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

Douglas W. Elmendorf, Director

October 29, 2009

Honorable Charles B. Rangel
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have completed a preliminary analysis of H.R. 3962, the Affordable Health Care for America Act, as introduced on October 29, 2009. For several reasons described later, this analysis does not constitute a final and comprehensive cost estimate for the bill.

Among other things, H.R. 3962 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 income tax surcharge on high-income individuals; and make various other changes to the federal tax code, Medicaid, Medicare, and other programs.

CBO and JCT's preliminary assessment of the bill's impact on the federal budget deficit is summarized in Table 1 below. Tables 2 and 3 provide estimates of the changes in the number of nonelderly people in the United States who would have health insurance, present the primary budgetary effects of H.R. 3962's provisions directly 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 and some aspects of federal revenue. The analysis also examines the longer-term effects of the proposal on the federal budget and reviews the main reasons why this analysis differs from the

preliminary analysis CBO released in July for H.R. 3200, the America's Affordable Health Choices Act of 2009, as introduced on July 14, 2009.

Estimated Budgetary Impact of H.R. 3962
According to CBO and JCT's assessment, enacting H.R. 3962 would result in a net reduction in federal budget deficits of $104 billion over the 2010–2019 period (see Table 1). In the subsequent decade, the collective effect of its provisions would probably be slight reductions in federal budget deficits. Those estimates are all subject to substantial uncertainty.

The estimate includes a projected net cost of $894 billion over 10 years for the proposed expansions in insurance coverage. That net cost itself reflects a gross total of $1,055 billion in subsidies provided through the exchanges (and related spending), 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 $167 billion in collections of penalties paid by individuals and employers. On balance, other effects on revenues and outlays associated with the coverage provisions add $6 billion to their total cost.

Over the 2010–2019 period, the net cost of the coverage expansions would be more than offset by the combination of other spending changes, which CBO estimates would save $426 billion, and receipts resulting from the income tax surcharge on high-income individuals and other provisions, which JCT and CBO estimate would increase federal revenues by $572 billion over that period.[1]

Provisions Regarding Insurance Coverage
H.R. 3962 would take several steps designed to increase the number of legal U.S. residents who have health insurance. It would require individuals to purchase health insurance, starting in 2013, and would in many cases impose a financial penalty on people who did not do so. The bill also would establish new insurance exchanges and would generally subsidize the purchase of health insurance through those exchanges for qualified individuals and families with income between 150 percent and 400 percent of the federal poverty level (FPL).

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[1] The $572 billion figure includes $558 billion in revenues from tax provisions (estimated by JCT) and $14 billion in additional revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by JCT and CBO). (For JCT's estimates, see JCX-43-09.)

TABLE 1. PRELIMINARY ESTIMATE OF THE EFFECTS ON THE DEFICIT OF H.R. 3962, THE AFFORDABLE HEALTH CARE FOR AMERICA ACT, AS INTRODUCED ON OCTOBER 29, 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]												
Effects on the Deficit	*	1	2	57	93	123	137	148	160	173	153	894
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING [b]												
Effects on the Deficit of Changes in Outlays	7	17	-16	-25	-52	-51	-54	-72	-85	-96	-69	-426
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [c]												
Effects on the Deficit of Changes in Revenues [d]	*	-33	-35	-57	-62	-67	-72	-77	-82	-86	-188	-572
NET CHANGES IN THE DEFICIT [a]												
Net Increase or Decrease (-) in the Budget Deficit	6	-15	-49	-25	-21	5	11	-1	-7	-9	-104	-104
On-Budget	6	-15	-49	-27	-23	4	10	-3	-8	-10	-108	-115
Off-Budget [e]	*	*	*	2	2	2	2	1	1	1	4	11

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

Notes: Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

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

a. Does not include effects on spending subject to future appropriations.

b. These estimates reflect the effects of interactions between insurance coverage provisions and other Medicare and Medicaid provisions. In addition, CBO has included $33 billion of spending over the 2010–2019 period for public health, prevention, and wellness provisions in these direct spending totals, as directed by the Committee on the Budget, even though that spending would be subject to future appropriation action.

c. The changes in revenues include effects on Social Security revenues, which are classified as off-budget.

d. The 10-year figure of $572 billion includes $558 billion in revenues from tax provisions (estimated by JCT) and $14 billion in additional revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by JCT and CBO). (For JCT's estimates see JCX-43-09.)

e. Off-budget effects include changes in Social Security spending and revenues.

Policies purchased through the exchanges (or directly from insurers) would have to meet several requirements: In particular, insurers would have to accept all applicants, could not limit coverage for preexisting medical conditions, and could not vary premiums to reflect differences in enrollees' health.[2] The options available in the insurance exchange would include private health insurance plans as well as a public plan that would be administered by the Secretary of Health and Human Services (HHS). The public plan would negotiate payment rates with all providers and suppliers of health care goods and services; providers would not be required to participate in the public plan in order to participate in Medicare. The public plan would have to charge premiums that covered its costs, including the costs of paying back start-up funding that the government would provide.

Starting in 2013, nonelderly people with income below 150 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 averaged about 91 percent. (Under current rules, the federal government usually pays about 57 percent, on average, of the costs of Medicaid benefits.) In addition, states would be required to maintain current coverage levels for individuals under Medicaid and some children in CHIP through 2019. Beginning in 2014, states would shift some children in CHIP to Medicaid, but the federal government would continue to provide enhanced reimbursement, which currently averages about 70 percent, to states for providing such benefits. CBO estimates that state spending on Medicaid would increase on net by about $34 billion over the 2010–2019 period as a result of the provisions affecting insurance coverage reflected in Table 2. That estimate reflects states' flexibility to make programmatic and other budgetary changes to Medicaid and CHIP.

H.R. 3962 contains a number of other key provisions related to insurance coverage. It would impose a "play-or-pay" requirement on employers, who would either have to offer qualifying insurance to their employees and contribute a substantial share toward the premiums, or pay a fee to the federal government that would generally equal 8 percent of their payroll. Smaller employers (those with an annual payroll of less than $750,000) would either pay a lower rate or be exempt from that requirement

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[2] The analysis also takes into account the provisions of section 262 of Division A regarding the application of federal antitrust laws to health insurers. CBO estimates that implementing those provisions would have no significant effects on either the federal budget or the premiums that private insurers charged for health insurance. For an analysis of a similar proposal, see CBO's cost estimate for H.R. 3596, the Health Insurance Industry Antitrust Enforcement Act of 2009 (October 23, 2009).

altogether. As a rule, full-time employees with a qualifying offer of coverage from their employers 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 12 percent of their income for their employers' insurance. In that case, the employers would have to pay an amount equal to the per-worker fee due for firms subject to the play-or-pay penalty. 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.

