FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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Assessing Congressional Budget Office Estimates of the Cost and Coverage Implications of Health Reform Proposals

Under Congressional budget rules, the Congressional Budget Office (CBO) – in conjunction with the Joint Committee on Taxation – prepares estimates of the federal budgetary implications of legislation (often referred to as "scores"). Throughout the current health reform debate, CBO has analyzed bills considered by major Congressional committees, providing projections of the federal costs and savings associated with the plans over a 10-year period, as well as estimates of how the sources of insurance coverage would change.

While CBO itself emphasizes the uncertainty inherent in assessing the implications of major changes to the health system, its analysis – using a common set of methods and assumptions across proposals – informs the legislative process in important ways and helps to provide an understanding of how different bills would affect the federal budget and the health insurance coverage people receive.

There are now two major health reform bills pending in Congress: the Affordable Health Care for America Act (H.R. 3962), passed by the House on November 7; and the Patient Protection and Affordable Care Act (H.R. 3590), which is pending in the Senate. This brief explains key elements of CBO's estimates of these proposals.

Changes in Health Insurance Coverage

A primary aim of health reform legislation is to decrease the number of people who are uninsured, which CBO projects will be 54 million by 2019 under the status quo. (Note that CBO in its analysis generally compares the effects of bills to a current law baseline over a 10-year period, which projects what would happen to budget costs and coverage under federal laws that exist today.)

Both the House and Senate proposals would decrease the number of uninsured substantially, primarily through expansions in the Medicaid program, premium subsidies provided to people with incomes up to 400% of the federal poverty level buying health insurance through newly-created purchasing exchanges, and a requirement that everyone (with some exceptions) be insured. Under the House bill, 18 million people would remain uninsured in 2019, meaning 94% of non-elderly people would be insured (96% if unauthorized immigrants, who would not be eligible for subsidies, are excluded from the calculation). The Senate bill would result in 24 million people uninsured, with 92% of the non-elderly population insured (94% without unauthorized immigrants).

Among the factors that likely result in greater coverage under the House plan are: more generous premium subsidies for lower income people, who make up the bulk of the uninsured (though the subsidies under the Senate bill are more substantial at the upper end of the income range of people eligible for assistance); generally higher penalties for people who do not comply with the requirement to obtain insurance; and substantially higher penalties assessed on employers that do not offer coverage to their workers.

Table 1: Changes in Coverage, 2019
(in millions)

	House-Passed Bill	Senate-Proposed Bill
Medicaid & CHIP	15	15
Employer	6	-5
Non-group & other	-6	-5
Exchanges (individual purchasers)	21	25
Uninsured	-36	-31

A significant number of people under each of the proposals would buy insurance through the new purchasing exchanges (about 30 million in 2019). These would include primarily people buying coverage on their own, as well those whose employers elect to arrange for coverage through an exchange – about 9 million people under the House bill and 5 million under the Senate. Those with employer-sponsored coverage (reflected under the employer category in Table 1) are generally not eligible for subsidies in the exchange. According to CBO's estimates, the vast majority of people buying insurance on their own through exchanges would be receiving subsidies (just 3 million are unsubsidized under the House plan and 6 million in the Senate).

Both the House and Senate bills include a so-called "public option" plan that would compete with the private insurers in the exchanges (states could opt out of the public option in the Senate proposal). CBO projects that about 6 million out of the 30 million people in the exchange in 2019 would enroll in the public plan under the House bill, compared to 3-4 million in the Senate. CBO estimates that the public plan under each proposal would have lower administrative costs than private plans, but would also attract a less healthy group of enrollees because it would engage in less aggressive management of health care utilization. As a result, the public plan would have premiums higher than private plans on average. (While a risk adjustment mechanism would adjust premiums across plans based on the health status of people that they attract, CBO does not believe that the adjustments would fully compensate the public plan for a sicker-than-average pool of enrollees.)

Cost of Expanding Coverage

The federal cost of the various health reform plans has emerged as one of the most visible focal points in the debate. In his speech on health care to a joint session of Congress, President Obama said that a health reform plan would cost the federal government about $900 billion over 10 years, a statement widely interpreted as setting a ceiling on the budgetary cost of reform.

There are any number of ways to tally up the cost of one of the current health reform plans, since they not only expand coverage but also have significant effects on existing government health programs such as Medicare and Medicaid, as well as on tax revenues. However, the generally accepted definition in the context of the current debate centers around the cost of expanding health coverage, which can be measured on both a gross and net basis (as shown in Table 2, which shows costs as presented by CBO). CBO treats improvements in Medicare and Medicaid that increase costs as part of the net overall change in spending for current federal programs.

