



November 5, 2009

Honorable John D. Dingell  
U.S. House of Representatives  
Washington, DC 20515

Dear Congressman:

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. 3962, the Affordable Health Care for America Act, as introduced on October 29, 2009, incorporating the manager's amendment that you proposed on November 3, 2009. Among other things, the legislation 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; establish a public plan that would be administered by the Secretary of Health and Human Services (HHS); 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 income tax surcharge on high-income individuals; and make various other changes to the federal tax code, Medicaid, Medicare, and other programs.<sup>1</sup>

CBO and the staff of JCT estimate that, on balance, the direct spending and revenue effects of enacting H.R. 3962, incorporating the manager's amendment, would yield a net reduction in federal budget deficits of \$129 billion over the 2010-2019 period (see Table 1). CBO has not completed a comprehensive estimate of the legislation's potential impact on spending that is subject to future appropriation action.

On October 29, 2009, CBO transmitted a preliminary analysis of H.R. 3962 as introduced. This estimate differs from that preliminary analysis for several reasons:

- First, this analysis incorporates the effects on spending and revenues of the manager's amendment. Those changes are relatively small with the exception of

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<sup>1</sup> For further description of the legislation and CBO and JCT's analysis of the bill, see Congressional Budget Office, letter to the Honorable Charles B. Rangel providing a preliminary analysis of the Affordable Health Care for America Act (October 29, 2009).

the addition of a tax provision regarding credits for producers of biofuel, which would increase net revenues by about \$24 billion over the 2010-2019 period, according to JCT.

- Second, the updated analysis reflects Medicare's payment rates for calendar year 2010 and other changes announced in final rules that were posted on the *Federal Register's* Web site on October 30, 2009. Those final rules involve home health services, hospital outpatient services, the physician fee schedule, and other Medicare Part B services.
- Finally, this analysis incorporates several technical revisions that had a small impact on the estimated budgetary effects of the legislation.

CBO and JCT have determined that the bill contains several private-sector and intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The total cost to the private sector of those mandates, as estimated by CBO and JCT, would greatly exceed the threshold established in that act for private entities (\$139 million in 2009, adjusted annually for inflation). CBO estimates that the total cost of intergovernmental mandates would be small and would not exceed the annual threshold established for state, local, and tribal entities (\$69 million in 2009, adjusted annually for inflation).

CBO and JCT's assessment of the bill's impact on the federal budget deficit is summarized in Table 1. Table 2 shows federal budgetary cash flows for direct spending and revenues associated with the legislation. Tables 3 and 4 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 bill's provisions directly related to insurance coverage, and display 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 federal revenues. Detailed estimates of the budgetary impact of the bill's tax provisions are provided by JCT in JCX-46-09, and an explanation of those provisions is provided in JCX-47-09 (see [www.jct.gov](http://www.jct.gov)).

**Table 1. Estimate of the Effects on the Deficit of H.R. 3962, the Affordable Health Care for America Act, as Introduced on October 29, 2009, Incorporating the Manager's Amendment Offered by Representative Dingell on November 3**

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2015-2019
<b>NET CHANGES IN THE DEFICIT FROM INSURANCE COVERAGE PROVISIONS <sup>a</sup></b>												
Effects on the Deficit	*	2	2	56	92	122	137	147	160	173	152	891
<b>NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING <sup>b</sup></b>												
Effects on the Deficit of Changes in Outlays	6	16	-16	-25	-52	-51	-54	-72	-85	-96	-69	-427
<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>	*	-39	-41	-62	-65	-69	-72	-77	-82	-86	-209	-594
<b>NET CHANGES IN THE DEFICIT <sup>a</sup></b>												
Net Increase or Decrease (-) in the Budget Deficit	6	-21	-55	-31	-24	3	11	-1	-7	-9	-126	-129
On-Budget	6	-21	-55	-33	-27	2	9	-3	-8	-10	-130	-141
Off-Budget <sup>e</sup>	*	*	*	2	2	2	2	1	1	1	4	11

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 appropriations.
- b. These estimates reflect the effects of interactions between insurance coverage provisions and other Medicare and Medicaid provisions. In addition, CBO has included \$33 billion of spending over the 2010–2019 period for public health, prevention, and wellness provisions in these direct spending totals, as directed by the Committee on the Budget, even though that spending would be subject to future appropriation action.
- c. The changes in revenues include effects on Social Security revenues, which are classified as off-budget.
- d. The 10-year figure of \$594 billion includes \$581 billion in revenues from tax provisions (estimated by JCT) and \$13 billion in additional revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by JCT and CBO). For JCT's estimates, see JCX-46-09.
- e. Off-budget effects include changes in Social Security spending and revenues.

