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

Douglas W. Elmendorf, Director

July 26, 2009

Honorable Dave Camp
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

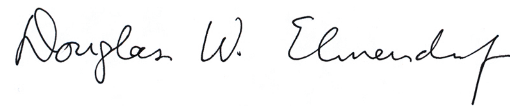
The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) recently completed a preliminary analysis of the specifications related to health insurance coverage that are reflected in the America's Affordable Health Choices Act, which was released by the House Committee on Ways and Means on July 14, 2009.

Among other things, those specifications would establish a mandate for most legal residents to obtain health insurance, significantly expand eligibility for Medicaid, regulate the pricing and terms of private health insurance policies, set up insurance "exchanges" through which certain individuals and families could receive federal subsidies to reduce the cost of purchasing insurance, and offer a "public plan" option similar to Medicare through those exchanges. For reasons outlined in CBO's July 14 letter summarizing that analysis—and in our letter of July 17, which took into account the other parts of the legislation that would raise taxes or reduce other spending—our analysis to date does not represent a formal or complete cost estimate for the draft legislation.

The attached analysis responds to your request for additional information about the effects of the specifications regarding health insurance coverage. In particular, you asked about the effects on enrollment in private coverage, in the new public plan, and in Medicaid; the effects on private-sector insurance premiums and the labor market; the longer-term cost of the plan; and the allocation of its net budget impact between outlays and revenues. Because of the complexity of the changes that have been proposed and their potential effects, we are unable to address all aspects of every question that you raised.

I hope this information is helpful to you. If you have any further 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

Identical letters sent to the Honorable Joe Barton, the Honorable John Kline, and the Honorable Paul Ryan.

Attachment

cc: Honorable Charles B. Rangel
Chairman

Additional Information Regarding the Effects of Specifications in the America's Affordable Health Choices Act Pertaining to Health Insurance Coverage

July 26, 2009

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) recently completed a preliminary analysis of the specifications related to health insurance coverage that are reflected in the America's Affordable Health Choices Act. That analysis, which was transmitted in a letter to the House Committee on Ways and Means, was released on July 14, 2009; subsequent analysis, which took into account the other parts of the legislation that would raise taxes or reduce other spending, was released on July 17. Among other things, those specifications would establish a mandate for most legal residents to obtain health insurance, significantly expand eligibility for Medicaid, regulate the pricing and terms of private health insurance policies, set up insurance "exchanges" through which certain individuals and families could receive federal subsidies to reduce the cost of purchasing insurance, and offer a "public plan" option similar to Medicare through those exchanges.

This report provides additional information about the effects of the specifications in that act regarding health insurance coverage. In particular, it examines their likely effects on enrollment in private coverage, in the new public plan, and in Medicaid; the effects on private-sector insurance premiums and the labor market; the longer-term cost of the plan; and the allocation of its net budget impact between outlays and revenues. For reference, the table released on July 14 summarizing the preliminary analysis of the coverage specifications is included in this report. The report, however, does not represent a formal or complete cost estimate for the draft legislation.

Effects on Enrollment in Private Coverage

Compared with what would happen under current law, the legislation would induce some people to move out of employment-based coverage and others to move into employment-based coverage, and our estimate of the net effect of those changes is shown in the attached table. A number of questions have arisen about that estimate—particularly regarding our conclusion that only a small share of firms would choose to stop offering health insurance to their workers once the new subsidies became available in the insurance exchanges. Several factors contribute to that conclusion:

- Workers who get insurance through their employer receive a significant subsidy because the cost of that insurance is not treated as taxable earnings for the worker and thus avoids both income and payroll taxes. In most cases, that exclusion applies to the portion of the premium that workers pay as well as the amount the employer

contributes. On average, that tax exclusion gives workers a subsidy of roughly 30 percent for purchasing insurance through their employer—a subsidy that would be forgone if the employer chose not to offer coverage and the workers instead obtained coverage in the new insurance exchanges.

- In general, firms that decided to stop sponsoring insurance coverage for their workers would not be able to reduce their operating costs because, in a competitive labor market, they would have to offer higher wages and other forms of compensation instead. Indeed, workers might be particularly motivated to demand such increases under the proposal because they would be required to obtain insurance. That added compensation would generally be taxable. (This consideration and the preceding one help explain why most workers are offered health insurance by their employers today.)

