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

Douglas W. Elmendorf, Director

November 4, 2009

Honorable John A. Boehner
Republican Leader
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Leader:

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have completed a preliminary analysis of the amendment in the nature of a substitute for H.R. 3962, the Affordable Health Care for America Act, as you proposed on November 3, 2009. For several reasons described later, this analysis does not constitute a comprehensive cost estimate for the amendment.

The amendment includes a number of provisions intended to increase the availability and improve the affordability of private health insurance. CBO's and JCT's preliminary assessment of the amendment's impact on federal budget deficits is summarized in the following table. The enclosures with this letter provide estimates of the changes in the number of nonelderly people in the United States who would have health insurance, present the primary budgetary effects of the amendment's provisions related to insurance coverage, and give estimates of the costs or savings from other proposed changes that would affect the federal government's direct spending and revenues.

According to CBO and JCT's assessment, enacting the amendment would result in a net reduction in federal budget deficits of $68 billion over the 2010–2019 period. That estimate reflects a projected net cost of $8 billion over 10 years for the provisions directly related to insurance coverage; that net cost reflects a gross cost of $61 billion that is partly offset by about $52 billion in additional revenues associated with the coverage provisions. Over the same period, the other provisions of the amendment would reduce direct spending by $49 billion and increase tax revenues by $27 billion.

PRELIMINARY ESTIMATE OF THE EFFECTS ON THE DEFICIT OF THE AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 3962, OFFERED BY REPRESENTATIVE BOEHNER

	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	*	*	-2	14	-3	3	3	-1	-3	-2	8	8
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING												
Effects on the Deficit of Changes in Outlays	*	*	-2	-3	-5	-6	-7	-8	-9	-10	-9	-49
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [b]												
Effects on the Deficit of Changes in Revenues	0	*	*	-1	-2	-3	-4	-5	-6	-6	-4	-27
NET CHANGES IN THE DEFICIT [a]												
Net Increase or Decrease (-) in the Budget Deficit	*	*	-4	9	-10	-6	-7	-14	-18	-18	-5	-68
Memorandum:												
Changes from Direct Spending	*	*	-1	15	-4	2	2	-3	-6	-6	10	*
Changes from Revenues	*	-1	-3	-5	-6	-8	-10	-11	-12	-13	-15	-68

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

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 appropriations.

b. The changes in revenues include effects on Social Security revenues, which are classified as off-budget.

The figures presented here do not represent a comprehensive cost estimate for the amendment. The analysis does not take into account all of the proposal's effects on spending for other federal programs or the administrative costs for oversight and implementation. In addition, the estimates address the amendment's impact on direct spending and revenues but do not include the potential costs of provisions that would be subject to future appropriations or that would affect programs that are subject to future appropriations. Nevertheless, the estimates reflect the major net budgetary effects of the proposal.

CBO and JCT have assumed that the amendment's key provisions—including grant funds for high-risk pools and reinsurance programs and insurance market reforms—

would become effective on the date of enactment, which is assumed to be in December 2009. Provisions establishing association health plans (AHPs) would become effective 12 months after the date of enactment.

Effects of the Insurance Coverage Provisions

The amendment contains several provisions that are intended to increase rates of insurance coverage by reducing its costs or subsidizing its purchase, including:

- Regulatory reforms in the small group and nongroup markets, including establishing AHPs and individual membership associations, and allowing states to establish interstate compacts with a unified regulatory structure;

- A State Innovations grant program to provide federal payments to states that achieve specified reductions in the number of uninsured individuals or in the premiums for small group or individually purchased policies; [1]

- Federal funding for states to use for high-risk pools in the individual insurance market and reinsurance programs in the small group market; and

- Changes to health savings accounts (HSAs) to allow funds in them to be used to pay premiums under certain circumstances, to make net contributions to HSAs eligible for the saver's credit, and to provide a 60-day grace period for medical expenses incurred prior to the establishment of an HSA.

By 2019, CBO and JCT estimate, the number of nonelderly people without health insurance would be reduced by about 3 million relative to current law, leaving about 52 million nonelderly residents uninsured. The share of legal nonelderly residents with insurance coverage in 2019 would be about 83 percent, roughly in line with the current share. CBO and JCT estimate that enacting the amendment's insurance coverage provisions would increase deficits by $8 billion over the 2010–2019 period.

Effects of Other Provisions

Other provisions of the amendment would alter federal spending and revenues in significant ways as well. The key provisions include these:

- Limits on costs related to medical malpractice ("tort reform"), including capping noneconomic and punitive damages and making changes in the allocation of liability. CBO expects that those limits would reduce health

[1] We expect that states would also spend several billion dollars to help achieve the targets specified under the State Innovations program.

care costs directly—by reducing premiums for medical liability insurance and associated costs—and indirectly by slightly reducing the utilization of health care services. Over the 2010–2019 period, those changes would reduce spending on mandatory programs by about $41 billion and would increase revenues by $13 billion as an indirect effect of reducing the costs of private health insurance plans (which would result in a shift of some workers' compensation from nontaxable health insurance benefits to taxable wages).

