DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N3-01-21
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Office of the Actuary

DATE: October 21, 2009

FROM: Richard S. Foster
Chief Actuary

SUBJECT: Estimated Financial Effects of the "America's Affordable Health Choices Act of 2009" (H.R. 3200), as Reported by the Ways and Means Committee

The Office of the Actuary has prepared this memorandum in our longstanding capacity as an independent technical advisor to both the Administration and the Congress. The costs, savings, and coverage impacts shown herein represent our best estimates for H.R. 3200. We offer this analysis in the hope that it will be of interest and value to policy makers as they develop and debate national health care reforms. The statements, estimates, and other information provided in this memorandum are those of the Office of the Actuary and do not represent an official position of the Department of Health and Human Services or the Administration.

This memorandum summarizes the Office of the Actuary's estimates of the financial and coverage effects of the proposed "America's Affordable Health Choices Act of 2009" (H.R. 3200) through fiscal year 2019. The estimates are based on the bill as reported by the Ways and Means Committee and include the estimated net Federal expenditures in support of expanded health insurance coverage, the associated numbers of people by insured status, the changes in Medicare and Medicaid expenditures and revenues, and the overall impact on total National health expenditures. We have not estimated the impact of the proposed income-tax surcharge for high-income taxpayers on Federal income taxes or the impact on income and payroll taxes due to economic effects of the legislation. Similarly, the impact on Federal administrative expenses is excluded. An appendix is attached summarizing the data, assumptions, and methodology underlying these estimates. At the earliest opportunity, we will provide additional memoranda describing our estimates and methods in greater detail.

Summary

The table shown on page 2 presents the key, non-tax financial impacts of H.R. 3200 on the Federal Budget in fiscal years 2010-2019. We have grouped the provisions of the bill into four major categories:

(i) Coverage proposals, which include both the mandated coverage for health insurance and the expansion of Medicaid eligibility to those with incomes at or under 133⅓ percent of the Federal poverty level (FPL);

(ii) Medicare provisions;

(iii) Medicaid and CHIP provisions other than the coverage expansion; and

(iv) Proposals aimed in part at changing the trend in health spending growth.

The estimated costs and savings shown in the table are based on the effective dates specified in the bill as reported. Additionally, we assume that employers and individuals would take roughly 3 to 5 years to fully adapt to the insurance coverage provisions and that the enrollment of additional individuals under the Medicaid coverage expansion would be completed by the third year following enactment. Because of these transition effects and the fact that most of the provisions would be in effect for only 7 of the 10 years of the budget period, the cost estimates shown in this memorandum do not represent a full 10-year cost for the proposed legislation.

Estimated Federal Costs (+) or Savings (–) under H.R. 3200
(in billions)

	Fiscal Year										Total,
Provisions	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-19
Total*	$11.6	$7.6	$8.5	$78.9	$82.1	$125.3	$131.1	$131.4	$138.2	$146.4	$861.2
Coverage†	—	—	—	82.2	116.4	134.5	150.8	166.6	183.1	201.1	1,034.7
Medicare	9.4	3.1	1.2	–1.0	–31.0	–10.2	–20.9	–34.9	–43.8	–50.5	–178.7
Medicaid/CHIP	2.2	4.6	7.3	–2.3	–3.3	1.1	1.4	0.2	–0.5	–3.4	7.3
Cost Trend‡	—	—	—	—	–0.0	–0.1	–0.2	–0.4	–0.6	–0.8	–2.1

* Excludes income tax surcharge for high-income taxpayers and Federal administrative costs.
† Includes expansion of Medicaid eligibility.
‡ Comparative effectiveness research, prevention and wellness, fraud and abuse, and administrative simplification.

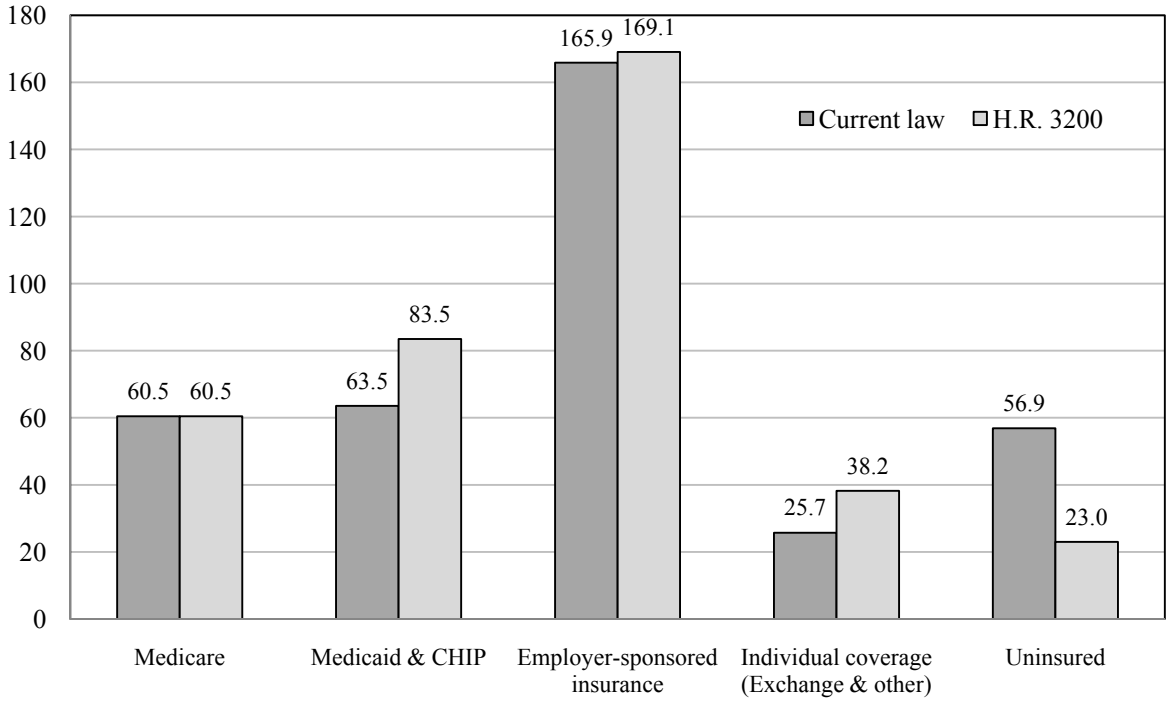
As indicated in the table above, the provisions in support of expanding health insurance coverage (including the Medicaid eligibility changes) are estimated to cost about $1.0 trillion through fiscal year 2019. The net savings from the Medicare, Medicaid, and growth-trend proposals are estimated to total $173 billion, leaving a net cost for this period of $861 billion before consideration of additional Federal administrative expenses and the increase in Federal income tax revenues that would result from the surcharge on high-income individuals and families.

The chart shown on the following page summarizes the estimated impacts of H.R. 3200 on insurance coverage. The mandated coverage provisions, which include the individual and employer mandates and the creation of the Health Insurance Exchange(s) (hereafter referred to as the "Exchange"), would lead to shifts across coverage types and a substantial overall reduction in the number of uninsured, as many of these individuals become covered through their employers, Medicaid, or the Exchange.

By calendar year 2019, the mandates, coupled with the Medicaid expansion, would reduce the number of uninsured from 57 million, as projected under the current-law baseline, to an estimated 23 million under H.R. 3200. The additional 34 million people who would become insured by 2019 reflect the net effect of several shifts. First, an estimated 18 million would gain primary Medicaid coverage as a result of the expansion of eligibility to all legal resident adults

under 133⅓ percent of the FPL.[1] (In addition, roughly 2 million people with employer-sponsored health insurance would enroll in Medicaid for supplemental coverage.) Another 13 million currently uninsured persons would receive individual insurance coverage through the newly created Exchange, with the majority of these qualifying for Federal affordability credits (that is, premium and cost-sharing subsidies) and an estimated 40 percent choosing to participate in the public insurance plan option. Finally, we estimate that the number of individuals with employer-sponsored health insurance would increase overall by about 3 million, reflecting both gains and losses in such coverage under H.R. 3200.

Estimated Effect of H.R. 3200 on Enrollment by Insurance Coverage, 2019
(in millions)



Note: Totals across categories are not meaningful due to overlaps among categories (e.g., Medicare and Medicaid).

As described in more detail in a later section of this memorandum, we estimate that the provisions of H.R. 3200 that were designed, in part, to reduce the rate of growth in health care costs would have a relatively small savings impact. Total national health expenditures under this bill would increase by an estimated 2.7 percent in calendar year 2019, reflecting the net impact of (i) greater utilization of health care services by individuals becoming newly covered (or having more complete coverage), (ii) lower prices paid to health providers for the subset of those individuals who become covered by Medicaid or the public plan option through the health insurance Exchange, and (iii) lower payments and payment updates for Medicare services.

[1] This proposal would extend eligibility to two significant groups: (i) individuals who would meet current Medicaid eligibility requirements, for example as disabled adults, but who have incomes in excess of the existing State thresholds but less than 133⅓ percent of the FPL; and (ii) people who live in households with incomes below 133⅓ percent of the FPL but who have no other qualifying factors that make them eligible for Medicaid under current law, such as being under age 18, age 65 or older, disabled, pregnant, or parents of eligible children.

The actual future impacts of H.R. 3200 on health expenditures, insured status, individual decisions, and employer behavior are very uncertain. The legislation would result in numerous changes in the way that health care insurance is provided and paid for in the U.S., and the scope and magnitude of these changes are such that few precedents exist for use in estimation. Consequently, the estimates presented here are subject to a substantially greater degree of uncertainty than is usually the case with more routine health care proposals.

The balance of this memorandum discusses these financial and coverage estimates—and their limitations—in greater detail.

Effects of Coverage Proposals on Federal Expenditures and Health Insurance Coverage

Federal Expenditure Impacts

The estimated Federal costs of the coverage provisions in H.R. 3200 are provided in table 1, attached, for fiscal years 2010 through 2019. We estimate that Federal expenditures would increase by a net total of $861 billion during this period—a combination of $1,035 billion in net costs associated with coverage provisions, $179 billion in net savings for the Medicare provisions, a net cost of $7 billion for the Medicaid/CHIP provisions (excluding the expansion of eligibility), and $2 billion in savings from proposals intended to help reduce the rate of growth in health spending. These latter three impacts are discussed in subsequent sections of this memorandum.

Of the estimated $1,035 billion net increase in Federal expenditures related to the coverage provisions of H.R. 3200, a little less than one-half ($502 billion) can be attributed to expanding Medicaid coverage for all adults who make less than 133⅓ percent of the FPL and all uninsured newborns. This cost reflects the fact that newly eligible persons would be covered with a 100-percent Federal Medical Assistance Percentage (FMAP); that is, the Federal government would bear the full cost of the newly eligible enrollees.[2] The remaining costs of the coverage provisions arise from the affordability credits for low-income enrollees purchasing health insurance through the Exchange and credits for small employers who choose to offer insurance coverage. These estimated expenses amount to $672 billion and $44 billion, respectively, for fiscal years 2010-2019. The increases in Federal expenditures would be partially offset by the penalties paid by individuals who choose to remain uninsured and employers who opt not to offer coverage; such penalties together total $182 billion through this period.

The $672 billion of individual affordability credits are the combination of both premium and cost-sharing subsidies. The premium credits in section 243 of H.R. 3200 would limit the premiums paid by individuals between 133⅓ percent and 400 percent of the FPL to at most

[2] The definition of "income," for purposes of establishing Medicaid eligibility under the proposed expansion, would be "determined using methodologies and procedures specified by the Secretary [of HHS] in consultation with the [Exchange] Commissioner." To estimate the effects of this proposal, we assumed that the same definition of income as currently used for Medicaid would also apply under the proposal. In addition, the estimated cost includes the so-called "woodworking" effect— that is, new Medicaid enrollments by previously eligible individuals as a result of the publicity, enrollment assistance through the Exchange, and reduced stigma associated with Federal assistance for health care.