- Under the proposal, nearly 90 percent of workers would be employed by firms that would either have to offer qualified coverage and contribute a significant share toward the premium or pay a tax equal to 8 percent of their total payroll. That "play-or-pay" penalty would constitute a substantial portion of the average cost of providing insurance coverage, which has been estimated at about 12 percent of payroll currently (but which would rise over time). In dollar terms, the penalty would obviously vary depending on a firm's payroll; for example, a firm with average wages of $40,000 per year that did not offer qualified coverage would have to pay a penalty of $3,200 per worker. Moreover, that penalty would make no direct contribution to those workers' insurance costs; they would then need to obtain coverage from another source in order to fulfill the individual mandate.

- Many firms have a mix of employees with differing levels of individual or family income—some of whom would qualify for relatively generous subsidies in the new insurance exchange and some of whom would not. Consistent with the available evidence, we anticipate that an employer would generally take into account the effects on all of its workers in deciding whether or not to offer coverage. In most cases, having their employer offer coverage would be the best option for the workforce overall, even with the new insurance exchanges.

- Finally, the available evidence indicates that in making decisions about offering insurance, many firms are not very responsive to the availability of outside options for their workers to obtain coverage; in particular, that responsiveness tends to decline as firm size increases. One reason is that larger firms have relatively low administrative costs that would generally make it advantageous for their workers to keep that coverage rather than pay higher administrative costs for a plan in an

insurance exchange. Because larger firms account for the lion's share of all employment-based coverage, that lack of responsiveness limits the likely extent of any erosion in coverage.[1]

In most cases, the combination of the subsidy from the current tax exclusion and the penalty for firms that did not offer qualified coverage would provide a strong financial inducement for employers to continue offering coverage to their workers.[2] To give an example in today's terms, the average employment-based health insurance plan currently has a premium of about $5,000 for single coverage and $13,000 for family coverage. The subsidy provided by the tax exclusion is thus worth about $1,500 for single coverage and about $4,000 for family coverage, on average. For a firm with average wages of $40,000, the $3,200 penalty combined with the subsidy from the tax exclusion would roughly equal the total amount of the single premium and would constitute more than half of the typical cost of family coverage. Only workers who would receive larger percentage subsidies in the exchanges would be better off if their employer stopped offering coverage—and that would be a distinct minority of workers.[3]

Taking those considerations into account, some firms would probably decide not to offer coverage, CBO and the JCT staff estimate. That option would be most attractive to firms with lower-wage workers—both because the play-or-pay penalty for not offering coverage would be smaller in dollar terms and because their workers would be eligible for larger subsidies in the insurance exchanges (or through Medicaid). An additional factor is that smaller firms (those with an annual payroll of less than $400,000) would either be exempt from the play-or-pay penalty or would pay a lower tax rate. However, an offsetting consideration is that small employers with low-wage workers would be eligible for a tax credit covering up to 50 percent of the employer's contribution toward health insurance premiums. On balance, CBO and the JCT staff estimate that, in 2016, about 3 million people (including spouses and dependents of workers) who would be covered by an employment-based plan under current law would not have an offer of coverage under the proposal.

Other people would have an offer of coverage from an employer but would choose to make use of the subsidies that would be available in certain cases through the exchanges.

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[1] For further discussion of the factors affecting employer coverage, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 4–8 and 43–48; and *CBO's Health Insurance Simulation Model: A Technical Description*, Background Paper (October 2007).

[2] In the legislation considered by the Senate Committee on Health, Education, Labor, and Pensions, the penalty amounts per worker are much smaller. However, that proposal would also provide less inducement for employers to stop offering coverage, because it would provide no new subsidies for insurance coverage for individuals with income below 150 percent of the federal poverty level.

[3] Over time, as the costs of health care rose more rapidly than payrolls, the penalties would gradually decline in importance relative to the tax exclusion and exchange subsidies. That evolution is incorporated in CBO's analysis and helps explain why the estimated effect of the proposal on employer coverage changes gradually over time.

In 2016, nearly 3 million people who would be covered under an employment-based plan under current law—and who could be covered by that plan under the proposal—would choose instead to obtain coverage in the exchanges because the employer's offer would be deemed unaffordable and they would therefore be eligible to receive subsidies through the exchanges. In addition, some part-time employees, who could receive subsidies via an exchange even though they had an employer's offer of coverage, would choose to do so. All told, we estimate that, in 2016, about 9 million people who would otherwise have had employer coverage would not be enrolled in an employment-based plan under the proposal.

The net effect of the proposal on employment-based health insurance reflects larger changes in the other direction, however. We estimate that about 12 million people who would not be enrolled in an employment-based plan under current law would be covered by one in 2016, largely because the mandate for individuals to be insured would increase workers' demand for insurance coverage through their employer. On net, therefore, about 3 million more people would have their primary coverage through an employer under the proposal than under current law (as shown in the attached table).

