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Office of the Actuary

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FROM: Richard S. Foster
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SUBJECT: Estimated Financial Effects of the "America's Affordable Health Choices Act of 2009" (H.R. 3962), as Passed by the House on November 7, 2009

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. 3962. 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 non-tax provisions in the proposed "America's Affordable Health Choices Act of 2009" (H.R. 3962) through fiscal year 2019. The estimates are based on the bill as passed by the House on November 7 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 various income and excise tax proposals or the impact on income and payroll taxes due to economic effects of the legislation. Similarly, the impact on Federal administrative expenses is excluded. A summary of the data, assumptions, and methodology underlying our estimates of national health reform proposals is available in the appendix to our October 21 memorandum on H.R. 3200.

Summary

The table shown on page 2 presents the key, non-tax financial impacts of H.R. 3962 on the Federal Budget in fiscal years 2010-2019. We have grouped the provisions of the bill into six 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 150 percent of the Federal poverty level (FPL);

(ii) Medicare provisions;

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

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

(v) The Community Living Assistance Services and Supports (CLASS) proposal; and

(vi) Immediate health insurance reforms.

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 Non-Tax Federal Costs (+) or Savings (–) under H.R. 3962
(in billions)

	Fiscal Year										Total,
Provisions	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-19
Total*	$1.5	$2.9	–$26.7	$41.4	$39.6	$67.0	$70.0	$69.5	$70.7	$70.4	$406.3
Coverage†	—	—	—	84.1	118.0	124.8	134.7	146.1	157.6	169.9	935.2
Medicare	–6.5	–22.0	–30.9	–40.9	–74.5	–58.8	–67.7	–79.5	–89.8	–100.2	–570.6
Medicaid/CHIP	3.0	27.8	8.8	3.9	2.2	7.1	7.6	6.7	6.4	3.9	77.5
Cost Trend‡	—	—	—	—	–0.0	–0.1	–0.2	–0.4	–0.6	–0.8	–2.1
CLASS program	—	–2.9	–4.7	–5.8	–6.1	–6.1	–4.4	–3.4	–2.9	–2.5	–38.7
Immediate reforms	5.0	—	—	—	—	—	—	—	—	—	5.0

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

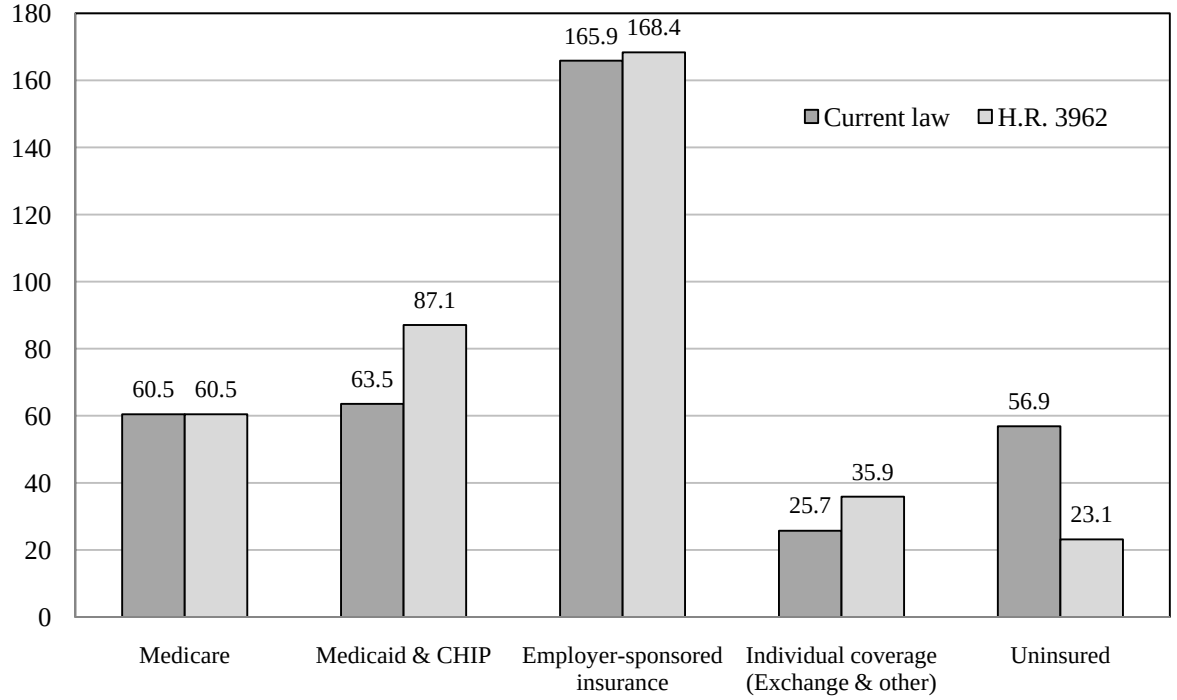
Note: The estimates shown in this table exclude the impact of the Federal income tax surcharge for high-income taxpayers and other revenue provisions.

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 $935 billion through fiscal year 2019. The net savings from the Medicare, Medicaid, growth-trend, CLASS, and immediate reform proposals are estimated to total $529 billion, leaving a net cost for this period of $406 billion before consideration of additional Federal administrative expenses and the increase in Federal income and other tax revenues that would result from the surcharge on high-income individuals and families and other revenue provisions. The Congressional Budget Office and Joint Committee on Taxation have estimated that the total net amount of Medicare savings and additional tax and other revenues would somewhat more than offset the cost of the national coverage provisions, resulting in an overall reduction in the Federal deficit through 2019.

The chart shown on the following page summarizes the estimated impacts of H.R. 3962 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 current law, to an estimated 23 million under H.R. 3962. The additional 34 million people who would become insured by 2019 reflect the net effect of several shifts. First, an estimated 21 million would gain primary Medicaid coverage as a result of the expansion of eligibility to all legal resident adults under 150 percent of the FPL.[1] (In addition, roughly 2 million people with employer-sponsored health insurance would enroll in Medicaid for supplemental coverage.) Another 10 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 25 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 2.5 million, reflecting both gains and losses in such coverage under H.R. 3962.

Estimated Effect of H.R. 3962 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 most of the provisions of H.R. 3962 that were designed, in part, to reduce the rate of growth in health care costs would have a relatively small savings impact. An important exception is the reductions in the "market basket" price indices that are used to update Medicare payments to health providers. Total national health expenditures under this bill would increase by an estimated 1.3 percent in

[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 150 percent of the FPL; and (ii) people who live in households with incomes below 150 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.