- Requirements that the Secretary of Health and Human Services (HHS) adopt and regularly update standards for electronic administrative transactions that enable electronic funds transfers, claims management processes, and verification of eligibility, among other administrative tasks. Those provisions would result in about $6 billion in federal savings in Medicaid. In addition, those standards would result in an increase in revenues of about $13 billion as an indirect effect of reducing the costs of private health insurance plans.

- Establishment of an abbreviated approval pathway for follow-on biologics (biological products that are highly similar to or interchangeable with their brand-name counterparts), which would reduce direct spending by an estimated $5 billion and increase revenues by about $1 billion over the 2010-2019 period.

- An increase in funding for HHS's investigations into fraud and abuse, which would increase direct spending by an estimated $3 billion during the next 10 years.

In total, CBO estimates, the provisions of the amendment not directly related to insurance coverage would reduce direct spending by $49 billion, on net, over the 2010–2019 period and would increase revenues by $27 billion.

Effects on Health Insurance Premiums

CBO estimates that the combination of provisions included in the amendment would reduce average private health insurance premiums per enrollee in the United States relative to what they would be under current law. The average reductions would be larger in the markets for small group and individually purchased policies, which are the focus of many of the legislation's provisions. In the small group market, which represents about 15 percent of total private premiums, the amendment would lower average insurance premiums in 2016 by an estimated 7 percent to 10 percent compared with amounts under current law. In the market for individually purchased insurance, which represents a little more than 5 percent of total private premiums, the amendment would lower average insurance premiums in

2016 by an estimated 5 percent to 8 percent compared with amounts under current law. And in the large group market, which represents nearly 80 percent of total private premiums, the amendment would lower average insurance premiums in 2016 by zero to 3 percent compared with amounts under current law, according to CBO's estimates. The figures are presented for 2016 as an illustrative example.

Two caveats regarding those estimates bear emphasis:

- Many individuals and families would experience changes in premiums that differed from the changes in average premiums in their insurance market. As explained below, some provisions of the legislation would tend to decrease the premiums paid by all insurance enrollees, while other provisions would tend to increase the premiums paid by less healthy enrollees or would tend to increase the premiums paid by enrollees in some states relative to enrollees in other states. As a result, some individuals and families within each market would see reductions in premiums that would be larger or smaller than the estimated average reductions, and some people would see increases.

- The estimates of changes in average premiums are very preliminary and are subject to an unusually high degree of uncertainty, even compared with the significant uncertainty attending estimates of the effects of proposals making broad changes in the nation's health care and health insurance systems. Although the estimated budgetary effects of such proposals incorporate changes in aggregate premiums, disentangling the array of factors that affect premiums and estimating their overall effect on premiums per enrollee in different insurance markets is difficult. In response to many requests, CBO is now working to provide that sort of analysis for a number of health care reform proposals being discussed in the Congress. For proposals that make a number of complex and interrelated changes in the health care and health insurance systems, the challenge of estimating the effects on premiums is especially acute, and CBO has not yet finished that analysis. For proposals with a comparatively limited number of policy changes, like the amendment you proposed, the analysis is somewhat more straightforward. Still, the estimates reported here are tentative and could be revised as CBO continues its analysis of the many avenues through which elements of reform proposals might affect insurance premiums.

The changes in average premiums per enrollee that are expected to occur under the amendment can be attributed to three broad sources:

- Changes in the price of a given amount of insurance coverage for a given group of enrollees,

- Changes in the extent of insurance coverage purchased, and

- Changes in the distribution of enrollees with different characteristics among the various insurance markets and in the uninsured population.

The first source encompasses factors that affect an "apples-to-apples" comparison of the average price of equivalent insurance coverage for an equivalent population under the amendment and under current law. Provisions in the amendment that belong in this category include the medical malpractice reforms and the requirements for administrative simplification assigned to the Secretary of HHS. Those changes would reduce spending related to the delivery of health care services and would thereby reduce health insurance premiums without substantially changing the amount of coverage provided or the mix of enrollees covered. Similarly, the amendment's subsidies for reinsurance in the small group market would reduce the average premiums charged in that market because those subsidies would reduce the net costs that insurers incurred to provide that coverage.