Enrollment in the Public Plan

A related question concerns how many firms would provide coverage to their workers but would do so by letting their workers purchase coverage in the insurance exchanges—and, in particular, how many of those enrollees would end up in the new public plan. Under the proposal, firms with 20 or fewer workers would be given the option to let their workers buy coverage through the insurance exchanges starting in 2014, and the official overseeing the exchanges would be allowed to let larger employers purchase coverage in that way starting in 2015. In those cases, the workers would not receive exchange subsidies but would instead be subsidized through the tax exclusion as under current law; as a result, CBO's table showing the effect of the proposal on sources of insurance coverage counts those enrollees as being covered by employment-based insurance rather than as exchange enrollees.

For the preliminary estimate of the proposal, CBO and the JCT staff assumed that only firms with 50 or fewer employees would be permitted to buy coverage through the exchanges, and we estimated that about 6 million workers and their dependents would obtain coverage in that way. We also estimated that about one third of those enrollees would choose the public plan—an assessment that is consistent with our overall estimate of the share of people in the exchanges choosing that plan.

What options employers would have under the proposal depends on whether the official overseeing the insurance exchanges would give larger firms access to the exchanges, and predicting what that official would do is difficult. On the one hand, workers at some firms would find that option attractive, particularly in areas where the public plan has relatively low premiums, and they might apply pressure to be admitted to the exchanges. On the other hand, providers of health care and private insurers might be opposed to expanding access to the public plan, and they might apply pressure to keep larger firms

out of the exchanges. In addition, the official might be concerned about the potential for adverse selection into the exchanges, which could arise if employers choosing to take advantage of the option had older or less healthy workers.

If we assumed that workers at larger firms would be allowed to purchase coverage through the exchanges, our estimate of the number of enrollees involved would undoubtedly be greater than 6 million, but we have not estimated the magnitude. Analysts at the Lewin Group recently estimated that if all employers were given access to the insurance exchanges, more than 100 million people would end up enrolling in the public plan.[4] For several reasons, we anticipate that our estimate of the number of enrollees in the public plan would be substantially smaller than the Lewin Group's, even if we assumed that all employers would have that option.

One consideration that would affect our analysis is that large employers would generally have lower administrative costs for health insurance than would plans offered in the exchanges, because (under the proposal) those plans would need to sign up enrollees individually; as a result, employees of large firms would be less likely than those of small firms to find the option of purchasing coverage through the exchange attractive, holding other factors equal. Although we assumed that the public plan would have somewhat lower administrative cost per enrollee than would private plans in the exchanges, the public plan would probably have to incur much of the same cost in order to attract and retain members.

More generally, the Lewin analysis uses a much larger gap than does our analysis between the premium of the public plan and the premiums of the private plans against which it would be competing. As indicated in our letter of July 14, we estimate that the public plan's premium would, on average, be about 10 percent lower than that of a typical private plan offered in the insurance exchanges. That estimate is based in part on available data from the Medicare Advantage program about the difference in costs incurred by private plans and the traditional Medicare plan to provide the same set of benefits. Indeed, the most recent analysis of that difference concluded that the costs of the traditional Medicare plan were only 2 percent lower, on average, than the costs of private plans participating in Medicare to provide the same benefits (though that difference varied geographically and by the type of private plan that was offered).[5]

Another factor relevant to our estimate is our assessment that some providers would choose not to participate in the public plan, which would discourage some enrollees from choosing that plan despite its lower average premium. Even so, we expect that the

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[4] Statement of John Sheils, Vice President, The Lewin Group, before the House Committee on Energy and Commerce, *The Impact of the House Health Reform Legislation on Coverage and Provider Incomes* (June 25, 2009).

[5] See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2009), Chapter 3. CBO's larger estimate of the gap in premiums between the public plan and private plans under the proposal also incorporates expected differences in such factors as benefit management and providers' payment rates.

provider network would be large enough to attract a sizable minority of participants in the exchanges.

Because all of these factors are uncertain, estimating enrollment in the public plan is especially difficult—as we emphasized in our earlier letter. Given our assessment of the likely difference in premiums, however, offering more firms the option of letting their workers purchase insurance through the exchanges would probably have a limited effect on the proposal's net budgetary impact. As noted above, workers with employment-based insurance who obtained coverage through the exchanges would receive no exchange subsidies and would have the same tax preference as if they had obtained coverage outside the exchanges. Thus, if more employers purchased coverage through the exchanges than we anticipate and purchased somewhat less expensive insurance via the public plan, the principal effect on federal deficits is that those employers would end up increasing their workers' taxable compensation and thereby would generate slightly higher tax revenues. Greater enrollment in the public plan would also increase the plan's outlays and premium collections, which would be included in the federal budget, but as long as the public plan charged premiums that covered its costs (as it is supposed to do under the proposal), those amounts would be offsetting.