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, and (iii) lower payments and payment updates for Medicare services.

The actual future impacts of H.R. 3962 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. 3962 are provided in table 1, attached, for fiscal years 2010 through 2019. We estimate that Federal expenditures would increase by a net total of $406 billion during this period—a combination of $935 billion in net costs associated with coverage provisions, $571 billion in net savings for the Medicare provisions, a net cost of $78 billion for the Medicaid/CHIP provisions (excluding the expansion of eligibility), $2 billion in savings from proposals intended to help reduce the rate of growth in health spending, $39 billion in net savings from the CLASS proposal, and $5 billion in costs for the immediate insurance reforms. These latter five impact categories are discussed in subsequent sections of this memorandum.

Of the estimated $935 billion net increase in Federal expenditures related to the coverage provisions of H.R. 3962, a little more than one-half ($512 billion) can be attributed to expanding Medicaid coverage for all adults who make less than 150 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) for the first 2 years and 91 percent thereafter; that is, the Federal government would bear a significantly greater proportion of the cost of the newly eligible enrollees than is the case for current Medicaid beneficiaries.[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 $592 billion and $11 billion, respectively, for fiscal years 2010-2019. The increases in Federal expenditures

[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.

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 $180 billion through this period.

The $592 billion of individual affordability credits are the combination of both premium and cost-sharing subsidies. The premium credits in section 343 of H.R. 3962 would limit the premiums paid by individuals between 150 percent and 400 percent of the FPL to at most 12.0 percent of their income and would cost an estimated $505 billion through 2019. An estimated 18 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 344. These credits are estimated to cost $86 billion through 2019.

H.R. 3962 changes the basis for future Exchange premium subsidies in such a way that the reduced premiums payable by those with incomes below 400 percent of FPL would maintain the same share of total premiums over time. As a result, the Federal premium subsidies for a qualifying individual would grow at the same pace as per capita health care costs. (Under H.R. 3200, Federal premium subsidies would have increased at a faster rate.)

H.R. 3962 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 per capita growth in health care costs. With this change from H.R. 3200,[3] the proportion of health care costs above the out-of-pocket maximum would be relatively stable. For the basic essential-benefits plans for individuals, with an actuarial value of 70 percent, we estimate that the cost-sharing percentage applicable before the out-of-pocket maximum is reached would be about 50 percent in 2013 and later. The corresponding cost-sharing rate for family coverage is 45 percent. For the more comprehensive benefit packages authorized through the Exchange, these initial cost-sharing levels would be significantly lower.

Somewhat offsetting the Federal costs resulting from the coverage expansion provisions are the individual and employer penalties stipulated by H.R. 3962. 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 501). We estimate that this provision would provide $62 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 do not offer health insurance and are subject to the “play or pay” penalties, we estimate that the penalties would total $118 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

[3] Under H.R. 3200, the maximum out-of-pocket limits would have been indexed by the CPI, and over time an increasing share of total health expenditures for Exchange enrollees would have exceeded the limits.

employers are estimated to grow more slowly than the Federal expenditures for affordability credits.

Health Insurance Coverage Impacts

The estimated effects of H.R. 3962 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. 3962. 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. 3962, about three-fifths (21 million) would receive Medicaid coverage due to the expansion of eligibility to those adults under 150 percent of the FPL. We anticipate that the requirement in H.R. 3962—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 (19 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 enroll in Medicaid as a supplement to their existing coverage.

Of the remaining 12.5 million who are estimated to receive health coverage in 2019 because of H.R. 3962, about 10 million would be covered by health insurance through the newly created Exchange. (Another 15 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.[4] Our model indicated that roughly 57 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 and would negotiate payment rates with providers (rather than paying based on Medicare rates, as under H.R. 3200). We estimate that the public plan would have costs that were 5 percent below the average level for private plans but that the public plan premiums would be roughly 4 percent

[4] 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 penalty amount would be small.

higher than private as a result of antiselection by enrollees.[5] We further estimate that about 25 percent of the approximately 25 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. 3962. 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. 3962. As indicated in table 2, the total number of persons with employer coverage in 2019 is estimated to be 2.5 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 the proposed legislation. 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. 3962 are provided in detail in table 3, attached, which is organized by section of the proposed legislation. Net Medicare savings are estimated to total $571 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,

[5] The lower estimated cost level for the public plan assumes that the Secretary could negotiate somewhat lower provider payment rates than those prevailing for commercial plans, in view of the larger enrollment base. 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 much of the cost advantage. The impact of antiselection is estimated as the amount remaining after risk adjustment is applied.

reduce Part A and Part B market basket payment updates and adjust them for productivity improvements ($282 billion); eliminate the Medicare Improvement Fund ($15 billion); reduce Medicare Advantage payment benchmarks and extend the authority to adjust for coding intensity ($201 billion); require prescription drug rebates at Medicaid levels from manufacturers for all low-income Part D enrollees ($115 billion); and establish arrangements with drug manufacturers for 50-percent price discounts on drugs purchased by enrollees in the coverage gap ($14 billions).[6] The provisions in other titles would generate relatively smaller amounts of savings, principally through Title IV ("Quality") and Title VI ("Program Integrity") with combined savings of $4 billion.

The Title I savings are partially offset by the costs of phasing out the Part D coverage gap ($31 billion).[7] Other titles with costs, include Title II ("Medicare Beneficiary Improvements") with an estimated 10-year cost of $32 billion and Title III ("Promoting Primary Care, Mental Health, and Coordinated Care") with costs of $12 billion.

Based on the estimated savings for Part A of Medicare, the assets of the Hospital Insurance trust fund would be exhausted in 2022, 5 years later than under current law.

It is important to note that the estimated savings shown in this memorandum for one category of Medicare proposals may be unrealistic. H.R. 3962 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.[8] 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. 3962 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

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[6] Such price discounts would continue to apply as if the coverage gap were not phased out.

[7] The provision in H.R. 3200 to reform Medicare's current physician payment mechanism (the Sustainable Growth Rate or SGR formula) has been deleted from H.R. 3962 and introduced separately as a new bill (H.R. 3961). Thus, the cost of addressing the SGR formula is no longer associated with H.R. 3962.

[8] 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.)

current law, would reduce MA rebates to plans and thereby result in less generous benefit packages.[9] 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).

Medicaid/CHIP

The estimated Federal financial effects of the Medicaid and CHIP provisions in H.R. 3962 are shown in table 4, attached. As noted previously, the costs associated with the expansion of eligibility under the applicable provisions of section 1701 are included with the national coverage proposals shown in table 1.