Table 2: Federal Costs Associated with Expanding Coverage, 2010-2019
(in billions of dollars)

	House-Passed Bill	Senate- Proposed Bill
Cost of Expanded Coverage		
Medicaid & CHIP	$ 425	$ 374
Exchange subsidies & high risk pool	602	447
Small business tax credits	25	27
Gross cost	**1,052**	**848**
Adjustments		
Penalty payments by uninsured	-33	-8
Penalty payments by employers	-135	-28
Tax on high-premium health plans	*	-149
Effects on tax revenues	6	-64
Net cost of coverage expansion	**891**	**599**

On a gross basis, expanded coverage in the House bill is estimated to cost $204 billion more than the Senate proposal over 10 years, reflecting more generous subsidies – both for premiums and for cost sharing – and a higher level of insurance coverage.

The net costs of the two bills are somewhat harder to interpret, in part because of differences in how the proposals are financed. For example, the House bill calls for higher penalties on employers that do not offer coverage (raising $107 billion more in revenues), while the Senate plan includes a tax on high-premium employer-sponsored health plans that raises $149 billion.

Financing

According to Congressional budget rules, the added cost of reform can be offset (or "financed") in a variety of ways, including reductions in federal spending in existing programs relative to current law, changes in existing taxes, and imposition of new taxes.

Fully assessing how a reform plan is financed involves looking at a large number of provisions, understanding the interactions among them, and recognizing how CBO accounts for them in its scoring rules. However, just a few primary components provide the vast majority of the financing for the House and Senate plans (shown in Table 3).

Table 3: Major Financing Components, 2010-2019
(in billions of dollars)

	House-Passed Bill	Senate- Proposed Bill
Changes in baseline federal spending	$456	$491
Surtax on high income taxpayers	460	*
Increased Medicare payroll tax	*	54
High-premium plan tax	*	149
Health industry excise taxes	20	102

The largest element of the financing of the House plan is a surtax on high income taxpayers (raising $460 billion over 10 years), a proposal not included in the Senate bill. The Senate plan, in turn, includes two proposals not in the House bill – an increase in the Medicare payroll tax for high income workers (producing $54 billion), and a new tax on high-premium employer-sponsored health plans (raising $149 billion). Both proposals contain new excise taxes on various health industries, though the scope of the taxes varies – the House taxes only medical device makers (for revenues of $20 billion), while the Senate bill also includes taxes on brand-name drug companies and health insurers (for total revenue of $102 billion).

A major financing component of both proposals is a reduction (relative to current law) in federal spending on existing health programs such as Medicare and Medicaid ($456 billion in the House and $491 billion in the Senate). The savings, which come primarily from Medicare changes, are net amounts, reflecting changes in the programs that increase costs as well (though not increased eligibility for Medicaid, which is accounted for under the cost of expanded coverage). The House bill, for example, includes increased payments to primary care providers in Medicaid at a cost of $57 billon over 10 years.

Effect on the Federal Budget Deficit

Throughout the health reform debate, the President and Congressional leaders have committed to the idea that reform should not increase the federal budget deficit, and potentially reduce it over time. This means that the financing provisions must fully offset the new federal costs.

As shown in Table 4, CBO estimates that both bills would reduce the federal deficit over 10 years by similar amounts – $138 billion for the House and $130 billion for the Senate.

Table 4: Effect on the Federal Budget Deficit, 2010-2019
(in billions of dollars)

	House-Passed Bill	Senate- Proposed Bill
Net cost of coverage provisions	$891	$599
Changes in existing spending	-456	-491
Changes in revenues	-574	-238
Net effect on the deficit	-138	-130

While CBO only provides specific quantitative estimates of the effect of health reform proposals on the deficit for the next 10 years, members of Congress have expressed interest in how the bills would affect the federal government's fiscal balance over a longer time horizon.

One indication of how the proposals might play out in the long term is the effect on the budget deficit in 2019, the final year of the initial 10-year window for CBO forecasts. Both proposals would, in fact, reduce the federal budget deficit in 2019 – by $12 billion in the House bill and $8 billion in the Senate plan.

While pointing to the uncertainties involved in long-term forecasts, CBO has also offered a "rough outlook" of the second decade under reform. For the House bill, CBO finds that it would "slightly reduce" budget deficits "in a broad range between zero and one-quarter percent of GDP." For the Senate bill, the estimates suggest that the deficit could be reduced during the second 10 years "in a broad range around one-quarter percent of GDP." A key difference in CBO's assessment of the long-term effects of the two bills is the expected growth in key financing elements. CBO suggests that the House's surtax on high-income taxpayers might growth by a little more than 5% per year. In contrast, the Senate's tax on high-premium health plans could grow by 10-15% per year.

Summary

Any analysis of the cost and coverage implications of complex reforms to the health care system is fraught with uncertainty. It involves projecting the effects of the status quo for the next 10 years, and then assessing how that would be altered by the changes called for in reform proposals – many of which have not been implemented before and therefore offer little real-world guidance as to what the effects would be.

