



June 15, 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 major provisions related to health insurance coverage that are contained in title I of draft legislation called the Affordable Health Choices Act, which was released by the Senate Committee on Health, Education, Labor, and Pensions (HELP) on June 9, 2009. Among other things, that draft legislation would establish insurance exchanges (called “gateways”) through which individuals and families could purchase coverage and would provide federal subsidies to substantially reduce the cost of that coverage for some enrollees.

The attached table summarizes our preliminary assessment of the proposal’s budgetary effects and its likely impact on insurance coverage. According to that assessment, enacting the proposal would result in a net increase in federal budget deficits of about \$1.0 trillion over the 2010–2019 period. Once the proposal was fully implemented, about 39 million individuals would obtain coverage through the new insurance exchanges. At the same time, the number of people who had coverage through an employer would decline by about 15 million (or roughly 10 percent), and coverage from other sources would fall by about 8 million, so the net decrease in the number of people uninsured would be about 16 million.

It is important to note, however, that those figures do *not* represent a formal or complete cost estimate for the draft legislation, for reasons outlined below. Moreover, because expanded eligibility for the Medicaid program may be added at a later date, those figures are not likely to represent the impact that more comprehensive proposals—which might include a

significant expansion of Medicaid or other options for subsidizing coverage for those with income below 150 percent of the federal poverty level—would have both on the federal budget and on the extent of insurance coverage.

### **Key Provisions Related to Health Insurance Coverage**

Subtitles A through D of title I of the Affordable Health Choices Act would seek to increase the number of legal U.S. residents who have health insurance. Toward that end, the federal government would provide grants to states to establish insurance exchanges and—more importantly—would subsidize the purchase of health insurance through those exchanges for individuals and families with income between 150 percent and 500 percent of the federal poverty level; those subsidies would represent the greatest single component of the proposal’s cost. The proposal would also impose a financial cost on most people who do not obtain insurance, the size of which would be set by the Secretary of the Treasury.

The draft legislation released by the HELP Committee also indicates that certain features may be added at a later date. Because they are not reflected in the current draft, however, CBO and the JCT staff did not take them into account. In particular, the draft legislation does not contain provisions that would change the Medicaid program, although it envisions that the authority to extend Medicaid coverage will be added during Senate consideration of the bill. (By itself, adding such provisions would increase the proposal’s budgetary costs and would also yield a larger increase in the number of people who have health insurance.) The draft legislation also indicates that the committee is considering whether to incorporate other features, including a “public health insurance option” and requirements for “shared responsibility” by employers. Depending on their details, such provisions could also have substantial effects on our analysis. (A summary of the key provisions that were included in this analysis is attached.)

### **Important Caveats Regarding This Preliminary Analysis**

There are several reasons why the preliminary analysis that is provided in this letter and its attachments does not constitute a comprehensive cost estimate for the Affordable Health Choices Act:

- First, this analysis focuses exclusively on the major provisions on health insurance coverage contained in certain subtitles of title I of the draft legislation. Although other provisions in title I, along with provisions in the other five titles of the legislation, would have significant budgetary effects, the analysis contained in this letter and its attachment is limited to the provisions in subtitles A through D regarding health insurance coverage.

- Second, CBO and the JCT staff have not yet completed modeling all of the proposed changes related to insurance coverage. For example, the proposal would allow parents to cover children as dependents until they are 27 years old, and our analysis has not yet taken that provision into account. (Other instances are listed in the attachment.) Although this analysis reflects the proposal's major provisions, taking all of its provisions into account could change our assessment of the proposal's effects on the budget and insurance coverage rates—though probably not by substantial amounts relative to the net costs already identified. As our understanding of the provisions we have analyzed improves, that could also affect our future estimates.
- Third, the analysis of the proposal's effects on the federal budget and insurance coverage reflects CBO's and the JCT staff's understanding of its key features and discussions with committee staff—but does not represent a full assessment of the legislative language that was released by the committee. Although our reading of the draft language has informed our analysis, we have not had time to complete a thorough review of that language, which could have significant effects on any subsequent analysis provided by CBO and the JCT staff.

In particular, the draft legislation includes a section on “individual responsibility” that would generally impose a financial cost on people who do not obtain insurance—but is silent about whether people are required to have such coverage. On the basis of our discussions with the committee staff, we understand that it was the committee's intent to impose a clear requirement for individuals to have health insurance, and this analysis reflects that intent. However, the current draft is not clear on this point, and if the language remains ambiguous, that would affect our estimate of its impact on federal costs and insurance coverage.