On a preliminary basis, CBO and JCT estimate that H.R. 3962's provisions affecting health insurance coverage would result in a net increase in federal deficits of $894 billion over fiscal years 2010 through 2019. That estimate primarily reflects $425 billion in net federal outlays for Medicaid and CHIP and $605 billion in federal subsidies that would be provided to purchase coverage through the new insurance exchanges and related spending.[3] The other main element of the coverage provisions that would increase federal deficits is the tax credit for certain small employers who offer health insurance, which is estimated to reduce revenues by $25 billion over 10 years. Those costs would be partly offset by a net increase in receipts, totaling $167 billion over the period, from two sources: penalty payments by uninsured individuals, which would yield receipts of about $33 billion, and penalty payments by employers under the play-or-pay requirement, which would total about $135 billion. Other effects on tax revenues and outlays for Social Security that are associated with the coverage provisions would increase deficits by $6 billion.[4]

By 2019, CBO and JCT estimate, the number of nonelderly people who are uninsured would be reduced by about 36 million, leaving about 18 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under H.R. 3962, the share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 96 percent. Roughly 21 million people would purchase their own coverage through the new insurance exchanges, and there would

[3] Related spending includes the administrative costs of establishing and operating the exchanges, as well as $5 billion in spending for high-risk insurance pools.

[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 will 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.

be roughly 15 million more enrollees in Medicaid than the total number projected for Medicaid and CHIP combined under current law. (Under the bill, CHIP would no longer exist in 2019.) Relative to currently projected levels, the number of people purchasing individual coverage outside of the exchanges would decrease by about 6 million, and the number obtaining coverage through employers would increase by about 6 million.

Under the proposal, certain employers could allow all of their workers to choose among the plans available in the exchanges, but those enrollees would not be eligible to receive subsidies via the exchanges (and thus are shown in Table 2 as enrollees in employment-based coverage rather than as exchange enrollees). CBO and JCT expect that approximately 9 million people would obtain coverage in that way in 2019, bringing the total number of people enrolled in exchange plans to about 30 million in that year. Roughly one-fifth of the people purchasing coverage through the exchanges would enroll in the public plan, meaning that total enrollment in that plan would be about 6 million.

That estimate of enrollment reflects CBO's assessment that a public plan paying negotiated rates would attract a broad network of providers but would typically have premiums that are somewhat higher than the average premiums for the private plans in the exchanges. The rates the public plan pays to providers would, on average, probably be comparable to the rates paid by private insurers participating in the exchanges. The public plan would have lower administrative costs than those private plans but would probably engage in less management of utilization by its enrollees and attract a less healthy pool of enrollees. (The effects of that "adverse selection" on the public plan's premiums would be only partially offset by the "risk adjustment" procedures that would apply to all plans operating in the exchanges.)

Provisions Affecting Medicare, Medicaid, and Other Programs

Other components of H.R. 3962 would alter spending for Medicare, Medicaid, and other federal health programs. The bill would make numerous changes to payment rates and payment rules in those programs (the budgetary effects of which are summarized in Table 1 and detailed in Table 3). In total, CBO estimates that enacting those provisions would reduce direct spending by about $426 billion over the 2010–2019 period.[5]

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[5] In addition, the effects of certain Medicare and Medicaid and other provisions would increase federal revenues by about $14 billion over the 2010–2019 period.

Numerous changes to Medicare and Medicaid would reduce direct spending over the 2010–2019 period. The provisions that would result in the largest budgetary effects include these:

- 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 $229 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 on the basis of Medicare spending per beneficiary in the fee-for-service sector and changing the way that payments to Medicare Advantage plans reflect differences in the health status of enrollees, yielding savings of an estimated $170 billion (before interactions) over the 2010–2019 period.

- Increasing Medicaid's payment rates to physicians and other health care professionals for the provision of primary care services to Medicaid beneficiaries, costing roughly $57 billion over 10 years.

CBO expects that the Centers for Medicare and Medicaid Services (CMS) will soon announce payment rates and changes in payment rules for physicians' services and other services that are set on a calendar year basis. Those payment rates and rules may differ from the current-law assumptions underlying CBO's baseline projections. If so, CBO will update its estimates of Medicare spending under current law to reflect those changes and will revise these preliminary estimates of the impact of H.R. 3962 to reflect the effects of the new rules on spending under current law and under the bill.

H.R. 3962 includes a number of other provisions with a significant budgetary effect. They include the following:

- Community Living Assistance Services and Supports (CLASS) provisions, which would establish a voluntary federal program for long-term care insurance. Active workers could purchase coverage, usually through their employer. Premiums would be set to cover the full cost of the program as measured on an actuarial basis. However, the program's cash flows would initially show net receipts in early years, followed by net outlays in later years. In particular, the

program would pay out far less in benefits than it would receive in premiums over the 10-year budget window, reducing deficits by about $72 billion over that period.

- A Public Health Investment Fund and a Prevention and Wellness Trust, which would be funded through future appropriations of about $34 billion to finance various public health, prevention, and wellness programs. (Although outlays from that funding—estimated to total $33 billion over the 2010-2019 period—would be subject to future appropriation action, the Committee on the Budget has directed CBO to count those outlays as direct spending for purposes of budget scorekeeping in the House of Representatives.)

- Requirements that the Secretary of HHS adopt and regularly update standards for electronic administrative transactions that enable electronic funds transfers, claims management processes, and verification of eligibility, among other administrative tasks. These provisions would result in about $9 billion in federal savings in Medicaid and reduced subsidies paid through the insurance exchanges. In addition, these standards would result in an increase in revenues of about $13 billion as an indirect effect of reducing the cost of private health insurance plans.

- An abbreviated approval pathway for follow-on biologics (biological products that are highly similar to or interchangeable with their brand-name counterparts), which would yield direct spending savings of an estimated $6 billion over the 2010–2019 period.

Effect of H.R. 3962 on Discretionary Costs
CBO has not completed a comprehensive estimate of the discretionary costs that would be associated with H.R. 3962. Total costs would include those arising from the effects of H.R. 3962 on a variety of federal programs and agencies as well as from a number of new and existing programs subject to future appropriations.

The federal agencies that would be responsible for implementing the provisions of H.R. 3962 are funded through the appropriation process; sufficient appropriations would be essential for them to implement this legislation in the time frame it specifies. Major costs for programs subject to future appropriations would include these:

- Costs to the Internal Revenue Service of implementing the eligibility determination, documentation, and verification processes for subsidies. Those costs would probably be between $5 billion and $10 billion over 10 years.

- Costs to HHS (and especially CMS) of implementing the changes in Medicare, Medicaid, and CHIP as well as certain reforms to the private insurance market. Those costs would probably be at least $5 billion to $10 billion over 10 years. (The administrative costs of establishing and operating the exchanges, which are direct spending, are included in Table 1.)

- Costs of a number of grant programs and other changes in Divisions C and D of the legislation. CBO has not completed a review of those provisions.

Because those costs depend on future appropriations, they are not counted for enforcement of Congressional "pay-as-you-go" procedures, and are not included in Table 1.

As noted in the previous section and in Table 1, funding for the proposed Public Health Investment Fund and Prevention and Wellness Trust would also be subject to future appropriation action. The bill would authorize appropriations totaling about $34 billion for those purposes (of which approximately $33 billion would be spent over the next 10 years). The Committee on the Budget has directed CBO to count such spending as direct spending for purposes of budget scorekeeping in the House of Representatives.