### **Estimated Budgetary and Insurance Coverage Effects of H.R. 3962, Incorporating the Manager's Amendment**

According to CBO and JCT's assessment, enacting H.R. 3962 would result in a net reduction in federal budget deficits of \$129 billion over the 2010–2019 period (see Table 1). In the subsequent decade, the collective effect of its provisions would probably be slight reductions in federal budget deficits.<sup>2</sup> Those estimates are all subject to substantial uncertainty.

The estimate includes a projected net cost of \$891 billion over 10 years for the proposed expansions in insurance coverage. That net cost itself reflects a gross total of \$1,052 billion in subsidies provided through the exchanges (and related spending), 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 \$167 billion in collections of penalties paid by individuals and employers. On balance, other effects on revenues and outlays associated with the coverage provisions add \$6 billion to their total cost.

Over the 2010–2019 period, the net cost of the coverage expansions would be more than offset by the combination of other spending changes, which CBO estimates would save \$427 billion, and receipts resulting from the income tax surcharge on high-income individuals and other provisions, which JCT and CBO estimate would increase federal revenues by \$594 billion over that period.<sup>3</sup>

By 2019, CBO and JCT estimate, the number of nonelderly people who are uninsured would be reduced by about 36 million, leaving about 18 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under the bill, the share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 96 percent.

The legislation would increase outlays by \$672 billion and would increase revenues by \$801 billion between 2010 and 2019 (see Table 2).<sup>4</sup> Certain cash flows were not separately identified in the prior CBO estimate for H.R. 3962. For example, risk adjustment payments to health insurance plans are reflected in the top portion of Table 2

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<sup>2</sup> Although the estimates presented here for fiscal years 2010 through 2019 differ slightly from CBO's October 29 estimate, the agency's assessment of the long-term outlook is essentially unchanged.

<sup>3</sup> The \$594 billion figure includes \$581 billion in revenues from tax provisions (estimated by JCT) and \$13 billion in additional revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by JCT and CBO). For JCT's estimates, see JCX-46-09.

<sup>4</sup> The gross cost of coverage of \$1,052 billion over 10 years discussed above includes changes in both outlays and revenues. That figure includes \$610 billion in outlays for insurance subsidies and administration, \$425 billion in outlays for Medicaid and CHIP, and \$25 billion in reduced revenues from small employer tax credits. Subtracting \$4 billion in net collections of risk adjustment payments (\$69 billion in collections less \$65 billion in payments to plans) and \$5 billion in start-up costs and repayments for the public plan (shown in Table 3) yields a total of \$1,052 billion (after accounting for rounding).

as outlays of \$65 billion. Those amounts are offset by risk adjustment collections of about \$69 billion, shown in the revenue portion of that table. Risk adjustment funds are collected from all insurers in the market for individual plans and then distributed to insurers based on how the characteristics of their enrollees compare to the average enrollee. Although risk adjustment collections and payments would be equal over time, CBO expects payments for risk adjustment to lag slightly behind collections, resulting in a net deficit reduction of about \$4 billion between 2013 and 2019.

**Table 2. Estimated Changes in Direct Spending and Revenues Resulting From H.R. 3962, the Affordable Health Care for America Act, Incorporating the Manager's Amendment Offered by Representative Dingell on November 3, 2009**

	By Fiscal Year, in Billions of Dollars												
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	
<b>CHANGES IN DIRECT SPENDING (OUTLAYS)</b>													
Insurance Subsidies and Administration <sup>1</sup>													
Exchange Subsidies	0	0	0	26	54	79	93	100	107	117	79	574	
Administration of Exchanges	*	1	1	2	4	4	5	5	5	5	8	31	
Spending for High-Risk Pools	<u>0</u>	<u>1</u>	<u>2</u>	<u>1</u>	<u>*</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>5</u>	<u>5</u>	
Subtotal	*	2	3	30	57	83	97	104	112	121	92	610	
Total Risk Adjustment Payments to Plans <sup>2</sup>	0	0	0	2	6	9	11	12	13	14	8	65	
Public Health Insurance Plan Payments for Benefits and Administration	0	0	0	15	28	41	47	50	53	57	43	291	
Collections of Enrollee Premiums, Exchange Subsidies, and Risk Adjustment Payments <sup>3</sup>	0	0	0	-16	-29	-42	-48	-51	-54	-58	-44	-298	
Start-up Costs	<u>*</u>	<u>1</u>	<u>1</u>	<u>*</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>2</u>	<u>2</u>	
Subtotal	*	1	1	*	-1	-1	-1	-1	-1	-1	1	-5	
Effects of Coverage Provisions on Medicaid and CHIP	-1	-2	-3	27	43	58	66	72	79	85	64	425	

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Table 2. Continued.

