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

Douglas W. Elmendorf, Director

March 11, 2010

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 H.R. 3590, the Patient Protection and Affordable Care Act (PPACA), as it was passed by the Senate on December 24, 2009. This estimate differs from our December 19 estimate for an earlier version of that legislation in that it encompasses all of the amendments that were adopted by the Senate, reflects a revised assumption about its enactment date, and incorporates some technical revisions.[1]

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

Updated Estimate of Budgetary Impact

CBO and JCT now estimate that, on balance, the direct spending and revenue effects of enacting H.R. 3590 as passed by the Senate would yield a net reduction in federal deficits of $118 billion over the 2010–2019 period. Approximately $65 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. In the estimate that was provided on December 19, the estimated budgetary impact was a net reduction in deficits of $132 billion, of which approximately $81 billion would be on-budget. The

[1] The previous estimate by CBO and JCT was provided in a letter to the Honorable Harry Reid on December 19, 2009, for an amendment in the nature of a substitute to H.R. 3590, incorporating the effects of a proposed manager's amendment.

main reasons for the differences between the earlier estimate and this estimate are described below.

Tables 1 through 4 enclosed with this letter present the estimates of the direct spending, revenue, and deficit effects of H.R. 3590, as passed by the Senate. CBO and JCT's assessment of the legislation's impact on the federal budget deficit over the 2010–2019 period is summarized in Table 1. Table 2 shows federal budgetary cash flows for direct spending and revenues associated with the legislation. Table 3 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 provisions related to insurance coverage. Table 4 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 the legislation are provided by JCT in JCX-61-09 (see www.jct.gov).[2]

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

Because the legislation would affect direct spending and revenues, pay-as-you-go procedures would apply. The time periods used for pay-as-you-go calculations under the new Statutory Pay-As-You-Go Act extend from fiscal year 2010 through fiscal years 2015 and 2020. Although CBO and JCT have not conducted a detailed analysis of the legislation's effects in 2020, enactment of the legislation would probably reduce the budget deficit modestly in that year. Reflecting that assessment, CBO and JCT estimate that enacting H.R. 3590 would reduce projected on-budget deficits both through 2015 and through 2020.[3]

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[2] After JCX-61-09 was published, JCT made a small change to the estimate of the impact of limiting contributions to flexible spending accounts. That change increases the estimated revenues by about $1 billion over the 2010-2019 period.

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

Table 1. Estimate of the Effects on the Deficit From Direct Spending and Revenues Resulting From H.R. 3590, the Patient Protection and Affordable Care Act, as Passed by the Senate

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
NET CHANGES IN THE DEFICIT FROM INSURANCE COVERAGE PROVISIONS [a,b]												
Effects on the Deficit	3	7	9	4	34	69	110	123	129	136	56	624
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING [c]												
Effects on the Deficit of Changes in Outlays	2	-3	-13	-27	-45	-53	-65	-79	-91	-106	-85	-478
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [d]												
Effects on the Deficit of Changes in Revenues	-1	-6	-10	-30	-27	-33	-35	-38	-41	-42	-75	-264
NET CHANGES IN THE DEFICIT [a]												
Net Increase or Decrease (-) in the Budget Deficit	4	-3	-14	-53	-38	-16	10	6	-3	-11	-104	-118
On-Budget	4	-3	-14	-49	-36	-11	18	16	8	1	-98	-65
Off-Budget [e]	*	*	*	-4	-2	-5	-8	-10	-11	-13	-6	-53
Memorandum:												
Effects on the Deficit of H.R. 3590, Incorporating the Manager's Amendment, as Estimated on December 19												
Net Increase or Decrease	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

Continued

Table 1. Continued.

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

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

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

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

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 $249 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).

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

Differences from Previous Estimate

The estimate provided here differs from the one that was issued on December 19 for several reasons:

- It incorporates a number of technical corrections to the estimates of the legislation's provisions related to insurance coverage, the effect of which is to increase the gross cost of those provisions over the 2010–2019 period by about $4 billion (from $871 billion to $875 billion) and to increase the net cost of those provisions by about $10 billion (from $614 billion to $624 billion). Those technical corrections also yield relatively small changes in the estimated sources of insurance coverage under the legislation (see Table 3).