Important Caveats Regarding This Preliminary Analysis

For a number of reasons, the preliminary analysis that is provided in this letter does not constitute a final and comprehensive cost estimate for H.R. 3962:

- Although CBO completed a preliminary review of legislative language prior to its release, the agency has not thoroughly reviewed the introduced legislation to verify its consistency with the previous draft. Moreover, the analysis does not reflect all of the provisions of the bill. In particular, the analysis does not reflect the impact of section 110 of Division A, which would impose certain requirements on employers that currently provide health insurance to retirees.

- The budgetary information shown in the above table 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. However, some cash flows (such as risk adjustment payments and collections as well as certain cash flows related to the public plan) 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. Furthermore, CBO and JCT have not yet divided all of the estimated cash flows into spending and revenue components.

Comparison with CBO and JCT's Estimate for H.R. 3200
On July 17, 2009, CBO transmitted a preliminary analysis by CBO and JCT of H.R. 3200, the America's Affordable Health Choices Act of 2009, as introduced on July 14, 2009. The estimates provided here differ from the ones in that analysis for two primary reasons: First, the provisions of H.R. 3962 differ from those of H.R. 3200 in a number of significant ways. Second, CBO and JCT have made some technical refinements in their estimating procedures as well as some changes in the classification of certain provisions and their budgetary effects. Prominent examples of such changes are as follows:

- The current proposal expands eligibility for Medicaid to people with income up to 150 percent of the FPL, rather than 133 percent; and after 2014, it would have the federal government cover about 91 percent of the cost of newly eligible enrollees, rather than 100 percent.

- Previously, CBO had included the costs of increasing payments to primary care physicians under Medicaid (totaling roughly $60 billion over 10 years) in the table showing the budgetary effects of the provisions related to insurance coverage; however, those costs are more appropriately reflected in the table showing the budgetary effects of provisions affecting Medicare, Medicaid, and other programs (see Table 3).

- The estimated costs of providing subsidies through the new insurance exchanges are now lower for several reasons: the larger expansion of Medicaid means that fewer people would be eligible for coverage through the exchanges; the shares of income that enrollees would have to contribute toward their premiums in 2013

were increased; and those shares were also indexed so that they would rise gradually over time (meaning that federal subsidy payments would grow somewhat more slowly than those under H.R. 3200).

- More firms were exempted from the play-or-pay requirement, reducing the amount of revenue collected from those penalties. In addition, CBO and JCT now estimate that the federal administrator overseeing the insurance exchanges might well allow medium-sized and large firms to purchase coverage through the exchanges. That change affects the expected number of people enrolling via the exchanges and the number of firms likely to offer coverage to their workers; consequently, projected play-or-pay revenues are lower than they would have been under the previous assumptions.

- The current proposal does not include any changes to the sustainable growth rate (SGR) mechanism for setting Medicare's payment rates for physicians' services. A provision of H.R. 3200 that would have restructured that mechanism added about $245 billion to CBO's estimate of the net cost of that bill.

Effects of H.R. 3962 Beyond the First 10 Years

Although CBO does not generally provide cost estimates beyond the 10-year budget projection period (2010 through 2019 currently), 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 bill into broad categories and assessing the rate at which the budgetary impact of each of those broad categories is likely to increase over time. Under H.R. 3962, the major categories are as follows:

- The gross cost of the coverage expansions, consisting of exchange subsidies, the net costs of expanded eligibility for Medicaid, and tax credits for employers: Those provisions have an estimated cost of $208 billion in 2019, and that cost is growing at about 8 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 income tax surcharge on high-income individuals: JCT estimates that the provision would generate about $68 billion in additional revenues in 2019, and those revenues are growing a little faster than 5 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.

- Other taxes and the effects of coverage provisions on revenues: The increase in revenues from those provisions is estimated to total about $52 billion in 2019 and is growing a little faster than 5 percent per year toward the end of the budget window. As a rough approximation, CBO assumes continued growth at about that rate during the following decade.

- Changes to the Medicare program and changes to Medicaid and CHIP other than those associated directly with expanded insurance coverage: Savings from those provisions are estimated to total $96 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, H.R. 3962 would reduce the federal deficit by $9 billion in 2019, CBO and JCT estimate. After that, the added revenues and cost savings are projected to grow slightly more rapidly than the cost of the coverage expansions. In the decade after 2019, the gross cost of the coverage expansions would probably exceed 1 percent of gross domestic product (GDP), but the added revenues and cost savings would probably be greater. Consequently, CBO expects that the legislation would slightly reduce federal budget deficits in that decade relative to those projected under current law—with a total effect during that decade that is in a broad range between zero and one-quarter percent of GDP. The imprecision of that calculation reflects the even greater degree of uncertainty that attends to it, compared with CBO's 10-year budget estimates, and the effects of the bill could fall outside of that range.

As noted earlier, the CLASS program included in the bill would generate net receipts for the government in the initial years when total premiums would exceed total benefit payments, but it would eventually lead to net outlays when benefits exceed premiums. As a result, the program would reduce deficits by $72 billion during the 10-year budget window and would reduce them by a smaller amount in the ensuing decade (an amount that is included in the calculations described in the preceding paragraphs). In the decade following 2029, the CLASS program would begin to increase budget deficits. However, the magnitude of the increase would be fairly small compared with the effects of the bill's other provisions, so the CLASS program does not substantially alter CBO's assessment of the longer-term effects of the legislation.

Many Members have expressed interest in the effects of reform proposals on various measures of spending on health care. CBO uses the term "federal budgetary commitment to health care" to describe the sum of net federal outlays for health programs and tax preferences for health care—a broad measure of the resources committed by the federal government that includes both its spending for health care and the subsidies for health care that are conveyed through reductions in federal taxes (for example, through the exclusion of premiums for employment-based health insurance from income and payroll taxes). In H.R. 3962, the gross cost of the coverage expansions would represent an increase in this commitment. That increase would be offset only in part by the changes to net spending for Medicare, Medicaid, CHIP, and other federal programs (other than those associated directly with expanded insurance coverage), as well as some small changes in the revenues lost through tax expenditures related to health care. On balance, during the decade following the 10-year budget window, the bill would increase both federal outlays for health care and the federal budgetary commitment to health care, relative to the amounts under current law.

Members have also requested information about the effect of proposals on national health expenditures. CBO does not analyze those expenditures as closely as it does the federal budget, however, and at this point the agency has not assessed the net effect of H.R. 3962 on them, either within the 10-year budget window or for the subsequent decade.

These longer-term projections assume that the provisions of H.R. 3962 are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation. For example, the SGR mechanism governing Medicare's payments to physicians has frequently been modified

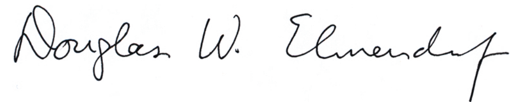
to avoid reductions in those payments, and legislation to do so again is currently under consideration in the Congress. The bill would put into effect (or leave in effect) a number of procedures that might be difficult to maintain over a long period of time. It would leave in place the 21 percent reduction in the payment rates for physicians currently scheduled for 2010. At the same time, the bill includes a number of provisions that would constrain payment rates for other providers of Medicare services. In particular, increases in payment rates for many providers would be held below the rate of inflation (in expectation of ongoing productivity improvements in the delivery of health care). Based on the extrapolation described above, CBO expects that Medicare spending under the bill would increase at an average annual rate of roughly 6 percent during the next two decades—well below the roughly 8 percent annual growth rate of the past two decades, despite a growing number of Medicare beneficiaries as the baby-boom generation retires.[6]

The long-term budgetary impact of H.R. 3962 could be quite different if those provisions generating savings 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.

