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

Douglas W. Elmendorf, Director

September 16, 2009

Honorable Max Baucus
Chairman
Committee on Finance
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 specifications for the Chairman's mark for proposed health care legislation that were provided by the staff of the Senate Finance Committee. (CBO has not completed a review of the document entitled "Chairman's Mark, America's Healthy Future Act," which was released by the Committee earlier today.) Among other things, the Chairman's proposal 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; 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 excise tax on insurance plans with relatively high premiums; and make various other changes to the Medicaid and Medicare programs and the federal tax code.

CBO and JCT's preliminary assessment of the proposal's impact on the federal budget deficit is summarized below. The enclosures with this letter provide estimates of the resulting changes in the number of nonelderly people in the United States who would have health insurance, present the primary budgetary effects of the proposal's major provisions related to insurance coverage, and display detailed estimates of the cost or savings from other proposed changes (primarily to the Medicare program) that would affect the federal government's direct spending.

Estimated Budgetary Impact of the Chairman's Proposal

According to CBO and JCT's assessment, enacting the Chairman's proposal would result in a net reduction in federal budget deficits of $49 billion over the 2010–2019 period (see Table 1). The estimate includes a projected net cost of $500 billion over 10 years for the proposed expansions in insurance coverage. That net cost itself reflects a gross total of $774 billion in credits and subsidies provided through the exchanges, 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 $215 billion in revenues from the excise tax on high-premium insurance plans and $59 billion in revenues from other sources.[1] The net cost of the coverage expansions would be more than offset by the combination of other spending changes that CBO estimates would save $409 billion over the 10 years and other tax provisions that JCT and CBO estimate would increase federal revenues by $139 billion over the same period.[2] In subsequent years, the collective effect of those provisions would probably be continued reductions in federal budget deficits.

Those estimates are all subject to substantial uncertainty. Furthermore, although we understand that the published document describing the Chairman's mark was intended to reflect the specifications provided to us, CBO and JCT have not reviewed that document to determine whether it conforms in all respects to those specifications.

Specifications Regarding Insurance Coverage

The proposal would take several steps designed to increase the number of legal U.S. residents who have health insurance. Starting in 2013, the proposal would establish a requirement for such residents to obtain insurance and would typically impose a financial penalty on people who did not do so (the size of which would depend on their income). In that same year, the proposal would establish new insurance exchanges and would subsidize the purchase of health insurance through those exchanges for individuals and families with income between 133 percent and 400 percent of the federal poverty level (FPL). Policies purchased through those exchanges (or directly from insurers) would have to meet several requirements: In particular, insurers would have to accept all applicants,

[1] The increase in net outlays for Medicaid and CHIP reflects an increase in spending for Medicaid and a decrease in spending for CHIP.

[2] The $139 billion figure includes $134 billion in additional revenues estimated by JCT apart from the excise tax on high-premium insurance plans (see JCX-35-09) and $5 billion in additional revenues from certain Medicare and Medicaid provisions estimated by CBO.

TABLE 1. PRELIMINARY ESTIMATE OF THE EFFECTS ON THE DEFICIT OF THE CHAIRMAN'S PROPOSAL OF SEPTEMBER 16, 2009

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
NET CHANGES IN THE DEFICIT FROM INSURANCE COVERAGE PROVISIONS [a, b]												
Effects on the Deficit	*	3	5	12	43	72	88	90	92	94	64	500
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING [c]												
Effects on the Deficit of Changes in Outlays	8	2	-11	-22	-42	-50	-56	-66	-79	-93	-64	-409
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [d]												
Effects on the Deficit of Changes in Revenues [e]	-8	-10	-11	-16	-15	-15	-16	-16	-16	-16	-61	-139
NET CHANGES IN THE DEFICIT [a, b]												
Net Increase or Decrease (-) in the Budget Deficit	*	-4	-17	-25	-14	7	16	8	-3	-16	-61	-49
On-Budget	*	-5	-17	-27	-15	8	20	12	3	-9	-62	-28
Off-Budget [f]	*	*	*	1	*	-2	-3	-4	-6	-7	2	-20

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

Note: Components may not sum to totals because of rounding; * = between $0.5 billion and -$0.5 billion..

a. Does not account for all effects on other federal programs.

b. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit. Does not include effects on spending subject to future appropriations.

c. These estimates reflect the effects of interactions between insurance coverage provisions and other Medicare and Medicaid provisions.

d. The changes in revenues include effects on Social Security revenues that are classified as off-budget.

e. The 10-year figure of $139 billion includes $134 billion in additional revenues estimated by JCT apart from the excise tax on high-premium insurance plans (see JCX-35-09) and $5 billion in additional revenues from certain Medicare and Medicaid provisions estimated by CBO.

f. Almost all off-budget effects are revenue effects.

could not limit coverage for preexisting medical conditions, and could not vary premiums to reflect differences in enrollees' health. The proposal also would provide start-up funds to encourage the creation of co-op insurance plans that could be offered through the exchanges; existing insurers could not be approved as co-ops. Starting in 2014, nonelderly people with income below 133 percent of the FPL would generally be made eligible for Medicaid; the federal government would pay a share of the costs of covering newly eligible enrollees that varied somewhat from year to year but ultimately would average about 90 percent.[3] (Under current rules, the federal government pays about 57 percent of the costs of Medicaid.)

The proposal contains a number of other key provisions. Although it would not explicitly require employers to offer health insurance, firms with more than 50 workers that did not offer coverage would be subject to a penalty for any workers who obtained subsidized coverage through the insurance exchanges. As a rule, full-time employees who were offered coverage from their employer would not be eligible to obtain subsidies via the exchanges, but an exception to that "firewall" would be allowed for workers who had to pay more than 13 percent of their income for their employer's insurance (in which case the employer would also be penalized). Under certain circumstances, 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. Beginning in 2013, insurance policies with relatively high total premiums would be subject to a 35 percent excise tax on the amount by which the premiums exceeded a specified threshold. In general, that threshold would be set initially at $8,000 for single policies and $21,000 for family policies; after 2013, those amounts would be indexed to overall inflation. (A more detailed summary of the proposal's key provisions regarding insurance coverage is attached.)