- It reflects an updated assumption about when the legislation would be enacted, a step that is now assumed to occur in the spring of 2010; the previous estimate assumed enactment by the end of December 2009. It also includes some technical corrections as well as adjustments to account for laws enacted since December 18, 2009—in particular, an adjustment related to the Medicare Improvement Fund (which is discussed further below). Those changes increase the estimated cost of the provisions that are not related to insurance coverage by about $5 billion over 10 years.

- It includes a revised estimate of the impact of limiting contributions to flexible spending accounts, which increased by about $1 billion the estimated revenues generated by that provision.

- It includes the effects of amendments that were adopted by the Senate during its consideration of H.R. 3590 but were not reflected in the December 19 estimate. The only one with a significant budgetary impact was an amendment introduced by Senator Mikulski related to coverage of preventive health care services. (During Senate consideration, CBO estimated that amendment would add approximately $1 billion to the costs of the legislation over 10 years.)

Other Considerations

CBO has not completed an estimate of all of the discretionary costs that would be associated with H.R. 3590. (Those costs would depend on future appropriations and are not included in the tables accompanying this letter.) As indicated in CBO's earlier estimate, such costs would probably include an estimated $5 billion to $10 billion over 10 years for administrative costs of the Internal Revenue Service (IRS) and at least a similar amount for expenses of the Department of Health and Human Services (HHS). CBO has also identified at least $50 billion in specified and estimated authorizations of future discretionary spending for a number of grant programs and other provisions of the legislation; whether some or all of those costs would be incurred would depend on future appropriation legislation.

Other elements of the analysis that CBO and JCT provided on December 19 have not changed significantly:

- Although CBO and JCT have not updated their estimates of the likely impact of the legislation on health insurance premiums, that impact would probably be quite similar to the one estimated for an earlier version of the legislation.[4]

- CBO expects that the legislation, if enacted, would reduce federal budget deficits over the decade after 2019 relative to those projected under current law—with a total effect during that decade that is in a broad range between one-quarter percent and one-half percent of GDP. That judgment is unchanged from CBO's previous assessment, and the imprecision of that calculation reflects the even greater degree of uncertainty that attends to it, compared with CBO's 10-year budget estimates.[5]

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[4] 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).

[5] See Congressional Budget Office, letter to the Honorable Harry Reid regarding the longer-term effects of the manager's amendment to the Patient Protection and Affordable Care Act (December 20, 2009).

- Under the legislation, federal outlays for health care would increase during the 2010–2019 period, as would the federal budgetary commitment to health care.[6] CBO now estimates that the federal commitment would increase by about $210 billion over that period, rather than by $200 billion as previously estimated. In subsequent years, however, 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 2019; that judgment is unchanged from CBO's previous assessment.

- 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 ($70 million and $141 million, respectively, in 2010, adjusted annually for inflation).

There is some question as to how section 3112 of H.R. 3590, which changes funding for the Medicare Improvement Fund (MIF), would be implemented. That section would strike the amount that, until recently, was the funding provided for the MIF for 2014 and replace it with zero, thereby yielding savings that would offset part of the cost of H.R. 3590. However, the underlying provision that section 3112 would amend was changed by the Department of Defense Appropriations Act, 2010 (Public Law 111-118), so the amount of current-law funding for 2014 has changed (from about $22.3 billion to $20.7 billion). This estimate incorporates the assumption that enacting H.R. 3590 would reduce the funding for the MIF for 2014 to zero—the clear intent of section 3112—thus yielding savings of $20.7 billion. An alternative interpretation would be that enacting section 3112 would have no effect because it now contains an incorrect reference to current law. However, experts in appropriations law and statutory construction have advised CBO that, regardless of the technical error in describing current-law funding, the intention to set the funding at zero in 2014 is clear, and the provision would probably be interpreted and implemented accordingly.[7]

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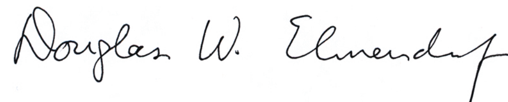
[6] For additional discussion of this term, see Congressional Budget Office, letter to the Honorable Max Baucus regarding different measures for analyzing current proposals to reform health care (October 30, 2009).