[6] Based on the same extrapolation, Medicare spending per beneficiary under the bill would increase roughly 4 percent per year, on average, during the next two decades—compared with a 7 percent average growth rate (excluding the effect of establishing Part D) during the past two decades.

I hope this preliminary analysis is helpful for your deliberations. 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 Dave Camp
Ranking Member

Identical letters sent to the Honorable George Miller, the Honorable Henry A. Waxman, and the Honorable John D. Dingell.

TABLE 2. Preliminary Analysis of the Insurance Coverage Provisions Contained in H.R. 3962

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 & Other /c	27	26	25	26	28	29	29	29	30	30
	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	8	7	13	14	14	15	15
	Employer	1	1	1	12	11	7	7	7	7	6
	Nongroup & Other /c	*	*	*	-3	-4	-6	-6	-6	-6	-6
	Exchanges	0	0	0	9	14	19	20	20	20	21
	Uninsured /d	*	*	1	-25	-28	-34	-34	-35	-35	-36
Post-Policy Insurance Coverage											
Number of Uninsured People /d		50	51	51	26	23	17	18	18	18	18
Insured Share of the Nonelderly Population /a											
Including All Residents		81%	81%	81%	91%	92%	94%	94%	94%	94%	94%
Excluding Unauthorized Immigrants		83%	83%	83%	92%	93%	96%	96%	96%	96%	96%
Memo: Exchange Enrollees and Subsidies											
Number w/ Unaffordable Offer from Employer /e					*	1	1	1	1	1	1
Number of Unsubsidized Exchange Enrollees					1	2	3	3	3	3	3
Approximate Average Subsidy per Subsidized Enrollee							$5,500	$5,800	$6,100	$6,500	$6,800

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. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.
b. Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source.
c. Other includes Medicare; 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 12 percent of their income for employment-based coverage could receive subsidies via an exchange.

TABLE 2. Preliminary Analysis of the Insurance Coverage Provisions Contained in H.R. 3962

EFFECTS ON THE FEDERAL DEFICIT / a,b (Billions of dollars, by fiscal year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Medicaid & CHIP Outlays /c	-1	-2	-3	27	43	58	66	72	79	85	425
Exchange Subsidies & Related Spending /d	1	2	4	29	57	82	96	103	111	120	605
Small Employer Tax Credits /e	0	0	0	4	8	5	2	2	2	2	25
Gross Cost of Coverage Provisions	0	1	0	59	108	146	165	177	192	208	1,055
Penalty Payments by Uninsured Individuals	0	0	0	0	-5	-6	-5	-5	-6	-6	-33
Penalty Payments by Employers /e	0	0	0	-6	-14	-18	-22	-23	-25	-27	-135
Associated Effects on Tax Revenues & Outlays /f	0	1	1	4	5	1	-1	-1	-1	-2	6
NET COST OF COVERAGE PROVISIONS	**0**	**1**	**2**	**57**	**93**	**123**	**137**	**148**	**160**	**173**	**894**

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

Note: CHIP = Children's Health Insurance Program.

a. Does not include federal administrative costs that are subject to appropriation.
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. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that, under the proposal, state spending on Medicaid and CHIP would increase by about $34 billion over the 2010-2019 period as a result of the insurance coverage provisions that are reflected in this table.
d. Includes $5 billion in spending for high-risk insurance pools.
e. The effects on the deficit shown for this provision include the associated effects of changes in taxable compensation on tax revenues.
f. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about $2 billion over the 2010-2019 period, and that the coverage provisions would have negligible effects on outlays for other federal programs.

Table 3. Preliminary Estimate of the Effects on Direct Spending and Revenues of Divisions B, C, and D and Sections 111, 115, and 346 of H.R. 3962, the Affordable Health Care for America Act, as Introduced on October 29, 2009

By Fiscal Year, in Billions of Dollars

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN DIRECT SPENDING													
DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS													
TITLE I—IMPROVING HEALTH CARE VALUE													
Subtitle A—Provisions Related to Medicare Part A													
PART 1—MARKET BASKET UPDATES													
1101	Skilled Nursing Facility Payment Update (includes interaction with section 1103)	-0.4	-0.9	-1.3	-1.6	-1.9	-2.4	-2.9	-3.5	-4.1	-4.8	-6.0	-23.9
1102	Inpatient Rehabilitation Facility Payment Update (includes interaction with section 1103)	-0.1	-0.2	-0.3	-0.4	-0.4	-0.5	-0.6	-0.8	-0.9	-1.0	-1.4	-5.3
1103	Incorporating Productivity Improvements Into Market Basket Updates That Do Not Already Incorporate Such Improvements	-1.2	-3.5	-5.1	-6.5	-8.0	-10.3	-12.9	-15.4	-18.1	-21.1	-24.2	-102.0
PART 2—OTHER MEDICARE PART A PROVISIONS													
1111	Payments to Skilled Nursing Facilities	0	0	0	0	0	0	0	0	0	0	0	0
1112	Medicare DSH Report and Payment Adjustments in Response to Coverage Expansion	0	0	0	0	0	0	0	-3.0	-3.5	-3.8	0	-10.3
1113	Extension of Hospice Regulation Moratorium	*	*	0	0	0	0	0	0	0	0	0.1	0.1
1114	Permitting Physician Assistants to Order Post-Hospital Extended Care Services and to Provide for Recognition of Attending Physician Assistants as Attending Physicians to Serve Hospice Patients	*	*	*	*	*	*	*	*	*	*	*	*
Subtitle B—Provisions Related to Part B													
PART 1—PHYSICIANS' SERVICES													
1121	Resource-Based Feedback Program for Physicians	0	0	0	0	0	0	0	0	0	0	0	0
1122	Misvalued Codes Under the Physician Fee Schedule	*	*	*	*	*	*	*	*	*	*	0.1	0.2
1123	Payments for Efficient Areas	0	0.1	0.2	0.1	0	0	0	0	0	0	0.4	0.4
1124	Modifications to the Physician Quality Reporting Initiative	0	0	0.5	0.8	0	0	0	0	0	0	1.3	1.3
1125	Adjustment to Medicare Payment Localities	0	*	0.1	0.1	0.1	0.1	0	0	0	0	0.2	0.3