On a preliminary basis, CBO and JCT estimate that the proposal's specifications affecting health insurance coverage would result in a net increase in federal deficits of $500 billion over fiscal years 2010 through 2019. That estimate primarily reflects $287 billion in additional federal outlays for Medicaid (net of reduced outlays for CHIP) and $463 billion in federal subsidies that would be provided to purchase coverage through the new insurance exchanges. The other main element of the proposal that would increase federal deficits is the tax credit for small employers who offered health insurance, which is estimated to reduce revenues by

[3] 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 would increase by about $37 billion over the 2010–2019 period as a result of the coverage specifications.

$24 billion over 10 years. Those costs would be partly offset by receipts or savings, totaling $274 billion over the 10-year budget window, from four sources: revenues from the excise tax on high-premium insurance plans, totaling $215 billion; penalty payments by uninsured individuals, which would amount to $20 billion; penalty payments by employers whose workers received subsidies via the exchanges, which would total $27 billion; and indirect effects on federal revenues associated with the expansion of federally subsidized insurance, which would add up to $12 billion.[4]

By 2019, CBO and JCT estimate, the number of nonelderly people who are uninsured would be reduced by about 29 million, leaving about 25 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under the proposal, the share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 94 percent. Roughly 25 million people would purchase coverage through the new insurance exchanges, and there would be roughly 11 million more enrollees in Medicaid than is projected under current law. (The proposed co-ops had very little effect on the estimates of total enrollment in the exchanges or federal costs because, as they are described in the specifications, they seem unlikely to establish a significant market presence in many areas of the country or to noticeably affect federal subsidy payments.) The number of people purchasing individual coverage outside the exchanges or obtaining coverage through employers would decline slightly, relative to currently projected levels.

Specifications Affecting Medicare and Medicaid

Other components of the proposal would alter spending under Medicare, Medicaid, CHIP, and other federal health programs. The proposal would make numerous changes to payment rates and payment rules in those programs (the budgetary effects of which are shown in the enclosed tables). In total, CBO estimates that enacting those provisions would reduce direct spending by $409 billion over the 2010–2019 period. The provisions that would result in the largest budget savings include these:

[4] Changes in the extent of employment-based health insurance affect federal revenues because most payments for that coverage are tax-preferred. If employers increase or decrease the amount of compensation they provide in the form of health insurance (relative to current-law projections), CBO and JCT assume that offsetting changes would occur in wages and other forms of compensation—which are generally taxable—to hold total compensation roughly the same. Such effects also arise with respect to specific elements of the proposal (such as the tax credits for small employers), and those effects are included within the estimate for those elements.

- Permanent reductions in the annual updates to Medicare's payment rates for most services in the fee-for-service sector (other than physicians' services), yielding budgetary savings of $182 billion over 10 years. (That calculation excludes interactions between those provisions and others—namely, the effects of those changes on payments to Medicare Advantage plans and collections of Part B premiums.)

- Setting payment rates in the Medicare Advantage program based on the average of the bids submitted by Medicare Advantage plans in each market, yielding savings of an estimated $123 billion (before interactions) over the 2010–2019 period.

- Reducing Medicare and Medicaid payments to hospitals that serve a large number of low-income patients, known as disproportionate share (DSH) hospitals, by about $48 billion—composed of $25 billion from Medicaid DSH payments and $23 billion from Medicare DSH payments.

The proposal also would establish a Medicare Commission, which would be required, under certain circumstances, to recommend changes to the Medicare program to limit the rate of growth in that program's spending. Those recommendations would go into effect automatically unless blocked by subsequent legislative action. Before 2019, such recommendations would be required if the Medicare Trustees project that Medicare spending per beneficiary will grow more rapidly than a measure of inflation (the average of the growth rates of the consumer price index for medical services and the overall index for all urban consumers). After 2019, recommendations would be required if projected growth exceeded the rate of increase in gross domestic product (GDP) per capita plus 1 percentage point. The proposal would prohibit the commission from modifying eligibility or benefits, so its recommendations probably would focus on changes to payment rates or methodologies. The commission would develop its first set of recommendations during 2013 for implementation in 2015. CBO estimates that—given all of the reductions that would result from other provisions—this arrangement would reduce Medicare spending by an additional $23 billion over the 2015–2019 period.

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 proposal:

- First, while we understand that specifications provided to CBO were intended to be consistent with the Chairman's published mark document, CBO and JCT have not reviewed that document to determine whether it conforms in all respects to those specifications.

- Second, CBO has not yet completed its review of legislative language that would translate those specifications into law; review of that language could have a significant effect on the analysis. In particular, this analysis reflects an assumption that sufficient reporting and enforcement provisions will be included to implement the specified policies in an effective manner. More generally, as CBO's and JCT's understanding of the specifications improves, that could also affect our future estimates.

- Third, we have sought to model all of the specifications and to capture their principal effects on federal spending, but we have not taken into account all of the proposal's effects on spending for other federal programs or estimated the federal government's administrative costs for oversight and implementation that would be subject to future appropriations.

- Fourth, the budgetary information shown in the tables reflects many of the major cash flows that would affect the federal budget as a result of implementing the specified policies and provides a preliminary assessment of the net effects on the federal budget deficit (subject to the caveats listed above). Some cash flows (such as risk adjustment payments) would appear in the budget but would net to zero and thus would not affect the deficit; CBO and JCT have not yet estimated all of those cash flows.

Effects of the Proposal Beyond the First 10 Years

Although CBO does not generally provide cost estimates beyond the 10-year budget window, Senate rules require some information about the budgetary impact of legislation in subsequent decades, and many Members have requested CBO analyses of the long-term budgetary impact of broad changes in the nation's health care and health insurance systems. However, a detailed year-by-year projection, like those that CBO prepares for the 10-year budget window, would not be meaningful because the uncertainties involved are simply too great. Among other factors, a wide range of changes could occur—in people's health, in the sources and extent of their insurance coverage, and in the delivery of medical care (such as advances

in medical research, technological developments, and changes in physicians' practice patterns)—that are likely to be significant but are very difficult to predict, both under current law and under any proposal.

CBO has therefore developed a rough outlook for the decade following the 10-year budget window by grouping the elements of the proposal into broad categories and assessing the rate at which the budgetary impact of each of those broad categories is likely to increase over time.[5] Under this proposal, the major categories are as follows:

- Elements dealing with expanded insurance coverage (including exchange subsidies, the costs of expanded Medicaid eligibility, penalty payments, and employer tax credits): Those provisions have an estimated net cost of $147 billion in 2019, and that cost is growing at about 7 percent per year toward the end of the 10-year budget window. As a rough approximation, CBO assumes continued growth at about that rate during the following decade.