11.0 percent of their income and would cost an estimated $562 billion through 2019. An estimated 21 million Exchange enrollees would be eligible for these Federal premium subsidies. The cost-sharing credits would reimburse qualifying individuals and families for a portion of the amounts they pay out-of-pocket for health services, as specified in section 244. These credits are estimated to cost $110 billion through 2019.

It should be noted that full premiums for health insurance coverage through Exchange plans would increase by the growth in per capita health care costs, while the reduced premiums payable by those with incomes below 400 percent of FPL would increase at the generally slower rate of personal income. As a result, a qualifying individual's subsidized premium would tend to stay at a constant share of his or her income, but Federal premium subsidies would grow at a faster pace than health care costs.

H.R. 3200 specifies maximum out-of-pocket limits in 2013 of $5,000 for an individual and $10,000 for a family with qualified creditable coverage (including employer-sponsored health insurance). For future years, the limits are indexed to the CPI (all items). Over time, since per capita health care costs are expected to continue growing at a significantly faster pace than the CPI, this provision would gradually increase the proportion of health care costs that would be above the out-of-pocket maximum. As a result, the cost-sharing requirements applicable to expenditures below the out-of-pocket maximum would have to increase in future years to maintain the overall actuarial value of the benefit package relative to average health care costs (i.e., 70 percent, 85 percent, or 95 percent for the three Exchange coverage categories). For the basic essential-benefits plans for individuals, we estimate that the cost-sharing percentage applicable before the out-of-pocket maximum is reached would increase from about 50 percent in 2013 to 65 percent in 2023. The corresponding cost-sharing rates for family coverage are 45 percent in 2013, growing to 55 percent in 2023.

Somewhat offsetting the Federal costs resulting from the coverage expansion provisions are the individual and employer penalties stipulated by H.R. 3200. For individuals, there is a requirement to obtain health insurance or otherwise pay a penalty tax of 2.5 percent of modified adjusted gross income above the exemption amount (section 401). We estimate that this provision would provide $59 billion in revenue to the Federal government in fiscal years 2014-2019, taking into account the time lag associated with collecting the penalty amounts through the Federal income tax system. (A discussion of the estimated number of individuals who would choose to remain uninsured is provided below.) Additionally, for firms that are ineligible for small business credits and that do not offer health insurance, we estimate that the "play or pay" penalties would total $124 billion in 2013-2019.

The penalty amounts for noncovered individuals would increase over time as a function of their incomes. Similarly, penalties for nonparticipating employers would rise with growth in company payrolls. In both cases, the bases for assessing the penalties would normally increase more slowly than health care costs. As a result, penalty revenues for nonparticipating individuals and employers are estimated to grow more slowly than the Federal expenditures for affordability credits.

Health Insurance Coverage Impacts

The estimated effects of H.R. 3200 on health insurance coverage are provided in table 2, attached. As summarized earlier, we believe that these effects would be quite significant. By calendar year 2019, the individual mandate, Medicaid expansion, and other provisions are estimated to reduce the number of uninsured from 57 million under current law to 23 million after H.R. 3200. The percentage of the U.S. population with health insurance coverage is estimated to increase from 83 percent under the current baseline to 93 percent after the changes have become fully effective.

Of the additional 34 million people who are estimated to be insured in 2019 as a result of H.R. 3200, just over half (18 million) would receive Medicaid coverage due to the expansion of eligibility to those adults under 133⅓ percent of the FPL. We anticipate that the requirement in H.R. 3200—that the Health Choices (Exchange) Commissioner help people determine which insurance plans are available, and identify whether individuals qualify for Medicaid coverage, affordability credits, etc.—would result in a high percentage of eligible persons becoming enrolled in Medicaid. We further believe that the great majority of such persons (16 million) would become covered in the first year, 2013, with the rest covered by 2015. Another 2 million people who currently have employer-sponsored health insurance are estimated to qualify for Medicaid as a supplement to their existing coverage.

Of the remaining 16 million who are estimated to receive health coverage in 2019 because of H.R. 3200, about 13 million would be covered by health insurance through the newly created Exchange. (Another 14 million, who currently have individual health insurance policies, are also expected to switch to Exchange plans.) We modeled the choice to purchase coverage from the Exchange as a function of individuals' and families' expected health expenditures relative to the cost of coverage if they were insured (taking account of applicable premium subsidies). We also considered the required penalty associated with the individual mandate if they chose to remain uninsured, along with other factors.[3] Our model indicated that roughly 62 percent of those eligible for the Exchange would choose to take such coverage and avoid the individual penalty.

The proposed legislation specifies that a Federally operated "public health insurance option" would also be available through the Exchange. This plan would meet the same benefit, cost-sharing, network, and other requirements applicable to private Exchange plans but would generally pay providers at Medicare payment rates plus 5 percent (rather than plan-negotiated rates). We estimate that the public plan would have costs that were 18 percent below the average level for private plans but that the public plan premiums would be roughly 11 percent lower than private as a result of antiselection by enrollees.[4] We further estimate that about 40 percent of the

[3] Such other factors include age, gender of head of household, race, children, marital status, health status, and employment status (for both the head of household and the spouse), as well as adjustments to reflect the availability of health insurance on a guaranteed-issue basis and at community-rated, group insurance premium rates. Finally, we also considered the general desire to comply with the intent of the law and to avoid penalties, even in cases in which the amount would be small.

[4] The lower estimated cost level for the public plan reflects the statutory provider payment rates, which would be substantially lower than prevailing commercial plan negotiated rates. Lower administrative costs—due to the economy of scale, reduced marketing costs, and lack of a margin for profit—also contribute to the difference. We anticipate, however, that the public plan would not apply utilization-management techniques as strict as those prevailing in private PPOs and HMOs, thereby offsetting some of the cost advantage.

approximately 27 million people with Exchange coverage would choose the public plan option; the actual percentage could be substantially different, although the impacts on Federal costs and the number of insured persons are not especially sensitive to this percentage.

Employer-sponsored health insurance has traditionally been the largest source of coverage in the U.S., and we anticipate that it would continue to be so under H.R. 3200. By 2019, an estimated 15 million workers and family members would become newly covered as a result of additional employers offering health coverage and a greater proportion of workers enrolling in employer plans. However, a number of workers who currently have employer coverage would likely become enrolled in the expanded Medicaid program or receive subsidized coverage through the Exchange. For example, some smaller employers would be inclined to terminate their existing coverage, and companies with low average salaries might find it to their—and their employees'—advantage to end their plans, thereby allowing their workers to qualify for heavily subsidized coverage through the Exchange. Somewhat similarly, many part-time workers could obtain coverage more inexpensively through the Exchange or by enrolling in the expanded Medicaid program. We estimate that such actions would collectively reduce the number of people with employer-sponsored health coverage by about 12 million, or slightly less than the number newly covered through existing and new employer plans under H.R. 3200. As indicated in table 2, the total number of persons with employer coverage in 2019 is estimated to be 3 million higher under the reform package than under current law.

For the estimated 23 million people who would remain uninsured in 2019, roughly 5 million are undocumented aliens who would be ineligible for any of the new coverage options under H.R. 3200. The balance of 18 million are estimated to choose not to be insured and to pay the penalty associated with the individual mandate. For the most part, these would be individuals with relatively low health care expenses for whom the individual or family insurance premium would be significantly in excess of the penalty and their anticipated health benefit value. In other instances, as appears to happen under current law, some people would not enroll in their employer plans (or take advantage of the Exchange opportunities) even though it would be in their best financial interest to do so.

Impact on Medicare and Medicaid

Medicare

The estimated financial impacts of the Medicare provisions in H.R. 3200 are provided in detail in table 3, attached, which is organized by section of the proposed legislation. Net Medicare savings are estimated to total $179 billion for fiscal years 2010-2019, with the majority of the savings arising from provisions in Title I of Division B ("Improving Health Care Value"). Specifically, substantial savings are attributable to provisions in this title that would, among other changes, (i) adjust Part A and Part B market basket payment updates for productivity improvements ($244 billion), (ii) reduce Medicare Advantage payment benchmarks and extend the authority to adjust for coding intensity ($201 billion), and (iii) require prescription drug rebates at Medicaid levels from manufacturers for dual Medicare-Medicaid Part D enrollees ($79 billion). The provisions in other titles would generate relatively smaller amounts of savings, principally through Title VI ("Program Integrity") with savings of $4 billion.

The Title I savings are partially offset by the costs of reforming the physician payment Sustainable Growth Rate (SGR) formula ($336 billion[5]) and of phasing out the Part D coverage gap ($31 billion). Other titles would generate relatively smaller amounts of costs, including Title II ("Medicare Beneficiary Improvements") with an estimated 10-year cost of $31 billion and Title III ("Promoting Primary Care, Mental Health, and Coordinated Care") with costs of $12 billion.

It is important to note that the estimated savings shown in this memorandum for one category of Medicare proposals may be unrealistic. H.R. 3200 would introduce permanent annual productivity adjustments to price updates for institutional providers (such as acute care hospitals, skilled nursing facilities, and home health agencies), using a 10-year moving average of economy-wide productivity gains. While such payment update reductions would provide a strong incentive for institutional providers to maximize efficiency, it is doubtful that many could improve their own productivity to the degree achieved by the economy at large.[6] Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the providers' costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and might end their participation in the program (possibly jeopardizing access to care for beneficiaries). While this policy could be monitored over time to avoid such an outcome, so doing would likely result in significantly smaller actual savings than shown here for these provisions.

Section 1161 of Division B of H.R. 3200 would set Medicare Advantage capitation benchmarks equal to 100 percent of the prevailing fee-for-service cost level in each county. This reduction in benchmarks, which are generally in the range of 100 to 140 percent of fee-for-service costs under current law, would reduce MA rebates to plans and thereby result in less generous benefit packages.[7] We estimate that in 2014, when the MA provisions would be fully phased in, enrollment in MA plans would decrease by about 64 percent (from its projected level of 13.2 million under current law to 4.7 million under the proposal).

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[5] Following the Office of the Actuary's normal convention for assessing financial effects, this cost estimate represents the difference between Medicare physician expenditures under the reformed SGR system and those under current law and current regulations as of October 15, 2009. CMS has issued a proposed regulation that would retrospectively remove physician-administered drugs from the determination of actual and allowed expenditures for the SGR formula. Should this change be finalized prior to the enactment of H.R. 3200, then the estimated cost of the SGR reforms in the bill would be reduced to $214 billion, reflecting the allocation of $122 billion of the total cost to the change in regulations.

[6] The provision of most health services tends to be very labor-intensive. Economy-wide productivity gains reflect relatively modest improvements in the service sector together with much larger improvements in manufacturing. Except in the case of physician services, we are not aware of any empirical evidence demonstrating the medical community's ability to achieve productivity improvements equal to those of the overall economy. The Office of the Actuary's most recent analysis of hospital productivity highlights the difficulties in measurement but suggests that such productivity has been small or negligible during 1981 to 2005. (See http://www.cms.hhs.gov/HealthCareFinancingReview/downloads/07-08Winterpg49.pdf.)

[7] Under current law, MA plans use rebate revenues to reduce Medicare coinsurance requirements, add extra benefits such as vision or dental care, and/or reduce enrollee premiums for Part B or Part D of Medicare. Section 1163 (extension of authority for coding intensity adjustments) would also reduce MA plan revenues.

Medicaid/CHIP

The estimated Federal financial effects of the Medicaid and CHIP provisions in H.R. 3200 are shown in table 4, attached. As noted previously, the costs associated with the expansion of eligibility under section 1701 are included with the national coverage proposals shown in table 1.

