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

Douglas W. Elmendorf, Director

September 10, 2009

Honorable Michael B. Enzi
Ranking Member
Committee on Health, Education,
Labor, and Pensions
United States Senate
Washington, DC 20510

Dear Senator:

This letter responds to several questions that you raised following my appearance before the Committee on Health, Education, Labor, and Pensions (HELP) during its consideration of the Affordable Health Choices Act. The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) issued a preliminary and partial analysis of that legislation as it was introduced on July 1, 2009.[1] We have not completed an assessment of the legislation as it was ultimately approved by the committee, including the amendments that were adopted during markup of the bill.

Effects of Expanding the Medicaid Program

You asked what the total cost would be of combining the committee's legislation with an expansion of eligibility for Medicaid for all legal U.S. residents with income below 150 percent of the federal poverty level (FPL). As you know, the Affordable Health Choices Act, as introduced, would not expand eligibility for Medicaid, but an earlier draft included language indicating that such an expansion would be added by the Senate Finance Committee (which has jurisdiction over Medicaid). Because our analysis of the introduced legislation examined only the changes in law that would result from it, we could not presume an expansion of eligibility for Medicaid or other new subsidies for health insurance beyond those that were specified. Overall, our preliminary assessment was that the provisions of the legislation pertaining to insurance coverage (contained in title I of the

[1] Congressional Budget Office, letter to the Honorable Edward M. Kennedy providing CBO's preliminary analysis of title I of the Affordable Health Choices Act (July 2, 2009).

bill) would increase federal deficits by $645 billion over the 2010–2019 period.

As CBO indicated in its letter to Senator Gregg on July 6, 2009, expanding eligibility for Medicaid to legal residents with income up to 150 percent of the FPL would increase the federal cost of the legislation considerably—by an amount that is probably on the order of $500 billion over 10 years.[2] (CBO did not estimate the costs to state governments of such a Medicaid expansion, but those costs would probably be relatively small because the options that CBO examined to expand Medicaid would have required states to cover a much smaller share of total spending than is seen in the current Medicaid program.) Therefore, the 10-year cost of the coverage expansion to the federal government, including such a change in Medicaid eligibility, would probably exceed $1 trillion. Combining such an expansion with the Affordable Health Choices Act as introduced would also yield a substantially larger reduction in the number of people who are uninsured than would arise from the act alone, because about half of the people projected to be uninsured under current law would have income below 150 percent of the FPL.

Because the magnitude of the effects on both federal costs and rates of insurance coverage for the combination of the committee's legislation and a Medicaid expansion would depend importantly on the details of the proposal, we cannot give you a more precise estimate at this time. For example, the effects would depend on how eligibility for Medicaid was determined and on whether the expansion started in 2010 or at a later date. The effects would also depend on what share of the costs for newly eligible people was borne by the federal government and what share was borne by the states. Furthermore, the effects would depend on whether states faced a maintenance-of-effort requirement relative to their current Medicaid programs. Regardless of its specific features, adding a Medicaid expansion to the introduced bill would not only affect federal costs for Medicaid but also have implications for other components of our preliminary estimate—because employers and individuals would probably respond to the bill's other provisions differently in that case.

An illustration of the effects of including a substantial expansion of Medicaid can be seen in the preliminary analysis that CBO and JCT have provided of the coverage specifications reflected in H.R. 3200, the

[2] Congressional Budget Office, letter to the Honorable Judd Gregg regarding the likely effects of substantially expanding eligibility for Medicaid (July 8, 2009).

America's Affordable Health Choices Act of 2009, as introduced in the House of Representatives on July 14, 2009.[3] That proposal would expand eligibility for Medicaid to all nonelderly individuals with income below 133 percent of the FPL (with all of the costs for newly eligible enrollees borne by the federal government) and would provide subsidies via insurance exchanges on a sliding scale for those with income up to 400 percent of the FPL. CBO estimated that federal outlays for Medicaid would increase by $438 billion over the 2010–2019 period because of that expansion of eligibility for the program and related measures. That figure includes the estimated costs of a proposed increase in Medicaid's payment rates for primary care physicians, but does not include the costs of providing subsidies for insurance to people with income between 133 percent and 150 percent of the FPL (which have not been separately estimated).

Effects on Employers and Employees

You also asked whether the costs borne by employers as a result of the proposal would be passed on to workers in the form of lower wages than they would otherwise be paid, and about the effects of the proposal on employment-based health insurance. Under the legislation as introduced, firms with more than 25 workers would have to offer health insurance (and contribute a specified share of the premiums) or pay a penalty. In general, CBO believes that firms that are subject to the penalty but opt not to offer health insurance would pass that cost on to their workers, primarily in the form of lower wages—just as firms that offer insurance today and contribute toward the premiums pay lower wages than they otherwise would, keeping their total compensation costs about the same. One exception would be workers earning close to the minimum wage, because their wages might not be able to adjust downward to offset the cost of the penalty; as a result, employment of those workers might be adversely affected, though that impact is likely to be small.[4]

As for the effects of the legislation on employment-based health insurance, CBO and JCT estimated that the version that was introduced on July 1 would not have a major effect on the aggregate number of people obtaining coverage through an employer; we estimated that in 2016, for example, the total number of people covered by an employment-based plan would be

---

[3] Congressional Budget Office, letter to the Honorable Charles B. Rangel providing a preliminary analysis of the America's Affordable Health Choices Act of 2009 (July 17, 2009).