- The excise tax on high-premium insurance plans and other taxes: JCT estimates that those provisions would generate about $69 billion in additional revenues in 2019 and that receipts would grow by an average of roughly 15 percent per year in the following decade.

- Changes to the Medicare program and changes to the Medicaid program other than those associated directly with expanded insurance coverage: Savings from those provisions are estimated to total $93 billion in 2019, and CBO projects that, in combination, they will increase by 10 percent to 15 percent per year in the next decade.

All told, the Chairman's proposal would reduce the federal deficit by $16 billion in 2019, CBO and JCT estimate. After that, the added revenues and cost savings are projected to grow more rapidly than the cost of the coverage expansion. Consequently, CBO expects that the proposal, if enacted, would reduce federal budget deficits over the ensuing decade relative to those projected under current law, with a total effect during that decade that is in a broad range around one-half percent of GDP. The imprecision of that calculation reflects the even greater degree of

[5] CBO applied a similar approach—that of grouping changes into broad categories—to an analysis of the longer-term effects of H.R. 3200, as described in a letter to Representative Dave Camp dated July 26, 2009.

uncertainty that attends to it, compared with CBO's 10-year budget estimates.

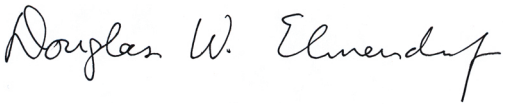
Many Members have expressed interest in the effects of reform proposals on various other measures of spending on health care. Under the Chairman's proposal, the projected effects on the federal budget deficit also represent the change in the federal government's overall commitment of resources to health care because essentially all of the spending and tax elements contained in the proposal are related to health care. Thus, the proposal would reduce the federal budgetary commitment to health care, relative to that under current law, during the decade following the 10-year budget window. Members have also requested information about the effect of proposals on national health expenditures (NHEs). CBO does not analyze NHE as closely as it does the federal budget, however, and at this point the agency has not assessed the net effect of the current proposal on NHEs, either within the 10-year budget window or for the subsequent decade.

These projections assume that the proposals are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation. For example, the sustainable growth rate (SGR) mechanism governing Medicare's payments to physicians has frequently been modified (either through legislation or administrative action) to avoid reductions in those payments. The projected savings for the Chairman's proposal reflect the cumulative impact of a number of specifications that would constrain payment rates for providers of Medicare services. In particular, the proposal would increase payment rates for physicians' services for 2010, but those rates would be reduced by about 25 percent for 2011 and then remain at current-law levels (that is, as specified under the SGR) for subsequent years. Under the proposal, increases in payment rates for many other providers would be held below the rate of inflation (in expectation of ongoing productivity improvements in the delivery of health care). The projected savings for the proposal also assume that the Medicare Commission is relatively effective in reducing costs—beyond the reductions that would be achieved by other aspects of the proposal—to meet the targets specified in the legislation. The long-term budgetary impact could be quite different if those provisions were ultimately changed or not fully implemented. (If those changes arose from future legislation, CBO would estimate their costs when that legislation was being considered by the Congress.)

CBO has not extrapolated estimates further into the future, because the uncertainties surrounding them are magnified even more. However, in view of the projected net savings during the decade following the 10-year budget window, CBO anticipates that the proposal would probably continue to reduce budget deficits relative to those under current law in subsequent decades. Therefore, pursuant to section 311 of S. Con. Res. 70, CBO estimates that enacting the Chairman's proposal would not cause a net increase in deficits in excess of $5 billion in any of the four 10-year periods beginning after 2019.

I hope this preliminary analysis is helpful for your consideration of this proposal. 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 Charles E. Grassley
Ranking Member

A Summary of the Specifications for Health Insurance Coverage
Provided by the Staff of the Senate Finance Committee

September 15, 2009

- Most of the proposal's major provisions regarding health insurance coverage—including the establishment of an individual mandate to obtain insurance, the creation of new insurance exchanges through which to purchase coverage, and the provision of new subsidies via those exchanges—would be implemented beginning in 2013. An expansion of eligibility for the Medicaid program would begin in 2014.

- The proposal would require all legal residents to enroll in a health insurance plan meeting minimum benefit standards. In general, a penalty would be assessed on people subject to the mandate who did not obtain insurance, but all individuals with income below 100 percent of the federal poverty level (FPL) would be exempt from the penalty (and in 2013 only, those with income between the FPL and 133 percent of the FPL would also be exempt). Exemptions from the mandate would also be granted to Native Americans, individuals who would have to pay more than 10 percent of their income to purchase qualifying coverage, and certain other individuals. (After 2013, the 10 percent threshold would be indexed to the excess of average premium growth over average growth in income.)

- Those who do not enroll in a qualified health insurance plan and do not receive an exemption would face a penalty, the amount of which would vary on the basis of income. For those with income between 100 percent and 300 percent of the FPL, the penalty would be $750 per person, subject to a cap of $1,500 per family. For those with income above 300 percent of the FPL, the penalty would be $950 per person, subject to a cap of $3,800 per family. After 2013, those dollar amounts would be indexed to the measured rate of medical price inflation.

- New health insurance policies sold in the individual and small group insurance markets would be subject to several requirements regarding their availability and pricing. Insurers would be required to issue policies 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, but could vary by age by a factor of 5 (under a system known as adjusted community rating). Existing policies purchased in the individual market that are maintained continuously would be "grandfathered," meaning that they would not have to conform to the new rules.

- Each state would be required to establish a new insurance exchange through which individuals and small firms could purchase health insurance. Insurance policies sold through the exchanges would be required to cover certain services and could offer various levels of coverage—but those policies would generally have to have an actuarial value of at least 65 percent (known as minimum creditable coverage). (A plan's actuarial value reflects the share of costs for covered services that is paid by the plan.)

- Individuals and families who enroll in exchange plans and have income between 100 percent and 400 percent of the FPL would be eligible to receive refundable tax credits that limited the share of their income that they had to pay for a specified level of coverage (described below). All enrollees could purchase more extensive coverage at their own expense. Individuals and families with income above 400 percent of the FPL would be able to purchase coverage through the exchange but would not be eligible for exchange credits.