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PART 2—MARKET BASKET UPDATES													
1131	Incorporating Productivity Improvements Into Market Basket Updates That Do Not Already Incorporate Such Improvements	-0.5	-1.2	-1.8	-2.4	-3.0	-3.9	-5.2	-6.5	-7.8	-9.1	-9.0	-41.6
PART 3—OTHER PROVISIONS													
1141	Rental and Purchase of Power-Driven Wheelchairs	0	-0.4	-0.1	*	*	*	*	-0.1	-0.1	-0.1	-0.6	-0.8
1141A	Election to Take Ownership, or to Decline Ownership, of Certain Complex Durable Medical Equipment After the 13-Month Capped Rental Period Ends	0	0	0	0	0	0	0	0	0	0	0	0
1142	Extension of Payment Rule for Brachytherapy	*	*	*	0	0	0	0	0	0	0	*	*
1143	Home Infusion Therapy Report to Congress	0	0	0	0	0	0	0	0	0	0	0	0
1144	Require Ambulatory Surgical Centers to Submit Data	0	0	0	0	0	0	0	0	0	0	0	0
1145	Treatment of Certain Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
1146	Payment for Imaging Services	0	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-1.2	-3.0
1147	Durable Medical Equipment Program Improvements	*	*	*	*	*	*	*	*	*	*	*	0.1
1148	MedPAC Study and Report on Bone Mass Measurement	0	0	0	0	0	0	0	0	0	0	0	0
1149	Timely Access to Post-Mastectomy Items	*	*	*	*	*	*	*	*	*	*	*	*
1149A	Payment for Biosimilar Biological Products	Included in estimate for section 2565											
1149B	Study and Report on DME Competitive Bidding Process	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle C—Provisions Related to Medicare Parts A and B													
1151	Reducing Potentially Preventable Hospital Readmissions	*	*	-0.3	-0.6	-1.2	-1.3	-1.4	-1.4	-1.5	-1.6	-2.0	-9.3
1152	Post-Acute-Care Services Payment Reform Plan and Bundling Pilot Program	*	*	*	*	0	0	0	0	0	0	*	*
1153 - 1155	Home Health Changes	-0.7	-2.8	-3.8	-4.4	-5.0	-5.9	-6.8	-7.9	-9.1	-10.3	-16.7	-56.7
1155A	MedPAC Study on Variation in Home Health Margins	0	0	0	0	0	0	0	0	0	0	0	0
1155B	Home Health: Initial Assessment Visit for Rehabilitation Cases	0	*	*	*	*	*	*	*	*	*	*	*
1156	Limitation on Medicare Exceptions to the Prohibition on Certain Physician Referrals Made to Hospitals	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-1.0
1157	Study of Geographic Adjustment Factors	0	0	0	0	0	0	0	0	0	0	0	0
1158	Revision of Medicare Payment Systems to Address Geographic Inequities	0	0	2.7	2.7	-14.1	-5.6	0	0	0	0	-8.7	-14.3
1159	Study of Geographic Variation in Health Care Spending and Promoting High-Value Health Care	*	*	0	0	0	0	0	0	0	0	*	*
1160	Implementation, and Congressional Review, of Proposal to Revise Medicare Payments to Promote High-Value Health Care	0	0	0	0	0	0	0	0	0	0	0	0

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Subtitle D—Medicare Advantage Reforms													
PART 1—PAYMENT AND ADMINISTRATION													
1161	Phase-In of Payment Based on Fee-for-Service Costs, and Quality Bonus Payments	0	-4.7	-10.2	-14.8	-17.7	-18.9	-19.8	-21.1	-22.7	-24.4	-47.5	-154.3
1162	Coding Intensity Adjustment	0	-0.2	-0.6	-0.9	-1.2	-1.6	-2.0	-2.5	-3.0	-3.5	-2.9	-15.5
1163	Simplification of Annual Beneficiary Election Periods	0	0	0	0	0	0	0	0	0	0	0	0
1164	Extension of Reasonable Cost Contracts	0	*	*	0	0	0	0	0	0	0	*	*
1165	Limitation of Waiver Authority for Employer Group Plans	0	0	0	0	0	0	0	0	0	0	0	0
1166	Improving Risk Adjustment for Payments	0	0	0	0	0	0	0	0	0	0	0	0
1167	Elimination of MA Regional Plan Stabilization Fund	0	0	0	0	-0.2	-0.1	0	0	0	0	-0.2	-0.2
1168	Study Regarding Calculation of Medicare Advantage Payment Rates	0	0	0	0	0	0	0	0	0	0	0	0
PART 2—BENEFICIARY PROTECTIONS AND ANTI-FRAUD													
1171	Limitation on Cost-Sharing for Individual Health Services	0	0	0	0	0	0	0	0	0	0	0	0
1172	Continuous Open Enrollment for Enrollees in Plans With Enrollment Suspension	0	0	0	0	0	0	0	0	0	0	0	0
1173	Information on MA Plan Administrative Costs	0	0	0	0	0	0	0	0	0	0	0	0
1174	Strengthening Audit Authority	0	0	0	0	0	0	0	0	0	0	0	0
1175	Authority to Deny Plan Bids	0	0	0	0	0	0	0	0	0	0	0	0
1175A	State Authority to Enforce Standardized Marketing Requirements	0	0	0	0	0	0	0	0	0	0	0	0
PART 3—TREATMENT OF SPECIAL NEEDS PLANS													
1176 - 1178	Special Needs Plans	0	0.1	0.1	*	*	*	*	*	*	*	0.2	0.1
Subtitle E—Improvements to Medicare Part D													
1181 - 1182	Elimination of Coverage Gap; Discounts for Certain Part D Drugs in Original Coverage Gap	0.1	-7.1	-5.3	-4.9	-3.9	-4.1	-3.4	-4.6	-5.4	-3.7	-21.1	-42.3
1183	Submission of Claims by Pharmacies Located in or Contracting With Long-Term Care Facilities	0	0	0	0	0	0	0	0	0	0	0	0
1184	Including Costs Incurred by AIDS Drug Assistance Programs and Indian Health Service in Providing Prescription Drugs Toward the Annual Out-of-Pocket Threshold Under Part D	0	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
1185	No Mid-Year Formulary Changes Permitted	0	0	0	0	0	0	0	0	0	0	0	0
1186	Negotiation of Lower Covered Part D Drug Prices on Behalf of Medicare Beneficiaries	0	0	0	0	0	0	0	0	0	0	0	0
1187	Accurate Dispensing in Long-Term Care Facilities	0	0	-0.1	-0.3	-0.5	-0.8	-1.0	-1.0	-0.9	-1.1	-1.0	-5.7
1188	Free Generic Fill	0	-0.2	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-1.1	-3.0
1189	State Certification Prior to Waiver of Licensure Requirements Under Medicare Prescription Drug Program	0	0	0	0	0	0	0	0	0	0	0	0