Effects of the Proposed Medicaid Expansion

A further question is the number of people who we estimate would enroll in Medicaid under the proposal that would have private coverage under current law. CBO does not anticipate a substantial shift from private insurance to Medicaid. Specifically, we estimate that about 1 million people who would otherwise have employment-based insurance or individually purchased coverage would end up enrolling in Medicaid in 2016. We also estimate that about 10 million people would newly enroll in Medicaid under the proposal, but the great majority of them would be people who would otherwise be uninsured rather than privately insured. As a result, our estimated rate of crowd-out—that is, the share of people gaining Medicaid coverage who would otherwise be insured privately—is about 10 percent under this proposal.

Although the proposal would sharply increase the number of people eligible for Medicaid, several factors help to explain the relatively low rate of crowd-out of private insurance that we expect:

- The expansion of Medicaid would encompass relatively poor people (including some childless adults whose income is well below the poverty level), who are less likely than people with higher income to have private insurance coverage. Our analysis indicates that only about a quarter of the people who would be made newly eligible for Medicaid under the proposal would have private coverage under current law.

- Unlike prior expansions of public coverage on which estimates of crowd-out are generally based, this proposal would impose a considerable penalty on employers that did not offer qualified insurance and contribute a substantial share of the premium.

Those requirements would help offset the incentives under the proposal for employers to cease offering coverage as a result of the expansion in Medicaid eligibility.

- Unlike past expansions of Medicaid, the proposal would include a requirement for people to obtain insurance. As a result, those who would be eligible for Medicaid (whether under current law or because of the expansion) and who would otherwise be uninsured would be more likely to enroll in that program.

In sum, because of the specific features of the proposal, the number of people who might leave private coverage for Medicaid would be relatively small, and the number of people who would newly enroll in Medicaid would be relatively large—so together, those features of the proposal would reduce the expected rate of crowd-out.[6]

Effects on Private-Sector Premiums

Many observers have asked about the effect of the proposal on health insurance premiums in the private sector outside the insurance exchanges. After 2012, all newly issued policies purchased by individuals would have to be bought through the insurance exchanges; as a result, the proposal's effects on premiums outside the exchanges would be seen in premiums for coverage provided by or through employers (which is the predominant source of insurance for the nonelderly population under current law and would remain so, in our estimation, under this proposal). The proposal contains a number of elements that could affect those premiums, both directly and indirectly—some of which could cause the premiums to increase and some of which could cause them to decrease. Although the direction of the overall impact is not certain, the magnitude of the effect on average premiums would probably be modest.

Effects on the Risk Pool

One concern that has been expressed about proposals to establish and subsidize coverage through the new insurance exchanges is that firms would see their relatively young or healthy enrollees switch to those plans. If that happened, the average costs for covering the remaining enrollees would be higher. Under the proposal, however, full-time workers with an offer of coverage from their employer would generally be prohibited from receiving subsidies through the exchanges—a restriction known as a "firewall," which we believe would be largely effective.[7] Moreover, the proposal would allow premiums in the insurance exchanges to vary only by age and then only to a limited degree, so the plans available in the exchanges might not be substantially more attractive to younger and

[6] For more information about the potential effect of expanding public insurance coverage on the number of people with private insurance, see Congressional Budget Office, *The State Children's Health Insurance Program* (May 2007), pp. 7–13.

[7] An exception would be granted for full-time workers who had to pay more than 11 percent of their income for their employer's insurance. In addition, part-time workers could receive subsidies via the exchanges regardless of the availability or cost of coverage through their employers. As noted above, CBO and the JCT staff estimated that several million workers would take advantage of those exceptions.

healthier workers than they would be for other workers—reducing the incentive to circumvent the firewall.

At the same time, CBO and the JCT staff estimate that several million more people, on balance, would enroll in employment-based insurance than is projected under current law. The resulting pool of enrollees would be somewhat healthier, on average, than is the pool of enrollees in employment-based insurance today; as a consequence, the average cost of covering those enrollees would be several percent lower than under current law (holding other factors equal). The extent and manner in which that change would affect premiums for employment-based coverage is more difficult to determine; for example, that effect might be seen primarily in the premiums for single coverage (rather than family coverage) because most of the younger and healthier enrollees who would sign up for employment-based coverage as a result of the proposal would choose that type, but how premium costs are allocated within firms is less clear. Also, the main reason some people would be paying less for their coverage is because newly enrolled people would be making premium payments they would not otherwise have made—so the changes in premiums would largely represent a transfer among workers rather than an improvement in the efficiency of employment-based insurance plans.