The overall net cost of these provisions is estimated to be $7.3 billion in fiscal years 2010-2019 and reflects numerous cost increases and decreases under the individual provisions. Proposals with significant Federal costs include an increase in payments for primary care practitioners to Medicare levels ($37.9 billion) and higher payments in Puerto Rico and the U.S. territories ($10.4 billion). In addition, the higher Medicare Part B premium levels resulting from the physician payment changes would increase Federal Medicaid costs for dual-beneficiaries ($8.2 billion).

The key savings provisions include maintenance-of-effort requirements under section 1703 ($47.4 billion), reductions in Medicaid DSH expenditures ($10.0 billion), and prescription drug discounts for Medicaid managed care organizations ($8.2 billion).

Impact of Proposals Intended to Change the Trend in Health Spending

H.R. 3200 includes a number of proposals that are intended, in part, to help control health care costs and to change the overall trend in health spending growth. Many of these proposals are specific to the Medicare program, and their estimated financial effects are shown in table 3. In addition, other provisions are intended to help control health care costs more generally, through promotion of comparative effectiveness research, greater use of prevention and wellness measures, administrative simplification, and augmented fraud and abuse enforcement. For fiscal years 2010 through 2019, we estimate a relatively small reduction in non-Medicare Federal health care expenditures of $2.1 billion, all of which is associated with the comparative effectiveness research provision.

Comparative Effectiveness Research

We reviewed literature and consulted experts to determine the potential cost savings that could be derived from comparative effectiveness research (CER). We found that the magnitude of potential savings varies widely depending upon the scope and influence of comparative effectiveness efforts. Small savings could be achieved through the wide availability of non-binding research, while substantial savings could be generated by a comparative effectiveness board with authority over payment and coverage policies.

The CER provisions in H.R. 3200 are consistent with the least stringent of these levels of influence, translating into an estimated total reduction in national health expenditures of $8 billion for calendar years 2010 through 2019, and Federal savings of about $4 billion for fiscal years 2010 through 2019 (including Medicare). We anticipate that such savings would develop gradually, as changes in provider practice and culture evolved over time. Expert input on this subject suggests that the full impact of comparative effectiveness research, together with dissemination and application of its results, would require 15 to 20 years.

Other Provisions

We show a negligible financial impact over the next 10 years for the other proposals intended to help control future health care cost growth. There is no consensus in the available literature or among experts that prevention and wellness efforts result in lower costs. Several prominent studies conclude that such provisions—while improving the quality of individuals' lives in important ways—generally increase costs overall. For example, while it is possible that savings can be achieved for many people by diagnosing diseases in early stages and promoting lifestyle and behavioral changes that reduce the risk for serious and costly illnesses, additional costs are incurred as a result of increased screenings, preventive care, and extended years of life.

Regarding the general fraud and abuse and administrative simplification provisions (that is, excluding the Medicare and Medicaid proposals), we find that the language as it now reads is not sufficiently specific to provide estimates.

National Health Expenditure Impacts

The estimated effects of H.R. 3200 on overall national health expenditures (NHE) are shown in table 5. In aggregate, we estimate that for calendar years 2010 through 2019 NHE would increase by $750 billion, or 2.1 percent, over the updated baseline projection that was released on June 29, 2009.[8] As a result, the NHE share of GDP is projected to be 21.3 percent in 2019, compared to 20.8 percent under current law.

The increase in total NHE is estimated to occur as a net result of the substantial expansions in coverage under H.R. 3200, together with the expenditure reductions for Medicare. Numerous studies have demonstrated that individuals and families with health insurance use more health services than otherwise-similar persons without insurance. Under the health reform legislation, as noted above, an estimated 34 million currently uninsured people would gain comprehensive coverage through the health insurance Exchange, their employers, or Medicaid. The availability of coverage would typically result in a fairly substantial increase in the utilization of health care services, with a corresponding impact on total health expenditures. These higher costs would be partially offset by the sizable discounts imposed on providers by State Medicaid payment rules and the Exchange public plan option (using Medicare-based rates), together with the significant discounts negotiated by private health insurance plans. We estimate that the net effect of the utilization increases and price reductions arising from the coverage provisions of H.R. 3200 would increase NHE in 2019 by about 3.9 percent.

H.R. 3200 would also affect aggregate health expenditures through the Medicare and Medicaid savings provisions. We estimate that these impacts would reduce NHE by roughly 1.2 percent in 2019. The bill would have only a slight impact on the utilization of health care services by Medicare beneficiaries (subject to the caveat mentioned previously regarding possible access issues under the proposal to permanently reduce annual provider payment updates by economy-wide productivity gains).

[8] R. Foster and S. Heffler, "Updated and Extended National Health Expenditure Projections, 2010-2019." Memorandum dated June 29, 2009. Available online at http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/NHE_Extended_Projections.pdf.

Underlying the overall moderate effects on NHE would be various changes by payer. Because of (i) the substantial coverage expansions, (ii) the significant cost-sharing subsidies for low-income persons, and (iii) the maximum out-of-pocket limitations associated with the qualified health benefit, we estimate that overall out-of-pocket spending would decline by $156 billion in calendar years 2010-2019 due to H.R. 3200. Under the baseline projections, out-of-pocket expenditures would account for about 10 percent of NHE in 2019; inclusive of the impacts of H.R. 3200, this share would decrease to 9 percent.

Public spending would increase under H.R. 3200 as a result of the expansion of the Medicaid program but would decrease by the net Medicare savings under the bill. Private expenditures would be higher as well, because of the net increase in the number of persons with employer-sponsored health insurance. The sizable growth in health insurance coverage through Exchange plans would also affect NHE amounts by payer, although the classification of such spending is not straightforward. Based on current law, public expenditures (principally Medicare and Medicaid) are estimated to represent 52 percent of total NHE in 2019. Under H.R. 3200, the public share would be between 52 and 55 percent, depending on how health expenditures by Exchange plans were classified. Similarly, expenditures from private health insurance, which are estimated to be 31 percent of NHE under current law, would fall in the range of 30 to 33 percent.[9]

Caveats and Limitations of Estimates

The costs, savings, and changes in health insurance coverage presented in this memorandum represent the Office of the Actuary's best estimates for H.R. 3200. Although we believe that these estimates are reasonable and fairly portray the likely future effects of this comprehensive package of health care reforms, they are subject to much greater uncertainty than normal. The following caveats should be noted, and the estimates should be interpreted cautiously in view of their limitations.

- These financial and coverage impacts are based on the provisions of H.R. 3200 as reported by the Ways and Means Committee on July 17, 2009 and do not pertain to other versions of the bill.

[9] The allocation of NHE *by payer* is based on the entity that is responsible for establishing the coverage and benefit provisions and that has the primary responsibility to ensure that payment is made for health care services. (Auxiliary analyses of NHE *by sponsor* are also prepared, based on the financing of health expenditures in the U.S.) The classification of health expenditures made by Exchange plans is complicated by four factors:

(i) The Exchange would be a government entity, with a role in setting minimum benefit standards, but it would not directly provide health insurance coverage.

(ii) Exchange plans would include both the public option and a number of private health insurance plans.

(iii) The Federal government, through the affordability credits, would subsidize a significant portion of Exchange plan premiums and cost-sharing liabilities.

(iv) These subsidies would vary between zero and 95 percent from one person to another, regardless of whether the individuals were covered by the public option or private plans.

The ranges for public and private shares of NHE shown above are based on the illustrative assumptions that either all Exchange plan expenditures are "public" or they are all "private." A more precise determination of these shares under H.R. 3200 will require a careful application of NHE accounting definitions and principles to this new category of payer.

- As mentioned previously, H.R. 3200 does not specify a definition of income for determining Medicaid eligibility under the proposed expansion. If the Secretary of HHS were to adopt a definition other than the one currently used by the State Medicaid programs, then the estimated costs for this provision could differ from those shown in this memorandum.
- Many of the provisions, particularly the coverage proposals, are unprecedented or have been implemented only on a smaller scale (for example, at the State level). Consequently, little historical experience is available with which to estimate the potential impacts.
- The behavioral responses to changes introduced by national health reform legislation are impossible to predict with certainty. In particular, the responses of individuals, employers, insurance companies, and Exchange administrators to the new coverage mandates, Exchange options, and insurance reforms could differ significantly from the assumptions underlying the estimates presented here.
- The nominal dollar amounts of costs and savings under national health reform are sensitive to the assumed trajectory of future health cost trends. Relative measures, such as the cost as a percentage of GDP, are less sensitive.
- Due to the very substantial challenges inherent in modeling national health reform proposals, our estimates will vary from those of other experts and agencies. Differences in results from one estimating entity to another may tend to cause confusion among policy makers. These differences, however, provide a useful reminder that all such estimates are uncertain and that actual future impacts could differ significantly from the estimates of any given organization. Indeed, the future costs and coverage effects could lie outside of the range of estimates provided by the various estimators.
- The existing number of uninsured persons in the U.S. is difficult to measure, and the number of uninsured persons who are undocumented aliens is considerably more uncertain. Medicaid coverage and Exchange premium subsidies under H.R. 3200 are not available to undocumented aliens. As a result of the measurement difficulties described above, the actual costs associated with H.R. 3200 and the reduction in the number of uninsured persons may be somewhat higher or lower than estimated in this memorandum.
- Certain Federal costs and savings were not included in our estimates if (i) a provision would have no, or a negligible, impact; (ii) the legislative language did not provide sufficient detail with which to estimate a provision's impact; or (iii) the estimates are outside of the scope of the Office of the Actuary's expertise and will be prepared by other agencies. In particular, we did not include any savings pertaining to the income tax surcharge provisions of H.R. 3200, as those estimates are provided by the Department of the Treasury. Similarly, Federal administrative expenses associated with H.R. 3200 are not included here and will be estimated separately.
- We did not estimate whether Exchange enrollees would choose an enhanced benefit plan (with 5-percent or 15-percent cost sharing) versus the basic "essential benefits package" (with 30-percent cost sharing), since their decisions would not affect Federal costs. A future iteration of these cost estimates will incorporate such choices to refine the determination of NHE-level impacts.

- In estimating the financial impacts of H.R. 3200, we assumed that the increased demand for health care services could be met without market disruptions. In practice, supply constraints might interfere with providing the services desired by the additional 34 million insured persons. Price reactions—that is, providers successfully negotiating higher fees in response to the greater demand—could result in higher total expenditures or in some of this demand being unsatisfied. Alternatively, providers might tend to accept more patients who have private insurance (with relatively attractive payment rates) and fewer Medicaid patients, exacerbating existing access problems for the latter group. Either outcome (or a combination of both) should be considered plausible and even probable.

  The latter possibility is especially likely in the case of the higher volume of Medicaid services. Despite a provision to increase payment rates for primary care to Medicare levels, most Medicaid payments would still be well below average. Therefore, it is reasonable to expect that a significant portion of the increased demand for Medicaid would not be realized.

  At this time, we have not attempted to model that impact or other plausible supply and price effects, such as supplier entry and exit or cost-shifting towards private payers. The uncertainty associated with both the magnitude of these effects and the interrelationships among these market dynamics has led us to conclude that it would be best not to speculate on their impact. We may include such factors in future estimates, should we determine that they can be estimated with a reasonable degree of confidence. For now, we believe that consideration should be given to the potential consequences of a significant increase in demand for health care meeting a relatively fixed supply of health care providers and services.

- As noted in the section on Medicare estimates, reductions in payment updates to institutional providers, based on economy-wide productivity gains, are unlikely to be sustainable on a permanent annual basis. If such reductions were to prove unworkable within the 10-year period 2010-2019, then the actual Medicare savings from these provisions would be less than shown in this memorandum.

- In estimating the financial impact of the Medicaid eligibility expansion, we have assumed that the associated "maintenance of effort" requirement would be effective and that existing and new Medicaid enrollees would be appropriately classified for FMAP purposes.