The second source of change in average insurance premiums is changes in the average extent of coverage purchased. Those changes can reflect both changes in the *scope* of insurance coverage—the benefits or services that are included—and changes in the *share of costs* for covered services paid by the insurer—known as the "actuarial value." With other factors held equal, insurance policies that cover more benefits or services or have smaller copayments or deductibles have higher premiums, while policies that cover fewer benefits or services or have larger copayments or deductibles have lower premiums. Provisions in the amendment that would reduce insurance premiums by affecting the amount of coverage purchased include the State Innovations program, which would encourage states to reduce the number and extent of benefit mandates that they impose, and provisions that would allow individuals or affiliated groups to purchase insurance policies in other states that have less stringent mandates. CBO's assessment was that the amendment would not have a substantial effect on actuarial values. However, that assessment represents an important source of uncertainty in this analysis of effects on premiums, because some of the savings from avoiding state mandates of benefits might be used to purchase coverage with a higher actuarial value.

The third source of change in average insurance premiums is changes in the characteristics of the people who are enrolled in different insurance pools. If relatively healthy people join an insurance pool, then the average insurance premiums for that pool would tend to decline; conversely, an influx of relatively unhealthy people would tend to raise premiums for that pool. For example, provisions in the amendment that promote the automatic enrollment of workers in

health insurance and the coverage of dependents under age 26 in family policies would act to improve the average health status of both the small group and large group insurance markets and thereby reduce average premiums per enrollee in those markets.[2]

As another example of that third source of premium changes, the State Innovations program would induce states to take some actions affecting the average health status of people with insurance and people without insurance. For example, states that loosened rating rules in the market for individually purchased insurance to allow premiums to vary more on the basis of age would cause premiums for older people to increase and premiums for younger people to decrease. With other factors held equal, fewer older people (who tend to have higher health care costs) and more young people (who tend to have lower health care costs) would then sign up for coverage, and the improved average health status of insured people would lower average premiums; at the same time, the pool of people without health insurance would end up being less healthy, on average, than under current law.[3]

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), 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. CBO has therefore developed a rough outlook for the decade following the 10-year budget window by considering which provisions of the amendment would persist beyond 2019 and assessing the rate at which the budgetary impact of those provisions is likely to change over time.

All told, the amendment would reduce the federal deficit by $18 billion in 2019, CBO and JCT estimate. As a rough approximation, CBO assumes that the effect of the proposal on budget deficits would grow at roughly the rate of health care spending during the following decade. Consequently, CBO expects that the legislation would slightly reduce federal budget deficits in that decade relative to those projected under current law—with a total effect during that decade that is in a broad range between zero and one-quarter percent of gross domestic product. The imprecision of that calculation reflects the even greater degree of uncertainty that

[2] The increase in the number of dependents covered would tend to raise premiums for family policies, but premiums per enrollee would decline, reflecting the better-than-average health of the new enrollees.

[3] For further discussion of this issue, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 82–84.

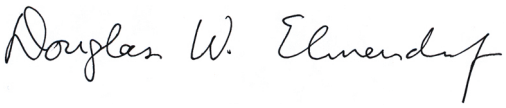
attends to it, compared with CBO's 10-year budget estimates, and the effects of the amendment could fall outside of that range.

Many Members have expressed interest in the effects of reform proposals on various measures of spending on health care. CBO uses the term "federal budgetary commitment to health care" to describe the sum of net federal outlays for health programs and tax preferences for health care—a broad measure of the resources committed by the federal government.[4] Because essentially all of the budgetary effects of the amendment involve federal spending for health care or subsidies for health care conveyed through reductions in federal tax expenditures, the effects of the amendment on federal deficits also represent its effects on the federal budgetary commitment to health care. Therefore, during both the 10-year budget window and the following decade, the amendment would decrease the federal budgetary commitment to health care, relative to the amounts under current law.

Members have also requested information about the effect of proposals on national health expenditures. However, CBO does not analyze those expenditures as closely as it does the federal budget, and at this point, the agency has not assessed the net effect of the amendment on them, either within the 10-year budget window or for the subsequent decade.

I hope this preliminary analysis is helpful in your consideration of the amendment in the nature of a substitute for H.R. 3962, the Affordable Health Care for America Act. If you have any questions, please contact me or CBO staff. The primary staff contacts for this analysis are Bruce Vavrichek and Jean Hearne.

Sincerely,



Douglas W. Elmendorf
Director

Enclosures

cc: Honorable Nancy Pelosi
Speaker
U.S. House of Representatives

[4] For an extensive 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).