The proposal's restrictions on insurance markets could also affect premiums for employment-based coverage. In particular, the proposal would prohibit insurers from varying the premiums charged to employers to reflect differences in the health status or likely costs of their employees. Existing policies would be exempt from that requirement through 2017 but would then have to come into compliance with that prohibition. (Insurers would still be permitted to adjust premiums, albeit to a limited degree, to reflect the age of the enrollees.) That change would not apply to employers who chose to bear the financial risk of providing health insurance to their workers, but it would affect employers who purchased such coverage from an insurer. Relative to current law (under which relatively few states impose the same restrictions on variation in premiums), those limits might not have a substantial effect on the average premium paid by employers, but they would tend to increase premiums for firms with relatively healthy workers and decrease them for firms with relatively unhealthy workers.

Effects of Cost Shifting

A less direct way in which the proposal could cause private-sector premiums to change is by affecting the extent of "cost shifting"—a phenomenon in which lower rates paid to health care providers for some patients (such as uninsured people or enrollees in government insurance programs) can lead to higher payment rates for others (privately insured individuals). The proposal would have opposing effects on the pressures for such cost shifting to occur.

On the one hand, the proposal's expansion of eligibility for Medicaid and other provisions would substantially increase enrollment in that program (by an estimated 10 million to 11 million people in the latter part of the 2010–2019 period). In addition, many provisions of the proposal would reduce payments to hospitals and other providers

under Medicare. Furthermore, the legislation would establish a public plan to be offered in the insurance exchanges; that plan would be set up by the Secretary of Health and Human Services and pay Medicare-based rates to providers of health care. By themselves, those changes would tend to increase the pressure on providers to shift costs to private payers.

On the other hand, we estimate that the proposal would ultimately reduce the uninsured population by roughly two-thirds, which would greatly attenuate the pressure to shift costs that arises today when uncompensated or undercompensated care is provided to people who lack health insurance. One recent estimate indicates that hospitals provided about $35 billion in such care in 2008—an amount that would grow under current law but would be expected to decline considerably under the proposal. (Recent evidence also indicates that physicians collectively provide much smaller amounts of uncompensated or undercompensated care, so all else held equal, the overall impact of expanded insurance coverage on their payments rates would also be smaller.)

The net effect of those opposing pressures would thus depend on their relative magnitude and also on the degree to which cost shifting occurred in each case. Given the size of the annual decline in undercompensated care that seems likely to ensue, the adverse effects on hospital finances stemming from greater enrollment in Medicaid, cuts in Medicare payment rates, and enrollment in the public plan would also have to be substantial to offset those savings for hospitals as a group. (The net effect would differ from hospital to hospital.) As for the extent of cost shifting, CBO's assessment of the evidence is that some does occur but that it is not as widespread or extensive as is commonly assumed. Well-designed studies have found that a relatively small share of the changes in payment rates for the government's programs is passed on to private payment rates, and the impact of changes in uncompensated care is likely to be similar.[8] Overall, therefore, the effect the proposal would have on private-sector premiums via cost shifting is unclear.

Changes in Payment Methods

In addition to proposed changes in Medicare's payment rates, the proposal would also alter some of Medicare's payment methods—or at least test such changes—which might ultimately reduce private insurance costs to a limited degree. For example, the proposal would establish a demonstration project to examine the use of "accountable care organizations" and would make other modifications that could encourage reductions in health care spending.[9] To the extent that future steps to implement such changes in a more aggressive way also changed how doctors treated privately insured patients, some benefits could "spill over" to the private sector. However, such effects would probably represent a small fraction of privately insured medical costs over the next 10 years,

[8] For a more extensive discussion of this issue and the evidence about its effects, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 112–116.

[9] For an explanation of how accountable care organizations might reduce Medicare spending, see Option 37 in Congressional Budget Office, *Budget Options, Volume 1: Health Care* (December 2008), p. 72.

paralleling the relatively small effects in Medicare itself as a proportion of total program spending in that period.

Impact on the Labor Market

This proposal, like others to reform the health insurance system, could affect labor markets in several ways.[10] In general:

- Requiring employers to offer health insurance—or pay a fee if they do not—would be likely to reduce employment, although the effect would probably be small.

- Providing new subsidies for health insurance that decline in value as a person's income rises could discourage some people from working more hours.