- Finally, the updated NHE baseline and estimated NHE impacts under H.R. 3200, as described in this memorandum, reflect changes in Personal Health Care (PHC) expenditures and amounts for Program Administration and the Net Cost of Private Health Insurance. Any effects of the legislation on non-PHC components of NHE would be small and would not substantially affect the cost estimates presented here.

Conclusions

The national health care reform proposals in H.R. 3200, "America's Affordable Health Choices Act of 2009" (as reported by the Ways and Means Committee on July 17, 2009), would make far-reaching changes to the health sector, including mandated coverage for most people, "pay or play" requirements for most employers, expanded eligibility for Medicaid, Federal premium subsidies for many individuals and families, and a new system of health insurance exchanges for facilitating coverage. Additional provisions would reduce costs and address other issues with

Medicare and Medicaid and increase Federal income tax revenues through a surcharge on high-income taxpayers.

The Office of the Actuary at CMS has estimated the effects of the non-tax provisions of H.R. 3200 on Federal outlays, overall national health expenditures, and health insurance coverage in the U.S. Our estimates are based on multiple data sources and what we believe are reasonable assumptions regarding individual, employer, and health plan responses to the legislation, together with analyses of the likely changes in the cost and use of health care services. Our primary estimates for H.R. 3200 are as follows:

- The total Federal cost of the national insurance coverage provisions would be about $1.0 trillion during fiscal years 2013 through 2019.
- By 2019, an additional 34 million U.S. citizens and other legal residents would have health insurance coverage meeting the essential-benefit requirements.
- Total net savings in 2010-2019 from Medicare and Medicaid provisions would offset about $173 million of the Federal costs for the national coverage provisions. Additional Federal income tax revenues would further offset the coverage costs; however, the Office of the Actuary does not have the expertise necessary to estimate such tax impacts.
- Total national health expenditures in the U.S. during 2010-2019 would increase by about 2.1 percent. The additional demand for health services could be difficult to meet initially with existing health provider resources and could lead to price increases, cost-shifting, and/or changes in providers' willingness to treat patients with low-reimbursement health coverage.
- With the exception of the proposed reductions in Medicare payment updates for institutional providers, the provisions of H.R. 3200 would not have a significant impact on future health care cost growth rates. In addition, the longer-term viability of the Medicare update reductions is doubtful.

We hope that the information presented here will be of value to policy makers as they continue to develop and debate the many facets of health reform legislation. Future reports will explain our estimates in greater detail and provide a full description of the data, methods, and assumptions underlying them.

Richard S. Foster, FSA, MAAA
Chief Actuary

Table 1 — Estimated Federal Costs (+) or Savings (-) under H.R. 3200, in billions

	Fiscal Year										Total, FY
Provisions	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total*	$ 11.6	$ 7.6	$ 8.5	$ 78.9	$ 82.1	$ 125.3	$ 131.1	$ 131.4	$ 138.2	$ 146.4	$ 861.2
Coverage Provisions:	—	—	—	82.2	116.4	134.5	150.8	166.6	183.1	201.1	1,034.7
Medicaid Expansion	—	—	—	36.2	55.6	67.3	75.7	82.7	89.0	95.3	501.7
Credits:	—	—	—	54.7	80.4	92.4	103.8	115.6	127.7	140.8	715.4
Individual Exchange Subsidies:	—	—	—	51.4	75.3	86.4	97.2	108.6	120.2	132.7	671.6
Affordability Premium Credits	—	—	—	42.8	62.9	72.4	81.4	90.9	100.6	111.0	562.0
Affordability Cost-Sharing Credits	—	—	—	8.5	12.4	14.0	15.8	17.7	19.6	21.6	109.6
Small Employer Credits	—	—	—	3.3	5.1	6.0	6.6	7.1	7.6	8.1	43.8
Penalties:	—	—	—	-8.6	-19.5	-25.2	-28.6	-31.8	-33.6	-35.0	-182.3
Individual Penalties	—	—	—	0.0	-6.8	-9.4	-9.8	-10.4	-10.9	-11.4	-58.6
Employer Penalties	—	—	—	-8.6	-12.8	-15.8	-18.8	-21.4	-22.7	-23.6	-123.7
Medicare	9.4	3.1	1.2	-1.0	-31.0	-10.2	-20.9	-34.9	-43.8	-50.5	-178.7
Medicaid/CHIP	2.2	4.6	7.3	-2.3	-3.3	1.1	1.4	0.2	-0.5	-3.4	7.3
Cost Trend Proposals:	—	—	—	—	0.0	-0.1	-0.2	-0.4	-0.6	-0.8	-2.1
Comparative Effectiveness Research†	—	—	—	—	0.0	-0.1	-0.2	-0.4	-0.6	-0.8	-2.1
Prevention and Wellness	—	—	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Fraud and Abuse	—	—	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Administrative Simplification	—	—	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0

*Excludes income tax surcharge for high-income taxpayers.

†Excludes the Medicare impact

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

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Table 2 — Estimated Effects of H.R. 3200 on Enrollment by Insurance Coverage, in millions

	Calendar Year									
Current Law Baseline	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare	46.9	48.0	49.4	50.9	52.4	53.9	55.4	57.1	58.7	60.5
Medicaid/CHIP	59.2	60.5	61.6	62.0	60.6	60.3	61.1	61.9	62.7	63.5
Other Public	12.3	12.6	12.9	13.2	13.6	13.9	14.2	14.6	14.9	15.2
Employer-sponsored Private Health Insurance	163.8	163.2	164.5	165.0	166.1	166.6	166.4	166.2	166.0	165.9
Other Private Health Insurance*	26.1	25.3	25.5	25.6	25.8	25.8	25.8	25.8	25.8	25.7
Uninsured	48.3	48.6	47.9	48.1	50.0	51.7	53.1	54.4	55.6	56.9
Insured Share of US Population†	84.4%	84.5%	84.8%	84.9%	84.4%	84.0%	83.8%	83.5%	83.3%	83.0%

	Calendar Year									
Proposed — H.R. 3200	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare	46.9	48.0	49.4	50.9	52.4	53.9	55.4	57.1	58.7	60.5
Medicaid/CHIP	59.2	60.5	61.6	80.2	79.1	79.1	80.4	81.5	82.5	83.5
Other Public	12.3	12.6	12.9	13.2	13.6	13.9	14.2	14.6	14.9	15.2
Employer-sponsored Private Health Insurance	163.8	163.2	164.5	168.0	169.0	168.6	167.7	167.3	168.2	169.1
Other Private Health Insurance*	26.1	25.3	25.5	13.3	13.3	13.0	12.5	12.0	11.6	11.1
Exchange	—	—	—	19.0	21.6	24.8	25.8	26.7	26.9	27.1
Private Plan	—	—	—	11.4	13.0	14.9	15.5	16.0	16.1	16.3
Public Plan	—	—	—	7.6	8.6	9.9	10.3	10.7	10.8	10.8
Uninsured	48.3	48.6	47.9	22.9	22.1	21.2	21.9	22.5	22.7	23.0
Insured Share of US Population†	84.4%	84.5%	84.8%	92.8%	93.1%	93.5%	93.3%	93.2%	93.2%	93.1%

	Calendar Year									
Impact of H.R. 3200	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare	—	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicaid/CHIP	—	—	—	18.2	18.5	18.9	19.3	19.6	19.8	19.9
Other Public	—	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Employer-sponsored Private Health Insurance	—	—	—	3.0	2.9	2.0	1.4	1.2	2.2	3.2
Other Private Health Insurance*	—	—	—	-12.3	-12.5	-12.8	-13.3	-13.8	-14.2	-14.6
Exchange	—	—	—	19.0	21.6	24.8	25.8	26.7	26.9	27.1
Private Plan	—	—	—	11.4	13.0	14.9	15.5	16.0	16.1	16.3
Public Plan	—	—	—	7.6	8.6	9.9	10.3	10.7	10.8	10.8
Uninsured	—	—	—	-25.2	-27.9	-30.5	-31.2	-31.9	-32.9	-33.9
Insured Share of US Population†	—	—	—	7.9%	8.7%	9.4%	9.5%	9.7%	9.9%	10.1%

*In the baseline, other private health insurance includes private Medicare supplemental coverage and individual coverage. In the proposal estimates, other private health insurance includes only those with Medicare supplemental coverage.

†Calculated as a proportion of total U.S. population, including unauthorized immigrants.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

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Table 3 — Estimated Impacts of H.R. 3200 on Medicare (in millions)

Sec.	Provision	Fiscal year 2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	Total, 2010-19
	TITLE I—IMPROVING HEALTH CARE VALUE													
	Subtitle A—Provisions related to Medicare Part A													
Part I—Market basket updates														
1101	Skilled nursing facility update	$0	-$420	-$940	-$1,020	-$1,130	-$1,200	-$1,280	-$1,390	-$1,440	-$1,510	-$1,640	-$4,710	-$11,970
1102	Inpatient rehabilitation facility payment update	0	-110	-230	-250	-270	-280	-300	-330	-340	-360	-390	-1,140	-2,860
1103	Incorporating productivity improvements in market basket updates that do not already include them	0	-1,540	-4,870	-7,330	-10,430	-14,040	-18,110	-23,150	-27,530	-31,750	-38,070	-38,210	-176,820
Part II—Other Medicare Part A provisions														
1111	Payments to skilled nursing facilities	0	0	0	0	0	0	0	0	0	0	0	0	0
1112	Medicare DSH report and payment adjustments	0	0	0	0	0	0	0	0	-2,680	-3,170	-3,390	0	-9,240
1113	Extension of Hospice Regulation Moratorium	0	340	430	390	320	240	150	40	20	20	20	1,720	1,970
	Subtitle B—Provisions related to Medicare Part B													
Part I—Physicians services														
1121	Sustainable growth rate reform	0	11,100	21,500	28,300	35,200	39,000	43,600	41,000	37,700	37,800	40,800	135,100	336,000
1122	Misvalued codes under the physician fee schedule	0	0	0	0	0	0	0	0	0	0	0	0	0
1123	Payments for efficient areas	0	0	0	0	0	0	0	0	0	0	0	0	0
1124	Modifications to the physician quality reporting initiative (PQRI)	0	0	0	140	150	0	0	0	0	0	0	290	290
1125	Adjustments to Medicare payment localities	0	0	20	50	50	50	50	20	0	0	0	170	240
Part II—Market basket updates														
1131	Incorporating productivity improvements in market basket updates that do not already include them	0	-200	-670	-1,210	-1,800	-2,540	-3,400	-4,420	-5,520	-6,720	-8,100	-6,420	-34,580
Part III—Other provisions														
1141	Rental and purchase of power-driven wheelchairs	0	0	-40	-50	-50	-50	-60	-70	-70	-80	-80	-190	-550
1142	Extension of payment rule for brachytherapy and therapeutic radiopharmaceuticals	0	0	10	0	0	0	0	0	0	0	0	10	10
1143	Home infusion therapy report to Congress	0	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	0
1145	Treatment of certain cancer hospitals	0	0	0	0	0	0	0	0	0	0	0	0	0
1146	Medicare Improvement Fund	0	0	0	4,000	4,000	-23,130	0	0	0	0	0	-15,130	-15,130
1147	Payment for imaging services	0	-220	-470	-550	-560	-570	-590	-640	-700	-770	-820	-2,370	-5,890
1148	Durable medical equipment program improvments	0	0	0	0	0	0	0	0	0	0	0	0	0
1149	MedPAC study and report on bone mass measurement	0	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	0	0	-140	-270	-350	-350	-370	-390	-420	-450	-760	-2,740
1152	Post acute care services payment reform plan	0	0	0	0	0	0	0	0	0	0	0	0	0
1153	Home health payment update for 2010													
	Part A	0	-100	-230	-260	-280	-300	-320	-350	-370	-390	-420	-1,170	-3,020
	Part B	0	-110	-260	-290	-320	-340	-360	-400	-410	-440	-470	-1,320	-3,400
1154	Payment adjustments for home health care													
	Part A	0	-110	-940	-1,330	-1,480	-1,580	-1,690	-1,840	-1,930	-2,020	-2,200	-5,440	-15,120
	Part B	0	-130	-1,020	-1,480	-1,650	-1,760	-1,880	-2,050	-2,150	-2,250	-2,450	-6,040	-16,820
1155	Incorporating productivity improvements in market basket update for home health services													
	Part A	0	0	-80	-180	-280	-400	-540	-710	-870	-1,010	-1,230	-940	-5,300
	Part B	0	0	-80	-200	-320	-450	-600	-800	-960	-1,130	-1,370	-1,050	-5,910