The overall net cost of the other Medicaid and CHIP provisions is estimated to be $77.5 billion in fiscal years 2010-2019 and reflects numerous cost increases and decreases under the individual provisions. Proposals with significant Federal costs include application of the 100-percent FMAP (first 2 years) and 91-percent FMAP (thereafter) to new traditional Medicaid eligibles with incomes below 150 percent of FPL who have already been covered under section 1115 waivers ($44.7 billion); an increase in payments for primary care practitioners to Medicare levels[10] ($37.3 billion); an extension of the higher FMAPs authorized under the American Recovery and Reinvestment Act of 2009 ($21.9 billion); and higher payments in Puerto Rico and the U.S. territories ($10.4 billion).

The key savings provisions include maintenance-of-effort requirements under section 1703 ($47.4 billion), reductions in Medicaid DSH expenditures ($10.0 billion), higher minimum manufacturer rebates for brand-name prescription drugs ($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. 3962 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.

[9] 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 1162 (extension of authority for coding intensity adjustments) would also reduce MA plan revenues.

[10] To avoid problems arising from the substantial Medicare physician payment reductions under current law, H.R. 3962 specifies use of Medicare payment rates in 2009, with 1.25-percent annual increases thereafter.

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.

Our interpretation of the CER provisions in H.R. 3962 is 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 take many years to develop.

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.[11]

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.

CLASS Program

Section 2581 would establish a new, voluntary, Federal insurance program providing a cash benefit if a participant were unable to perform at least two or three activities of daily living or had substantial cognitive impairment. The program would be financed by participant premiums, with no Federal subsidy. Participants would have to meet certain modest work requirements during a 5-year vesting period before becoming eligible for benefits. Benefits are intended to be used to help purchase community living assistance services and supports (CLASS) that would help qualifying beneficiaries maintain their personal and financial independence and continue living in the community. Benefits could also be used to help cover the cost of institutional long-term care.

[11] The public health and workforce development provisions in H.R. 3962 (Division C) would create a Public Health Investment Fund and a Prevention and Wellness Trust and would authorize the appropriation of $34 billion for these purposes. We consider these expenditures to be primarily administrative in nature and thus have not included them as program costs in this memorandum.

As shown in the table on page 2, we estimate a net Federal savings for the CLASS program of $39 billion during the first 9 years of operations—the first 5 of which are prior to the commencement of benefit payments. After 2015, as benefits were paid, the net savings from this program would decline; in 2025 and later, projected benefits exceed premium revenues, resulting in a net Federal cost in the longer term.[12]

We estimate that about 2.8 million persons would participate in the program by the third year. This level represents about 2 percent of potential participants, compared to a participation rate of 4 percent for private long-term care insurance offered through employers. Factors affecting participation in CLASS include the program's voluntary nature, the lack of a Federal subsidy, a relatively high premium as a result of adverse selection, a new and unfamiliar benefit, and the availability of lower-priced private long-term care insurance for many. Compounding this situation would be the probable participation of a significant number of individuals who would already meet the functional limitation requirements to qualify for benefits. In the sixth year of the program (2016), these participants would begin to receive benefits, along with others who had developed such limitations in the interim. We estimate that an initial average premium level of about $180 per month would be required to adequately fund CLASS program costs for this level of enrollment and antiselection. (Individuals enrolling in a given year would pay a constant premium amount throughout their participation, unless trust fund deficits necessitated a premium increase. Premiums would vary by age at enrollment and year of enrollment.)

In general, voluntary, unsubsidized, and non-underwritten insurance programs such as CLASS face a significant risk of failure as a result of adverse selection by participants. Individuals with health problems or who anticipate a greater risk of functional limitation would be more likely to participate than those in better-than-average health. Setting the premium at a rate sufficient to cover the costs for such a group further discourages persons in better health from participating, which may lead to further premium increases. This effect has been termed the "classic assessment spiral" or "insurance death spiral." Although section 2581 includes modest work requirements in lieu of underwriting, and specifies that the program is to be "actuarially sound" and based on "an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period," there is a significant risk that the problem of adverse selection would make the CLASS program unsustainable.[13]

Immediate Insurance Reforms

A number of provisions in H.R. 3962 would have an immediate effect on insurance coverage. Most of these proposals, however, would not have a direct impact on Federal expenditures. (A discussion of their impact on national health expenditures is included in the following section of

[12] The CLASS program is intended to be financed on a long-range, 75-year basis through participant premiums that would fully fund benefits and administrative expenses. If this goal can be achieved, despite anticipated serious adverse selection problems (described subsequently), then annual expenditures would be met through a combination of premium income and interest earnings on the assets of the CLASS trust fund. The Federal budget impact would be the net difference between premium receipts and program outlays. Thus, the trust fund would be adequately financed in this scenario, but the Federal budget would have a net savings each year prior to 2025 and a net cost each year thereafter.

[13] An analysis of the potential antiselection problems for the CLASS program was performed by a nonpartisan, joint workgroup of the American Academy of Actuaries and the Society of Actuaries. Their report was issued on July 22, 2009, and is available at http://www.actuary.org/pdf/health/class_july09.pdf .

this memorandum.) Section 101 of H.R. 3962 authorizes the expenditure of up to $5 billion in support of a temporary national insurance pool for high-risk individuals without other health insurance.

National Health Expenditure Impacts

The estimated effects of H.R. 3962 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 $289 billion, or 0.8 percent, over the updated baseline projection that was released on June 29, 2009.[14] Year by year, the relative increases are largest in 2015, when the coverage expansions would be fully phased in (1.5 percent), and gradually decline thereafter, as the effects of the Medicare market basket reductions compound, reaching 1.3 percent in 2019. The NHE share of GDP is projected to be 21.1 percent in 2019, compared to 20.8 percent under current law.

The increase in total NHE is estimated to occur primarily as a net result of the substantial expansions in coverage under H.R. 3962, 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, together with the significant discounts negotiated by private and public health insurance plans. We estimate that the net effect of the utilization increases and price reductions arising from the coverage provisions of H.R. 3962 would increase NHE in 2019 by about 3.4 percent.

H.R. 3962 would also affect aggregate health expenditures through the Medicare and Medicaid savings provisions. We estimate that these impacts would reduce NHE by roughly 2.1 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).