- Fourth, some effects of the insurance proposals that we have modeled have not yet been fully captured. For example, we have not yet estimated the administrative costs to the federal government of implementing the proposal or the costs of establishing and operating the insurance exchanges, nor have we taken into account the proposal's effects on spending for other federal programs. Those effects could be noticeable but would not affect the main conclusions of this analysis.
- Fifth, 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 the proposal and provides our preliminary assessment of its net effects on the federal budget deficit. Some cash flows would appear in

the budget but would net to zero and not affect the deficit; CBO has not yet estimated all of those cash flows.<sup>1</sup>

### **Likely Effects of the Proposal**

The proposal would have significant effects on the number of people who are enrolled in health insurance plans, the sources of that coverage, and the federal budget.

**Effects on Insurance Coverage.** Under current law, the number of nonelderly residents (those under age 65) with health insurance coverage will grow from about 217 million in 2010 to about 228 million in 2019, according to CBO's estimates. Over that same period, the number of nonelderly residents without health insurance at any given point in time will grow from approximately 50 million people to about 54 million people—constituting about 19 percent of the nonelderly population.<sup>2</sup> Because the Medicare program covers nearly all legal residents over the age of 65, our analysis has focused on the effects of proposals on the nonelderly population.

People obtain insurance coverage from a variety of sources. Under current law, about 150 million nonelderly people will get their coverage through an employer in 2010, CBO estimates. Similarly, another 40 million people will be covered through the federal/state Medicaid program or the Children's Health Insurance Program (CHIP). Other nonelderly people are covered by policies purchased individually in the "nongroup" market, or they obtain coverage from various other sources (including Medicare and the health benefit programs of the Department of Defense).

According to the preliminary analysis, once the proposal was fully implemented, the number of people who are uninsured would decline to about 36 million or 37 million, representing about 13 percent of the nonelderly population. (Roughly a third of those would be unauthorized immigrants or individuals who are eligible for Medicaid but not enrolled in that program.) That decline would be the net effect of several broad changes, which can be illustrated by examining the effects in a specific year. In 2017, for example, the number of uninsured would fall by about 16 million, relative to current-law projections. In that year, about 39 million people would be covered by policies purchased through the new insurance

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<sup>1</sup> For a discussion of the considerations that affect whether and how various cash flows should be reflected in the federal budget, see Congressional Budget Office, *The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System*, Issue Brief (May 27, 2009).

<sup>2</sup> Those estimates are "point-in-time" enrollment figures and thus represent annual averages. Also, some people have coverage from multiple sources at the same time (for example, Medicare and employment-based coverage), in which case they are assigned a primary source of coverage.

exchange. At the same time, about 147 million people would be covered by an employment-based health plan, 15 million fewer than under current law.<sup>3</sup> Smaller net declines (totaling about 8 million) would occur in coverage under Medicaid and CHIP and in nongroup coverage because of the subsidies offered in the exchanges.

**Budgetary Impact of Insurance Coverage Provisions.** On a preliminary basis, CBO and the JCT staff estimate that the major provisions in title I of the Affordable Health Choices Act affecting health insurance coverage would result in a net increase in federal deficits of about \$1.0 trillion for fiscal years 2010 through 2019. That estimate primarily reflects the subsidies that would be provided to purchase coverage through the new insurance exchanges, which would amount to nearly \$1.3 trillion in that period. The average subsidy per exchange enrollee (including those who would receive no subsidy) would rise from roughly \$5,000 in 2015 to roughly \$6,000 in 2019. The other element of the proposal that would increase the federal deficit is a credit for small employers who offer health insurance, which is estimated to cost \$60 billion over 10 years. Because a given firm would be allowed take the credit for only three consecutive years, the pattern of outlays would vary from year to year.

Those costs would be partly offset by receipts or savings from three sources: increases in tax revenues stemming from the decline in employment-based coverage; payments of penalties by uninsured individuals; and reductions in outlays for Medicaid and CHIP (relative to current-law projections).