- The amount of the tax credits for exchange plans in each area of the country would be tied to the premium of the second-lowest-cost plan in the "silver" tier (the "reference plan"), which would have an actuarial value of 70 percent. The exchange credits would equal the difference between the premium for the reference plan and a specified share of the taxpayer's income. In 2013, that share of income would range linearly from 3 percent for those with income equal to the FPL to 13 percent for those with income equal to 300 percent of the FPL and would be 13 percent for those with income between 300 percent and 400 percent of the FPL. In later years, those shares of income would be indexed so that the portion of the premium paid by enrollees would be maintained over time. (To achieve that, the income caps would have to increase at a rate equal to the excess of average growth in health insurance premiums over average income growth.)

- Insurers would also receive subsidies to reduce cost-sharing obligations for certain low-income enrollees in plans sold through the exchange. For individuals and families with income between 100 percent and 150 percent of the FPL, the subsidies would increase the actuarial value of their coverage to 90 percent. For those with income between 150 percent and 200 percent of the FPL, the subsidies would increase the actuarial value of their coverage to 80 percent. Those cost-sharing subsidies would be financed entirely by the federal government, so enrollees' premiums would be unaffected. In 2013, however, individuals and families with income below 133 percent of the FPL would not be eligible for exchange credits or cost-sharing subsidies.

- Exchange credits would be determined on the basis of adjusted gross income during the plan year (modified to include tax-exempt interest and certain other types of income). During a fall open-enrollment period, participants would have to provide information from their prior year tax return (for example, tax return data on income in 2011 would be provided when applying in the fall of 2012 for subsidies to be received in 2013), which would be used to determine interim credit amounts to be paid out during the year. The exchange would be given authority to have the Internal Revenue Service verify the information that is provided on income from the prior year. Individuals who experienced specified changes in circumstances, such as a substantial drop in income from the prior year, would be allowed to apply for a redetermination of their eligibility for exchange credits.

- In all cases, exchange credits would be recalculated on the basis of actual income during the plan year (for example, credits for the 2013 would be recalculated using the tax return filed in 2014 reporting income for 2013), subject to a "safe harbor." For filers whose income turns out to be less than 300 percent of the FPL—but who received too large a credit—the "safe harbor" would limit the amount that they had to repay to $250 for single filers and $400 for joint filers (and for those filing as the head of household). For filers whose income turns out

to exceed 300 percent of the FPL, no safe harbor would apply—so they would have to repay in full any credits they received.

- The specifications include provisions to establish health care cooperatives that would provide insurance coverage and operate as nonprofit organizations. Existing insurers could not be approved as co-ops. Start-up funds of $6 billion would be provided. The proposal also includes $5 billion in funding to increase the availability of high-risk insurance pools until the new insurance exchanges are operational.

- Eligibility for the Medicaid program would be expanded to all nonelderly individuals and families with income below 133 percent of the FPL, starting in 2014. From that date forward, Medicaid eligibility would generally be determined on the basis of adjusted gross income without income "disregards" and without asset tests (with exceptions regarding the provision of long-term care and home and community-based services). Individuals who become ineligible for Medicaid under the revised income definitions would continue to be covered in Medicaid until their next scheduled eligibility redetermination. The specifications include provisions that would simplify Medicaid enrollment processes, including Web-based enrollment strategies and certain forms of presumptive eligibility. From 2011 through 2013, states would have the option to cover nonelderly adults who are not pregnant through a state plan amendment.

- Under the specifications, Medicaid-eligible individuals with income below 100 percent of the FPL would be ineligible for exchange credits. Starting in 2014, nonelderly adults who are not pregnant and have income between 100 percent and 133 percent of the FPL would have a choice between enrolling in Medicaid and obtaining subsidized coverage through one of the new insurance exchanges. Medicaid-eligible individuals who chose to get coverage through an exchange would receive exchange credits, calculated using the same income-based formula applicable to other populations (described above), and would receive the same the cost-sharing subsidies available to people with income between 133 percent and 150 percent of the FPL.

- States would be required to provide payments according to the Federal Medical Assistance Percentage (as amended in the proposal) for Medicaid-eligible individuals choosing the exchange in an amount no more than the average Medicaid cost per enrollee by eligibility category. States would also be required to provide early and periodic screening, diagnostic, and treatment (EPSDT) services, as currently defined in Medicaid, to eligible children who enrolled in an exchange plan. In addition, beginning in 2014, states would be required to provide premium assistance, as long as it is determined to be cost-effective to do so.

- States would have a "maintenance of effort" requirement for their existing Medicaid populations, preventing them from reducing eligibility levels until 2013 for populations above 133 percent of the FPL and until 2014 for populations below 133 percent of the FPL. States would receive enhanced federal matching rates for newly eligible individuals. The enhanced reimbursement rates would vary depending on whether the state has an existing 1115 waiver for childless adults or a state-funded program for childless adults. States with such a waiver or state-funded program would have their reimbursement rate increased by

27.3 percentage points initially, with that increment rising to 32.3 percentage points for 2019 and subsequent years. States without such a waiver or state-funded program would have their reimbursement rate increased by 37.3 percentage points initially, with that increment phasing down to 32.3 percentage points for 2019 and subsequent years. The resulting reimbursement rates could not exceed 95 percent and would average about 90 percent in 2019.

- Newly eligible individuals would be defined as nonelderly individuals who are not pregnant and have income below 133 percent of the FPL who were either previously ineligible for a full Medicaid or benchmark benefit package or were eligible through a capped 1115 waiver but not enrolled. Benefits for newly eligible individuals would be limited to a benchmark benefit package consistent with section 1937 of the Social Security Act.

- Once the new insurance exchanges are operational, the Children's Health Insurance Program (CHIP) would be changed to a "wrap-around" program. States would be required to provide supplemental benefits through CHIP to children who are enrolled in an exchange plan and who are in families with income below 250 percent of the FPL. The supplemental benefits would include EPSDT services, as currently defined in Medicaid.

- Individuals with an offer of employer-sponsored insurance would not be permitted to receive exchange credits (under an approach known as a "firewall"), unless they qualify for an affordability waiver. Such waivers would be available to employees for whom the minimum employee contribution would exceed 13 percent of their income. Firms offering a section 125 ("cafeteria") plan allowing their workers to pay premiums with pretax funds would be considered offering firms for purposes of the firewall, and employees who received an affordability exemption to the firewall would not be allowed to pay their portion of the exchange premium through a cafeteria plan.