Table 3 — Estimated Impacts of H.R. 3200 on Medicare (in millions)

Sec.	Provision	Fiscal year 2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
1156	Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals	0	0	0	0	0	0	0	0	0	0	0	0	0
1157	Institute of Medicine study of geographic adjustment factors	0	0	0	0	0	0	0	0	0	0	0	0	0
1158	Revision of Medicare payment systems to address geographic inequities (impact included in section 1146)	0	0	0	0	0	0	0	0	0	0	0	0	0
1159	Institute of Medicine study of geographic variation in health care spending and promoting high value care	0	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle D—Medicare Advantage Reforms													
	Part I—Payment and Administration													
1161	Phase-in of payment based on fee-for-service costs													
	Part A	0	0	-2,400	-5,290	-7,600	-8,720	-9,420	-10,090	-10,810	-11,490	-12,270	-24,010	-78,090
	Part B	0	0	-1,620	-3,530	-5,060	-5,740	-6,260	-6,860	-7,550	-8,270	-9,040	-15,950	-53,930
1162	Quality bonus payments													
	Part A	0	0	130	190	170	170	180	200	210	220	240	660	1,710
	Part B	0	0	80	130	120	120	130	140	150	170	180	450	1,220
1163	Extension of Secretarial coding intensity adjustment authority													
	Part A	0	0	-2,250	-3,410	-3,890	-4,320	-4,720	-5,060	-5,410	-5,750	-6,140	-13,870	-40,950
	Part B	0	0	-1,490	-2,250	-2,560	-2,810	-3,100	-3,410	-3,740	-4,100	-4,490	-9,110	-27,950
1164	Simplification of annual beneficiary election periods	0	0	0	0	0	0	0	0	0	0	0	0	0
1165	Extension of reasonable cost contracts	0	0	0	0	0	0	0	0	0	0	0	0	0
1166	Limitation of waiver authority for employer group plans	0	0	0	0	0	0	0	0	0	0	0	0	0
1167	Improving risk adjustment for MA payments	0	0	0	0	0	0	0	0	0	0	0	0	0
1168	Elimination of MA regional plan stabilization fund													
	Part A	0	60	0	0	-80	-110	-70	-50	-50	-50	-50	-130	-400
	Part B	0	-60	0	0	-70	-100	-60	-40	-40	-50	-50	-230	-470
	Part II—Consumer protection and anti-fraud													
1171	Limitation on out-of-pocket costs for individual health services	0	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	0
1173	Information for beneficiaries on MA plan admin costs	0	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	0
1175	Authority to deny plan bids	0	0	0	0	0	0	0	0	0	0	0	0	0
	Part III—Treatment of special needs individuals: Medicaid integration													
1176	Limitation on enrollment outside open enrollment period of individuals into chronic care specialized MA plans for special needs individuals	0	0	0	0	0	0	0	0	0	0	0	0	0
1177	Extension of authority of special needs plans to restrict enrollment	0	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle E—Improvements to Medicare Part D													
1181	Elimination of coverage gap and Medicaid rebates	0	0	-4,100	-5,900	-5,800	-5,500	-5,600	-5,100	-5,400	-6,100	-5,000	-21,300	-48,500
1182	Discounts for certain Part D drugs in original coverage gap	0	0	0	10	30	50	60	90	100	110	130	90	580
1183	Repeal of provision relating to 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	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	50	70	70	80	90	100	110	120	130	270	820

Table 3 — Estimated Impacts of H.R. 3200 on Medicare (in millions)

Sec.	Provision	Fiscal year 2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
1185	Permitting mid-year changes in enrollment for formulary changes adversely impact an enrollee	0	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle F—Medicare Rural Access Protections													
1191	Telehealth expansion and enhancements	0	0	0	0	0	0	0	0	0	0	0	0	0
1192	Extension of outpatient hold-harmess provision	0	50	50	20	0	0	0	0	0	0	0	120	120
1193	Extension of section 508 hospital reclassifications	0	260	390	40	0	0	0	0	0	0	0	690	690
1194	Extension of geographic floor for work	0	170	370	140	0	0	0	0	0	0	0	680	680
1195	Extension of payment for technical component of certain physician pathology services	0	40	80	40	0	0	0	0	0	0	0	160	160
1196	Extension of ambulance add-ons	20	20	20	10	0	0	0	0	0	0	0	50	50
TOTAL, TITLE I		20	8,700	1,010	-1,530	-3,960	-34,610	-14,470	-25,490	-40,000	-49,310	-56,540	-30,390	-216,200
	TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS													
	Subtitle A—Improving and Simplifying Financial Assistance for Low Income Mediare Beneficiaries													
1201	Improving assets tests for Medicare Savings Program for low-income subsidy program	0	0	0	670	1,290	1,810	2,360	2,590	2,850	3,150	3,470	3,770	18,190
1202	Elimination of Part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals	0	0	60	90	100	120	130	150	160	180	210	370	1,200
1203	Eliminating barriers to enrollment	0	280	500	600	680	760	850	940	1,060	1,190	1,330	2,820	8,190
1204	Enhanced oversight relating to reimbursements for retroactive low-income subsidy enrollment	0	0	0	0	0	0	0	0	0	0	0	0	0
1205	Intelligent assignment in enrollment	0	0	0	0	0	0	0	0	0	0	0	0	0
1206	Special enrollment period and automatic enrollment process for certain subsidy eligible individuals	0	0	0	0	0	0	0	0	0	0	0	0	0
1207	Application of MA premiums prior to rebate in calculation of low-income subsidy benchmark	0	0	90	120	130	140	140	150	170	180	190	480	1,310
	Subtitle B—Reducing Health Disparities													
1221	Ensuring effective communication in Medicare	0	0	0	0	0	0	0	0	0	0	0	0	0
1222	Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing reimbursement for culturally and linguistically appropriate services	0	0	0	0	0	0	0	0	0	0	0	0	0
1223	IOM report on impact of language access services	0	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	0
	Subtitle C—Miscellaneous Improvements													
1231	Extension of therapy caps exceptions process	0	520	1,160	500	10	10	20	20	20	20	20	2,200	2,300
1232	Extended months of coverage of immunosuppressive drugs for kidney transplants patients and other renal provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
1233	Advanced care planning consultation	0	0	0	0	0	0	0	0	0	0	0	0	0
1234	Part B special enrollment period and waiver of limited enrollment penalty for TRICARE beneficiaries	0	0	0	0	0	0	0	0	0	0	0	0	0
1235	Exception for use of more recent tax year in case of gains from sale of primary residence in computing part B income-related preimum	0	0	0	0	0	0	0	0	0	0	0	0	0
1236	Demonstration program on use of patient decision aids	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE II		0	800	1,810	1,980	2,210	2,840	3,500	3,850	4,260	4,720	5,220	9,640	31,190

Table 3 — Estimated Impacts of H.R. 3200 on Medicare (in millions)

Sec.	Provision	Fiscal year 2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH, AND COORDINATED CARE													
1301	Accountable care organization pilot program	0	0	0	0	0	0	0	0	0	0	0	0	0
1302	Medicare home pilot program	0	0	0	0	0	0	0	0	0	0	0	0	0
1303	Payment incentive for selected primary care services	0	0	120	490	520	550	590	640	710	800	880	1,680	5,300
1304	Increased reimbursement rate for certified nurse midwives	0	0	0	0	0	0	0	0	0	0	0	0	0
1305	Coverage and waiver of cost-sharing for preventive services	0	0	160	270	290	310	330	360	390	430	470	1,030	3,010
1306	Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal	0	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	0
1308	Coverage of marriage and family therapist services and mental health counselor services	0	0	200	260	260	270	280	310	340	370	400	990	2,690
1309	Extension of physician fee schedule mental health add-on	0	40	50	20	0	0	0	0	0	0	0	110	110
1310	Expanding access to vaccines	0	0	30	50	70	70	80	80	100	110	110	220	700
1311	Expansion of preventive services for FQHCs	0	0	10	20	20	20	20	20	20	20	20	70	170
TOTAL, TITLE III		0	40	560	1,090	1,140	1,200	1,280	1,390	1,540	1,710	1,860	4,030	11,810
	TITLE IV—QUALITY													
	Subtitle A—Comparative Effectiveness Research													
1401	Comparative effectiveness research	0	0	0	0	0	-30	-70	-160	-270	-400	-550	-30	-1,480
	Subtitle B—Nursing Home Transparency													
	Part I—Improving Transparency of Information on Skilled Nursing Facilities and Nursing Facilities													
1411	Required disclosure of ownership and additional disclosable parties information	0	0	0	0	0	0	0	0	0	0	0	0	0
1412	Accountability requirements	0	0	0	0	0	0	0	0	0	0	0	0	0
1413	Nursing home compare Medicare website	0	0	0	0	0	0	0	0	0	0	0	0	0
1414	Reporting of expenditures	0	0	0	0	0	0	0	0	0	0	0	0	0
1415	Standardized complaint form	0	0	0	0	0	0	0	0	0	0	0	0	0
1416	Ensuring staffing accountability	0	0	0	0	0	0	0	0	0	0	0	0	0
	Part II—Targeting Enforcement													
1421	Civil monetary penalties	0	0	0	0	0	0	0	0	0	0	0	0	0
1422	National independent monitor pilot program	0	0	0	0	0	0	0	0	0	0	0	0	0
1423	Notification of facility closure	0	0	0	0	0	0	0	0	0	0	0	0	0
	Part III—Improving Staff Training													
1431	Dementia and abuse prevention training	0	0	0	0	0	0	0	0	0	0	0	0	0
1432	Study and report on training required for certified nurse aides and supervisory staff	0	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle C—Quality Measurements													
1441	Establishment of national priorities and performance measures for quality improvement	0	0	0	0	0	0	0	0	0	0	0	0	0
1442	Development of new quality measures; GAO evaluation	0	0	0	0	0	0	0	0	0	0	0	0	0
1443	Multi-stakeholder pre-rulemaking input into selection of quality measures	0	0	0	0	0	0	0	0	0	0	0	0	0
1444	Application of quality measures	0	0	0	0	0	0	0	0	0	0	0	0	0

Table 3 — Estimated Impacts of H.R. 3200 on Medicare (in millions)

