



July 22, 2010

Honorable Fortney Pete Stark  
Chairman  
Subcommittee on Health  
Committee on Ways and Means  
U.S. House of Representatives  
Washington, DC 20515

Dear Mr. Chairman,

This letter responds to your request for an analysis of a specific proposal to add a “public plan” to the options available through the health insurance exchanges that will be established in 2014 under the Patient Protection and Affordable Care Act, or PPACA (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). That proposal was recently introduced as H.R. 5808.

Under the proposal, a public health insurance plan would be established and administered by the Secretary of Health and Human Services (HHS), and it would have to charge premiums that fully cover its costs for benefit payments and administrative expenses. The plan’s payment rates for physicians and other practitioners would be based on Medicare’s current rates but would not be subject to the future reductions required by Medicare’s sustainable growth rate formula; instead, those rates would initially increase by 5 percent and then would rise annually to reflect estimated increases in physicians’ costs. The plan would pay hospitals and other providers the same amounts that would be paid under Medicare, on average, and would establish payment rates for prescription drugs through negotiation. Health care providers would not be required to participate in the public plan in order to participate in Medicare.

### **Premiums and Enrollment**

The Congressional Budget Office (CBO) estimates that the public plan’s premiums would be 5 percent to 7 percent lower, on average, than the premiums of private plans offered in the exchanges. The differences between the premiums of the public plan and the average premiums of private plans would vary across the country because of geographic

differences in the plans' relative costs. Those differences in premiums would reflect the net impact of differences in the factors that affect all health insurance premiums, including the rates paid to providers, administrative costs, the degree of benefit management applied to control spending, and the characteristics of the enrollees (the effects of which would be partly offset by the exchanges' risk-adjustment mechanisms).

In deciding whether to enroll in the public plan, potential subscribers would consider those premium differences along with various other factors, including the number of providers who chose to participate in that plan. CBO expects that some providers would decline to participate in the public plan because its payment rates would be lower, on average, than private plans' payment rates. Even so, many providers would be likely to participate, in part because they would expect a plan administered by HHS to attract a substantial number of enrollees.

Taking into account all of the relevant factors, CBO estimates that roughly one-third of the people obtaining coverage through the insurance exchanges would enroll in the public plan. CBO estimates that about 25 million people would purchase coverage individually through the exchanges in the 2017–2019 period under the proposal; in addition, about 13 million people would be expected to obtain employment-based coverage through the exchanges—so total enrollment in exchange plans would be about 38 million. Total enrollment in the public plan would thus be roughly 13 million. Given all of the factors at work, however, those estimates are subject to an unusually high degree of uncertainty.

Compared with projections of enrollment under current law for the 2017–2019 period, CBO estimates that about three-quarters of a million more people would obtain individually purchased coverage and about three-quarters of a million fewer would have employment-based coverage. The proposal would have minimal effects on the number of people with other sources of coverage and on the number of people who would be uninsured.

### **Budgetary Effects**

CBO and the staff of the Joint Committee on Taxation (JCT) estimate that the proposal would reduce federal budget deficits through 2019 by about \$53 billion. That estimate includes a \$37 billion reduction in exchange subsidies and a \$27 billion increase in tax revenues that would result from changes in employment-based coverage, partly offset by an \$11 billion

increase in costs for providing tax credits to small employers. (The proposal would have minimal effects on other outlays and revenues related to the insurance coverage provisions of PPACA.) The bulk of those effects would occur in the second half of the decade; the savings estimated for 2019 are about \$14 billion. Although CBO and JCT have not yet extended to 2020 the models they use to estimate insurance coverage, the proposal would probably reduce the federal budget deficit by about \$15 billion in that year, bringing the total budgetary savings through 2020 to about \$68 billion.

The reductions estimated for exchange subsidies are the net result of several effects. Under PPACA, federal premium subsidies provided through the exchanges will be tied to the premium of the second-lowest-cost plan offering a specified level of coverage (the “silver” level) in an area. CBO estimates that, in many parts of the country, the public plan’s premium would be lower than the second-lowest premium among private plans, so the introduction of the public plan in those places would reduce federal subsidies. CBO also expects that the existence of a public plan with substantial enrollment would place additional competitive pressure on private plans, leading them to reduce their premiums slightly and further reducing subsidies. Partly offsetting those two sources of federal savings would be higher enrollment in exchange plans, which would increase subsidy payments.

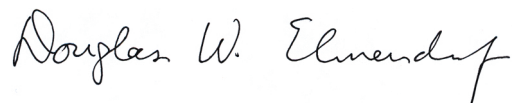
The proposal’s estimated effects on tax revenues related to employment-based coverage reflect several competing influences. Two developments would result in a greater share of employees’ compensation taking the form of taxable wages and salaries (rather than nontaxable health benefits), thereby resulting in higher federal tax revenues. First, because the public plan would make the exchanges more attractive to individual purchasers, some employers would forgo offering coverage altogether, thus reducing their spending on employment-based health insurance (relative to current-law projections) and increasing the share of compensation devoted to taxable wages and salaries. (As noted above, the proposal’s net effect would be to slightly reduce the number of people with employment-based coverage.) Second, the availability of a relatively inexpensive public plan would also lead some employers to purchase lower-cost coverage for their employees through the exchanges. The resulting reduction in spending on employment-based coverage would further increase the share of total compensation devoted to taxable wages and salaries. Those budgetary effects would be partly offset by a reduction in revenues that would occur

as more small employers took advantage of the tax credits that will be available when purchasing coverage through the exchanges.

CBO and JCT's current estimate of the budgetary savings that would result from the public plan under PPACA is lower than an estimate that was conveyed to Congressional staff last fall for a similar proposal connected to legislation then being considered in the House of Representatives. The difference reflects several factors. Most important, CBO and JCT estimate that total federal subsidies for exchange participants will be substantially smaller under PPACA than they would have been under the legislation that was considered in the House; the smaller subsidies reduce the "base" from which savings could be generated by adding the proposed public plan. In addition, under the earlier legislation, the subsidies would have depended on the average premium of the three lowest-cost plans, rather than on the premium of the second-lowest-cost plan as under PPACA. In CBO's estimation, adding the proposed public plan would result in a greater reduction in federal subsidies under the former approach, particularly in geographic areas where the public plan's premiums would be substantially lower than those of private plans. Under the approach used in PPACA, some of the savings from adding the public plan that would have been captured by the federal government through lower subsidy payments would instead be passed on to enrollees in the form of lower premiums.

I hope that this analysis is helpful. If you have any questions, please contact me or CBO staff. The primary staff contact for this analysis is Philip Ellis.

Sincerely,



Douglas W. Elmendorf  
Director

cc: Honorable Wally Herger  
Ranking Member  
Subcommittee on Health  
Committee on Ways and Means

Honorable Fortney Pete Stark  
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Honorable Sander M. Levin  
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