low-Income Subsidy Plans	*	*	*	*	*	*	*	*	*	*	*	*
Funding Outreach and Education of Low-Income Programs	*	*	*	0	0	0	0	0	0	0	*	*
Strengthening Formularies with Respect to Certain Categories or Classes of Drugs	0	0	0	0	0	0	0	0	0	0	0	0
Reducing the Part D Premium Subsidy for High-Income Beneficiaries	0	-0.4	-0.5	-0.7	-0.9	-1.1	-1.3	-1.6	-2.0	-2.4	-2.4	-10.7
Simplifying Part D Plan Information	0	*	0	0	0	0	0	0	0	0	*	*
Limitation on Removal or Change of Coverage of Covered Part D Drugs	0	0	0	0	0	0	0	0	0	0	0	0
Medicare Part D Copayment Equity	0	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.2	0.4	1.2
AIDS Drug Assistance Programs and Indian Health Service	0	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
Generic "First Fill"	0	-0.2	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-1.1	-3.0
Long-Term Care Pharmacy	0	-0.1	-0.2	-0.4	-0.6	-0.8	-1.0	-1.0	-0.9	-1.1	-1.3	-6.1
Pharmacy Benefit Manager Transparency	0	0	0	0	0	0	0	0	0	0	0	0
Office of the Inspector General	0	0	0	0	0	0	0	0	0	0	0	0
Study on Coverage for Dual Eligibles	0	0	0	0	0	0	0	0	0	0	0	0
SUBTITLE C-MEDICARE ADVANTAGE												
Medicare Advantage Payment (Including Grandfathered and Transitional Benefits)	0	-6.2	-6.6	-10.3	-11.0	-12.2	-13.9	-16.7	-18.9	-21.5	-34.1	-117.4
Benefit Protection and Simplification	0	0	0	0	0	0	0	0	0	0	0	0
Simplification of Annual Beneficiary Election Periods	*	*	*	*	*	*	*	*	*	*	*	*
Extension for Specialized MA Plans for Special Need Individuals and for Erickson Demonstration Plans	0	0.2	0.2	0.2	0.1	0.1	*	*	*	*	0.7	0.9
Extension of Reasonable Cost Contracts	0	*	*	*	0	0	0	0	0	0	*	*
MA Private Fee-for-Service Plans	0	*	1.0	0.7	0.5	0.5	0.5	0.4	0.4	0.4	2.1	4.3
Medigap	0	0	0	0	0	*	*	*	*	*	0	-0.1
Extend Changes for Coding Intensity Through 2013	0	-0.6	-0.8	-0.5	0	0	0	0	0	0	-1.9	-1.9

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SUBTITLE D-IMPROVING PAYMENT ACCURACY												
Home Health Payment Changes	-0.1	-0.3	-0.3	-0.9	-2.0	-3.3	-5.1	-6.2	-6.8	-7.5	-3.6	-32.5
Hospice Payment Reforms	0	*	*	*	*	*	*	*	*	*	*	-0.1
Hospice Concurrent Care Demonstration Project	0	*	*	*	*	0	0	0	0	0	*	*
Medicare DSH Changes	0	0	0	0	0	-4.0	-4.3	-4.7	-4.6	-4.9	0	-22.5
Plan to Reform Medicare Hospital Wage Index	0	0	0	0	0	0	0	0	0	0	0	0
Geographic Hospital Wage Index Provisions	0	0	0	0	0	0	0	0	0	0	0	0
Extend Section 508 Reclassifications	0.2	0.3	*	0	0	0	0	0	0	0	0.5	0.5
Imaging Use-Rate Assumption	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.9	-3.0
Durable Medical Equipment												
Elimination of additional payment in 2014	included in estimate of market basket cuts and productivity adjustments for durable medical equipment											
Power wheelchairs	0	-0.4	-0.1	*	*	*	*	-0.1	-0.1	-0.1	-0.6	-0.8
Accreditation Exemption for Certain Pharmacies	0	0	0	0	0	0	0	0	0	0	0	0
Treatment of Certain Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
Nurse Midwifery Payments	*	*	*	*	*	*	*	*	*	*	*	*
SUBTITLE E-ENSURING MEDICARE SUSTAINABILITY												
Market Basket Cuts and Productivity Adjustments												
Hospitals paid under the inpatient PPS	-0.3	-0.8	-2.9	-5.5	-8.1	-10.9	-13.8	-17.2	-21.1	-25.9	-17.6	-106.3
Skilled nursing faciltities	0	0	-0.3	-0.7	-1.1	-1.5	-1.9	-2.4	-3.0	-3.7	-2.1	-14.6
Hospice	0	0	0	-0.3	-0.5	-0.8	-1.0	-1.4	-1.7	-2.1	-0.8	-7.8
Home health	0	-0.2	-0.4	-0.5	-0.5	-0.8	-1.2	-1.7	-2.3	-3.1	-1.6	-10.6
Part B fee schedules, except physicians' services	0	-0.4	-0.8	-1.3	-1.9	-2.5	-3.1	-3.7	-4.4	-5.1	-4.4	-23.1
Temporary Adjustment to the Income-Related Part B Premium	0	-0.7	-1.2	-1.5	-2.0	-2.4	-2.8	-3.3	-4.0	-4.9	-5.4	-22.8
Medicare Commission	0	0	0	0	0	-1.5	-3.1	-4.3	-6.2	-7.1	0	-22.2
SUBTITLE F-PATIENT-CENTERED OUTCOMES RESEARCH												
Comparative effectiveness (Medicare components)	0	*	*	*	*	*	*	*	-0.1	-0.2	*	-0.3
Comparative effectiveness (Non-Medicare components)	*	*	0.1	0.1	0.2	0.3	0.4	0.4	0.4	0.5	0.4	2.5
SUBTITLE G-ADMINISTRATIVE SIMPLIFICATION												
Effects on Medicaid Spending	*	*	-0.1	-0.2	-0.3	-0.4	-0.5	-0.6	-0.8	-0.9	-0.5	-3.7
SUBTITLE H-SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE	0	0	0	0	0	0	0	0	0	0	0	0

