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

Douglas W. Elmendorf, Director

July 2, 2009

Honorable Edward M. Kennedy
Chairman
Committee on Health, Education,
Labor, and Pensions
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 provisions of title I of draft legislation called the Affordable Health Choices Act, which has been posted on the Web site of the Senate Committee on Health, Education, Labor, and Pensions (labeled BAI09F54.xml).

Much of title I addresses health insurance coverage. Among other things, that title would: require all legal residents to have insurance; establish insurance exchanges (called "gateways") through which individuals and families could purchase coverage; set certain minimum requirements regarding the availability, pricing, and actuarial value of policies; and provide federal subsidies to substantially reduce the cost of coverage for some enrollees. (Attachment 1 summarizes the major provisions of title I dealing with health insurance coverage.) Title I also includes provisions that, among other things, would establish a reinsurance program for early retirees and improve access to and availability of community living assistance services and supports.

The attached tables summarize CBO's preliminary assessment of the effects of title I on federal revenues and direct spending and its likely impact on health insurance coverage. According to that assessment, enacting those provisions would result in a net increase in federal budget deficits of $597 billion over the 2010-2019 period—reflecting net costs of $645 billion for the coverage provisions, which would be partially offset by net savings of $48 billion from other provisions of title I. (CBO has also estimated the budgetary impact of provisions in titles III and VI of an earlier draft of the legislation, which would add another $14 billion to the net cost of the proposal.)

Once the legislation was fully implemented, CBO and JCT staff estimate, about 20 million fewer people would be uninsured compared with projections under current law. About 26 million individuals would obtain coverage through the new insurance exchanges, and about 6 million fewer people would purchase nongroup coverage outside the exchanges. In the aggregate, the number of people obtaining coverage through an employer would change very little.

The draft legislation does not include a significant expansion of the Medicaid program or other options for subsidizing coverage for those with income below 150 percent of the federal poverty level (FPL); such provisions may be incorporated at a later date. By CBO's estimate, about three-quarters of the people who would remain uninsured under this version of the legislation would have income below 150 percent of the FPL.

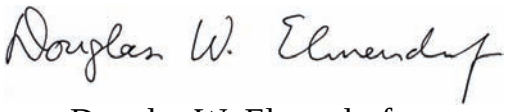
The figures presented in this letter do not represent a formal or complete cost estimate for the draft legislation. This estimate reflects the major provisions of the legislation but CBO has not yet completed an analysis of all of its effects. Specifically, the agency has not yet estimated the administrative costs to the federal government of implementing the specified policies or the costs of establishing and operating the new insurance exchanges, nor has it taken into account all of the proposal's likely effects on spending for other federal programs or their potential effects on revenues from corporate taxes.

The estimated cost of this draft of the legislation is roughly $400 billion less over 10 years than the cost CBO estimated for an earlier version of the proposal (in CBO's letter dated June 15, 2009). A number of changes in the legislation account for that difference. First, the subsidies available in the insurance exchanges would be less extensive; there would now be no premium subsidies for individuals and families with income above 400 percent of the federal poverty level, and subsidies for people below that level would be smaller. Second, a penalty (labeled an "equity assessment") was added for employers that do not offer insurance coverage to their workers and contribute a specified share of the premium. Third, the new draft substantially limits the opportunity for employees with an offer of health insurance from their employer to receive subsidies in the insurance exchange because their employer's offer was deemed unaffordable. Collectively, those changes contributed to a substantially lower estimate of

the number of people who would purchase coverage through the insurance exchanges (and a corresponding reduction in federal subsidy payments) and led to a much smaller estimated impact on the amount of coverage provided through employment-based plans. The new draft also includes provisions regarding a "public plan," but those provisions did not have a substantial effect on the cost or enrollment projections, largely because the public plan would pay providers of health care at rates comparable to privately negotiated rates—and thus was not projected to have premiums lower than those charged by private insurance plans in the exchanges.