- Increasing the availability of health insurance that is not related to employment could lead more people to retire before age 65 or choose not to work at younger ages. It might also encourage other workers to take jobs that better match their skills, because they would not have to stay in less desirable jobs solely to maintain their health insurance.

Under the proposal, employers with annual payroll above specified levels would be required to offer health insurance to their workers and contribute a significant share toward the premium or pay a tax equal to as much as 8 percent of their total payroll. For the firms that chose not to offer qualified insurance, that penalty would increase the cost of employing each worker by somewhat less than 8 percent (because total compensation generally exceeds the taxable payroll to which this fee would apply). The overall impact on employment would probably be muted, however, because employers would be expected to pass the costs of such fees on to workers in the form of lower wages than would otherwise be paid—just as the costs paid by employers for health insurance are generally passed on to workers. Because the requirement would not be instituted until 2013, employers would be able to plan for its implementation; CBO also projects that the economy will have largely recovered from the current recession by that date.

Nonetheless, such a change would tend to reduce the hiring of workers at or near the minimum wage, because their wages might not be able to decline by the full amount of the fee (or by the costs of the health insurance that would have to be provided to avoid the fee). Still, the impact of the proposal on low-wage workers would probably be small because studies suggest that moderate increases in the minimum wage generally have limited effects on employment. An 8 percent increase in the cost of hiring a worker

[10] For a more extensive discussion, see Congressional Budget Office, *Effects of Changes to the Health Insurance System on Labor Markets*, Issue Brief (July 13, 2009). The overall impact of health reform proposals on labor markets is difficult to predict. Although economic theory and experience provide some guidance as to the effect of specific provisions, large-scale changes to the health insurance system could have more extensive repercussions than have previously been observed and could also involve numerous factors that would interact—affecting labor markets in significant but potentially offsetting ways.

making the minimum wage—which was just increased to $7.25 per hour—would amount to roughly $0.60 per hour, which is also about the size of the increase in the minimum wage that just took effect. Moreover, firms with an annual payroll below $250,000 would be exempt from the play-or-pay requirement.

Another feature of the proposal relevant to labor markets is that the subsidies for insurance coverage offered via the exchanges would phase out as enrollees' income rose, effectively reducing the compensation they would receive for each additional hour worked. That effect, which is an "implicit tax," can lead people to work fewer hours than they otherwise would, in the same way that income and payroll taxes can. Specifically, the proposal would provide subsidies to help cover the costs of purchasing insurance and would phase out those subsidies as income increased from 133 percent to 400 percent of the federal poverty level. Over that range, the share of income that enrollees would have to pay in premiums for coverage in the exchanges would increase from 1.5 percent to 11 percent, and the extent of coverage that would be subsidized would also decline so that enrollees with higher income would pay higher out-of-pocket costs as well. With limited exceptions, the subsidies would not be available to the vast majority of workers who had a qualified offer of health insurance from their employer; in addition, some workers who would not have employment-based insurance would have income above 400 percent of the poverty level. As a result, changes in the work hours of people affected by this implicit tax would have a much smaller proportionate effect on total hours worked in the U.S. economy.[11]

To express those effects in round terms using current levels of premiums and income, the subsidy might decline from roughly $5,000 to zero for single adults over an income range of about $30,000, and from roughly $13,000 to zero for a family of four over an income range of about $60,000. Thus, the implicit tax rate over that income range—that is, the extent to which those subsidies would decline as income rose—would be around 20 percent (but would vary somewhat across income levels because the subsidies would not phase out in a uniform way).[12] A proposal that phased out subsidies more quickly would yield even higher implicit tax rates; for example, the implicit tax rate would range from about 28 percent to about 35 percent if the same subsidies were phased out uniformly between 133 percent and 300 percent of the federal poverty level. Conversely, those implicit tax rates could be reduced by extending the subsidies further up the income scale, but doing so would expand the number of people affected by this implicit tax and would also increase the budgetary cost of the proposal. In any event, the implicit tax rates created by the phase-out of subsidies would come on top of existing income and payroll tax rates.

[11] The proposal would also raise tax rates on higher-income taxpayers through a surcharge. This report does not address the effects of that surcharge.

[12] Over time, as the costs of health care rose more rapidly than income, the implicit tax rate would increase.

Through the insurance exchanges and expanded eligibility for Medicaid, the proposal would enhance access to health insurance for people who are not employed and would provide subsidies for insurance to people with income below 400 percent of the federal poverty level who do not have employment-based coverage. Those provisions could encourage more people to retire before age 65, and they might lead some people to choose not to work at younger ages. The provisions might also lead to better matches between workers and jobs, because workers would not have to stay in less desirable jobs solely to maintain their health insurance.