The proposal would not change the tax treatment of health insurance premiums. Nevertheless, the reduction in the number of people receiving employment-based health insurance coverage, relative to current-law projections, would affect the government's tax revenues. Because total compensation costs are determined by market forces, CBO and the JCT staff estimate that wages and other forms of compensation would rise by roughly the amounts of any reductions in employers' health insurance costs. Employers' payments for health insurance are tax-preferred, but most of those offsetting changes in compensation would come in the form of taxable wages and salaries. As a result, the shift in compensation brought about by the proposal would cause tax revenues to rise by \$257 billion over

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<sup>3</sup> That net decline in employment-based coverage is itself the result of several flows. In particular, it includes roughly 10 million people who would have an offer of employment-based coverage but would be allowed to obtain subsidies in the insurance exchanges because that coverage would be deemed "unaffordable." Although the legislation did not specify a standard for affordability, CBO and the JCT staff assumed that coverage would be deemed unaffordable if workers had to pay a larger share of their income for their employer's plan than they would have to pay in the exchanges.

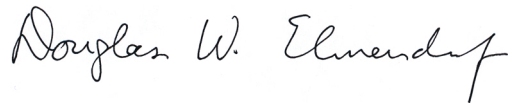
10 years. (Those figures are generally shown as negative numbers in the attached table because increases in revenues reduce the federal budget deficit.)

The government would also collect the payments that uninsured individuals would have to make. CBO and the JCT staff assume that the annual amount, which would be set by the Treasury Secretary, would be relatively small (about \$100 per person). Moreover, individuals with income below 150 percent of the federal poverty level would not have to pay that amount. As a result, collections of those payments would total \$2 billion over 10 years.

Finally, although the proposal would not change federal laws regarding Medicaid and CHIP, it would affect outlays for those programs. CBO assumes that states that had expanded eligibility for Medicaid and CHIP to people with income above 150 percent of the federal poverty level would be inclined to reverse those policies, because those individuals could instead obtain subsidies through the insurance exchanges that would be financed entirely by the federal government. Reflecting those reductions in enrollment, federal outlays for Medicaid and CHIP would decline by \$38 billion over 10 years.

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 staff. The primary staff contacts for this analysis are Philip Ellis and Holly Harvey.

Sincerely,



Douglas W. Elmendorf  
Director

#### Attachments

cc: Honorable Michael B. Enzi  
Ranking Member

**A Summary of the Key Provisions of  
the HELP Committee's Proposal**  
(As released on June 9, 2009)

Congressional Budget Office  
June 15, 2009

- Most of the proposal's key provisions would become operative in a state when that state establishes an insurance exchange (called a "gateway") through which its residents could obtain coverage; such exchanges might start offering health insurance in some states in 2012; all exchanges would be fully operational by 2014.
- The proposal is assumed to require most legal residents to have insurance (though the draft language is not explicit in this regard). In general, the government would collect a payment from uninsured people, but individuals with income below 150 percent of the federal poverty level (FPL) would be exempt and the payment would be waived in certain other cases. The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) assumed that the annual payment amount, which would be set administratively, would be relatively small (about \$100 per person).
- 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). Existing policies that are maintained continuously would be "grandfathered."
- 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 exchanges would have actuarial values chosen by the Secretary of Health and Human Services from specified ranges within three tiers. (A plan's actuarial value reflects the share of costs for covered services that is paid by the plan.) CBO and the JCT staff assumed that the chosen actuarial values would be 95 percent (for the highest tier), 85 percent (for the middle tier), and 76 percent (for the lowest tier). Plans would be allowed to offer added coverage or benefits for an extra 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. For people with income between 150 percent and 200 percent of the FPL, the subsidies would apply to that average bid for the highest-tier plans; for people with income between 200 percent and 300 percent of the FPL, the subsidies would apply to that average bid for the middle-tier plans; and for people with income between 300 percent and 500 percent of the FPL, the subsidies would apply to that average 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 10 percent of income at 500 percent of the FPL. 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 income below 150 percent of the FPL would not be eligible for those subsidies. (The proposal envisions that Medicaid would be expanded to cover those individuals and families but the draft legislation does not include provisions to accomplish that goal.)
- Subsidies would be delivered by the Department of Health and Human Services via the insurance exchanges with some provisions for income verification. Subsidy amounts would be determined using a measure of income for a previous tax year, implying that subsidies received for a given year (for example, in 2013) would be based on income received two years prior (for example, in 2011). Individuals might be eligible for larger subsidies if their income declined significantly in the intervening period or if other extenuating circumstances arose. (The draft legislation's provisions regarding verification of income are unclear, which is reflected in the analysis.)
- The proposal does not include a "public plan" that would be offered in the exchanges, nor does it contain provisions that would require employers to offer health insurance benefits or impose a fee or tax on them if they did not offer insurance coverage to their workers.
- 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; because the exchange subsidies would limit the share of income that enrollees would have to pay (as described above), CBO and the JCT staff assumed that an "unaffordable" offer from an employer would be one that required the employee to pay a larger share of income for that plan than he or she would have to pay for coverage in an exchange.