I hope this preliminary analysis is helpful for the committee's consideration of the Affordable Health Choices Act. If you have any questions, please contact me or CBO's primary staff contacts for this analysis, Philip Ellis and Holly Harvey.

Sincerely,



Douglas W. Elmendorf
Director

cc: Honorable Michael B. Enzi
Ranking Member

ATTACHMENT 1

A Preliminary Analysis of the HELP Committee's Health Insurance Coverage Provisions

Congressional Budget Office
July 2, 2009

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have completed a preliminary analysis of draft legislation regarding health insurance coverage that is posted on the Web site of the Senate Committee on Health, Education, Labor, and Pensions, and summarized below. The attached tables present the main results of that analysis but do not represent a formal or complete cost estimate, for the following reasons:

- Some effects of the proposal have not yet been fully captured in our analysis. Specifically, we have not yet estimated the administrative costs to the federal government of implementing the specified policies or the costs of establishing and operating the new insurance exchanges (described further below), nor have we taken into account all of the proposal's likely effects on spending for other federal programs or their potential effects on revenues from corporate taxes.

- The budgetary information shown in the attached table reflects many of the major cash flows that would affect the federal budget as a result of implementing the specified policies and provides our preliminary assessment of the proposal's net effects on the federal budget deficit. Some cash flows would appear in the budget but would net to zero and not the affect the deficit; CBO has not yet estimated all of those cash flows. In particular, flows related to the risk adjustment process would be reflected as revenues (collected from insurers with relatively low-risk enrollees) and outlays (paid to insurers with relatively high-risk enrollees) of roughly equal magnitude—but that magnitude has not yet been estimated.

The key specifications upon which our analysis was based are as follows:

- Nearly all of the proposal's key provisions would become operative in a state when an insurance exchange (called a "gateway") is established there to provide a new mechanism through which its residents could obtain coverage. Such exchanges would probably start offering health insurance in some states in 2012, and exchanges would have to be operational in all states by 2014 (the federal government would step in to establish exchanges in any states that had not done so).

- The proposal would require all legal residents to have insurance. In general, the Internal Revenue Service (IRS) would charge a penalty to uninsured people, but all individuals with income below 150 percent of the federal poverty level (FPL) would be exempt from the penalty. For others, the penalty would be set at 50 percent of the unsubsidized premium of a qualifying health plan that provided the lowest level of coverage in the insurance exchange (see below).

- New health insurance policies sold in the individual and group insurance markets would be subject to several requirements regarding their availability and pricing. Insurers would be required to issue coverage to all applicants and could not limit coverage for preexisting medical conditions. In addition, premiums for a given plan could not vary because of enrollees' health and could vary by their age to only a limited degree (under a system known as adjusted community rating). Policies that were established before enactment and that are maintained continuously would be "grandfathered," meaning that they would not have to meet those requirements.

- There would be no change from current law regarding Medicaid or the Children's Health Insurance Program (CHIP).

- Insurance policies covering required benefits that are sold through the exchange would have minimum actuarial values set at three specified levels: 93 percent (for the highest tier), 84 percent (for the middle tier), and 76 percent (for the lowest tier). (A plan's actuarial value reflects the share of costs for covered services that is paid by the plan.). The Secretary of Health and Human Services would have to establish requirements for covered benefits that are equal in scope to the benefits typically covered by employment-based insurance plans. Plans offered through the exchange would be allowed to offer added coverage or extra benefits for an additional (unsubsidized) premium.

- The subsidies available through the exchanges would be tied to the average of the three lowest premium bids submitted by insurers in each area of the country for each tier of coverage (the "reference bid"). For people with income between 150 and 200 percent of the FPL, the subsidies would apply to that reference bid for the highest-tier plans; for people with income between 200 and 300 percent of the FPL, the subsidies would apply to that reference bid for the middle-tier plans; and for people with income between 300 and 400 percent of the FPL, the subsidies would apply to that reference bid for the lowest-tier plans.