Longer-Term Costs of the Proposal

Estimating the effects of major changes to the health care and health insurance systems over the next 10 years is very difficult and involves substantial uncertainty; generating longer-term estimates is even more challenging and is fraught with even greater uncertainty. As a result, CBO does not provide formal cost estimates beyond the 10-year budget window. However, we have said that in evaluating proposals to reform health care, the agency will endeavor to offer a qualitative indication of whether they would be more likely to increase or decrease the budget deficit over the second decade.[13]

The starting point for such an analysis of the recent House proposal is our estimate of the proposal's impact on the federal budget deficit in the first 10 years. As discussed in CBO's letter of July 17, we estimate that the proposal as a whole would increase federal deficits by $239 billion over the 2010–2019 period. That estimate has three major components: the net effect of the coverage specifications, which affect both spending and revenues and which would add an estimated $1,042 billion to cumulative deficits over that period; the effect of other provisions, primarily regarding Medicare, that would reduce direct spending by a net $219 billion; and the effect of still other provisions (primarily, an income tax surcharge on high-income individuals) that would increase revenues by $583 billion. Under the proposal, federal spending on health care would increase by approximately the difference between the net cost of the coverage specifications and the reductions in direct spending.

Looking ahead to the decade beyond 2019, CBO tries to evaluate the rate at which the budgetary impact of each of those broad categories would be likely to change over time. The net cost of the coverage provisions would be growing at a rate of more than 8 percent per year in nominal terms between 2017 and 2019; we would anticipate a similar trend in the subsequent decade. The reductions in direct spending would also be larger in the second decade than in the first, and they would represent an increasing share of spending on Medicare over that period; however, they would be much smaller at the end of the 10-year budget window than the cost of the coverage provisions, so they would not be likely to keep pace in dollar terms with the rising cost of the coverage expansion. Revenue from the surcharge on high-income individuals would be growing at about 5 percent per year in nominal terms between 2017 and 2019; that component would

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[13] For discussion of our approach to developing such qualitative information, see the CBO Director's Blog, "The Effects of Health Reform Legislation beyond the Next Decade" (July 24, 2009).

continue to grow at a slower rate than the cost of the coverage expansion in the following decade. In sum, relative to current law, the proposal would probably generate substantial increases in federal budget deficits during the decade beyond the current 10-year budget window.

Under any proposal that provided new federal subsidies for the purchase of health insurance, the rate of growth in federal spending would depend importantly on how the subsidies were indexed over time. As long as overall spending for health care continued to expand as a share of the economy, people's share of insurance costs would continue to rise faster than their income, or the government's subsidy costs would continue to rise faster than the tax base, or both. The proposal limits the share of income that eligible people would have to pay when they purchased coverage in the insurance exchanges, and that share of income would not change over time. In addition, insurance plans offered through the exchanges would be required to pay a specified share of costs for covered services (on average), and that share also would not change over time. Combining those provisions, increases in health care spending in excess of the rate of growth in income would be borne entirely by the federal government in the form of higher subsidy payments—because those payments would have to cover the entire difference between the total premium for insurance coverage and the capped amount that enrollees would pay. Those factors help explain why the costs of the coverage provisions would continue to grow rapidly in the decade after 2019.

Allocation of the Net Budgetary Impact Between Outlays and Revenues

On July 14, CBO and the JCT staff provided preliminary estimates of the effects of the proposal's specifications regarding insurance coverage on the federal budget; the relevant table from that letter is attached for reference. Those estimates included the major cash flows that would affect the budget and the net effects on the budget deficit during the 2010–2019 period, but they did not allocate the net budgetary impact into changes in outlays and changes in revenues. Moreover, the preliminary estimates did not include all of the cash flows that would appear in a formal and complete cost estimate.

The amounts shown in the table for new federal spending on Medicaid and the Children's Health Insurance Program would be outlays, as would the spending for subsidies to purchase insurance coverage through the new exchanges. Those two streams of outlays would amount to an estimated $1,211 billion over 10 years.

All of the other flows of funds shown in the table would represent changes in revenues, netting to a projected increase in federal revenues of $169 billion over 10 years. Increases in revenues would include the payments by employers to the exchanges for workers who received coverage there (amounting to $45 billion); payments of penalties by uninsured individuals ($29 billion); and payments of play-or-pay penalties by employers ($163 billion). Together, those provisions would increase federal revenues by a total of $238 billion over 10 years. Other flows would represent decreases in revenues. Under the

proposal, firms with relatively few employees and relatively low average wages would also be eligible for tax credits to cover up to half of their contributions toward health insurance premiums, which would reduce revenues by an estimated $53 billion over 10 years. The proposal would also have other effects on tax revenues, largely stemming from changes in the mix of compensation provided to workers between taxable wages and salaries and nontaxable health insurance benefits; on net, those changes would reduce federal revenues by $15 billion over 10 years.