- The proposal would offer subsidies to small employers whose workers have low average wages and who offer health benefits to those workers. 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' health insurance would receive larger subsidies. The credit would be available indefinitely, but firms would be eligible to take the credit for only three consecutive years at a time.

### **Key Provisions Not Yet Taken Into Account**

There are several features of the proposal that CBO and the JCT staff have not yet reflected in their budget estimates. The most significant features of the proposal that have not yet been estimated would do the following:

- Require insurers to offer dependent coverage for children of policyholders who are less than 27 years of age.
- Delegate authority to a Medical Advisory Council to establish minimum requirements for covered health benefits and to determine the level of coverage that individuals would need to obtain in order to qualify as having insurance.
- Require insurers to maintain a minimum level of medical claims paid relative to premium revenues (otherwise known as a “medical loss ratio”), or to repay certain amounts to policyholders; the HHS Secretary would have the authority to set the minimum medical loss ratio.
- Apply “risk adjustment” (a process that involves shifting payments from plans with low-risk enrollees to plans with high-risk enrollees) to all health insurance policies sold in the individual and group insurance markets.
- Allow employers to buy health coverage through the exchanges.
- Require health insurance plans participating in the new exchanges to adopt measures that are intended to simplify financial and administrative transactions in the health sector (such as claims processing).

Preliminary Analysis of HELP Committee's Insurance Proposal

6/15/2009

NOTE: Figures in table do not reflect all elements of the proposal (see text)

**EFFECTS ON COVERAGE OF NONELDERLY PEOPLE <sup>a</sup>**

(Millions of people, by calendar year)

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law	Medicaid/CHIP	40	39	39	38	35	34	35	35	35	35
Coverage	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup	13	12	12	12	13	14	14	14	14	15
	Other	14	14	14	14	14	15	15	15	15	16
	Uninsured	<u>50</u>	<u>51</u>	<u>51</u>	<u>51</u>	<u>51</u>	<u>51</u>	<u>52</u>	<u>53</u>	<u>53</u>	<u>54</u>
	<b>TOTAL</b>	<b>267</b>	<b>269</b>	<b>271</b>	<b>273</b>	<b>274</b>	<b>276</b>	<b>277</b>	<b>279</b>	<b>281</b>	<b>282</b>
Change (+/-)	Medicaid/CHIP	-1	-1	*	1	-4	-3	-2	-2	-2	-2
	Employer	2	2	-1	-7	-14	-14	-15	-15	-15	-15
	Nongroup/Other	*	*	-1	-2	-5	-5	-5	-6	-6	-6
	Exchanges	0	0	5	17	38	38	38	39	39	40
	Uninsured	-1	-1	-3	-9	-15	-16	-16	-16	-17	-17
Post-Policy Uninsured <sup>d</sup>	Number of People	49	51	48	42	36	35	36	36	37	37
	as a Share of Nonelderly	19%	19%	18%	15%	13%	13%	13%	13%	13%	13%

**EFFECTS ON THE FEDERAL DEFICIT<sup>a,c</sup>**

(Billions of dollars, by fiscal year)

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Exchange Subsidies		0	0	17	66	148	183	196	209	223	237	1,279
Employer Subsidies <sup>d</sup>		4	8	8	5	4	7	7	6	6	7	60
Payments by Uninsured Individuals		0	0	0	*	*	*	*	*	*	*	-2
Medicaid/CHIP Outlays		-1	-2	-1	2	-6	-7	-6	-6	-6	-6	-38
Tax Revenue Effects of Coverage Changes <sup>e</sup>		1	2	-2	-15	-30	-37	-40	-43	-45	-48	-257
<b>NET IMPACT</b>		<b>4</b>	<b>7</b>	<b>21</b>	<b>58</b>	<b>116</b>	<b>146</b>	<b>157</b>	<b>166</b>	<b>177</b>	<b>189</b>	<b>1,042</b>

\* = Less than 0.5 million people or spending/savings of less than \$0.5 billion

Notes: a. Components may not sum to totals because of rounding. b. The count of uninsured people includes unauthorized immigrants and people eligible for, but not enrolled in, Medicaid. c. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit. d. The effects on the deficit from employer subsidies include their impact on taxable compensation. e. Increases in tax revenues reduce the deficit.

Sources: Congressional Budget Office and Joint Committee on Taxation.