- Firms would not be required to offer insurance or to contribute a certain percentage of the premium. All firms with more than 50 employees would be subject to a so-called "free rider" penalty for each employee who enrolled in an exchange plan and who either was a full-time employee or received an affordability waiver. Depending on what type of coverage the worker chose, the penalty per worker would equal the average exchange credit for single or family coverage but would be subject to an overall cap. In 2013, a firm's total payment (averaged over all workers) could not exceed $400 per worker. In subsequent years, that dollar amount would be indexed to growth in premiums in the exchange.

- The proposal includes nonrefundable business tax credits to small employers with lower-wage workers who offer health benefits to their employees. In 2011 and 2012, a temporary credit would vary with the size of the firm (up to a limit of 25 workers) and the average annual wages at the firm (up to a limit of $40,000). Firms that contribute larger amounts to their workers' health insurance would receive larger subsidies, with a maximum credit of 35 percent. In 2013 and later years, the full amount of the credit would equal 50 percent of the firm's premium contributions; the credit would be available only for firms that purchase coverage through the exchange, and the full amount would be available only to firms with 10 or fewer workers and with average annual wages that are less than $20,000. For larger firms

and firms with higher wages, the credit would be phased out. The credit would be permanent, but, beginning in 2013, a given firm could claim it for only two years.

- The specifications also describe a system of reinsurance payments and risk corridors that would operate during the initial years of the new insurance exchanges. The reinsurance system would be established by the Secretary of Health and Human Services and would reimburse plans a fixed amount for specified types of high-cost cases. Total funding for the reinsurance payments would amount to $10 billion in 2013, $6 billion in 2014, and $4 billion in 2015. Those payments would be financed entirely by a broad-based fee paid by private insurers and third-party administrators. The risk corridors would be modeled on those specified in the 2003 Medicare Modernization Act and would be in effect for 3 years. In that period, if plans incur costs (net of their reinsurance payments) that differ from their premium bids by more than 3 percent, the federal government would bear an increasing share of any losses or be paid the same increasing share of any gains.

- Beginning in 2013, insurance policies with relatively high total premiums would be subject to a 35 percent excise tax on the amount by which the premium exceeds a specified threshold. Except as described below, the threshold would be set (beginning in 2013) at $8,000 for single policies and $21,000 for family policies. After 2013, those amounts would be indexed to overall inflation. (The full premium would continue to be excluded from enrollees' taxable income and thus would not be subject to income or payroll taxes.) All tax-excluded contributions toward flexible spending arrangements, health reimbursement arrangements, and health savings accounts would be included in the determination of the total premium that is subject to the tax. The excise tax would be payable by insurers and would also apply to self-insured plans. It would be nondeductible.

- In 2013, residents of the 17 states with the highest health-care costs would have a threshold for the excise tax that is 20 percent higher than in other states. Over the ensuing two years, the adjustment to the threshold in high-cost states would decrease, so that in 2016 and subsequent years, the same cap would apply in all states.

Preliminary Analysis of the Insurance Coverage Specifications Provided by the Senate Finance Committee

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	-4	2	6	10	10	11	11
	Employer	*	2	2	7	4	*	*	-1	-1	-2
	Nongroup/Other /c	*	*	*	-2	-3	-4	-4	-4	-4	-5
	Exchanges	0	0	0	8	17	23	23	23	24	25
	Uninsured /d	*	-1	*	-10	-20	-26	-28	-29	-29	-29
Post-Policy Uninsured Population											
Number of Nonelderly People /d		51	50	50	40	30	25	24	24	24	25
Insured Share of the Nonelderly Population											
Including All Residents		81%	81%	81%	85%	89%	91%	91%	91%	91%	91%
Excluding Unauthorized Immigrants		83%	83%	83%	87%	91%	93%	94%	94%	94%	94%
Memo: Exchange Enrollees and Subsidies											
Number w/ Unaffordable Offer from Employer /e					*	1	1	1	2	2	2
Number of Unsubsidized Exchange Enrollees					2	4	5	5	5	6	6
Average Exchange Subsidy per Subsidized Enrollee							$4,200	$4,300	$4,500	$4,800	$5,000

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. Workers who would have to pay more than 13 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 Senate Finance Committee

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	-1	-1	-2	-6	14	35	52	60	65	71	287
Exchange Subsidies /e	1	2	2	14	43	66	75	79	86	93	463
Associated Effects on Tax Revenues /f	*	1	2	6	5	-1	-4	-5	-7	-10	-12
Subtotal	*	2	1	15	62	100	124	134	144	154	738
Small Employer Tax Credits /g	0	2	4	4	3	3	2	2	2	2	24
Penalty Payments by Uninsured Individuals /f	0	0	0	0	-3	-4	-3	-3	-3	-3	-20
Penalty Payments by Employers /f,g	0	0	0	-1	-2	-3	-4	-5	-5	-6	-27
Excise Tax on High Premium Insurance Plans /f,g	0	0	0	-5	-17	-24	-31	-39	-46	-53	-215
NET IMPACT OF COVERAGE SPECIFICATIONS	*****	**3**	**5**	**12**	**43**	**72**	**88**	**90**	**92**	**94**	**500**

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 subject to appropriation or account for all effects on other federal programs.
b. Components may not sum to totals because of rounding; positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
c. Reflects specifications received from committee staff; estimates could change based on review of legislative language.
d. 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 increase by about $37 billion as a result of the coverage specifications (see text).
e. Includes $5 billion in funding for high-risk pools in 2010-2012 and $6 billion in funding for insurance co-ops in 2013-2014.
f. Increases in tax revenues reduce the deficit.
g. The effects on the deficit of this provision include the associated effects of changes in taxable compensation on tax revenues.