In addition to the cash flows that are shown in the table, some additional transactions would appear in the budget but would net to zero and thus would not affect the deficit. Those transactions, which CBO and the JCT staff have not yet estimated, would appear either as outlays and offsetting receipts or collections (that is, offsets to outlays), or as outlays and revenues. One set of additional cash flows would be the outlays for the public plan and its premiums, which would be offsetting receipts or collections. Another set of cash flows would be the risk-adjustment transfers among plans operating in the insurance exchanges—going from those with relatively healthy enrollees (which would be revenues) to those with relatively unhealthy enrollees (which would be outlays of an equal and offsetting magnitude).

Finally, as CBO noted in its letter of July 14, the preliminary analysis of the proposal did not include federal administrative costs or account for all effects on other federal programs. Including those factors and refining the preliminary analysis in other ways could affect our estimates of the changes in outlays and revenues generated by the proposal and thus its impact on federal deficits.

Preliminary Analysis of the Insurance Coverage Specifications Provided by the House Tri-Committee Group

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	-2	6	4	9	10	10	11	11
	Employer	*	*	1	10	7	4	3	3	2	2
	Nongroup/Other /c	*	*	*	-3	-4	-6	-6	-6	-6	-6
	Exchanges	0	0	0	11	20	27	28	29	29	30
	Uninsured /d	*	1	1	-23	-28	-35	-35	-36	-37	-37
Post-Policy Insurance Coverage											
Number of Uninsured People /d		51	52	52	27	23	16	16	17	17	17
Insured Share of the Nonelderly Population											
Including All Residents		81%	81%	81%	90%	92%	94%	94%	94%	94%	94%
Excluding Unauthorized Immigrants		83%	83%	83%	92%	94%	97%	97%	97%	97%	97%
Memo: Exchange Enrollees and Subsidies											
Number w/ Unaffordable Offer from Employer /e					***	*2*	*2*	*2*	*3*	*3*	*3*
Number of Unsubsidized Exchange Enrollees					*1*	*2*	*3*	*3*	*3*	*3*	*3*
Approximate Average Subsidy per Subsidized Enrollee						*$4,600*	*$4,800*	*$5,100*	*$5,300*	*$5,700*	*$6,000*

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. Components may not sum to totals because of rounding.
b. Figures reflect average annual enrollment. Individuals reporting mutiple sources of coverage are assigned a primary source.
c. Includes Medicare, TRICARE, and other sources; 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.
e. Full-time workers who would have to pay more than 11 percent of their income for employment-based coverage could receive subsidies via an exchange (see text).

Preliminary Analysis of the Insurance Coverage Specifications Provided by the House Tri-Committee Group

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
Medicaid/CHIP Outlays /d,e	3	4	1	29	42	58	66	72	78	84	438
Exchange Subsidies	0	0	0	33	72	105	123	134	146	160	773
Payments by Employers to Exchanges /f,g	0	0	0	0	-3	-6	-8	-8	-9	-11	-45
Associated Effects on Tax Revenues /f	*	*	*	10	10	3	-1	-1	-2	-4	15
Subtotal	3	4	1	72	122	160	180	196	213	230	1,182
Small Employer Credits /h	0	0	0	4	7	8	8	8	10	10	53
Payments by Uninsured Individuals	0	0	0	0	-6	-5	-4	-5	-5	-5	-29
"Play-or-Pay" Payments by Employers /f,h	0	0	0	-7	-16	-21	-26	-29	-31	-33	-163
NET IMPACT OF COVERAGE SPECIFICATIONS	**3**	**4**	**1**	**69**	**107**	**141**	**158**	**171**	**187**	**202**	**1,042**

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

Note: CHIP = Children's Health Insurance Program; * = between $0.5 billion and -$0.5 billion.

a. Does not include federal administrative costs or account for all effects on other federal programs.
b. Components may not sum to totals because of rounding.
c. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
d. Includes effects of coverage provisions and the proposed increase in Medicaid payment rates for primary care physicians (see text).
e. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2010-2019 period would be reduced by about $10 billion under the proposal (see text).
f. Increases in tax revenues reduce the deficit.
g. Employers would generally have to pay 8 percent of their average payroll per worker for each employee who received subsidies via an exchange (see text).
h. The effects on the deficit shown for this provision include the associated effects of changes in taxable compensation on tax revenues.