The immediate insurance reforms in Title I would affect national health expenditures as well, although by relatively small amounts. We estimate that the creation of a national high-risk insurance pool would result in roughly 375,000 people gaining coverage in 2010, increasing national health spending by $4 billion.[15] By 2011 and 2012 the initial $5 billion in Federal funding for this program would be exhausted, resulting in substantial premium increases to sustain the program; we anticipate that such increases would limit further participation. Beginning January 1, 2010, qualified child dependents up to age 27 who are uninsured would be

[14] 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.

[15] In practice, a national high-risk pool could probably not be implemented by January 1, 2010. This estimate, along with all others in this memorandum, assumes that implementation would occur by the mandated deadline.

allowed to enroll under dependent coverage. An estimated 600,000 dependent children would gain insurance coverage through their parents' private group health plans, increasing national health spending by $1.2 billion. These impacts are expected to persist through 2012. Additionally, because this provision would not expire when the Medicaid expansion, individual mandate, and Exchange start in 2013, we anticipate that these individuals would continue to remain covered as dependents even though they may be newly eligible for other coverage. Finally, we did not estimate NHE coverage or cost impacts for the other immediate reform provisions, such as prohibiting limitations on pre-existing conditions, elimination of lifetime aggregate benefit limits, prohibition of post-retirement reductions in retiree health benefits by group plans, and extension of COBRA continuation coverage. We believe that each of these provisions would have only a relatively minor upward impact on national health spending.

Underlying the overall moderate effects of H.R. 3962 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 $220 billion in calendar years 2010-2019 due to H.R. 3962. Under the baseline projections, out-of-pocket expenditures would account for about 10 percent of NHE in 2019; inclusive of the legislative impacts, this share would decrease to 9 percent.

Public spending would increase under H.R. 3962 as a result of the expansion of the Medicaid program and other Medicaid changes, less 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. 3962, 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 29 to 33 percent.[16]

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[16] 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 will require a careful application of NHE accounting definitions and principles to this new category of payer.

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. 3962. 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. 3962 as passed by the House on November 7, 2009 and do not pertain to other versions of the bill.
- As mentioned previously, H.R. 3962 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. 3962 are not available to undocumented aliens. As a result of the measurement difficulties described above, the actual costs under H.R. 3962 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 only a minor, 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 and other revenue provisions of H.R. 3962, as those estimates are provided by the Department of the Treasury. Similarly, Federal administrative expenses associated with H.R. 3962 are not included here and will be estimated separately. As noted previously, the Congressional Budget Office and Joint Committee on Taxation have estimated that the total amount of Medicare savings and additional income, excise, and other tax revenues would somewhat more than offset the cost of the national coverage provisions, resulting in an overall small reduction in the Federal deficit through 2019 and probably for the following 10 years as well.

- 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. 3962, 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.

  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. A specific estimate of these potential outcomes is impracticable at this time, given the uncertainty associated with both the magnitude of these effects and the interrelationships among these market dynamics. We may incorporate 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. 3962, 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. 3962, "America's Affordable Health Choices Act of 2009" (as passed by the House on November 7, 2009), would make far-reaching changes to the health sector, including mandated coverage for most people, "play or pay" 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 Medicare costs, increase Medicaid outlays, and address other issues with these programs, as well as increase Federal tax revenues through a surcharge on high-income taxpayers and other tax provisions.

The Office of the Actuary at CMS has estimated the effects of the non-tax provisions of H.R. 3962 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. 3962 are as follows:

- The total Federal cost of the national insurance coverage provisions would be about $935 billion 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 provisions would offset about $571 billion of the Federal costs for the national coverage provisions. (The reforms to the Medicare Sustainable Growth Rate physician payment mechanism, which would increase Medicare costs by an estimated $214 billion during this period, have been removed from H.R. 3962 and placed in a separate bill, H.R. 3961.) The non-coverage Medicaid provisions would increase costs by about $78 billion. Additional Federal 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. CBO and the Joint Committee on Taxation have estimated an overall reduction in the Federal budget deficit through 2019 under H.R. 3962 (and excluding the effects of H.R. 3961).
- The proposed Community Living Assistance Services and Supports insurance program would produce an estimated total net savings of $39 billion through fiscal year 2019. This result, however, is due to the initial 5-year period during which no benefits would be paid. Over the longer term, expenditures would exceed premium receipts, and there is a significant risk that the program would become unsustainable as a result of adverse selection by participants.
- Total national health expenditures in the U.S. during 2010-2019 would increase by about 0.8 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. 3962 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.

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Chief Actuary

Table 1 — Estimated Federal Costs (+) or Savings (-) under H.R. 3962, in billions

	Fiscal Year										Total, FY
Provisions	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total*	$1.5	$2.9	-$26.7	$41.4	$39.6	$67.0	$70.0	$69.5	$70.7	$70.4	$406.3
Coverage Provisions:	—	—	—	84.1	118.0	124.8	134.7	146.1	157.6	169.9	935.2
Medicaid Expansion	—	—	—	38.6	60.1	68.4	75.9	83.3	89.7	96.1	512.1
Credits:	—	—	—	53.9	77.2	81.3	87.1	94.2	101.2	108.4	603.1
Individual Exchange Subsidies:	—	—	—	49.7	71.4	79.8	87.1	94.2	101.2	108.4	591.8
Affordability Premium Credits	—	—	—	42.3	60.9	68.2	74.4	80.5	86.4	92.6	505.4
Affordability Cost-Sharing Credits	—	—	—	7.4	10.5	11.6	12.6	13.7	14.8	15.8	86.4
Small Employer Credits	—	—	—	4.1	5.8	1.5	0.0	0.0	0.0	0.0	11.3
Penalties:	—	—	—	-8.4	-19.3	-24.9	-28.3	-31.4	-33.2	-34.6	-180.0
Individual Penalties	—	—	—	0.0	-6.9	-9.7	-10.4	-11.1	-11.7	-12.2	-62.0
Employer Penalties	—	—	—	-8.4	-12.4	-15.2	-17.9	-20.3	-21.5	-22.4	-118.0
Medicare	-6.5	-22.0	-30.9	-40.9	-74.5	-58.8	-67.7	-79.5	-89.8	-100.2	-570.6
Medicaid/CHIP	3.0	27.8	8.8	3.9	2.2	7.1	7.6	6.7	6.4	3.9	77.5
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
Additional Proposals:	5.0	-2.9	-4.7	-5.8	-6.1	-6.1	-4.4	-3.4	-2.9	-2.5	-33.7
CLASS Program	—	-2.9	-4.7	-5.8	-6.1	-6.1	-4.4	-3.4	-2.9	-2.5	-38.7
Immediate Reforms	5.0	—	—	—	—	—	—	—	—	—	5.0

*Excludes income tax surcharge for high-income taxpayers and other revenue provisions.