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	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Changes in Direct Spending Outlays												
TITLE I-HEALTH CARE COVERAGE												
SUBTITLE F-ROLE OF PUBLIC PROGRAMS												
PART I-MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS												
Eligibility Standards and Methodologies	included in estimate for expanding insurance coverage											
Medicaid Program Payments	included in estimate for expanding insurance coverage											
Medicaid and Employer-Sponsored Insurance	included in estimate for expanding insurance coverage											
Treatment of the Territories	0	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.9
PART II-CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)	included in estimate for expanding insurance coverage											
PART III-IMPROVEMENTS TO MEDICAID												
Enrollment Coordination with the Exchange	included in estimate for expanding insurance coverage											
Presumptive Eligibility	included in estimate for expanding insurance coverage											
PART IV-MEDICAID SERVICES												
Free-Standing Birth Centers	*	*	*	*	*	*	*	*	*	*	*	*
Curative and Palliative Care for Children in Medicaid	*	*	*	*	*	*	*	*	*	*	0.1	0.2
PART V-MEDICAID PRESCRIPTION DRUG COVERAGE	-0.4	-1.4	-1.8	-1.8	-1.2	-1.3	-1.5	-1.6	-1.7	-1.7	-6.8	-14.6
Make Prescription Drugs a Mandatory Benefit	included above											
Change the Status of Some Excludable Drugs	included above											
Increase the Brand-Name Drug Rebate Amount	included above											
Increase the Generic Drug Rebate Amount	included above											
Extend to and Collect Rebates on Behalf of Managed Care Organizations	included above											
Application of Rebates to New Formulations of Existing Drugs	included above											
Changes to Medicaid Payment for Prescription Drugs	included above											
PART VI-MEDICAID DISPROPORTIONATE SHARE PAYMENTS	0	0	0	*	-1.3	-4.5	-4.6	-4.7	-4.8	-5.0	0	-24.9
PART VII-DUAL ELIGIBLES												
Waiver Authority for Dual Eligible Demonstrations	0	0	0	0	0	0	0	0	0	0	0	0
Office of Coordination for Dually Eligible Beneficiaries	*	*	*	*	*	*	*	*	*	*	*	*
PART VIII-MEDICAID QUALITY												
Medicaid Quality Measures	*	*	*	0.1	0.1	*	*	*	*	0	0.2	0.3
Medicaid Reimbursement for Health Care Acquired Conditions	0	0	*	*	*	*	*	*	*	*	*	*
Medicaid Bundled Payments Demonstration Project	0	0	0	0	0	0	0	0	0	0	0	0

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	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
PART IX-MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION	*	*	*	*	*	*	*	*	*	*	0.1	0.1
PART X-INDIANS												
Premiums and Cost-Sharing	included in estimate for expanding insurance coverage											
Payer of Last Resort	0	0	0	0	0	0	0	0	0	0	0	0
Eligibility Determination	0	0	0	0	0	0	0	0	0	0	0	0
Indian Providers and Medicare Part B	0	*	*	*	*	*	*	*	*	*	0.1	0.2
Other Policies Related to Exchange Coverage	0	0	0	0	0	0	0	0	0	0	0	0
SUBTITLE H-LONG-TERM SERVICES AND SUPPORTS												
Aging and Disability Resource Centers	*	*	*	*	*	*	*	*	0	0	*	0.1
Money Follows the Person Rebalancing Demonstration	0	0	0	*	0.1	0.2	0.3	0.3	0.3	0.2	0.1	1.5
SUBTITLE I-ADDRESSING HEALTH DISPARITIES												
Standardized Collection of Data	0	0	0	0	0	0	0	0	0	0	0	0
Sufficient Disparities Data	*	*	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.5
SUBTITLE J-MATERNAL, INFANT, AND EARLY CHILDHOOD VISITATION	0.1	0.3	0.3	0.3	0.3	0.1	*	*	0	0	1.3	1.5
TITLE II-PROMOTING DISEASE PREVENTION AND WELLNESS												
SUBTITLE A-MEDICARE												
Risk Assessment, Personalized Prevention Plan and Wellness Visit	0.2	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.5	0.5	1.6	3.7
Removing Barriers to Preventive Services	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.8
Evidence-Based Coverage of Preventive Services												
Authority to eliminate coverage for preventive services rated D	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.7
Mandatory appropriation	*	*	0	0	0	0	0	0	0	0	*	*
Incentives for Healthy Lifestyles	*	*	*	*	*	*	0	0	0	0	0.1	0.1
SUBTITLE B-MEDICAID												
Improving Access to Preventive Services for Eligible Adults	*	*	*	*	*	*	*	*	*	*	*	0.1
Incentives for Healthy Lifestyles	*	*	*	*	*	0	0	0	0	0	0.1	0.1
Medicaid State Plan Option Promoting Health Homes and Integrated Care	0	*	*	*	*	*	*	*	*	*	*	0.1
Appropriations for Childhood Obesity Demonstration Project	0.1	0.3	0.3	0.3	0.3	0.1	*	*	0	0	1.3	1.5
Tobacco Cessation	0	0	0	*	*	*	*	*	*	*	*	-0.1

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	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
SUBTITLE A-TRANSFORMING THE HEALTH CARE DELIVERY SYSTEM												
PART I-LINKING PAYMENT TO QUALITY OUTCOMES IN THE MEDICARE PROGRAM												
Hospital Value-Based Purchasing	0	0	0	0	0	0	0	0	0	0	0	0
Physician Quality Reporting Initiative	0	0.3	-0.1	-0.2	-0.2	0	0	0	0	0	-0.2	-0.2
Expansion of Physician Feedback Program	0	0	0	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.1	-1.0
Medicare Inpatient Rehabilitation Facility, Long-Term Acute Care Hospital and Hospice Quality Reporting	0	0	0	0	*	*	*	*	*	*	*	-0.2
PART II-STRENGTHENING THE QUALITY INFRASTRUCTURE												
Quality Infrastructure	*	0.1	0.1	0.1	0.1	*	0	0	0	0	0.2	0.3
PART III-ENCOURAGING DEVELOPMENT OF THE NEW PATIENT CARE MODELS												
Accountable Care Organizations	0	0	*	-0.1	-0.3	-0.6	-0.7	-0.9	-1.0	-1.2	-0.5	-4.9
CMS Innovation Center												
Funding for Center (including noncovered benefits)	*	0.1	0.3	0.5	0.7	0.8	0.9	1.0	1.1	1.1	1.6	6.6
Effect on Medicare spending for benefits	0	-0.1	-0.2	-0.3	-0.5	-0.6	-0.9	-1.3	-1.8	-2.4	-1.0	-8.0
National Pilot Program on Payment Bundling	0	0	0	0	0	0	0	0	0	0	0	0
Reducing Avoidable Hospital Readmissions	0	0	0	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.5	-2.1
Health-Care Acquired Infections	0	0	0	0	0	-0.2	-0.2	-0.2	-0.2	-0.3	0	-1.2
Transitional Care Program to Reduce Preventable Readmissions	0	0.1	0.2	0.2	*	0	0	0	0	0	0.5	0.5
Extension of Gainsharing Demonstration	*	*	0	0	0	0	0	0	0	0	*	*
PART IV-STRENGTHENING PRIMARY CARE AND OTHER WORKFORCE IMPROVEMENTS												
Primary Care/General Surgery Bonus	0	0.2	0.3	0.3	0.3	0.3	0.1	0	0	0	1.1	1.6
Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	1.0
Promoting Greater Flexibility for Residency Training Programs	included above											
Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities	included above											
Preservation of Resident Cap Positions from Closed and Acquired Hospitals	included above											