Honorable Charles B. Rangel
Chairman
Committee on Ways and Means

Honorable Dave Camp
Ranking Member

Honorable Henry A. Waxman
Chairman
Committee on Energy and Commerce

Honorable Joe Barton
Ranking Member

Honorable George Miller
Chairman
Committee on Education and Labor

Honorable John Kline
Senior Republican

Preliminary Analysis of the Insurance Coverage Provisions Contained in Rep. Boehner's Amendment to H.R. 3962

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 & Other /c	27	26	25	26	28	29	29	29	30	30
	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	0	*	*	*	*	*	*	*	*	*
	Employer	*	1	2	2	2	2	2	2	2	2
	Nongroup/Other /c	*	*	*	*	*	*	*	*	*	*
	Uninsured /d	*	-1	-2	-2	-2	-2	-2	-3	-3	-3
Post-Policy Uninsured Population											
Number of Nonelderly People /d		50	50	49	48	48	49	49	50	51	52
Insured Share of the Nonelderly Population /a											
Including All Residents		81%	81%	82%	82%	82%	82%	82%	82%	82%	82%
Excluding Unauthorized Immigrants		83%	84%	84%	84%	84%	84%	84%	84%	84%	83%

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. Other includes Medicare; 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.

Preliminary Analysis of the Insurance Coverage Provisions Contained in Rep. Boehner's Amendment to H.R. 3962

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
Funding for Reinsurance & High-Risk Pools	0	1	1	1	2	3	4	4	4	4	24
State Innovations Program	0	0	0	17	0	5	6	2	0	1	32
Provisions Affecting Health Savings Accounts	0	0	0	0	0	1	1	1	1	1	5
Gross Cost of Coverage Provisions	0	1	2	19	2	9	10	6	5	6	61
Associated Effects on Tax Revenues /d	0	-1	-3	-4	-4	-6	-6	-7	-7	-7	-46
Associated Effects on Medicaid & CHIP Outlays /e	0	0	-1	-1	-1	-1	-1	-1	-1	-1	-6
NET COST OF COVERAGE PROVISIONS	0	0	-2	14	-3	3	3	-1	-3	-2	8

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

Note: CHIP = Children's Health Insurance Program.

a. Does not include federal adminstrative costs subject to appropriation or account for all effects on other federal programs.
b. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit; increases in tax revenues reduce the deficit.
c. Components may not sum to totals because of rounding.
d. Effects are mainly due to changes in taxable compensation resulting from changes in payments for employer-sponsored insurance coverage.
e. Effects are mainly due to changes in Medicaid and CHIP enrollment resulting from the provisions affecting the private health insurance market.

Preliminary Estimate of Direct Spending and Revenue Effects of the Amendment in the Nature of A Substitute to H.R. 3962 offered by Rep. Boehner on Medicare, Medicaid, and Other Provisions

(Billions of dollars, by fiscal year)

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Changes in Direct Spending													
Sec. 113	Administrative Simplification	*	*	-0.1	-0.1	-0.2	-0.3	-0.7	-1.4	-1.5	-1.6	-0.4	-5.9
Sec. 301-310	Effects of Tort Reform on Mandatory Program Spending [a]	0	-0.7	-1.8	-3.2	-4.6	-5.4	-5.9	-6.0	-6.3	-7.0	-10.3	-40.9
Sec. 601	Increased funding to the HHS OIG and HCFAC	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	1.5	3.1
Sec. 603 - 605	Other Medicare and Medicaid program integrity provisions	*	*	*	*	*	*	*	*	*	*	-0.1	-0.3
Sec. 701	Licensure Pathway for Biosimilar Biological Products	0	0	0	*	-0.1	-0.2	-0.5	-0.9	-1.4	-2.0	-0.1	-5.1
Total Changes in Direct Spending		**0.2**	**-0.4**	**-1.6**	**-3.1**	**-4.6**	**-5.7**	**-6.8**	**-8.0**	**-9.0**	**-10.3**	**-9.4**	**-49.1**
Changes in Revenues													
	Effects of Tort Reform	0	0.2	0.6	1.0	1.5	1.7	1.8	1.9	2.1	2.2	3.2	13.0
	Effects of Administrative Simplification	0	-0.2	-0.2	0.1	0.6	1.2	2.0	2.9	3.3	3.4	0.3	13.1
	Effects of Biosimilar Biological Products	0	0	0	*	*	0.1	0.1	0.2	0.2	0.3	*	0.9
Total Changes in Revenues		**0**	*****	*****	**1.1**	**2.1**	**2.9**	**3.9**	**5.0**	**5.6**	**5.9**	**3.5**	**27.0**
Changes in Deficits		**0.2**	**-0.4**	**-2.0**	**-4.2**	**-6.7**	**-8.6**	**-10.7**	**-13.0**	**-14.6**	**-16.3**	**-13.0**	**-76.1**
Memorandum	Non-scoreable savings from HCFAC funding	-0.1	-0.2	-0.4	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.6	-1.8	-4.4

NOTES: * = between $50 million and -$50 million.

HHS = Department of Health and Human Services; OIG = Office of Inspector General; HCFAC = health care fraud and abuse control account

a. Estimate reflects mandatory spending across all federal health programs, and includes Medicare interactions (for Medicare Advantage and Part B premiums).