- The subsidies would cap premiums as a share of income on a sliding scale starting at 1 percent for those with income equal to 150 percent of the FPL, rising to 12.5 percent of income at 400 percent of the FPL. After 2013, those income caps would be indexed to medical price inflation, so that individuals would (on average) pay a higher portion of their income for exchange premiums over time. Individuals and families with incomes below 150 percent of the FPL or above 400 percent of the FPL would not be eligible for those subsidies. (The proposal envisions that Medicaid would be expanded to cover individuals and families with income below 150 percent of the FPL, but the draft legislation does not include provisions to accomplish that goal.)

- Exchange credits would be determined on the basis of adjusted gross income for the current year, with prescreening based on prior-year income. Participants would have to provide information from their prior year's tax return during the fall enrollment period for coverage during the next calendar year (for example, tax return data on income in 2011 would be provided when applying in the fall of 2012 for subsidies to be received in 2013). The exchange would be given authority to have the IRS verify this information for

prescreening. Individuals who would not qualify for a subsidy on the basis of their prior-year income would be allowed to apply for a subsidy based on specified changes in circumstances.

- In all cases, income eligibility would be re-verified based on the current year's tax return (for example, the one filed in April 2014 reporting income for 2013), subject to a "safe harbor." For filers whose current income turns out to be less that 400 percent of the FPL—but who received too large a subsidy—the "safe harbor" would limit the amount that they would have to repay to $250 for single filers and $400 for joint filers (and for those filing as the head of household). For filers whose current income turns out to exceed 400 percent of the FPL, however, no safe harbor would apply—they would have to repay any subsidies they had received.

- The proposal includes a "public plan" that would be offered in the exchanges. The plan would be established nationwide by the Secretary via contracts with local entities (which could include non-profit insurers) to administer the plan; payment rates would be negotiated by the Secretary. The public plan would offer the same tiers of benefits as other plans operating in the exchange, and its premium would vary from area to area to reflect the local costs of providing those benefits.

- Firms with more than 25 workers would be subject to a "play-or-pay" requirement. If a firm did not offer qualified health insurance and contribute at least 60 percent toward the premium, it would have to pay an annual penalty (labeled an "equity assessment") that is initially equal to $750 per full-time worker and $375 per part-time worker. Those dollar amounts would be indexed to medical price inflation after 2013.

- In general, individuals with an offer of employer-sponsored insurance would not be eligible for exchange subsidies under the proposal. However, employees with an offer from an employer that was deemed unaffordable could get those subsidies. The proposal would define an employer's offer of coverage as unaffordable if the portion of worker-paid premiums exceeded 12.5 percent of the worker's adjusted gross income in 2013 (a cap that would grow over time at the rate of medical price inflation).

- The government would provide subsidies to small employers whose workers have low average wages, who offer health benefits to those workers, and who contribute at least 60 percent of the premium. The amount of the subsidy would vary with the size of the firm (up to a limit of 50 workers), and firms that contribute larger amounts toward their workers' insurance would receive larger subsidies (up to a limit of $1,800 per worker for single coverage at firms with fewer than 10 employees who do not require any worker contribution toward health insurance premiums). The credit would be available indefinitely, but firms would be allowed to take the credit in only three out of every four years.