Sec.	Provision	Fiscal year 2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
1445	Consensus-based entity funding	0	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle D—Physician Payments Sunshine Provisions													
1451	Reports on financial relationships between manufacturers and distributors of covered drugs, devices, biologicals, or medical supplies under Medicare, Medicaid, or CHIP and physicians and other health care entities	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE IV		0	0	0	0	0	-30	-70	-160	-270	-400	-550	-30	-1,480
	TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION													
1501	Distribution of unused residency positions	0	0	0	0	0	0	0	0	0	0	0	0	0
1502	Increasing training in non-provider settings	0	0	0	0	0	0	0	0	0	0	0	0	0
1503	Rules for counting resident times for didactic and scholarly activities and other activitites	0	0	0	0	0	0	0	0	0	0	0	0	0
1504	Preservation of resident cap positions from closed hospitals	0	0	0	0	0	0	0	0	0	0	0	0	0
1505	Improving accountability for approved medical residency training	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE V		0	0	0	0	0	0	0	0	0	0	0	0	0
	TITLE VI—PROGRAM INTEGRITY													
	Subtitle A—Increased Funding for HCFAC Fund													
1601	Increased funding for HCFAC fund													
	Part A	0	0	10	10	10	10	10	10	10	10	10	40	90
	Part B	0	0	-70	-70	-70	-70	-70	-70	-70	-70	-70	-280	-630
	Subtitle B—Enhanced Penalties for Fraud and Abuse													
1611	Enhanced penalties for false statements on provider or supplier enrollment applications	0	0	0	0	0	0	0	0	0	0	0	0	0
1612	Enhanced penalties for submission of false Medicare, Medicaid, or CHIP claims data	0	0	0	0	0	0	0	0	0	0	0	0	0
1613	Enhance penalties for delaying investigations	0	0	0	0	0	0	0	0	0	0	0	0	0
1614	Enhanced hospice program safeguards	0	0	0	0	0	0	0	0	0	0	0	0	0
1615	Enhanced penalties for individuals excluded from program participation	0	0	0	0	0	0	0	0	0	0	0	0	0
1616	Enhanced penalties for provision of false informaiton by Medicare Advantage and Part D marketing violations	0	0	0	0	0	0	0	0	0	0	0	0	0
1617	Enhanced penalties for Medicare Advantage and Part D marketing violations	0	0	0	0	0	0	0	0	0	0	0	0	0
1618	Enhanced penalties for obstruction of program audits	0	0	0	0	0	0	0	0	0	0	0	0	0
1619	Exclusion of certain individuals and entities from participation inMedicare and State health care programs	0	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle C—Enhanced Program and Provider Protections													
1631	Enhanced CMS program protection authority													
	Part A	0	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	-10	-20	-20	-30	-30	-30	-30	-30	-40	-40	-110	-280
1632	Enhanced Medicare, Medicaid, and CHIP program disclosure requirements relating to previous affiliations	0	0	0	0	0	0	0	0	0	0	0	0	0

Table 3 — Estimated Impacts of H.R. 3200 on Medicare (in millions)

Sec.	Provision	Fiscal year 2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
1633	Required inclusion of payment modifier for certain evaluation and management services	0	0	0	0	0	0	0	0	0	0	0	0	0
1634	Evaluations and reports required under Medicare Integrity Program	0	0	0	0	0	0	0	0	0	0	0	0	0
1635	Require providers and suppliers to adopt programs to reduce wated, fraud, and abuse	0	0	0	0	0	0	0	0	0	0	0	0	0
1636	Maximum period for submission of Medicare claims reduced to not more than 12 months	0	0	0	0	0	0	0	0	0	0	0	0	0
1637	Physicians who order DME or home health services required to be Medicare participating physicians													
	Part A	0	-10	-20	-20	-30	-30	-30	-30	-30	-30	-40	-110	-270
	Part B	0	-30	-50	-50	-50	-60	-60	-70	-70	-80	-80	-240	-600
1638	Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse	0	0	0	0	0	0	0	0	0	0	0	0	0
1639	Face-to-face enconter with patient required before physicians may certify eligibility for home health services under Medicare													
	Part A	0	-50	-70	-70	-80	-80	-90	-100	-100	-110	-120	-350	-870
	Part B	0	-70	-110	-120	-130	-140	-150	-160	-170	-180	-190	-570	-1,420
1640	Extension of testimonial subpoena authority to program exclusion investigations	0	0	0	0	0	0	0	0	0	0	0	0	0
1641	Required repayments of Medicare and Medicaid overpayments	0	0	0	0	0	0	0	0	0	0	0	0	0
1642	Expanded application of hardship waivers for OIG exclusions to beneficiaries of any Federal health care program	0	0	0	0	0	0	0	0	0	0	0	0	0
1643	Access to certain information on renaly dialysis facilities	0	0	0	0	0	0	0	0	0	0	0	0	0
1644	Billing agents, clearinghouses, or other alternate payees required to register under Medicare	0	0	0	0	0	0	0	0	0	0	0	0	0
1645	Conforming civil monetary penalties to False Claims Act ammendments	0	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle D—Access to Information Needed to Prevent Fraud and Abuse													
1651	Access to information necessary to identify waste and abuse	0	0	0	0	0	0	0	0	0	0	0	0	0
1652	Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank	0	0	0	0	0	0	0	0	0	0	0	0	0
1653	Compliance with HIPAA privacy and security standards	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE VI		0	-170	-330	-340	-380	-400	-420	-450	-460	-500	-530	-1,620	-3,980
	TITLE IX—MISCELLANEOUS PROVISIONS													
1901	Repeal of trigger provision	0	0	0	0	0	0	0	0	0	0	0	0	0
1902	Repeal of comparative cost adjustment (CCA) program	0	0	0	0	0	0	0	0	0	0	0	0	0
1903	Extension of gainsharing demonstration	0	0	0	0	0	0	0	0	0	0	0	0	0
1904	Grants to States for quality home visitation programs for families with young children and families expecting children	0	0	0	0	0	0	0	0	0	0	0	0	0
1905	Improved coordination and protection for dual eligibles	0	0	0	0	0	0	0	0	0	0	0	0	0
1906	Assessment of Medicare Cost Intensive Diseases and Conditions	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE IX		0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL MEDICARE IMPACT (TITLES I-VI & TITLE IX)		**20**	**9,370**	**3,050**	**1,200**	**-990**	**-31,000**	**-10,180**	**-20,860**	**-34,930**	**-43,780**	**-50,540**	**-18,370**	**-178,660**

Table 3 — Estimated Impacts of H.R. 3200 on Medicare (in millions)

Sec.	Provision	Fiscal year 2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19

Notes: The provisions affecting Medicare Part B are net of premium offset.
The Medicare provisions that affect fee-for-service benefits also reflect the resulting impact on payments to managed care plans.
Interactions among the proposals are included within the estimates for each provision.

Table 4 — Estimated Impacts of H.R. 3200 on Medicaid and CHIP Expenditures
(Amounts in $millions)

Sec.	Provision	Fiscal year 2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	TITLE VII—MEDICAID AND CHIP													
	Subtitle A—Medicaid and Health Reform													
1702	Enrollees in non-Medicaid Exchange plans	0	0	0	0	0	0	0	0	0	0	0	0	0
1703	CHIP & Medicaid maintenance of effort	0	0	0	0	-9,750	-9,100	-5,700	-5,700	-5,700	-5,700	-5,700	-18,850	-47,350
1704	Reduction in Medicaid DSH	0	0	0	0	0	0	0	0	-1,500	-2,500	-6,000	0	-10,000
1705	Expanded outstationing	0	100	205	325	460	490	525	560	600	645	690	1,580	4,600
	Subtitle B—Prevention													
1711	Required coverage of preventive services	0	0	0	200	500	600	800	1,000	1,200	1,300	1,500	1,300	7,100
1712	Tobacco cessation	0	10	10	10	10	10	10	10	20	20	20	50	130
1713	Optional coverage of nurse home visits	0	11	41	88	144	226	298	356	413	473	497	510	2,548
1714	Optional family planning services	0	0	0	0	0	-5	-5	-10	-10	-15	-20	-5	-65
	Subtitle C—Access													
1721	Payments to primary care practitioners	0	1,670	2,890	3,950	3,880	3,850	3,820	4,010	4,310	4,620	4,940	16,240	37,940
1722	Medical home pilot program	0	247	247	247	247	247	0	0	0	0	0	1,235	1,235
1723	Translation services	0	45	50	55	60	70	75	80	85	90	95	280	705
1724	Optional coverage of free-standing birth centers	0	0	0	0	0	0	0	0	0	0	0	0	0
1725	Inclusion of public health clinics in VFC program	0	95	95	100	105	105	110	115	120	120	125	500	1,090
	Subtitle D—Coverage													
1731	Optional coverage of low-income HIV-infected	0	60	60	60	15	0	0	0	0	0	0	195	195
1732	Extension of TMA	0	0	230	640	425	10	0	0	0	0	0	1,305	1,305
1733	12-mo continuous elig for separate CHIP programs	0	40	65	70	80	30	0	0	0	0	0	285	285
	Subtitle E—Financing													
1741	Payments to pharmicists	0	0	85	175	180	190	200	215	225	240	255	630	1,765
1742(a)	Rebates on new drug formulations	0	-145	-270	-270	-280	-300	-320	-330	-350	-380	-400	-1,265	-3,045
1742(b)	Increase minimum rebate for brand drugs	0	-240	-450	-450	-470	-500	-530	-560	-590	-630	-660	-2,110	-5,080
1743	Prescription drug discounts for MMCOs	0	-200	-720	-720	-770	-820	-870	-930	-990	-1,040	-1,100	-3,230	-8,160
1744	Payments for GME	0	0	150	310	470	480	500	510	520	530	550	1,410	4,020
	Subtitle F—Waste, Fraud, and Abuse													
1751	Health-care acquired conditions	0	-3	-4	-4	-5	-5	-5	-6	-6	-7	-7	-21	-52
1752	Medicaid integrity program - evaluations/reports	0	0	0	0	0	0	0	0	0	0	0	0	0
1753	Provider WF&A program requirements	0	0	0	0	0	0	0	0	0	0	0	0	0
1754	Overpayments	0	135	0	-10	-10	-10	-10	-10	-10	-10	-10	105	55
1755	MCO minimum medical loss ratio requirements	0	-65	-265	-280	-265	-275	-300	-325	-350	-380	-405	-1,150	-2,910
1756	Termination of provider participation in MCD & CHIP	0	0	0	0	0	0	0	0	0	0	0	0	0
1757	Ownership, control & management affliiations	0	0	0	0	0	0	0	0	0	0	0	0	0
1758	Expanded data elements under MSIS	0	0	0	0	0	0	0	0	0	0	0	0	0
1759	Alternate payee registration requirements	0	0	0	0	0	0	0	0	0	0	0	0	0
1760	Payment denial for litigation-related misconduct	0	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle G—Puerto Rico and the Territories													
1771	Increased payments to Puerto Rico and territories	0	0	1,061	1,081	1,103	1,125	1,147	1,171	1,196	1,221	1,245	4,370	10,350
	Subtitle H—Miscellaneous													
1781	Technical corrections	0	0	0	0	0	0	0	0	0	0	0	0	0
1782	Making QI program permanent	0	0	560	935	220	0	0	0	0	0	0	1,715	1,715
SUBTOTAL		0	1,760	4,040	6,512	-3,651	-3,582	-255	156	-817	-1,403	-4,385	5,079	-1,624
	Interaction between drug proposals (1742 & 1743)	0	-70	-230	-250	-260	-280	-320	-330	-340	-390	-390	-1,090	-2,860
	Interaction with Medicaid Expansion (1701)	0	0	0	0	380	487	466	498	557	605	663	866	3,655
	Interaction with Medicare	0	490	790	1,080	1,230	110	1,250	1,040	790	680	690	3,700	8,150
TOTAL, TITLE VII		0	2,180	4,600	7,342	-2,301	-3,266	1,141	1,364	189	-508	-3,422	8,555	7,320

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Note: Costs for expansion of eligibility under section 1701 are included in table 1.