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SUBTITLE B-IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS												
PART I-ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES												
Sustainable Growth Rate	7.0	3.9	0	0	0	0	0	0	0	0	10.9	10.9
Extension of Floor on Medicare Work Geographic Adjustment	0.3	0.5	0.2	0	0	0	0	0	0	0	1.1	1.1
Misvalued Relative Value Units (RVUs)	0	0	0	0	0	0	0	0	0	0	0	0
Therapy Caps	0.7	0.9	0.2	0	0	0	0	0	0	0	1.8	1.8
Extension of Treatment of Certain Physician Pathology Services	0.1	0.1	*	0	0	0	0	0	0	0	0.2	0.2
Extension of Increased Payments for Ambulance Services Under Medicare	*	*	*	0	0	0	0	0	0	0	0.1	0.1
Extension of Long-Term Care Hospital Provisions	0	0.1	0.1	*	*	*	0	0	0	0	0.2	0.2
Extension of Payment Adjustment for Medicare Mental Health Services	*	*	*	0	0	0	0	0	0	0	0.1	0.1
Permitting Physician Assistants to Order Post-Hospital Extended Care Services	*	*	*	*	*	*	*	*	*	*	*	*
Recognizing Attending Physician Assistants as Attending Physicians to Serve Hospice Patients	included above											
Medicare Diabetes Self-Management Training	*	*	*	*	*	*	*	*	*	*	*	*
Medicare Improvement Fund	0	0	0	0	-16.7	-5.6	0	0	0	0	-16.7	-22.3
Medicare Part B Special Enrollment Period for Military Retirees	0	0	*	*	*	*	*	*	*	*	*	*
PART II-RURAL PROTECTIONS												
Extend Medicare Rural Hospital Flexibility Program	0	0	0	0	0	0	0	0	0	0	0	0
Extend Hospital Outpatient Department Hold Harmless for Small Rural Hospitals	*	*	*	0	0	0	0	0	0	0	0.1	0.1
Extend and Expand Hospital Outpatient Department Hold Harmless for Sole Community Hospitals	0.1	0.2	*	0	0	0	0	0	0	0	0.3	0.3
Extend Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals	*	*	*	0	0	0	0	0	0	0	*	*
Extend Rural Community Hospital Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0
Extend Medicare Dependent Hospital Program	0	0	*	*	*	0	0	0	0	0	0.1	0.1
Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals	0	0.1	0.1	*	0	0	0	0	0	0	0.3	0.3

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PART III-IMPROVING PAYMENT ACCURACY												
Home Health Payment Changes												
Outlier Formula: 2.5 Percent Payment Reduction	-0.2	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8	-0.8	-0.9	-1.0	-2.5	-6.8
Add-on Payments for Access	0	0	0.1	0.1	0.1	0.1	0.1	0	0	0	0.3	0.5
Hospice Payment Reforms	0	*	*	*	*	*	*	*	*	*	*	-0.1
Medicare DSH Changes	0	0	0	0	0	-4.6	-4.6	-4.5	-4.3	-4.9	0	-22.9
Plan to Reform Medicare Hospital Wage Index	0	0	0	0	0	0	0	0	0	0	0	0
Extend Section 508 Reclassifications	0.2	0.3	*	0	0	0	0	0	0	0	0.5	0.5
Imaging Use Rate Assumption	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.9	-3.0
Power Wheelchairs	0	-0.3	-0.1	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.5	-0.8
Accreditation Exemption for Certain Pharmacies	0	0	0	0	0	0	0	0	0	0	0	0
Treatment of Certain Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
SUBTITLE C-MEDICARE ADVANTAGE												
Medicare Advantage Payment												
Transition to Competitive Bidding and Private Fee-for-Service Plans	0	-2.5	-5.5	-11.1	-12.8	-14.3	-16.0	-18.0	-20.3	-23.1	-31.9	-123.5
Extend Changes for Coding Intensity Through 2013	0	-0.6	-0.8	-0.5	0	0	0	0	0	0	-1.9	-1.9
Benefit Protection and Simplification	0	0	0	0	0	0	0	0	0	0	0	0
Simplification of Annual Beneficiary Election Periods	0	0	0	0	0	0	0	0	0	0	0	0
Extension for Specialized MA Plans for Special Need Individuals												
Extend Special Needs Plans and Erickson Demonstration	0	0.2	0.2	0.2	0.1	0.1	*	*	*	*	0.7	0.9
Risk Scores for New Enrollees in Special Needs Plans	0	0	0	0	0	0	0	0	0	0	0	0
Extension of Reasonable Cost Contracts	0	*	*	*	0	0	0	0	0	0	*	*
Medigap	0	0	0	0	0	*	*	*	*	*	0	-0.1
SUBTITLE D-MEDICARE PART D IMPROVEMENTS												
Improving Coverage in the Part D Coverage Gap	0	1.3	1.2	1.4	1.6	1.8	2.2	2.3	2.5	3.2	5.5	17.4
Improving the Determination of Part D Low-Income Benchmarks	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.7
Voluntary De Minimus Policy for Low-Income Subsidy Plans	0	*	*	*	*	*	*	0.1	0.1	0.1	0.1	0.4
Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance	0	*	*	*	*	*	*	*	*	*	0.1	0.2
Facilitation of Reassignments of Beneficiaries in Low-Income Subsidy Plans	*	*	*	*	*	*	*	*	*	*	*	*
Funding Outreach and Education of Low-Income Programs	*	*	*	0	0	0	0	0	0	0	*	*
Strengthening Formularies with Respect to Certain Categories or Classes of Drugs	0	0	0	0	0	0	0	0	0	0	0	0
Reducing the Part D Premium Subsidy for High-Income Beneficiaries	0	-0.4	-0.5	-0.7	-0.9	-1.1	-1.3	-1.6	-2.0	-2.4	-2.4	-10.7
Simplifying Part D Plan Information	*	0	0	0	0	0	0	0	0	0	*	*
Limitation on Removal or Change of Coverage of Covered Part D Drugs Under a Formulary Under a Prescription Drug Plan or a MA-PD Plan	0	0	0	0	0	0	0	0	0	0	0	0