	By Fiscal Year, in Billions of Dollars										2010-	2010-
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2014	2019
<b>Medicare and Other Medicaid and CHIP Provisions</b>												
Reductions in Annual Updates to Medicare												
FFS Payment Rates	-3	-9	-12	-15	-18	-23	-28	-34	-40	-46	-57	-228
Medicare Advantage Rates Based on FFS	0	-5	-11	-16	-19	-21	-22	-24	-26	-28	-50	-170
Selected Medicare Prescription Drug Provisions <sup>4</sup>	*	-7	-5	-5	-4	-4	-3	-5	-5	-4	-21	-42
Medicaid Provider Payment Rates	3	6	6	7	7	6	6	6	5	5	29	57
Other	<u>3</u>	<u>27</u>	<u>7</u>	<u>7</u>	<u>-15</u>	<u>-7</u>	<u>-1</u>	<u>-7</u>	<u>-11</u>	<u>-16</u>	<u>29</u>	<u>-13</u>
Subtotal	3	13	-16	-23	-49	-48	-49	-64	-77	-88	-71	-396
<b>Other Changes in Direct Spending</b>												
Community Living Assistance Services and Supports	0	-4	-6	-9	-10	-11	-10	-9	-8	-7	-29	-72
Public Health Investment Fund & Prevention and Wellness Trust <sup>5</sup>	0	2	4	6	7	8	5	1	*	*	19	33
Other	<u>3</u>	<u>5</u>	<u>2</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>*</u>	<u>*</u>	<u>-1</u>	<u>-1</u>	<u>11</u>	<u>11</u>
Subtotal	3	3	*	-2	-2	-2	-5	-8	-8	-8	2	-29
Total Outlays	6	17	-15	34	55	99	120	115	117	124	97	672
On-budget	6	17	-15	34	54	99	119	115	117	123	96	669
Off-budget	0	0	0	*	*	*	*	*	*	*	*	3
<b>CHANGES IN REVENUES</b>												
Surcharge on Adjusted Gross Income	0	31	32	45	49	53	57	61	64	68	157	460
Penalty Payments by Uninsured Individuals	0	0	0	0	5	6	5	5	6	6	5	33
Penalty Payments by Employers	0	0	0	6	14	18	22	23	25	27	20	135
Risk Adjustment Collections	0	0	0	3	6	9	11	12	13	14	10	69
Small Employer Tax Credit	0	0	0	-4	-8	-5	-2	-2	-2	-2	-11	-25
Other Revenues <sup>6</sup>	*	8	8	14	12	15	17	18	19	20	42	130
Total Revenues	*	39	40	65	79	96	109	117	125	133	223	801
On-budget	*	39	40	66	81	97	110	118	125	133	226	810
Off-budget	*	*	*	-2	-2	-1	-1	-1	-1	-1	-4	-9

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Table 2. Continued.

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
<b>NET IMPACT ON THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES <sup>7</sup></b>												
Net Change in the Deficit	6	-21	-55	-31	-24	3	11	-1	-7	-9	-126	-129
On-budget	6	-21	-55	-33	-27	2	9	-3	-8	-10	-130	-141
Off-budget	*	*	*	2	2	2	2	1	1	1	4	11

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.

1. See table 3 for a cross-walk between the amounts shown here and the Exchange Subsidies and Related Spending line in that table.
2. Risk adjustment payments over the 10-year period include about \$27 billion in payments to the public health insurance plan and about \$39 billion in payments to other plans. Outlays shown here lag revenues shown later in the table by one quarter.
3. Premiums include amounts to cover amortized repayment of start-up funds, as well as to maintain the contingency reserve.
4. Includes the effects of section 1181 and section 1182, which would change the Medicare Part D program to establish a new prescription drug rebate program for some people who are eligible for both Medicaid and Medicare; impose a condition of participation that manufacturers provide discounts for brand-name drugs; and expand drug coverage to beneficiaries who are currently subject to a gap in coverage (often referred to as the Part D "doughnut hole").
5. Spending for the Public Health Investment Fund and Prevention and Wellness Trust provisions are reflected here, as directed by the House Committee on the Budget, even though that spending would be subject to future appropriation action.
6. Amounts include \$120 billion in increased revenues, as estimated by JCT, for tax provisions other than those not broken out separately in the table (for JCT's estimates, see JCX-46-09). In addition, the "other revenues" line includes a reduction in revenues of about \$4 billion from the coverage provisions in Table 3 and an increase in revenues of about \$13 billion for other provisions shown in Table 4.
7. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