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TITLE IV-TRANSPARENCY AND PROGRAM INTEGRITY												
Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.8
Physician Payment Sunshine	0	0	0	0	0	0	0	0	0	0	0	0
Prescription Drug Samples	0	0	0	0	0	0	0	0	0	0	0	0
Nursing Home Transparency	0	*	*	*	0	0	0	0	0	0	0.1	0.1
Imaging Self-Referral Sunshine	0	0	0	0	0	0	0	0	0	0	0	0
Hospital Average Charge Information	0	0	0	0	0	0	0	0	0	0	0	0
TITLE V-FRAUD, WASTE, AND ABUSE												
Fraud, Waste, and Abuse	*	*	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.4	-1.3
Accelerate Implementation of the Competitive Acquisition Program for Durable Medical Equipment	*	*	*	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-1.4
Medicaid National Correct Coding Initiative	0	*	*	*	*	*	*	*	*	*	-0.1	-0.3
INTERACTIONS												
Medicare Advantage Interactions	0	1.6	-0.6	-1.3	-2.0	-2.1	-2.4	-2.7	-2.9	-3.8	-2.4	-16.1
Premium Interactions	0	-1.4	-0.1	0.7	5.7	4.2	3.9	4.8	5.6	6.7	4.9	30.1
Implementation of Medicare Changes for 2010	*	0	0	0	0	0	0	0	0	0	*	*
Medicaid Interactions with Part D Provisions	*	*	*	*	*	0.1	0.1	0.1	0.1	0.2	0.1	0.6
TRICARE Interaction	0.1	0.1	-0.1	-0.2	-0.2	-0.3	-0.5	-0.6	-0.8	-0.9	-0.3	-3.4
Total, Changes in Direct Spending	**9.0**	**-0.6**	**-10.9**	**-21.0**	**-41.7**	**-46.7**	**-54.7**	**-66.0**	**-78.1**	**-93.5**	**-65.1**	**-404.1**

Preliminary Estimate for Title I, Subtitle F, Through Title V of the Chairman's Mark, as Amended, for the America's Healthy Future Act of 2009
Estimates reflect specifications and are subject to revision upon review of legislative language.
By fiscal year, in billions of dollars.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Changes in Revenues												
Fraud, Waste, and Abuse (CBO Estimate, On-budget)	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.9	2.0
Premium Taxes for Patient-Centered Outcomes Research (JCT estimate, on-budget)	0	0	0	0.1	0.3	0.3	0.4	0.4	0.5	0.7	0.4	2.6
Effect on Revenues of Changes in Health Insurance Premiums as a Result of Comparative Effectiveness Research, Administrative Simplification, and Changes in the Medicaid Drug Program (JCT and CBO estimates)												
Income and Medicare payroll taxes (on-budget)	*	-0.1	-0.1	0.1	0.5	1.0	1.6	2.2	2.2	2.2	0.4	9.5
Social Security payroll taxes (off-budget)	*	*	*	*	0.1	0.2	0.3	0.5	0.5	0.5	0.1	2.1
Subtotal, on-budget revenues	0.1	0.1	0.1	0.4	1.0	1.5	2.2	2.9	2.9	3.1	1.7	14.2
Total, unified budget revenues	0.1	0.1	*	0.4	1.1	1.7	2.5	3.3	3.4	3.6	1.7	16.3
Changes in Deficits												
Changes in on-budget deficits	**8.9**	**-0.7**	**-10.9**	**-21.3**	**-42.7**	**-48.2**	**-56.9**	**-68.8**	**-81.1**	**-96.5**	**-66.8**	**-418.3**
Changes in unified budget deficits	**8.9**	**-0.6**	**-10.9**	**-21.3**	**-42.8**	**-48.4**	**-57.2**	**-69.3**	**-81.6**	**-97.0**	**-66.8**	**-420.4**
Memorandum:												
Non-scoreable savings from increased HCFAC spending	0	*	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.4

NOTE: * = between -50 million and $50 million.
CMS = Centers for Medicare & Medicaid Services; DSH = disproportionate share hospital; GME = graduate medical education; HCFAC = Health Care Fraud and Abuse Control; HOPD = hospital outpatient department; JCT = Joint Committee on Taxation; MA = Medicare Advantage; MA-PD = Medicare Advantage prescription drug plan; PPS = prospective payment system; VA = Department of Veterans Affairs.