Table 5 - Estimated Impacts of H.R. 3200 on National Health Expenditures (NHE), in billions

	Calendar Year										Total, CY
Current Law Baseline	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total National Health Expenditures (NHE)	$ 2,632.2	$ 2,778.7	$ 2,944.4	$ 3,125.4	$ 3,325.5	$ 3,551.5	$ 3,798.5	$ 4,067.7	$ 4,358.8	$ 4,670.6	$ 35,253.3
Medicare	515.5	550.5	591.0	634.1	679.7	732.1	790.4	857.2	930.9	1,010.9	7,292.3
Medicaid/CHIP	436.1	473.0	512.4	553.4	593.9	641.7	696.6	755.9	821.7	893.2	6,377.9
Federal	282.2	277.9	292.7	315.9	337.8	364.3	395.0	427.9	464.6	504.5	3,662.8
State & Local	153.9	195.1	219.6	237.6	256.1	277.4	301.5	328.0	357.1	388.7	2,715.1
Other Public	307.7	325.1	343.9	364.6	386.6	410.5	436.4	464.0	493.2	523.6	4,055.5
Out of Pocket (OOP)	285.1	297.7	308.9	322.3	340.3	359.4	379.1	400.2	422.8	446.7	3,562.4
Employer-sponsored Private Health Insurance	847.0	879.0	919.3	966.0	1,024.5	1,088.4	1,156.0	1,228.7	1,305.6	1,387.3	10,801.8
Other Private Health Insurance*	49.2	51.0	54.6	57.7	59.4	61.5	63.5	65.9	68.2	70.6	601.7
Other Private†	191.6	202.4	214.5	227.3	241.1	257.8	276.4	296.0	316.4	338.3	2,561.8
NHE as percent of Gross Domestic Product (GDP)‡	17.8%	17.9%	18.1%	18.3%	18.6%	19.0%	19.4%	19.8%	20.3%	20.8%	

	Calendar Year										Total, CY
Proposed — H.R. 3200	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total National Health Expenditures (NHE)	$ 2,645.8	$ 2,786.7	$ 2,950.8	$ 3,190.5	$ 3,396.9	$ 3,665.4	$ 3,914.2	$ 4,180.3	$ 4,476.9	$ 4,796.0	$ 36,003.6
Medicare	525.7	553.1	591.6	625.8	654.1	719.5	766.3	820.3	885.7	958.8	7,100.9
Medicaid/CHIP	439.4	478.3	517.9	601.0	652.7	716.9	779.0	844.6	915.5	991.6	6,936.8
Federal	284.1	280.9	295.9	361.0	393.1	433.9	471.4	510.5	552.4	597.4	4,180.7
State & Local	155.3	197.4	222.0	240.0	259.5	283.0	307.6	334.1	363.1	394.2	2,756.1
Other Public	307.7	325.1	343.9	361.3	383.3	407.7	434.1	461.9	490.8	520.8	4,036.4
Out of Pocket (OOP)	285.2	297.7	309.0	312.2	325.3	338.0	354.1	373.5	394.5	416.6	3,406.2
Employer-sponsored Private Health Insurance	847.1	879.0	919.3	968.4	1,028.6	1,090.7	1,155.6	1,222.2	1,302.5	1,388.0	10,801.5
Other Private Health Insurance*	49.2	51.1	54.6	16.1	16.9	17.5	17.8	18.2	18.6	19.0	278.8
Other Private†	191.6	202.4	214.5	222.8	236.6	253.6	272.5	292.1	311.7	332.7	2,530.5
Exchange - Private Plan	—	—	—	52.0	62.4	76.2	84.5	92.5	98.9	105.7	572.2
Exchange - Public Plan	—	—	—	30.9	37.1	45.3	50.2	54.9	58.7	62.8	339.9
NHE as percent of Gross Domestic Product (GDP)‡	17.9%	18.0%	18.1%	18.7%	19.0%	19.6%	20.0%	20.4%	20.8%	21.3%	

Table 5, cont. - Estimated Impacts of H.R. 3200 on National Health Expenditures (NHE), in billions

Impact of H.R. 3200	Calendar Year										Total, CY 2010-2019
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	
Total National Health Expenditures (NHE)	$ 13.6	$ 8.0	$ 6.4	$ 65.1	$ 71.5	$ 114.0	$ 115.7	$ 112.6	$ 118.1	$ 125.3	$ 750.3
Medicare	10.1	2.6	0.7	-8.3	-25.6	-12.6	-24.1	-36.8	-45.1	-52.1	-191.4
Medicaid/CHIP	3.3	5.3	5.5	47.6	58.7	75.1	82.4	88.7	93.8	98.4	558.9
Federal	1.9	3.0	3.1	45.2	55.3	69.5	76.4	82.7	87.9	92.9	517.8
State & Local	1.4	2.3	2.4	2.4	3.4	5.6	6.0	6.1	6.0	5.5	41.1
Other Public	0.0	0.0	0.0	-3.3	-3.3	-2.8	-2.4	-2.1	-2.4	-2.8	-19.1
Out of Pocket (OOP)	0.1	0.1	0.1	-10.1	-15.0	-21.4	-25.0	-26.7	-28.3	-30.0	-156.2
Employer-sponsored Private Health Insurance	0.0	0.0	0.0	2.4	4.2	2.3	-0.3	-6.4	-3.2	0.6	-0.3
Other Private Health Insurance*	0.0	0.0	0.0	-41.6	-42.5	-44.0	-45.8	-47.7	-49.6	-51.6	-322.8
Other Private†	0.0	0.0	0.0	-4.5	-4.5	-4.2	-3.9	-3.9	-4.7	-5.6	-31.3
Exchange - Private Plan	—	—	—	52.0	62.4	76.2	84.5	92.5	98.9	105.7	572.2
Exchange - Public Plan	—	—	—	30.9	37.1	45.3	50.2	54.9	58.7	62.8	339.9
NHE as percent of Gross Domestic Product (GDP)‡	0.1%	0.1%	0.0%	0.4%	0.4%	0.6%	0.6%	0.5%	0.5%	0.6%	

*In the baseline, other private health insurance includes private Medicare supplemental coverage and individual coverage. In the proposal estimates, other private health insurance includes only those with Medicare supplemental coverage.

†In the NHE accounts, other private spending includes philanthropic giving and income from non-patient sources, such as parking and investment income, for institutional providers.

‡Based on Gross Domestic Product (GDP) projections that accompanied the February 24, 2009 NHE projections release for 2008-2018. (http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf)

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.
October 21, 2009

Appendix: Summary of Data, Assumptions, and Methodology underlying OACT's Estimates for H.R. 3200

The estimated financial and coverage effects of H.R. 3200 have been estimated using the Office of the Actuary's Health Reform Model (OHRM). The model was designed to estimate the impact of health reform proposals on the non-Medicare population. This appendix summarizes the key elements of the model as tailored to estimate H.R. 3200.

Model Overview and Data Sources

The OHRM model has two primary data components: one for households and the other for employers. These data provide a cross-sectional view of current health expenditures for individuals and families and their associated insurance coverage, together with employer coverage offer rates and employee take-up rates for that coverage. OACT's national health expenditure (NHE) projections provide an aggregate baseline for health spending and coverage trends through 2019.

Household Component

The household component of the OHRM is based upon the Medical Expenditure Panel Survey-Household Component (MEPS-HC) and Insurance Component (MEPS-IC).[1] These person-level survey data include the following characteristics of the sample population:

- Socio-demographics, including family structure;
- Personal and household income;
- Cost and use of health services by type, and source of payment for those services;
- Types of health insurance coverage; and
- Employment status.

The OHRM database combines the MEPS-HC data for 2003-2005 (providing roughly 100,000 total observations) and reweights it to equal the 2010 NHE estimates for spending and insurance coverage. Specifically, the sample weights for individuals were adjusted to reproduce the 2010 population, disaggregated by age, sex, and health insurance status. In addition, individuals' health expenditures by source of payment were first rebased to 2006 levels and then inflated so that the aggregate expenditures reproduced the NHE estimate for 2010. The MEPS-IC data is then merged with the MEPS-HC to add more robust information on insurance coverage, costs, and employment.

Employer Component

The employer component of the OHRM is based on data from the 2008 Kaiser/HRET Employer Health Benefits Survey, covering about 3,000 private and public firms that reported on their health plan offerings between January and May 2008.[2] This data source was selected because the data are collected at the firm level (as opposed to the establishment level), allowing us to model the decision to offer insurance at the appropriate corporate level.

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[1] More information about MEPS data is available at http://www.meps.ahrq.gov/mepsweb/.
[2] More information on the Kaiser/HRET survey is available at http://ehbs.kff.org/2008.html

The nine published industry categories from the Kaiser/HRET survey were collapsed into three broader industry groupings based on similar levels of coverage offer rates and employee take-up rates, premium levels, and employer contributions in those industries. The three groupings are:

- Retail
- Agriculture, construction, mining, manufacturing, wholesale trade, services, and health care
- Transportation, finance, and state/local government

Within each industry grouping, the data were further organized into four firm size categories:

- Fewer than 10 employees
- 10-24 employees
- 25-49 employees
- More than 50 employees

The Kaiser/HRET data were also adjusted at the small and large firm levels to ensure consistency with employment counts from the U.S. Census Bureau's County Business Patterns data.

Baseline National Health Expenditures and Insurance Enrollment

Health expenditures under current law are based on the NHE projections for 2008-2018 that were released on February 24, 2009, including estimates of spending by type of service and source of funds.[3] An updated and extended set of NHE projections for 2010-2019 was released on June 29, 2009, incorporating the impacts of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the American Recovery and Reinvestment Act of 2009 (ARRA), together with later economic data.[4] Additionally, the projections were expanded to include more detailed counts of individuals by insured status and an allocation of employer-sponsored versus individual private insurance spending. Estimates of the uninsured and Medicaid enrollees were based on the Current Population Survey (CPS) adjusted for Medicaid undercount.

Methods and Assumptions underlying the Coverage Proposal Estimates for H.R. 3200

To estimate the effects of the reform proposals, the legislative specifications in H.R. 3200 are superimposed on the baseline data and expenditure projections. Assumptions must be made to reflect behavioral responses to the proposals. The following sections describe our methods and assumptions for estimating the impacts of the major coverage proposals in H.R. 3200 on the Federal Budget, individuals' insurance coverage, and National Health Expenditures.

Medicaid Expansion

H.R. 3200 would expand Medicaid eligibility in two significant ways: (i) to individuals who would meet current Medicaid eligibility requirements, for example as a disabled adult, but who have incomes in excess of the existing State thresholds but less than 133⅓ percent of the Federal

[3] Information on the methodology used to produce the NHE projections can be found at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/projections-methodology.pdf

[4] The full text of the memo can be found at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/NHE_Extended_Projections.pdf

poverty level (FPL); and (ii) to people who live in households with incomes below 133⅓ percent of the FPL but who have no other qualifying factors that make them eligible for Medicaid currently. The provision would take effect in 2013.

In the OHRM model, current Medicaid participation rates are based on MEPS data and 2002 data from the Urban Institute's TRIM3 model. As summarized below, we developed assumptions to estimate (i) the percentage of newly eligible individuals who would enroll in Medicaid and (ii) their associated health expenditures. These assumptions vary based on their age and current insured status.

Medicaid Participation Assumptions

For modeling the coverage expansion, uninsured adults who are not currently eligible for Medicaid are split into two groups: those who have health care expenditures greater than zero in MEPS (or health care "users") and those who have zero expenditures ("non-users"). We initially assume that that the newly eligible (regardless of spending) would participate at the same rate as those eligible for Medicaid under current law (86 percent) and that health care users would participate at a higher rate than the non-users. An upward adjustment is made to account for the 100-percent Federal match rate for new enrollees. Participation among newly eligible persons who were previously uninsured is assumed to reach 88 to 92 percent for users and 50 to 70 percent for non-users, depending on age, prior to consideration of the facilitated enrollment that would be available through the health insurance Exchange(s).

For adults currently eligible for Medicaid but not enrolled, it is assumed that Medicaid participation would increase by 2 percentage points (from 86 percent to 88 percent) as a result of the outreach activities and publicity associated with the Medicaid expansion. We also assume that a child not currently enrolled in Medicaid would become covered if and only if one or more of the adults in the household were to enroll. Thus, for uninsured adults projected to enroll in Medicaid as described above, any children in the household would also be expected to enroll.