The legislation would require that the premiums for the public plan be set to fully fund expenditures for medical claims, administrative costs, and a contingency reserve. The legislation would provide for start-up funding of \$2 billion for the administrative costs associated with establishing the public plan and require that those funds be paid back in amortized amounts over 10 years. The legislation also would provide start-up funding for a contingency reserve in an amount sufficient to cover 90 days of claims. On an annual basis, collections of premiums would exceed benefit payments and administrative costs by the amount needed to cover the start-up costs and to maintain the contingency reserve.

### **Effects of H.R. 3962 on Discretionary Costs**

CBO has not completed a comprehensive estimate of the discretionary costs that would be associated with H.R. 3962, incorporating the manager's amendment. Total costs would include those arising from the effects of H.R. 3962 on a variety of federal programs and agencies, as well as from a number of new and existing programs subject to future appropriations.

The federal agencies that would be responsible for implementing the provisions of H.R. 3962 are funded through the appropriation process; sufficient appropriations would be essential for them to implement this legislation in the time frame it specifies. Major costs for programs subject to future appropriations would include these:

- Costs to the Internal Revenue Service of implementing the eligibility determination, documentation, and verification processes for subsidies. Those costs would probably be between \$5 billion and \$10 billion over 10 years.
- Costs to HHS (and especially the Centers for Medicare and Medicaid Services) of implementing the changes in Medicare, Medicaid, and CHIP as well as certain reforms to the private insurance market. Those costs would probably be at least \$5 billion to \$10 billion over 10 years. (The administrative costs of establishing and operating the exchanges, which are direct spending, are included in Tables 1 and 2.)
- Costs of a number of grant programs and other changes in Divisions C and D of the legislation. CBO has not completed a review of those provisions.

Because those costs depend on future appropriations, they are not counted for enforcement of Congressional "pay-as-you-go" procedures and are not included in Tables 1 and 2.

Funding for the proposed Public Health Investment Fund and Prevention and Wellness Trust would also be subject to future appropriation action. The bill would authorize appropriations totaling about \$34 billion for those purposes (of which approximately \$33 billion would be spent over the next 10 years). The Committee on the Budget has directed CBO to count such spending as direct spending for purposes of budget scorekeeping in the House of Representatives.

### **Private-Sector and Intergovernmental Impact**

CBO and JCT have determined that the bill contains several private-sector and intergovernmental mandates as defined in the Unfunded Mandates Reform Act.

The total cost of mandates to the private sector, as estimated by CBO and JCT, would greatly exceed the threshold established by that act for private entities (\$139 million in 2009, adjusted annually for inflation). The most costly mandates would be the new requirements regarding health insurance coverage that apply to the private sector. The bill would require individuals to obtain acceptable health insurance coverage, as defined in the bill, and would require employers to either offer health insurance to their employees or pay an excise tax to the federal government. The bill also would impose other mandates, including requirements on issuers of health insurance, new standards governing health information, nutrition labeling requirements, and limits on certain agreements between drug manufacturers for settling patent infringement claims.

CBO estimates that the total cost of intergovernmental mandates would be small and would not exceed the annual threshold established in UMRA for state, local, and tribal entities (\$69 million in 2009, adjusted annually for inflation). The new standards governing health information and nutrition labeling that apply to private-sector entities would also apply to governmental entities. In addition, the bill would preempt state and local laws that conflict with or are in addition to new federal standards established by the bill. Those preemptions would limit the application of state and local laws, but CBO estimates that they would not impose significant costs.

As conditions of federal assistance (and thus not mandates as defined in UMRA), the bill also would require state and local governments to offer health insurance to their employees and would require “maintenance of effort” payments associated with high-risk pools. New requirements in the Medicaid program also would result in an increase in state spending. However, because states have significant flexibility to make programmatic adjustments in their Medicaid programs to accommodate changes, the new requirements would not be intergovernmental mandates as defined in UMRA.

I hope this information is helpful. 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 George Miller  
Chairman, Committee on Education and Labor

Honorable John D. Dingell

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Honorable John Kline  
Senior Republican

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