[7] Statutory interpretation usually begins and ends with the plain meaning of legislative language. In rare cases where a literal interpretation would be demonstrably at odds with Congressional intent, an interpretation that gives full effect to Congressional intent is preferred over a literal interpretation. See *United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 242 (1989). Further, a literal interpretation would render section 3112 a nullity—a result to be avoided under principles of statutory interpretation.

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

Sincerely,



Douglas W. Elmendorf
Director

Enclosures

cc: Honorable Mitch McConnell
Republican Leader

Honorable Max Baucus
Chairman
Committee on Finance

Honorable Chuck Grassley
Ranking Member

Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor, and Pensions

Honorable Michael B. Enzi
Ranking Member

Honorable Kent Conrad
Chairman
Committee on the Budget

Honorable Judd Gregg
Ranking Member

Table 2. Estimated Changes in Direct Spending and Revenues Resulting From H.R. 3590, the Patient Protection and Affordable Care Act, as Passed by the Senate

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN DIRECT SPENDING (OUTLAYS)												
Health Insurance Exchanges												
Premium and Cost Sharing Subsidies	0	0	0	0	14	31	56	72	79	86	14	337
Start-up Costs	*	*	*	1	*	*	0	0	0	0	2	2
Other Related Spending	0	1	2	2	1	*	*	*	*	0	5	5
Subtotal	*	2	2	2	15	31	56	72	79	86	21	344
Reinsurance and Risk Adjustment Payments [a]	0	0	0	0	11	18	18	18	19	21	11	106
Effects of Coverage Provisions on Medicaid and CHIP	*	-1	-2	-4	25	51	75	78	80	86	18	386
Medicare and Other Medicaid and CHIP Provisions												
Reductions in Annual Updates to Medicare FFS Payment Rates	*	-1	-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	*	*	*	-7	-8	-9	-9	-10	*	-43
Other	1	*	-1	-2	-14	-9	-9	-12	-16	-20	-16	-82
Subtotal	1	-8	-12	-21	-39	-46	-56	-70	-82	-97	-79	-430
Other Changes in Direct Spending												
Community Living Assistance Services and Supports	0	0	-5	-9	-10	-11	-11	-9	-8	-7	-24	-70
Other	2	6	6	4	4	3	1	-2	-3	-2	21	19
Subtotal	2	6	1	-5	-6	-8	-10	-11	-10	-9	-3	-51
Total Outlays	3	-2	-11	-28	6	45	83	87	85	85	-31	355
On-budget	3	-2	-11	-28	6	45	83	86	84	84	-32	351
Off-budget	0	*	*	*	*	*	1	1	1	1	*	4

Continued

Table 2. Continued.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
	By Fiscal Year, in Billions of Dollars											
CHANGES IN REVENUES												
Coverage-Related Provisions												
Exchange Premium Credits	0	0	0	0	-5	-11	-18	-22	-24	-26	-5	-106
Reinsurance and Risk Adjustment Collections	0	0	0	0	12	16	18	18	19	22	12	106
Small Employer Tax Credit	-2	-4	-5	-6	-5	-3	-3	-3	-4	-4	-21	-37
Penalty Payments by Employers and Uninsured Individuals	0	0	0	0	2	5	7	8	9	10	2	39
Excise Tax on High-Premium Plans	0	0	0	7	13	17	22	26	30	35	20	149
Associated Effects of Coverage Provisions on Revenues	*	-1	-2	-6	*	4	12	16	17	18	-10	57
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	77
Total Revenues	-1	1	3	26	44	61	73	81	88	97	73	473
On-budget	-1	1	3	21	42	56	64	70	76	83	67	416
Off-budget	*	*	*	4	2	5	9	11	12	14	6	57
NET IMPACT ON THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES [d]												
Net Change in the Deficit	4	-3	-14	-53	-38	-16	10	6	-3	-11	-104	-118
On-budget	4	-3	-14	-49	-36	-11	18	16	8	1	-98	-65
Off-budget	*	*	*	-4	-2	-5	-8	-10	-11	-13	-6	-53

Continued

Table 2. Continued.

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

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

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

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

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 4.

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