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Subtitle F—Medicare Rural Access Protections													
1191	Telehealth Expansion and Enhancements	*	*	*	*	*	*	*	*	*	*	*	*
1192	Extension of Outpatient Hold Harmless Provision	0.1	0.1	*	0	0	0	0	0	0	0	0.2	0.2
1193	Extension of Section 508 Hospital Reclassifications	0.2	0.3	*	0	0	0	0	0	0	0	0.5	0.5
1194	Extension of Geographic Floor for Work	0.3	0.5	0.2	0	0	0	0	0	0	0	1.1	1.1
1195	Extension of Payment for Technical Component of Certain Physician Pathology Services	*	0.1	*	0	0	0	0	0	0	0	0.1	0.1
1196	Extension of Ambulance Add-Ons	0.1	0.1	*	0	0	0	0	0	0	0	0.2	0.2
TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS													
Subtitle A—Improving and Simplifying Financial Assistance for Low Income Medicare Beneficiaries													
1201 - 1207	Medicare Savings Program and Low-Income Subsidy Program												
	Effects on Medicare spending	0.1	0.3	0.6	1.0	1.2	1.3	1.6	1.7	1.8	2.2	3.2	11.8
	Effects on Medicaid spending	0	0	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.4	1.7
Subtitle B—Reducing Health Disparities													
1221	Ensuring Effective Communication in Medicare	*	*	0	0	0	0	0	0	0	0	*	*
1222	Demonstration to Promote Access for Medicare Beneficiaries With Limited English Proficiency	0	*	*	*	*	*	0	0	0	0	*	*
1223	Report on Impact of Language-Access Services	0	0	0	0	0	0	0	0	0	0	0	0
1224	Definitions	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle C—Miscellaneous Improvements													
1231	Extension of Therapy Caps Exceptions Process	0.6	0.9	0.2	0	0	0	0	0	0	0	1.7	1.7
1232	Extended Months of Coverage of Immunosuppressive Drugs and Other Renal Dialysis Provisions	0	*	*	*	*	*	*	*	*	*	*	-0.1
1233	Voluntary Advance Care Planning Consultation	0	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.6	1.9
1234	Part B Special Enrollment Period and Waiver of Limited Enrollment Penalty for TRICARE Beneficiaries	*	*	*	*	*	*	*	*	*	*	*	*
1235	Exception for Use of More Recent Tax Year in Case of Gains From Sale of Primary Residence in Computing Part B Income-Related Premium	*	*	*	*	*	*	*	*	*	*	*	*
1236	Demonstration Program: Patient Decisions Aids	*	*	*	*	*	*	*	*	*	*	*	*

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TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE												
1301 Accountable Care Organization Pilot Program	0	0	*	*	-0.1	-0.3	-0.3	-0.4	-0.7	-0.8	-0.2	-2.6
1302 Medical Home Pilot Program	0.2	0.3	0.3	0.3	0.3	0.2	0.1	*	0	0	1.5	1.8
1303 Payment Incentive for Selected Primary Care Services	0.2	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.6	0.6	2.0	4.7
1304 Payment for Certified Nurse-Midwives	*	*	*	*	*	*	*	*	*	*	*	*
1305 Coverage and Waiver of Cost-Sharing for Preventive Services	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.4	0.4	1.0	2.7
1306 Waive Deductible for Colorectal Cancer Screening Tests	0	0	0	0	0	0	0	0	0	0	0	0
1307 Excluding Clinical Social Worker Services From Coverage Under the Medicare Skilled Nursing Facility Prospective Payment System and Consolidated Payment	0	0	0	0	0	0	0	0	0	0	0	0
1308 Coverage of Marriage and Family Therapist Services and Mental Health Counselor Services	*	*	*	*	*	*	*	0.1	0.1	0.1	0.1	0.4
1309 Extension of Physician Fee Schedule Mental Health Add-On	*	*	*	0	0	0	0	0	0	0	0.1	0.1
1310 Expanding Access to Vaccines	0	*	*	0.1	0.1	0.1	0.2	0.2	0.3	0.4	0.2	1.4
1311 Expansion of Medicare-Covered Preventive Services at Federally Qualified Health Centers	*	*	*	*	*	*	*	*	*	*	0.1	0.1
1312 Independence at Home Demonstration Program	*	*	*	*	*	*	0	0	0	0	*	*
1313 Recognition of Certified Diabetes Educators as Providers	*	*	*	*	*	*	*	*	*	*	*	*
TITLE IV—QUALITY												
Subtitle A—Comparative Effectiveness Research												
1401 Comparative Effectiveness Research (effects on outlays)												
Medicare	*	0.1	0.1	*	*	*	*	-0.1	-0.1	-0.2	0.2	-0.1
Non-Medicare	0	*	*	0.1	0.2	0.2	0.2	0.2	0.2	0.1	0.3	1.2
Subtitle B—Nursing Home Transparency	*	*	*	0	0	0	0	0	0	0	0.1	0.1
Subtitle C—Quality Measurements	*	*	0.1	0.1	0.1	*	*	0	0	0	0.2	0.3
Subtitle D—Physician Payments Sunshine Provision	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle E—Public Reporting on Health Care-Associated Infections	0	0	*	*	*	*	*	*	*	*	*	*
TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION												
1501 - 1505 Graduate Medical Education Provisions	*	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.5	1.5

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TITLE VI—PROGRAM INTEGRITY												
Subtitle A—Increased Funding to Fight Waste, Fraud, and Abuse	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.9
Subtitle B—Enhanced Penalties for Fraud and Abuse	*	*	*	*	*	*	*	*	*	*	-0.1	-0.2
Subtitle C—Enhanced Program and Provider Protections	*	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.7	-2.1
Subtitle D—Access to Information Necessary to Prevent Fraud, Waste, and Abuse	0	0	0	0	0	0	0	0	0	0	0	0
TITLE VII—MEDICAID AND CHIP												
Subtitle A—Medicaid and Health Reform												
1701 Eligibility for Individuals With Income Below 150 Percent of the Federal Poverty Level	Included in estimate for expanding health insurance coverage (except for Medicare cost-sharing assistance).											
Medicare cost sharing assistance - - Medicare effects	0	0	0	0.3	0.6	0.7	0.8	0.9	0.9	1.0	0.9	5.3
Medicare cost sharing assistance - - Medicaid effects	0	0	0	0.6	0.9	1.0	1.0	1.1	1.2	1.3	1.5	7.2
1702 Special Rules for Certain Medicaid Eligible Individuals	Included in estimate for expanding health insurance coverage.											
1703 CHIP and Medicaid Maintenance of Eligibility	Included in estimate for expanding health insurance coverage.											
1704 Reduction in Medicaid DSH	*	*	*	*	*	*	*	-1.5	-2.5	-6.0	*	-10.0
1705 Expanded Outstationing	Included in estimate for expanding health insurance coverage.											
Subtitle B—Prevention												
1711 Required Coverage of Preventive Services	*	0.2	0.2	0.8	0.8	1.3	1.5	1.7	1.9	2.1	2.1	10.7
1712 Tobacco Cessation	*	*	*	*	*	*	*	*	*	*	*	0.1
1713 Optional Coverage of Nurse Home Visitation Services	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
1714 State Eligibility Option for Family Planning Services	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle C—Access												
1721 Payments to Primary Care Practitioners	3.3	6.4	5.5	6.5	6.9	6.4	5.7	5.7	5.1	5.4	28.7	57.0
1722 Medical Home Pilot Program	*	0.1	0.1	0.1	0.1	*	0	0	0	0	0.5	0.5
1723 Translation or Interpretation Services	*	*	*	*	*	*	*	*	*	0.1	0.1	0.3
1724 Optional Coverage for Freestanding Birth Center Services	*	*	*	*	*	*	*	*	*	*	*	*
1725 Inclusion of Public Health Clinics Under the Vaccines for Children Program	*	0.1	0.1	0.1	0.1	*	*	0	0	0	0.4	0.5
1726 Requiring Coverage of Services of Podiatrists	*	*	*	*	*	*	*	*	*	*	0.1	0.2
1726A Requiring Coverage of Services of Optometrists	*	*	*	*	*	*	*	*	*	*	*	0.1
1727 Therapeutic Foster Care	*	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
1728 Assuring Adequate Payment Levels for Services	0	0	0	0	0	0	0	0	0	0	0	0
1729 Preserving Medicaid Coverage for Youths Upon Release From Public Institutions	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.6
1730 Quality Measures for Maternity and Adult Health Services Under Medicaid and CHIP	*	*	*	*	*	*	*	*	*	0	*	*
1730A Accountable Care Organization Pilot Program	0	0	*	*	*	*	*	*	*	*	*	-0.1
1730B FQHC Coverage	0	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	1.0