†Excludes the Medicare impact of CER, which is included in the Medicare savings total.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.
November 13, 2009

Table 2 — Estimated Effects of H.R. 3962 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. 3962	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	83.4	82.3	82.5	83.8	85.0	86.0	87.1
Other Public	12.6	12.6	12.9	13.2	13.6	13.9	14.2	14.6	14.9	15.2
Employer-sponsored Private Health Insurance	164.4	163.9	165.1	168.3	169.4	168.0	167.0	166.6	167.5	168.4
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	—	—	—	17.1	19.5	22.8	23.6	24.3	24.5	24.7
Private Plan	—	—	—	12.9	14.6	17.1	17.7	18.3	18.4	18.6
Public Plan	—	—	—	4.3	4.9	5.7	5.9	6.1	6.1	6.2
Uninsured	47.3	48.0	47.3	22.2	21.6	21.3	22.0	22.6	22.8	23.1
Insured Share of US Population†	84.7%	84.7%	85.0%	93.0%	93.3%	93.4%	93.3%	93.1%	93.1%	93.1%

	Calendar Year									
Impact of H.R. 3962	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	—	—	—	21.4	21.7	22.2	22.7	23.1	23.3	23.5
Other Public	0.4	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Employer-sponsored Private Health Insurance	0.6	0.6	0.6	3.3	3.2	1.4	0.7	0.5	1.5	2.5
Other Private Health Insurance*	—	—	—	-12.3	-12.5	-12.8	-13.3	-13.8	-14.2	-14.6
Exchange	—	—	—	17.1	19.5	22.8	23.6	24.3	24.5	24.7
Private Plan	—	—	—	12.9	14.6	17.1	17.7	18.3	18.4	18.6
Public Plan	—	—	—	4.3	4.9	5.7	5.9	6.1	6.1	6.2
Uninsured	-1.0	-0.6	-0.6	-25.9	-28.4	-30.4	-31.1	-31.8	-32.8	-33.8
Insured Share of US Population†	0.3%	0.2%	0.2%	8.1%	8.8%	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.

November 13, 2009

Table 3— Estimated Impacts of H.R. 3962 on Medicare (in millions)

Sec.	Provision	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 1—Market basket updates													
1101	Skilled nursing facility payment update	-$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	-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	-1,160	-4,870	-7,720	-10,990	-14,720	-18,870	-23,980	-28,530	-32,960	-39,530	-39,460	-183,330
Part 2—Other Medicare Part A provisions													
1111	Payments to skilled nursing facilities	0	0	0	0	0	0	0	0	0	0	0	0
1112	Medicare DSH report and payment adjustments in response to coverage expansions	0	0	0	0	0	0	0	-2,680	-3,170	-3,390	0	-9,240
1113	Extension of hospice regulation moratorium	340	430	390	320	240	150	40	20	20	20	1,720	1,970
1114	Permitting physician assistants to order post-hospital extended care services and to provide for recognition of attending physician assistants as attending physicians to serve hospice patients	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle B—Provisions related to Medicare Part B												
Part 1—Physicians' services													
1121	Resource-based feedback program for physicians	0	0	0	0	0	0	0	0	0	0	0	0
1122	Misvalued codes under the physician fee schedule	0	0	0	0	0	0	0	0	0	0	0	0
1123	Payments for efficient areas	0	50	60	20	0	0	0	0	0	0	130	130
1124	Modifications to the Physician Quality Reporting Initiative (PQRI)	0	0	140	150	0	0	0	0	0	0	290	290
1125	Adjustments to Medicare payment localities	0	20	50	50	50	50	20	0	0	0	170	240
Part 2—Market basket updates													
1131	Incorporating productivity improvements in market basket updates that do not already include them	-200	-670	-1,210	-1,800	-2,540	-3,400	-4,420	-5,520	-6,720	-8,100	-6,420	-34,580
Part 3—Other provisions													
1141	Rental and purchase of power-driven wheelchairs	0	-40	-50	-50	-50	-60	-70	-70	-80	-80	-190	-550
1141A	Election to take or decline ownership of a certain item of complex DME after the 13-month capped rental period ends	0	0	0	0	0	0	0	0	0	0	0	0
1142	Extension of payment rule for brachytherapy	0	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
1144	Require ambulatory surgical centers to submit data	0	0	0	0	0	0	0	0	0	0	0	0
1145	Treatment of certain cancer hospitals	0	0	0	0	0	0	0	0	0	0	0	0
1146	Payment for imaging services	-160	-320	-360	-380	-390	-410	-430	-470	-510	-410	-1,610	-3,840
1147	Durable medical equipment program improvments	0	0	0	0	0	0	0	0	0	0	0	0
1148	MedPAC study and report on bone mass measurement	0	0	0	0	0	0	0	0	0	0	0	0
1149	Timely access to post-mastectomy items	0	0	0	0	0	0	0	0	0	0	0	0
1149A	Payment for biosimilar biological products	0	0	0	10	20	-350	-810	-960	-1,150	-1,360	30	-4,600
1149B	Study and report on DME competitive bidding process	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle C—Provisions Related to Medicare Parts A and B												
1151	Reducing potentially preventable hospital readmissions	0	0	-140	-270	-350	-350	-370	-390	-420	-450	-760	-2,740
1152	Post acute care services payment reform plan and bundling pilot program	0	0	0	0	0	0	0	0	0	0	0	0

Table 3— Estimated Impacts of H.R. 3962 on Medicare (in millions)