Preliminary Analysis of Title I of the Affordable Health Choices Act

7/2/2009

EFFECTS ON INSURANCE COVERAGE /a (Millions of nonelderly people, by calendar year)		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law Coverage /b	Medicaid/CHIP	40	39	39	38	35	34	35	35	35	35
	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	-1	-1	*	*	-4	-2	-2	-2	-2	-1
	Employer	*	2	2	3	4	1	1	1	*	*
	Nongroup/Other /c	*	*	-1	-2	-3	-5	-5	-6	-6	-6
	Exchanges	0	0	4	11	20	24	26	26	27	27
	Uninsured	-1	-1	-5	-11	-16	-18	-19	-20	-20	-21
Post-Policy Uninsured Population											
Number of People /d		49	50	46	39	35	33	32	33	33	34
Number with Income Below 150% of Poverty /d,e		29	30	28	26	25	25	26	26	26	26
Share of the Nonelderly Population											
Including All Residents		19%	19%	17%	14%	13%	12%	12%	12%	12%	12%
Excluding Unauthorized Immigrants		17%	18%	16%	13%	11%	10%	10%	10%	10%	10%
Memo: Exchange Enrollees and Subsidies											
Number w/ Unaffordable Offer from Employer /f				*	1	2	2	2	2	2	2
Number of Unsubsidized Exchange Enrollees				1	2	3	4	4	4	4	4
Average Subsidy per Subsidized Enrollee						$4,700	$5,000	$5,200	$5,500	$5,800	$6,100

* = Fewer than 0.5 million people.

NOTES:

a. Components may not sum to totals because of rounding.

b. Individuals reporting mutiple sources of coverage are assigned a primary source.

c. Includes Medicare, TRICARE, and other sources; effects of 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. Reflects adjusted gross income measured for health insurance units (those that would be covered by a family insurance policy) relative to the federal povery level.

f. Workers who have to pay more than a specified share of their income for employment-based coverage (12.5% in 2013) could receive exchange subsidies; figures show the estimated number of enrollees who would have had employer insurance but who would obtain coverage in the exchange under that provision.

Preliminary Analysis of Title I of the Affordable Health Choices Act

7/2/2009

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
Coverage Provisions											
Medicaid/CHIP Outlays /d	-2	-2	*	0	-7	-7	-5	-5	-4	-4	-36
Exchange Subsidies	0	0	11	39	70	96	113	122	131	140	723
Associated Effects on Tax Revenues /e	*2*	*2*	*2*	*2*	*2*	*-1*	*-4*	*-4*	*-5*	*-5*	*-10*
Subtotal	*0*	*0*	*13*	*41*	*65*	*89*	*104*	*113*	*122*	*130*	*677*
Small Business Credits /e	3	6	6	4	4	6	6	6	7	8	56
Payments by Uninsured Individuals	0	0	0	-1	-3	-7	-7	-6	-6	-6	-36
Employer "Equity Assessments" /e,f	0	0	-1	-4	-5	-7	-8	-9	-9	-9	-52
NET IMPACT OF COVERAGE PROVISIONS	**3**	**6**	**17**	**40**	**61**	**81**	**96**	**105**	**114**	**123**	**645**
Other Provisions of Title I											
Equity for Certain Eligible Survivors	*	*	*	*	*	*	*	*	*	*	*
Reinsurance for Retirees	3	3	3	1	0	0	0	0	0	0	10
CLASS Act /g	0	-3	-6	-8	-9	-10	-8	-6	-4	-3	-58
OVERALL IMPACT ON THE DEFICIT	**6**	**6**	**14**	**33**	**52**	**71**	**88**	**99**	**110**	**120**	**597**

* = Less than $0.5 billion.

NOTES:

a. Does not include federal administrative costs and does not account for: all costs of establishing and operating insurance exchanges; all effects on other federal programs; or potential effects on corporate tax revenues.

b. Components may not sum to totals because of rounding.

c. Positive numbers indicate increases in the deficit, and negative numbers indicate decreases in the deficit; figures reflect only the effects of the provisions on direct spending and revenue.

d. Includes only the indirect effects of exchange subsidies and other coverage provisions on Medicaid and CHIP.

e. Increases in tax revenues reduce the deficit.

f. The effects on the deficit of this provision include the associated effects of changes in taxable compensation on tax revenues.

g. Reflects the net budgetary impact of direct spending and revenue effects. CBO estimates that premium collections would exceed benefit payments during the 2010-2019 period by about $59 billion. At some point beyond 2019, the proposal would add to the federal deficit.

Sources: Congressional Budget Office and Joint Committee on Taxation.