Beyond the coverage expansion, H.R. 3200 gives the Health Choices (Exchange) Commissioner the authority to facilitate enrollment, including automatic enrollment (Section 205). We anticipate that the Exchange(s) would be effective in assisting individuals with coverage options and in determining the degree of Federal financial support available through affordability credits or Medicaid. We also believe that any current stigma of receiving such support would be reduced under the reform program due to the significant expansion of credits available to higher income individuals and families. Consequently, we assume that 99 percent of individuals eligible for Medicaid would ultimately be enrolled, including all of those who utilize health care services. We further assume that States could and would accurately distinguish between newly eligible and currently eligible enrollees and that there would be a sufficient mechanism at the Federal level to enforce accurate reporting for FMAP purposes.

Newly eligible individuals who currently have private health insurance are divided into two groups: those with employer-sponsored insurance and those with individually purchased insurance. We anticipate that the latter group would participate in Medicaid at a much higher rate than the former, because those with individually purchased insurance typically pay substantially higher premiums than those with employer-sponsored coverage. Virtually all

qualifying persons with individually purchased insurance are assumed to switch to Medicaid under H.R. 3200. Of those with employer coverage currently, one-third are assumed to switch fully to Medicaid, one-half to remain in their employer plan but also enroll for supplemental coverage through Medicaid, and one-sixth to retain their employer coverage with no involvement in Medicaid.[5]

Dual Medicare-Medicaid beneficiaries under age 65, who have incomes below 133⅓ percent of the FPL but are not eligible for full Medicaid benefits, are assumed to become eligible for full benefits as a result of this expansion. Additionally, since they are already enrolled in Medicaid and receive assistance paying Medicare premiums and cost-sharing, it is assumed that all of these beneficiaries would be enrolled in the program with full benefits. (The expansion of Medicaid eligibility under H.R. 3200 does not apply to people aged 65 and older; despite the apparent coverage "notch" that would occur between ages 64 and 65, we have applied this provision as drafted in estimating the Medicaid coverage changes under the bill.)

Finally, we assume that the ultimate participation rate would be reached in 2015; assumed participation is 80 percent of the ultimate rate in 2013 and 90 percent in 2014.

Medicaid Expenditure Assumptions

Following conventional practice, we estimate that a change in health care coverage status would result in a change in the amount of health care services used. In particular, individuals with health insurance use more services than those without, and utilization increases in inverse proportion to the level of cost-sharing requirements. (State Medicaid programs generally impose very low levels of cost sharing.) Medicaid provider/plan payment rates, however, would offset a significant portion of the higher expenditures associated with becoming insured. Available evidence indicates that Medicaid payment rates are roughly 30 percent lower than prevailing commercial insurance rates.

Based on recent research into the increase in health spending expected when an uninsured person receives full coverage, we developed a set of factors to reflect this induced spending.[6] We developed alternative factors for adults and children, and for the type of coverage gained that reflects the price differences between Medicaid and private insurance as discussed above. This information was supplemented with research on the price elasticity behavior of those who have insurance but face different coinsurance rates.[7] The following table provides these factors for various coinsurance rates and two different types of coverage. For example, an adult who moves from an uninsured status to Medicaid coverage with no coinsurance would be expected to experience a 72-percent increase in their health expenditures. Likewise, an adult who moves from an uninsured status to private coverage with 30-percent coinsurance would experience an estimated 96-percent increase in their health spending.

[5] This statement pertains to persons under age 65.
[6] Based on Hadley, et. al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs*, August 25, 2008.
[7] Congressional Budget Office, "Behavioral Assumptions for Estimating the Effects of Health Care Proposals," November 1993.

OHRM Expenditure Induction Factors by Coinsurance Rate

Coinsurance Rate	Percentage Increase in Spending When Moving from Uninsured to:			
	Medicaid		Private Health Insurance	
	Adults	Children	Adults	Children
0%	72%	30%	145%	85%
5	61	22	130	74
10	54	16	119	66
15	48	12	111	60
20	44	9	105	55
25	40	6	100	52
30	38	4	96	49

The health expenditures for newly eligible Medicaid enrollees are estimated from the actual expenses of the individuals in question in the database, increased to account for uncompensated care, inflated to reflect the substantial reduction in out-of-pocket costs for those currently uninsured, per above,[8] and augmented by an estimate of Medicaid administrative costs. This latter estimate reflects the likelihood that new enrollees will become enrolled in Medicaid managed care plans. (Currently, about 71 percent of Medicaid beneficiaries under 65 are enrolled in private managed care plans, which have administrative costs amounting to approximately 12 percent of spending.)

Employer-Sponsored Insurance Provisions

H.R. 3200 would establish an employer mandate to offer insurance and an individual mandate to purchase insurance. Specifically, beginning in 2013 H.R. 3200 would require that employers with 25 or more employees, that do not offer health insurance, pay a penalty equal to 8 percent of their payroll. Individuals who do not purchase coverage would be subject to a penalty of 2.5 percent of their income above the standard deductions and exemptions permitted by the Internal Revenue Code.

As a result of the employer mandate, we would expect the offer rate among employers with 25 or more employees to increase from about 98 percent currently to nearly 100 percent.[9] However, the existence of an Exchange and income-related premium subsidies may prompt some large employers of mostly low-wage workers to drop their coverage. In such instances, the employer could reduce its costs by paying the penalty rather than the higher cost of offering health insurance; the employer would also gain a more stable and predictable, payroll-based liability for health care benefits. Moreover, without an employer offer of coverage, low-wage employees

[8] Costs for new Medicaid enrollees who currently have private health insurance reflect (i) an increase of approximately 19 percent in utilization of services, and (ii) the more-than-offsetting impact of a 30-percent reduction in the average price per service.

[9] The employer response to the coverage mandate is estimated to vary in a logistical relationship to the level of the penalty imposed for nonparticipation. Modest penalty levels would result in little change in offer rates, whereas penalties at about 6 percent of payroll or higher are estimated to result in substantial increases in offers among employers not currently providing coverage.

could acquire health insurance coverage on the Exchange or through Medicaid, typically with a significant reduction in their share of the total premium. We assume that the majority of employers fitting this description would ultimately drop their insurance offering,[10] bringing the overall offer rate down to 96 percent for employers with 25 or more employees.

Employers with fewer than 25 employees would not be required to pay the 8 percent penalty for not offering coverage. With the existence of the Exchange, employees of these firms would have access to affordable and guaranteed-issue group insurance coverage. Therefore, we assume that the offer rate for firms with 10-24 employees would decline slightly from 78 percent currently to 75 percent. For the smallest firms (10 or fewer employees), the offer rate is estimated to drop from 47 percent to 36 percent.

When developing assumptions regarding employee take-up of employer coverage under H.R. 3200, we analyzed the current take-up rates by plan type (self only, self plus spouse, or family), employee income, and worker/family health care spending. Assumed take-up rates are higher for higher-income employees and for those with higher health care spending. To incorporate the impacts of the individual mandate, we then reflected the 2.5-percent individual penalty in the financial decision made by the family to determine the estimated take-up percentages for the proposal. These percentages were further increased slightly to account for the psychological impact of a statutory mandate.

The impacts of the employer and individual penalties were phased in over a 3-year period (2013-2015, inclusive). The assumption that many large firms with low-wage employees would drop their coverage is expected to occur more slowly, as we believe that these firms would prefer to wait until the Exchange is well-established before dropping their offer of coverage. Therefore, we expect this change to take 5 years to fully materialize, with the bulk of the impact occurring in the later years.

Health Insurance Exchange Provisions—General

The OHRM Individual Insurance Choice Model determines the coverage decision made by individuals who are not enrolled in Medicaid or another public insurance program and who do not have employer-sponsored insurance (ESI). As an initial step, we assume that about 7 percent of those eligible and not yet covered would enroll in an Exchange plan regardless of financial implications. This reflects a psychological impetus to acquire coverage due to the individual mandate.

[10] We based this estimate on data from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey, updated to reflect wage growth between 1997 and 2006.

The next step is to estimate individuals' choices of whether to elect coverage from the Exchange, using a probit model.[11] The key factors in the probit model include:

- average Exchange premium
- subsidy amount
- penalty amount
- poverty level
- perceived health status
- employment status
- spouse's employment status
- gender of head of household
- age
- race
- children
- marital status

A final factor takes into account the increased accessibility of coverage given the insurance reforms associated with guaranteed issue and renewal, prohibiting pre-existing condition exclusions, insurance rating rules, and non-discrimination in benefits. (Such factors cannot be directly incorporated into a probabilistic model that is fitted to experience data in a period without such regulatory provisions.) Additionally, this factor ensures nearly full take-up when the expected insurance benefit equals or exceeds the cost of the coverage.

For the transition, it is assumed that once the Exchange is operational, beginning in 2013, roughly 80 percent of those who would ultimately choose to participate would enroll in the first year. By 2015, the full transition is assumed to be complete, with 100 percent of those who would ultimately choose to participate enrolled in Exchange plans.

Health Insurance Exchange Provisions—Public Plan Option

H.R. 3200 specifies that a Federally operated health insurance plan would be available through the health insurance Exchange, subject to the same coverage and benefit provisions applicable to Exchange plans generally, and with provider payment rates initially set at Medicare levels plus 5 percent.

Premiums for the public health insurance option are estimated to be 11 percent lower than those for private plans on the Exchange. This result is based on an estimate that (i) the cost of the public insurance option for a standard enrollment group would be 18 percent lower than the average for private health plans, but (ii) public plan enrollees would have costs that were 7 percent greater than average (beyond what can be accounted for through risk adjustment) as a result of antiselection. The estimated 18-percent cost differential between the public option and private plans reflects the combination of 17 percent lower prices, 10 percent lower administrative and margin costs, and 9 percent higher costs due to less strict and/or effective care coordination. The finding of 17-percent lower prices for the public plan is a function of the specification that the public plan payment rates would be Medicare rates plus 5 percent. [12] The assumed higher

[11] This model is based on the specifications in Marquis and Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics*, 14 (1995), updated and calibrated to the OHRM household database for non-public and non-ESI enrollees.

[12] A study by MedPAC found that Medicare payment rates are roughly 20 to 25 percent lower than private plan rates for equivalent services (MedPAC, March 2009 Report To Congress: Medicare Payment Policy).

average cost for public plan enrollees is based on an expectation that individuals with above-average costs would tend to prefer plans with less-restrictive utilization management practices.

We have assumed that 40 percent of those who choose to purchase health insurance coverage through the Exchange would select the public option, even though the public plan would be financially beneficial for most individuals. Based on insurance selection studies and experience from other programs, including Medicare Part D, not all individuals select plans that are in their financial best interest. In the first year of the Medicare Part D program, for example, fewer than half of the enrollees selected either the lowest cost plan or the plan with the greatest brand recognition. We would expect a somewhat similar level of enrollment in the public plan based on these factors—i.e., a significant number, but not a majority. In practice, the percentage of public option enrollees is one of the most uncertain estimation factors for H.R. 3200, but the overall net cost of the bill is not highly sensitive to the specific assumption employed.

As emphasized in the main text of this memorandum—and as should be apparent from this appendix on assumptions and estimation methods—actual behavioral responses, coverage changes, price levels, utilization impacts, and other key factors are quite uncertain and could easily differ from the individual assumptions used by the Office of the Actuary. While we believe that the data, assumptions, and methods we have employed to estimate the effects of H.R. 3200 are reasonable, we urge policy makers and other users of this information to be aware of the uncertainty and potential variation inherent in this—and any other—set of estimates for reform packages of the scope of H.R. 3200.

Prepared by:

OACT Health Reform Modeling Team

John D. Shatto, FSA
Team Leader and Deputy Director,
Parts C & D Actuarial Group

Richard S. Foster, FSA
Chief Actuary

Stephen K. Heffler, MBA
Director, National Health Statistics Group

John D. Klemm, Ph.D., ASA
Actuary

Gregory J. Savord, FSA
Actuary

Andrea M. Sisko
Economist

Paul I. Spitalnic, ASA
Director, Parts C & D Actuarial Group

John A. Wandishin, FSA
Actuary

October 21, 2009