Sec.	Provision	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	Total, 2010-19
1153	Home health payment update for 2010												
	Part A	-100	-230	-260	-280	-300	-320	-350	-370	-390	-420	-1,170	-3,020
	Part B	-110	-260	-290	-320	-340	-360	-400	-410	-440	-470	-1,320	-3,400
1154	Payment adjustments for home health care												
	Part A	-110	-940	-1,330	-1,480	-1,580	-1,690	-1,840	-1,930	-2,020	-2,200	-5,440	-15,120
	Part B	-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	-80	-180	-280	-400	-540	-710	-870	-1,010	-1,230	-940	-5,300
	Part B	0	-80	-200	-320	-450	-600	-800	-960	-1,130	-1,370	-1,050	-5,910
1155A	MedPAC study on variation in home health margins	0	0	0	0	0	0	0	0	0	0	0	0
1155B	Permitting home health agencies to assign the most appropriate skilled service to make the initial assessment visit under a home health plan of care for rehabilitation cases	0	0	0	0	0	0	0	0	0	0	0	0
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
1157	Institute of Medicine study of geographic adjustment factors	0	0	0	0	0	0	0	0	0	0	0	0
1158	Revision of Medicare payment systems to address geographic inequities (impact included in section 1146)	0	0	4,000	4,000	-23,130	0	0	0	0	0	-15,130	-15,130
1159	Institute of Medicine study of geographic variation in health care spending and promoting high-value health care	0	0	0	0	0	0	0	0	0	0	0	0
1160	Implementation, and Congressional review, of proposal to revise payments to promote high-vale health care	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle D—Medicare Advantage Reforms												
Part 1—Payment and Administration													
1161	Phase-in of payment based on fee-for-service costs; quality bonus payments												
	Part A	0	-2,390	-5,270	-7,580	-8,700	-9,400	-10,070	-10,790	-11,470	-12,240	-23,940	-77,910
	Part B	0	-1,610	-3,530	-5,040	-5,720	-6,240	-6,850	-7,530	-8,260	-9,020	-15,900	-53,800
1162	Authority for Secretarial coding intensity adjustment authority												
	Part A	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	-1,490	-2,250	-2,560	-2,810	-3,100	-3,410	-3,740	-4,100	-4,490	-9,110	-27,950
1163	Simplification of annual beneficiary election periods	0	0	0	0	0	0	0	0	0	0	0	0
1164	Extension of reasonable cost contracts	0	0	0	0	0	0	0	0	0	0	0	0
1165	Limitation of waiver authority for employer group plans	0	0	0	0	0	0	0	0	0	0	0	0
1166	Improving risk adjustment for payments	0	0	0	0	0	0	0	0	0	0	0	0
1167	Elimination of MA regional plan stabilization fund												
	Part A	60	0	0	-80	-110	-70	-50	-50	-50	-50	-130	-400
	Part B	-60	0	0	-70	-100	-60	-40	-40	-50	-50	-230	-470
1168	Study regarding the effects of calculating the MA payment rates on a regional average of FFS rates	0	0	0	0	0	0	0	0	0	0	0	0
Part 2—Beneficiary Protections and Anti-Fraud													
1171	Limitation on cost-sharing for individual health services	0	0	0	0	0	0	0	0	0	0	0	0
1172	Continuous open enrollment for enrollees in plans with enrollment suspension	0	0	0	0	0	0	0	0	0	0	0	0
1173	Information for beneficiaries on MA plan admin costs	0	0	0	0	0	0	0	0	0	0	0	0
1174	Strengthening audit authority	0	0	0	0	0	0	0	0	0	0	0	0

Table 3— Estimated Impacts of H.R. 3962 on Medicare (in millions)

Sec.	Provision	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	Total, 2010-19
1175	Authority to deny plan bids	0	0	0	0	0	0	0	0	0	0	0	0
1175A	State authority to enforce standardized marketing requirements	0	0	0	0	0	0	0	0	0	0	0	0
Part 3—Treatment of Special Needs Plans													
1176	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
1177	Extension of authority of special needs plans to restrict enrollment; service area moratorium for certain SNPs	0	0	0	0	0	0	0	0	0	0	0	0
1178	Extension of Medicare senior housing plans	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle E—Improvements to Medicare Part D												
1181	Elimination of coverage gap	-5,300	-8,100	-9,700	-10,000	-9,000	-8,800	-8,100	-8,500	-9,300	-7,500	-42,100	-84,300
1182	Discounts for certain Part D drugs in original coverage gap	-220	-210	-310	-500	-760	-1,150	-1,630	-2,270	-3,110	-4,180	-2,000	-14,340
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
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	50	70	70	80	90	100	110	120	130	270	820
1185	No mid-year formulary changes permitted	0	0	0	0	0	0	0	0	0	0	0	0
1186	Negotiation of lower covered Part D drug prices on behalf of Medicare beneficiaries											0	0
1187	Accurate dispensing in long-term care facilities											0	0
1188	Free generic refill											0	0
1189	State certification prior to waiver of licensure requirements under Medicare prescription drug program											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
1192	Extension of outpatient hold-harmess provision	50	50	20	0	0	0	0	0	0	0	120	120
1193	Extension of section 508 hospital reclassifications	260	390	40	0	0	0	0	0	0	0	690	690
1194	Extension of geographic floor for work	170	370	140	0	0	0	0	0	0	0	680	680
1195	Extension of payment for technical component of certain physician pathology services	40	80	40	0	0	0	0	0	0	0	160	160
1196	Extension of ambulance add-ons	20	20	10	0	0	0	0	0	0	0	50	50
TOTAL, TITLE I		-7,140	-24,260	-34,000	-44,320	-78,620	-63,660	-73,000	-85,290	-96,070	-107,010	-188,340	-613,370
	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	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	60	90	100	120	130	150	160	180	210	370	1,200
1203	Eliminating barriers to enrollment	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
1205	Intelligent assignment in enrollment	0	0	0	0	0	0	0	0	0	0	0	0

Table 3— Estimated Impacts of H.R. 3962 on Medicare (in millions)

Sec.	Provision	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	Total, 2010-19
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
1207	Application of MA premiums prior to rebate and quality bonus payments in calculation of low-income subsidy benchmark	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
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
1223	IOM report on impact of language access services	0	0	0	0	0	0	0	0	0	0	0	0
1224	Definitions	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle C—Miscellaneous Improvements												
1231	Extension of therapy caps exceptions process	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	10	20	20	30	10	-10	10	80
1233	Voluntary advanced care planning consultation												
	Part A	0	-20	-30	-30	-30	-30	-40	-40	-40	-40	-110	-300
	Part B	0	110	160	160	160	160	170	180	190	200	590	1,490
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
1235	Exception for use of more recent tax year in case of gains from sale of primary residence in computing Part B income-related premium	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
TOTAL, TITLE II		800	1,900	2,110	2,340	2,980	3,650	4,000	4,430	4,880	5,370	10,130	32,460
	TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE												
1301	Accountable care organization pilot program	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
1303	Payment incentive for selected primary care services	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
1305	Coverage and waiver of cost-sharing for preventive services	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
1307	Excluding clinical social worker services from coverage under the Medicare skilled nursing facility prospective payment system and consolidated payment	0	0	0	0	0	0	0	0	0	0	0	0
1308	Coverage of marriage and family therapist services and mental health counselor services	0	200	260	260	270	280	310	340	370	400	990	2,690
1309	Extension of physician fee schedule mental health add-on	40	50	20	0	0	0	0	0	0	0	110	110
1310	Expanding access to vaccines	0	30	50	70	70	80	80	100	110	110	220	700
1311	Expansion of Medicare-covered preventive services at FQHCs	0	10	20	20	20	20	20	20	20	20	70	170
1312	Independence at home demonstration program	0	0	0	0	0	0	0	0	0	0	0	0

