



CONGRESSIONAL BUDGET OFFICE  
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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.<sup>1</sup> 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).

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<sup>1</sup> 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	2010-2019	
<b>NET CHANGES IN THE DEFICIT FROM INSURANCE COVERAGE PROVISIONS <sup>a</sup></b>												
Effects on the Deficit	*	3	5	-7	30	78	96	101	104	107	32	518
<b>NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING <sup>b</sup></b>												
Effects on the Deficit of Changes in Outlays	9	-1	-11	-21	-42	-47	-55	-66	-78	-93	-65	-404
<b>NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES <sup>c</sup></b>												
Effects on the Deficit of Changes in Revenues <sup>d</sup>	-11	-13	-15	-19	-20	-21	-22	-23	-25	-26	-78	-196
<b>NET CHANGES IN THE DEFICIT <sup>a</sup></b>												
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 <sup>e</sup>	*	*	*	-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.<sup>2</sup> 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.<sup>3</sup>

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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<sup>2</sup> 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.

<sup>3</sup> 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.<sup>4</sup> 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.<sup>5</sup> 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.)

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<sup>4</sup> 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.

<sup>5</sup> 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.<sup>6</sup>

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<sup>6</sup> 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.

Honorable Max Baucus  
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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