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Subtitle D—Coverage													
1731	Optional Medicaid Coverage of Low-Income HIV-Infected Individuals	0.1	0.4	0.4	0.1	0	0	0	0	0	0	1.1	1.1
1732	Extending Transitional Medicaid Assistance	0	0.2	1.1	1.0	0.1	*	0	0	0	0	2.4	2.4
1733	Requirement of 12-Month Continuous Coverage Under Certain CHIP Programs	Included in estimate for expanding health insurance coverage.											
1734	Preventing the Application Under CHIP of Coverage Waiting Periods for Certain Children	Included in estimate for expanding health insurance coverage.											
1735	Adult Day Health Care Services	0	0	0	0	0	0	0	0	0	0	0	0
1736	Medicaid Coverage for Citizens of Freely Associated States	*	*	*	*	*	*	*	*	*	*	0.1	0.2
1737	Medicaid Coverage of Nonemergency Transportation to Medically Necessary Services	*	*	*	*	*	*	*	*	*	*	*	*
1738	State Option to Disregard Certain Income in Providing Continued Medicaid Coverage for Certain Individuals With Extremely High Prescription Costs	*	0.2	0.2	*	0	0	0	0	0	0	0.5	0.5
1739	Community Living Assistance Services and Supports	Included in estimate for section 2581.											
Subtitle E—Financing													
1741 - 1743	Medicaid Pharmacy Reimbursement and Prescription Drug Rebate Provisions (includes interactions with section 2501)	-0.4	-1.9	-2.5	-2.7	-2.9	-2.7	-2.8	-2.8	-2.9	-3.0	-10.4	-24.6
1744	Payments for Graduate Medical Education	0	0	0	0	0	0	0	0	0	0	0	0
1745	Nursing Facility Supplemental Payment Program	0.4	1.1	1.5	1.5	1.1	0.4	0	0	0	0	5.6	6.0
1746	Report on Medicaid Payments	0	0	0	0	0	0	0	0	0	0	0	0
1747	Reviews of Medicaid	0	0	0	0	0	0	0	0	0	0	0	0
1748	Extension of Delay in Managed Care Organization Provider Tax Elimination	0.4	0	0	0	0	0	0	0	0	0	0.4	0.4
1749	Extension of ARRA Increase in FMAP	0	23.5	0	0	0	0	0	0	0	0	23.5	23.5
Subtitle F—Waste, Fraud, and Abuse													
1751	Health Care Acquired Conditions	0	0	*	*	*	*	*	*	*	*	*	*
1752	Evaluations and Reports	0	0	0	0	0	0	0	0	0	0	0	0
1753	Require Providers and Suppliers to Adopt Programs to Reduce Waste, Fraud, and Abuse	0	0	0	0	0	0	0	0	0	0	0	0
1754	Overpayments	0.1	0	*	0	*	*	*	*	*	*	0.1	0.1
1755	Managed Care Organizations	0	0	0	0	0	0	0	0	0	0	0	0
1756	Termination of Provider Participation Under Medicaid and CHIP if Terminated Under Certain Other Plans	0	0	0	0	0	0	0	0	0	0	0	0
1757	Medicaid and CHIP Exclusion From Participation Relating to Certain Ownership and Other Affiliations	0	0	0	0	0	0	0	0	0	0	0	0
1758	Report Expanded Set of Data Elements Under MMIS	0	0	0	0	0	0	0	0	0	0	0	0
1759	Alternate Payees Required to Register Under Medicaid	0	0	0	0	0	0	0	0	0	0	0	0
1760	Denial of Payments for Litigation-Related Misconduct	0	0	0	0	0	0	0	0	0	0	0	0
1761	Mandatory State Use of National Correct Coding Initiative	0	0	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3
Subtitle G—Payments to the Territories													

Table 3. Preliminary Estimate of the Effects on Direct Spending and Revenues of Divisions B, C, and D and Sections 111, 115, and 346 of H.R. 3962, the Affordable Health Care for America Act, as Introduced on October 29, 2009

By Fiscal Year, in Billions of Dollars

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
1771	Payment to Territories	0	0.8	0.9	0.8	0.9	1.0	1.1	1.2	1.2	1.4	3.4	9.3
Subtitle H—Miscellaneous													
1781	Technical Corrections	0	0	0	0	0	0	0	0	0	0	0	0
1782	Extension of QI Program	0	0.5	0.7	0.2	0	0	0	0	0	0	1.4	1.4
1783	Assuring Transparency of Information	0	0	0	0	0	0	0	0	0	0	0	0
1784	Medicaid and CHIP Payment and Access Commission	0	0	0	0	0	0	0	0	0	0	0	0
1785	Outreach and Enrollment of Medicaid- and CHIP-Eligible Individuals	0	0	0	0	0	0	0	0	0	0	0	0
1786	Prohibitions on Federal Medicaid and CHIP Payment for Undocumented Aliens	0	0	0	0	0	0	0	0	0	0	0	0
1787	Demonstration Project for Stabilization of Emergency Medical Conditions by Institutions for Mental Diseases	*	*	*	0	0	0	0	0	0	0	0.1	0.1
1788	Application of Medicare Improvement Fund	0	0	0	0	-0.1	-0.2	-0.2	-0.2	-0.2	0	-0.1	-0.7
1789	Treatment of Certain Medicaid Brokers	0	0	0	0	0	0	0	0	0	0	0	0
1790	Rule for Changes Requiring State Legislation	0	0	0	0	0	0	0	0	0	0	0	0
TITLE VIII—REVENUE-RELATED PROVISIONS		Estimates provided separately by the Joint Committee on Taxation (see JCX-43-09)											
TITLE IX—MISCELLANEOUS PROVISIONS													
1901	Repeal of Trigger Provision	0	0	0	0	0	0	0	0	0	0	0	0
1902	Repeal of Comparative Cost Adjustment Program	0	*	*	*	*	*	*	0	0	0	-0.1	-0.1
1903	Extension of Gainsharing Demonstration	*	*	*	*	*	0	0	0	0	0	*	*
1904	Grants to States for Quality Home Visitation Programs for Families With Young Children or Expecting Children	*	*	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.6	1.8
1905	Improved Coordination and Protection for Dual Eligibles	0	0	0	0	0	0	0	0	0	0	0	0
1906	Assessment of Medicare Cost-Intensive Diseases	0	0	0	0	0	0	0	0	0	0	0	0
1907	Center for Medicare and Medicaid Innovation												
	Funding for Center (including noncovered benefits)	0.1	0.2	0.4	0.6	0.7	0.8	0.9	1.0	0.9	0.9	2.0	6.5
	Effect on Medicare spending for benefits	0	-0.1	-0.2	-0.4	-0.5	-0.6	-0.9	-1.3	-1.8	-2.3	-1.2	-8.2
1908	Application of Emergency Services Laws	0	0	0	0	0	0	0	0	0	0	0	0
1909	Disregard Under the Supplemental Security Income Program of Compensation for Participation in Clinical Trials for Rare Diseases or Conditions	0	0	0	0	0	0	0	0	0	0	0	0
INTERACTIONS AMONG PROVISIONS													
	Tricare Interaction	-0.1	-0.2	-0.3	-0.3	-0.4	-0.5	-0.6	-0.8	-0.9	-0.8	-1.2	-4.8
	Medicare Advantage Interactions	0	-1.1	-1.9	-2.8	-8.8	-7.8	-7.8	-10.3	-12.4	-14.3	-14.6	-67.3
	Premium Interactions	0	0.4	0.9	1.5	5.5	4.8	4.6	5.4	6.2	7.0	8.3	36.3
	Implementation of Medicare Changes	0.2	*	*	*	*	*	*	*	*	*	0.3	0.3
	Medicare Interactions with Medicaid Provisions	0	0	0	0	0	0	1.8	3.0	3.7	4.0	0	12.4
	Medicare Interactions with 340B Provision	*	*	*	*	*	*	*	*	*	*	*	*
SUBTOTAL, DIVISION B		**3.9**	**13.6**	**-15.6**	**-22.5**	**-49.1**	**-47.5**	**-47.9**	**-61.6**	**-73.8**	**-84.4**	**-69.8**	**-385.0**