Table 3— Estimated Impacts of H.R. 3962 on Medicare (in millions)

Sec.	Provision	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	Total, 2010-19
1313	Recognition of certified diabetes educators as certified providers for purposes of Medicare diabetes outpatient self-management training services	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE III		40	570	1,110	1,160	1,220	1,300	1,410	1,560	1,730	1,880	4,100	11,980
	TITLE IV—QUALITY												
	Subtitle A—Comparative Effectiveness Research												
1401	Comparative effectiveness research[1/]	0	0	0	0	-30	-70	-160	-270	-400	-550	-30	-1,480
	Subtitle B—Nursing Home Transparency												
	Part 1—Improving Transparency of Information on Skilled Nursing Facilities, Nursing Facilities, and Other Long-Term Care Facilities												
1411	Required disclosure of ownership and additional disclosable parties information	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
1413	Nursing home compare Medicare website	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
1415	Standardized complaint form	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
1417	Nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers	0	0	0	0	0	0	0	0	0	0	0	0
	Part 2—Targeting Enforcement												
1421	Civil monetary penalties	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
1423	Notification of facility closure	0	0	0	0	0	0	0	0	0	0	0	0
	Part 3—Improving Staff Training												
1431	Dementia and abuse prevention training	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
1433	Qualification of director of food services of a skilled nursing facility or nursing facility	0	0	0	0	0	0	0	0	0	0		
	Subtitle C—Quality Measurements												
1441	Establishment of national priorities for quality improvement	0	0	0	0	0	0	0	0	0	0	0	0
1442	Development of new quality measures; GAO evaluation of data collection process for quality measurement	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
1444	Application of quality measures	0	0	0	0	0	0	0	0	0	0	0	0
1445	Consensus-based entity funding	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle D—Physician Payments Sunshine Provision												
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 and between physicians and other health care entities	0	0	0	0	0	0	0	0	0	0	0	0

Table 3— Estimated Impacts of H.R. 3962 on Medicare (in millions)

Sec.	Provision	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	Total, 2010-19
	Subtitle E—Public Reporting on Health Care-Associated Infections												
1461	Requirements for public reporting by hospitals and ambulatory surgical centers on health care-associated infections	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE IV		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
1502	Increasing training in non-provider settings	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
1504	Preservation of resident cap positions from closed hospitals	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
TOTAL, TITLE V		0	0	0	0	0	0	0	0	0	0	0	0
	TITLE VI—PROGRAM INTEGRITY												
	Subtitle A—Increased Funding to Fight Waste, Fraud, and Abuse												
1601	Increased funding and flexibility to fight fraud and abuse												
	Part A	0	10	10	10	10	10	10	10	10	10	40	90
	Part B	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
1612	Enhanced penalties for submission of false statements material to a false claim	0	0	0	0	0	0	0	0	0	0	0	0
1613	Enhance penalties for delaying inspections	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
1615	Enhanced penalties for individuals excluded from program participation	0	0	0	0	0	0	0	0	0	0	0	0
1616	Enhanced penalties for provision of false information by Medicare Advantage and Part D plans	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
1618	Enhanced penalties for obstruction of program audits	0	0	0	0	0	0	0	0	0	0	0	0
1619	Exclusion of certain individuals and entities from participation in Medicare and State health care programs	0	0	0	0	0	0	0	0	0	0	0	0
1620	OIG authority to exclude from Federal health care programs officers and owners of entities convicted of fraud	0	0	0	0	0	0	0	0	0	0	0	0
1621	Self-referral disclosure protocol	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
	Part B	-10	-20	-20	-30	-30	-30	-30	-30	-40	-40	-110	-280

Table 3— Estimated Impacts of H.R. 3962 on Medicare (in millions)

Sec.	Provision	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	Total, 2010-19
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
1633	Required inclusion of payment modifier for certain evaluation and management services	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
1635	Require providers and suppliers to adopt programs to reduce waste, fraud, and abuse	0	0	0	0	0	0	0	0	0	0	0	0
1636	Maximum period for submission of Medicare claims reduced to not more than 12 months												
	Part A	0	60	70	70	80	80	90	90	100	110	280	750
	Part B	0	50	50	50	50	60	60	70	70	80	200	540
1637	Physicians who order DME or home health services required to be Medicare enrolled physicians or eligible professionals												
	Part A	-10	-20	-20	-30	-30	-30	-30	-30	-30	-40	-110	-270
	Part B	-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
1639	Face-to-face enconter with patient required before eligibility certifications for home health services or DME												
	Part A	-50	-70	-70	-80	-80	-90	-100	-100	-110	-120	-350	-870
	Part B	-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
1641	Required repayments of Medicare and Medicaid overpayments	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
1643	Access to certain information on renaly dialysis facilities	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
1645	Conforming civil monetary penalties to False Claims Act amendments	0	0	0	0	0	0	0	0	0	0	0	0
1646	Requiring provider and supplier payments under Medicare to be made through direct deposit or electronic funds transfer (EFT) at insured depository institutions	0	0	0	0	0	0	0	0	0	0	0	0
1647	Inspector General for the Health Choices Administration	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle D—Access to Information Needed to Prevent Fraud, Waste, and Abuse												
1651	Access to information necessary to identify fraud, waste, and abuse	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
1653	Compliance with HIPAA privacy and security standards	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE VI		-170	-220	-220	-260	-270	-280	-300	-300	-330	-340	-1,140	-2,690

Table 3— Estimated Impacts of H.R. 3962 on Medicare (in millions)