Irrespective of that uncertainty, CBO's estimates play a significant role in the legislative process. And, they offer a lens through which some of the similarities and differences across current health reform proposals can be understood:

- Both the House-passed bill and Senate-proposed bill would reduce the number of people uninsured substantially, with the House proposal leading to a somewhat larger reduction.
- Driven by greater increases in coverage and more generous subsidies, the House bill would cost more on a gross basis over 10 years.
- Perhaps the biggest difference between the two bills is in the financing, with large portions of it coming from new sources of revenue that vary across the proposals.
- Both bills would reduce the federal budget deficit by similar amounts over 10 years, and CBO suggests they would both reduce the deficit over the second decade of implementation as well.

For More Information

Figures in all of the tables come from CBO estimates of the House bill (in a letter dated November 20, 2009) and the Senate bill (in a letter dated November 18, 2009). Estimates publicly released by CBO include:

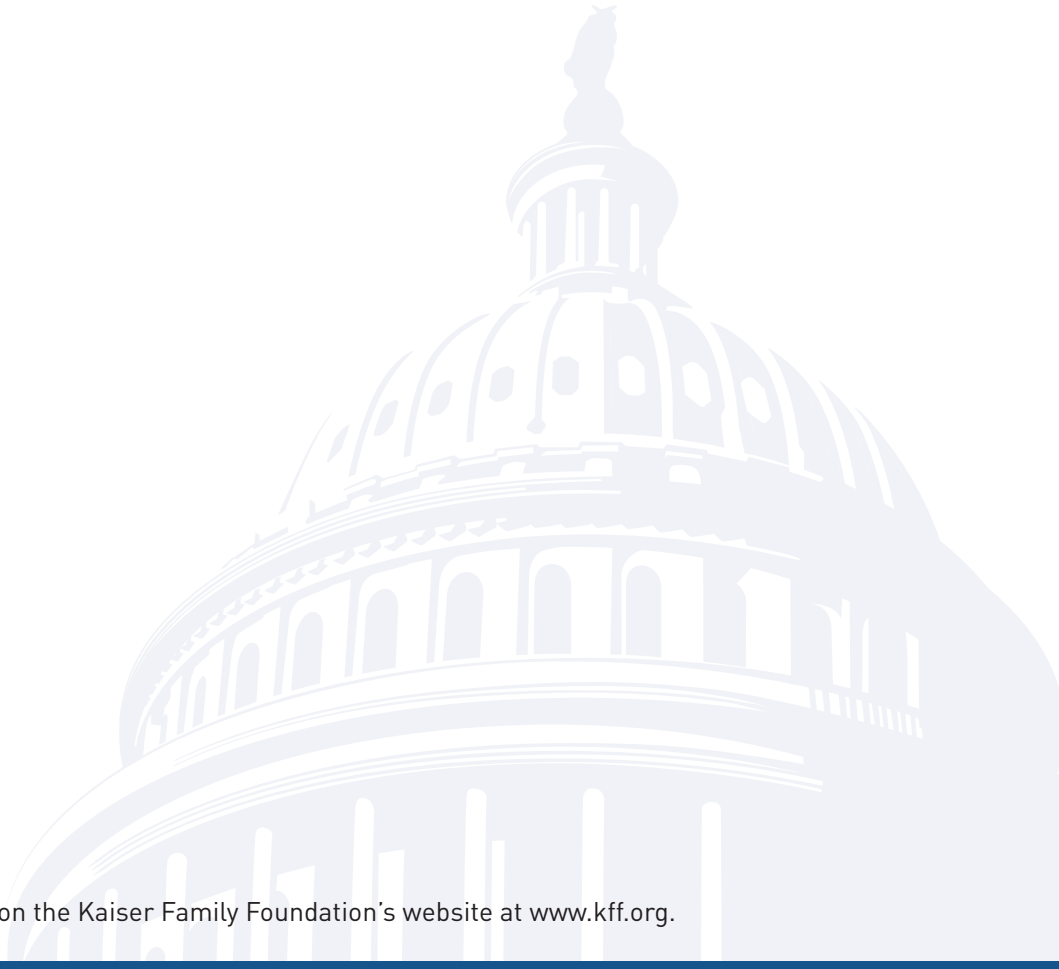
- November 20 estimate of the House bill: www.cbo.gov/doc.cfm?index=10741
- November 18 estimate of the Senate bill: www.cbo.gov/doc.cfm?index=10731
- Initial October 29 analysis of the House bill: www.cbo.gov/doc.cfm?index=10688

Side-by-side comparison of major health reform proposals: www.kff.org/healthreform/sidebyside.cfm

Online tool illustrating how premium subsidies work: healthreform.kff.org/SubsidyCalculator.aspx

Summary of key Medicare provisions in the House bill: www.kff.org/healthreform/7948.cfm

President Obama's speech on health care to a joint session of Congress: www.whitehouse.gov/the_press_office/remarks-by-the-president-to-a-joint-session-of-congress-on-health-care/



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