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SUBTITLE E-ENSURING MEDICARE SUSTAINABILITY												
Market Basket Cuts												
Skilled Nursing Faciltities	0	0	-0.3	-0.7	-1.1	-1.5	-1.9	-2.4	-3.0	-3.7	-2.1	-14.6
Long-Term Care Hospitals	*	*	-0.1	-0.2	-0.3	-0.3	-0.4	-0.5	-0.7	-0.8	-0.6	-3.4
Inpatient Rehabilitation Facilities	*	*	-0.1	-0.2	-0.3	-0.4	-0.5	-0.6	-0.8	-1.0	-0.7	-4.0
Hospitals Paid Under the Inpatient Prospective Payment System	-0.2	-0.6	-2.1	-3.9	-5.8	-7.8	-9.8	-12.2	-14.9	-18.4	-12.7	-75.8
Inpatient Psychiatric Facilities	*	*	-0.1	-0.2	-0.2	-0.3	-0.4	-0.5	-0.6	-0.8	-0.5	-3.1
Hospice	0	0	0	-0.3	-0.5	-0.8	-1.0	-1.4	-1.7	-2.1	-0.8	-7.8
Hospital Outpatient Services	-0.1	-0.1	-0.5	-1.0	-1.5	-2.0	-2.6	-3.3	-4.1	-5.0	-3.1	-20.0
Durable Medical Equipment	0	-0.1	-0.1	-0.2	-0.3	-0.4	-0.4	-0.6	-0.7	-0.8	-0.7	-3.6
All Other Part B Fee Schedules, Except Physicians' Services	0	-0.1	-0.3	-0.6	-0.9	-1.2	-1.6	-2.0	-2.5	-3.1	-1.9	-12.4
Home Health, Updates in 2015 and Subsequent Years	0	0	0	0	0	-0.2	-0.6	-1.0	-1.6	-2.3	0	-5.7
Home Health (Updates in 2011 and 2012, Rebasing, and Rural Add-on)	0.1	*	-0.3	-0.9	-1.9	-3.3	-5.1	-6.0	-6.6	-7.2	-3.0	-31.2
Temporary Adjustment to the Income-Related Premium for Part B of Medicare	0	-0.7	-1.2	-1.5	-2.0	-2.4	-2.8	-3.3	-4.0	-4.9	-5.4	-22.8
Medicare Commission	0	0	0	0	0	-1.7	-3.0	-4.2	-6.5	-7.3	0	-22.6
SUBTITLE F-PATIENT-CENTERED OUTCOMES RESEARCH												
Patient-Centered Outcomes Research Act of 2009												
Comparative effectiveness (Medicare components)	0	*	*	*	*	*	*	*	-0.1	-0.2	*	-0.3
Comparative effectiveness (Non-Medicare components)	*	*	0.1	0.1	0.2	0.3	0.4	0.4	0.4	0.5	0.4	2.5
TITLE IV-TRANSPARENCY AND PROGRAM INTEGRITY												
Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.8
Physician Payment Sunshine	0	0	0	0	0	0	0	0	0	0	0	0
Nursing Home Transparency	0	0	0	0	0	0	0	0	0	0	0	0
Imaging Self-Referral Sunshine	0	0	0	0	0	0	0	0	0	0	0	0
TITLE V-FRAUD, WASTE, AND ABUSE												
Fraud, Waste, and Abuse	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-1.1
Accelerate Implementation of the Competitive Acquisition Program for Durable Medical Equipment	*	*	*	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-1.4

Preliminary Estimate of Specifications for the Senate Finance Committee Chairman's Health Care Proposal
Title I, Subtitle F Through Title V, as of September 15, 2009

By fiscal year, in billions of dollars. Estimates reflect specifications provided by the Committee staff.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
INTERACTIONS												
Medicare Advantage Interactions	0	1.6	-0.5	-1.2	-2.0	-2.1	-2.3	-2.6	-2.8	-3.7	-2.1	-15.6
Premium Interactions	0	-1.6	*	0.8	5.8	4.2	3.9	4.7	5.6	6.6	5.0	30.0
Medicaid Interactions with Part D Provisions	0	*	*	*	*	0.1	0.1	0.1	0.1	0.2	0.1	0.7
TRICARE Interactions	0.1	0.1	-0.1	-0.2	-0.2	-0.4	-0.5	-0.7	-0.8	-1.0	-0.3	-3.7
Total, Changes in Direct Spending	**8.3**	**2.3**	**-11.0**	**-21.9**	**-42.1**	**-50.3**	**-55.8**	**-66.3**	**-79.0**	**-93.2**	**-64.4**	**-408.9**
Changes in Revenues												
Fraud, waste, and abuse (on-budget)	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.9	2.0
Premium Taxes for Patient-Centered Outcomes Research (JCT estimate, on-budget)	0	0	0	0.1	0.3	0.3	0.4	0.4	0.5	0.7	0.4	2.6
Effect on Revenues of Changes in Health Insurance Premiums as a Result of Comparative Effectiveness Research and Changes in the Medicaid Drug Program												
Income and Medicare payroll taxes (on-budget)	*	*	*	*	*	*	*	*	0.1	0.1	*	0.3
Social Security payroll taxes (off-budget)	*	*	*	*	*	*	*	*	*	*	*	0.2
Subtotal, on-budget revenues	0.1	0.2	0.2	0.3	0.5	0.6	0.6	0.7	0.8	1.0	1.4	5.0
Total, unified budget revenues	0.1	0.2	0.2	0.3	0.5	0.6	0.6	0.7	0.8	1.0	1.4	5.1
Changes in Deficits												
Changes in on-budget deficits	**8.2**	**2.1**	**-11.2**	**-22.2**	**-42.6**	**-50.9**	**-56.4**	**-67.0**	**-79.8**	**-94.1**	**-65.7**	**-413.9**
Changes in unified budget deficits	**8.2**	**2.0**	**-11.2**	**-22.2**	**-42.6**	**-50.9**	**-56.5**	**-67.0**	**-79.8**	**-94.2**	**-65.7**	**-414.0**
Memorandum												
Non-scoreable savings from increased HCFAC spending	0	*	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.4

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

CMS = Centers for Medicare & Medicaid Services; DSH = disproportionate share hospital; GME = graduate medical education; HCFAC = Health Care Fraud and Abuse Control; JCT = Joint Committee on Taxation; MA = Medicare Advantage; MA-PD = Medicare Advantage prescription drug plan.