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By Fiscal Year, in Billions of Dollars

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT													
2001 - 2403	Public Health Investment Fund, and Prevention and Wellness Trust[a]	0	1.8	4.4	5.9	7.1	8.2	4.8	0.9	0.2	*	19.2	33.4
2501 - 2503	340B Drug Discount Programs	Included in estimate for sections 1741-1743											
2511	School-based Health Clinics	0	0	0	0	0	0	0	0	0	0	0	0
2572	Nutrition labeling at Chain Restaurants and Vending Machines	0	0	0	0	0	0	0	0	0	0	0	0
2573	Protecting Consumer Access to Generic Drugs	-0.1	-0.1	-0.1	-0.2	-0.1	-0.1	-0.1	-0.2	-0.3	-0.4	-0.7	-1.8
2575	Licensure Pathway for Biosimilar Biological Products	0	0	0	*	-0.1	-0.3	-0.6	-1.1	-1.7	-2.5	-0.1	-6.2
2581	Community Living Assistance Services and Supports	0	-3.7	-6.4	-8.7	-9.9	-11.2	-9.6	-8.6	-7.5	-6.8	-28.7	-72.5
SUBTOTAL, DIVISION C		**-0.1**	**-2.0**	**-2.2**	**-2.9**	**-3.0**	**-3.4**	**-5.6**	**-8.9**	**-9.4**	**-9.7**	**-10.2**	**-47.1**
DIVISION D—INDIAN HEALTH CARE IMPROVEMENT													
TITLE I—AMENDMENTS TO INDIAN LAWS													
3101	Scholarship And Loan Repayment Recovery Fund and Exemption From Payment From Certain Fees	*	*	*	*	*	*	*	*	*	*	*	*
TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT													
3201	Expansion of Payments Under Medicare	0	*	*	*	*	*	*	*	*	*	0.1	0.2
SUBTOTAL, DIVISION D		*	*	*	*	*	*	*	*	*	*	**0.1**	**0.2**
OTHER (from Division A)													
111	Reinsurance Program for Retirees	3.0	5.0	2.0	0	0	0	0	0	0	0	10.0	10.0
115	Administrative Simplification												
	Effects on Medicaid spending	*	*	*	-0.1	-0.1	-0.2	-0.5	-1.0	-1.1	-1.2	-0.2	-4.2
	Effects on exchange subsidies	0	0	0	*	-0.1	-0.4	-0.7	-1.0	-1.1	-1.2	-0.2	-4.6
346	Special Rules for Application to Territories	0	0	0	0.7	0.7	0.7	0.7	0.7	0.7	0.7	1.4	5.0
Total, Changes in Direct Spending		**6.8**	**16.6**	**-15.8**	**-24.8**	**-51.7**	**-50.7**	**-53.9**	**-71.8**	**-84.7**	**-95.7**	**-68.9**	**-425.6**

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CHANGES IN REVENUES												
Fraud, Waste, and Abuse	*	*	*	*	*	*	*	*	*	*	0.1	0.2
Effect of Administrative Simplification on Revenues[b]	0	-0.1	-0.2	0.1	0.6	1.2	1.9	2.9	3.2	3.3	0.3	12.8
Effects on Revenues of Provisions Involving Comparative Effectiveness, Access to Generic Drugs, and Follow-On Biologicals												
Income and Medicare payroll taxes (on-budget)	*	*	*	*	*	*	0.1	0.2	0.2	0.3	0.1	0.9
Social Security payroll taxes (off-budget)	*	*	*	*	*	*	*	0.1	0.1	0.2	*	0.5
Total, Changes in Revenues (unified budget)	*****	**-0.1**	**-0.1**	**0.1**	**0.6**	**1.3**	**2.1**	**3.1**	**3.6**	**3.8**	**0.5**	**14.4**
CHANGES IN DEFICITS												
Total, Changes in Deficits (unified budget)	**6.8**	**16.7**	**-15.7**	**-24.9**	**-52.3**	**-52.0**	**-55.9**	**-74.9**	**-88.3**	**-99.5**	**-69.4**	**-440.0**
MEMORANDUM												
Non-scorable savings from increased HCFAC spending	0	*	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.4	-1.3

Notes:

* Between -$50 million and $50 million.

a. The legislation would authorize the appropriation of approximately $34 billion over the 2011-2015 period for public health, prevention, and wellness provisions. Although that spending would not occur without the enactment of subsequent discretionary appropriations, the House Committee on the Budget has directed CBO to consider such spending as direct spending in this cost estimate.

b. Estimated by the Joint Committee on Taxation. Includes both on-budget and off-budget effects.

AIDS = acquired immune deficiency syndrome; ARRA = American Recovery and Reinvestment Act (Public Law 111-5); CHIP = Children's Health Insurance Program; DSH = disproportionate share hospital; DME = durable medical equipment; FMAP = federal medical assistance percentage; FQHC = federally qualified health center; HCFAC = health care fraud and abuse control account; HIV = human immunodeficiency virus; MA = Medicare Advantage; MedPAC = Medicare Payment Advisory Commission; MMIS = Medicaid Management Information System; PPS = prospective payment system; QI = qualifying individual.