Additional Clarifications Provided by
the Staff of the Senate Finance Committee
Through October 6, 2009

Emergency Room Protections

- The limitation on cost sharing for emergency services received outside of a plan's network of providers would not prevent emergency departments and other providers from charging additional amounts to enrollees (a practice known as balance billing).

Benefit Options

- The requirement to eliminate cost sharing for preventive services would apply only to those services recommended by the U.S. Preventive Services Task Force and to immunizations recommended by the Advisory Council on Immunization Practices.

- The out-of-pocket limits specified at each level of coverage would all be subject to the same modified indexing provisions described there; that is, the out-of-pocket limits for exchange plans would be based on the maximum limits allowed for plans that were health savings accounts—but for those purposes only, the amount of those limits would be indexed by premium growth (rather than general inflation).

Personal Responsibility Requirement

- The requirement to have insurance coverage would begin in July 2013, at the same time that coverage purchased through the new insurance exchanges would become effective.

Required Payments for Employees Receiving Premium Credits

- The dollar amount of the penalty for employers would be calculated to include both the national average amount of the premium credit and the national average amount of any cost-sharing subsidies provided to exchange enrollees; total payments by an employer would still be subject to a specified per-worker cap.

Creation of Health Care Cooperatives

- The $6 billion in total funding provided for the consumer-operated and -oriented plan would be both authorized and appropriated.

Eligibility Standards and Methodologies for Medicaid

- The new measure of income to be used in determining eligibility and benefits—which would be based on modified gross income and would remove income "disregards"—would not apply to any applicants or enrollees who are aged, blind, disabled, or medically needy.

- The Medicaid expansion would not provide any expanded benefits to individuals enrolled in Medicare.

Medicaid Program Payments

- The definition of a newly eligible Medicaid enrollee would include individuals who were on waiting lists in waiver programs that were capped but would not include other people who were eligible for a capped waiver program but not enrolled in it.

Treatment of Territories

- The territories would receive a 5 percentage point increase (from 50 percent to 55 percent) in their federal medical assistance percentage (FMAP) under Medicaid, and a 30 percent increase in their statutory spending caps in 2011. In 2014, the territories would be required to provide coverage to childless adults who met income eligibility standards consistent with those already established by the territories. The costs of covering that newly eligible population would not be restricted by the territories' spending caps, and the territories would be reimbursed by Medicaid for 55 percent of those costs.

Children's Health Insurance Program (CHIP)

- In conjunction with the specified provisions regarding CHIP, the Medicaid FMAP would increase by 0.15 percentage points for expenditures on behalf of existing Medicaid enrollees and new enrollees who were previously eligible but had not enrolled. (In general, federal reimbursement for Medicaid benefits usually averages about 57 percent.) That increase would not apply to newly eligible enrollees as defined in the modified Chairman's mark.

- CHIP spending would continue at annual allotment levels of $5.7 billion from 2014 through 2019, consistent with the assumptions in CBO's baseline for that program.[1]

Clinical Laboratory Payments

- The update to Medicare's payment rates for 2015 would be subject to an additional reduction of 0.2 percentage points (on top of the 1.75 percentage-point reduction specified in the mark); furthermore, after application of the additional reductions (of 1.75 percentage points for 2011 through 2014 and 1.95 percentage points for 2015), the update could be negative.

Medicare Advantage

- The provision that would permit certain private fee-for-service plans to "deem" that providers outside of their main service area were participating in their plan would be limited to plans offered by employers that contracted directly with the Centers for Medicare and Medicaid Services.

Other Provisions

- Under the proposal, firms offering a section 125 ("cafeteria") plan allowing their workers to pay premiums with pretax funds would be considered offering firms for purposes of the exchange "firewall" (so those workers generally could not purchase subsidized coverage through the exchanges), and employees who had received an affordability exemption to that firewall would not be allowed to pay their portion of the exchange premiums through a cafeteria plan.

- The proposal would authorize expedited implementation in 2010 for changes to Medicare that could not be implemented on the normal schedule and would absolve the Centers for Medicare and Medicaid Services of the need to reprocess any payments made before the changes were implemented.

[1]Baseline rules established by the Balanced Budget and Emergency Deficit Control Act of 1985 call for extrapolating an annualized level of program funding at the end of authorization for the remainder of the baseline projection period. CHIP authorization ends in 2013. CBO's baseline assumes that funding for CHIP will continue at the extrapolated annual amount of $5.7 billion for 2014 through 2019.