[4] For additional discussion, see Congressional Budget Office, *Effects of Changes to the Health Insurance System on Labor Markets,* Issue Brief (July 13, 2009).

about 163 million, or about 1 million more than is projected under current law.

That net figure reflects changes going in both directions. Some people would gain employment-based coverage, because the mandate to obtain health insurance would induce some employers to make an offer of such coverage that would not have been made otherwise or would induce some individuals to take advantage of an existing offer that they would not have accepted otherwise. At the same time, we estimated that about 6 million people who would have employment-based coverage under current law would not have such coverage under the proposal. That figure includes about 2 million workers (and their dependents) who would have an offer from their employer that would be deemed "unaffordable" under the proposal, thus allowing them to purchase subsidized coverage through the new insurance exchanges. It also includes about 4 million people who would have coverage through an employer under current law but would not have such an offer under the proposal. To what extent those changes in coverage would represent the dropping of existing coverage or expected offers of coverage that would fail to materialize is difficult to determine.

Effects of a "Public Plan"

You also asked whether the federally administered "public plan" that would be offered under the legislation as introduced would have a substantial effect on federal spending for health care. Under that proposal, the public plan would be managed by the Department of Health and Human Services, would pay negotiated rates to providers of health care, and would have to be financially self-sufficient (albeit with the government bearing some risk, as discussed below). Given those provisions, CBO's assessment is that premiums for the public plan would typically be roughly comparable to the average premiums of private plans offered in the insurance exchanges—and thus the existence of such a plan would not directly affect the amount of federal subsidies for health insurance under the legislation.

Nevertheless, including a public plan would probably have two small effects on the premiums of the private plans against which it is competing, both of which would tend to lower federal subsidy payments through the exchanges to some degree—but we have not quantified that effect by comparing the legislation as introduced to a proposal that was identical in all other respects but did not include a public plan.

- First, a public plan as structured in the introduced bill would probably attract a substantial minority of enrollees (in part because it

would include a relatively broad network of providers and would be likely to engage in only limited management of its health care benefits). As a result, it would add some competitive pressure in many insurance markets that are currently served by a limited number of private insurers. That competitive pressure would probably lower private premiums in the insurance exchanges to a small degree.

- Second, a public plan is also apt to attract enrollees who, overall, are less healthy than average (again, because it would include a relatively broad network of providers and would probably engage in limited management of benefits). Although the payments that all plans in the exchanges receive would be adjusted to account for differences in the health of their enrollees, the methods used to make such adjustments are imperfect. As a result, the higher costs of those less healthy enrollees in the public plan would probably be offset partially but not entirely; the rest of the added costs would have to be reflected in the public plan's premiums. Correspondingly, the costs and premiums of competing private plans would, on average, be slightly lower than if no public plan was available.

At the same time, including a public plan in the proposal would increase the *gross* amount of federal spending on health care simply because all of the payments to and from that plan should be recorded in the federal budget, in CBO's judgment.[5] For the public plan, all payments to providers, administrative costs, and government subsidy payments would be federal expenses, and all subsidy payments and enrollees' premiums would be counted as offsetting receipts (a credit against direct spending). For private health insurance plans participating in the new insurance exchanges, by contrast, the portion of premiums that is subsidized would be recorded as federal outlays; the remainder of private plans' receipts and costs would not appear in the federal budget. Under the assumption that the public plan would charge premiums that covered its costs—as it is supposed to do—*net* federal outlays on health care would not be appreciably different as a result of applying those accounting rules. However, the federal government would be assuming the financial risk that the premiums charged in any given year might not fully cover all of the public plan's costs.

---

[5] Congressional Budget Office, *The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System*, Issue Brief (May 27, 2009).

Effects on Overall Expenditures for Health Care

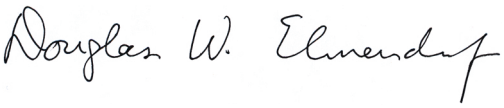
You also asked what effect the introduced legislation would have on national spending on health care. By itself, a substantial expansion of insurance coverage could cause an increase of between 2 percent and 5 percent in national spending on health care, largely because insured people generally receive somewhat more medical care than do uninsured people—notwithstanding the fact that some newly insured people would avoid expensive treatments by getting care sooner, before their illness progressed.[6] However, the rise in national spending on health care would be less than the increase for the federal government because some costs that are now paid by others would be shifted to the government (via the subsidies provided by the bill). Expanding insurance coverage would make it modestly easier to achieve certain types of reductions in national and federal spending on health care; for example, some governmental payments to hospitals that treat a disproportionate share of poor and uninsured patients might be trimmed accordingly.

More broadly, legislation could seek to offset the impact of an insurance expansion—on both federal costs and total spending for health care—by including other provisions affecting either the major federal programs that finance health care or the private insurance system. The bill as introduced would encourage private insurers to adopt measures to improve the coordination of the care they provide, but private insurers would be inclined to adopt cost-reducing strategies even in the absence of new legislation, so the effect of those provisions on costs is not clear. The insurance market reforms included in the bill would reduce administrative costs for individually purchased policies, but the resulting savings would probably be small relative to the increase in spending brought about by the insurance expansion. Given its overall scope, the bill would probably increase national spending on health care modestly.

[6] For additional discussion, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 71–76.

I hope this information is helpful to you. 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 Tom Harkin
Chairman

Honorable Christopher J. Dodd