Sec.	Provision	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	Total, 2010-19
	TITLE VIII—REVENUE-RELATED PROVISIONS												
1801	Disclosures to facilitate identification of individuals likely to be ineligible for the low-income assistance under the Medicare prescription drug program to assist SSA's outreach to eligible individuals	0	0	90	220	270	310	340	380	420	480	580	2,510
1802	Comparative effectiveness research Trust Fund; financing for Trust Fund	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE VIII		0	0	90	220	270	310	340	380	420	480	580	2,510
	TITLE IX—MISCELLANEOUS PROVISIONS												
1901	Repeal of trigger provision	0	0	0	0	0	0	0	0	0	0	0	0
1902	Repeal of comparative cost adjustment (CCA) program	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
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
1905	Improved coordination and protection for dual eligibles	0	0	0	0	0	0	0	0	0	0	0	0
1906	Assessment of Medicare cost intensive diseases and conditions	0	0	0	0	0	0	0	0	0	0	0	0
1907	Establishment of Center for Medicare and Medicaid Innovation within CMS	0	0	0	0	0	0	0	0	0	0	0	0
1908	Application of emergency services laws	0	0	0	0	0	0	0	0	0	0	0	0
1909	Disregard under the SSI program of compensation for participation in clinical trials for rare diseases or conditions	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE IX		0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL IMPACT, TITLES I-VI, VIII & IX	**-6,470**	**-22,010**	**-30,910**	**-40,860**	**-74,450**	**-58,750**	**-67,710**	**-79,490**	**-89,770**	**-100,170**	**-174,700**	**-570,590**

[1/] Estimate reflects Medicare impact only. See Table 1 for non-Medicare savings from CER.

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.
Interaction between the proposals is not reflected.

Table 4 - Estimated Impacts of H.R. 3962 on Medicaid and CHIP Expenditures, 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													
1701(b)	Eligibility for traditional Medicaid eligible individuals with income not exceeding 150 percent of the Federal Poverty Level	$0	$0	$0	$0	$5,100	$5,500	$5,900	$6,300	$6,800	$7,300	$7,800	$10,600	$44,700
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	204	326	461	491	525	562	602	644	690	1,582	4,604
	Subtitle B—Prevention													
1711	Required coverage of preventive services	0	0	220	460	750	1,090	1,200	1,310	1,420	1,550	1,690	2,520	9,690
1712	Tobacco cessation	0	10	10	10	10	10	10	10	20	20	20	50	130
1713	Optional coverage of nurse home visits	0	13	43	88	144	226	299	356	414	474	498	515	2,557
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	1,260	2,940	4,060	3,880	3,940	4,020	4,120	4,240	4,370	4,510	16,080	37,340
1722	Medical home pilot program	0	180	160	145	155	150	0	0	0	0	0	790	790
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
1726	Requiring coverage of services of podiatrists	0	15	25	25	25	25	30	30	35	35	40	115	285
1726A	Requiring coverage of services of optometrists	0	0	0	0	0	0	0	0	0	0	0	0	0
1727	Therapeutic foster care	0	15	25	40	50	65	80	95	100	105	110	195	685
1728	Assuring adequate payment levels for services	0	0	0	0	0	0	0	0	0	0	0	0	0
1729	Preserving Medicaid coverage for youths upon release from public institutions	0	*	*	*	*	*	*	*	*	*	*	*	*
1730	Quality measures for maternity and adult health services under Medicaid and CHIP	0	40	*	*	*	*	*	*	*	*	*	40	40
1730A	Accountable care organization pilot program	0	0	0	0	0	0	0	0	0	0	0	0	0
1730B	FQHC coverage	0	25	25	25	30	30	35	40	40	45	50	135	345
	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
1734	Preventing the application under CHIP of coverage waiting periods for certain children	0	170	270	300	80	0	0	0	0	0	0	820	820
1735	Adult day health care services	0	0	0	0	0	0	0	0	0	0	0	0	0
1736	Medicaid coverage for citizens of Freely Associated States	0	25	23	24	25	27	29	31	33	35	37	124	289
1737	Continuing requirement of Medicaid coverage of nonemergency transportation to medically necessary services	0	0	0	0	0	0	0	0	0	0	0	0	0
1738	State option to disregard certain income in providing continued Medicaid coverage for certain individuals with extremely high prescription costs	0	*	*	*	*	*	*	*	*	*	*	*	*
1739	Provisions relating to community living assistance services and supports (CLASS)	0	0	0	0	0	0	0	0	0	0	0	0	0
	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	-410	-860	-900	-940	-990	-1,050	-1,110	-1,180	-1,250	-1,330	-4,100	-10,020
1743	Prescription drug discounts for MMCOs	0	-580	-720	-720	-770	-820	-870	-930	-990	-1,040	-1,100	-3,610	-8,540

Table 4 - Estimated Impacts of H.R. 3962 on Medicaid and CHIP Expenditures, in millions

		Fiscal year											Total,	
Sec.	Provision	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
1744	Payments for GME	0	0	150	310	470	480	500	510	520	530	550	1,410	4,020
1745	Nursing Facility Supplemental Payment Program	0	1,500	1,500	1,500	1,500	0	0	0	0	0	0	6,000	6,000
1746	Report on Medicaid payments	0	0	0	0	0	0	0	0	0	0	0	0	0
1747	Reviews of Medicaid	0	0	0	0	0	0	0	0	0	0	0	0	0
1748	Extension of delay in managed care organization provider tax elimination	0	204	0	0	0	0	0	0	0	0	0	204	204
1749	Extension of ARRA increase in FMAP	0	0	21,900	0	0	0	0	0	0	0	0	21,900	21,900
	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
1761	Mandatoty State use of national correct coding initiative	0	-10	-25	-40	-45	-55	-75	-85	-90	-95	-100	-175	-620
	Subtitle G—Puerto Rico and the Territories													
1771	Increased payments to Puerto Rico and territories	0	0	831	887	970	1,053	1,136	1,219	1,302	1,386	1,565	3,742	10,350
	Subtitle H—Miscellaneous													
1781	Technical corrections	0	0	0	0	0	0	0	0	0	0	0	0	0
1782	Extension of QI program	0	0	560	935	220	0	0	0	0	0	0	1,715	1,715
1783	Assuring transparency of information	0	0	0	0	0	0	0	0	0	0	0	0	0
1784	Medicaid and CHIP Payment and Access Commission	0	0	0	0	0	0	0	0	0	0	0	0	0
1785	Outreach and enrollment of Medicaid and CHIP eligible individuals	0	0	0	0	0	0	0	0	0	0	0	0	0
1786	Prohibitions on Federal Medicaid and CHIP payments for undocumented aliens	0	0	0	0	0	0	0	0	0	0	0	0	0
1787	Demonstration project for stabilization of emergency medical conditions by institutions for mental diseases	0	25	25	25	0	0	0	0	0	0	0	75	75
1788	Application of Medicaid Improvement Fund	0	0	0	0	0	-100	-150	-150	-150	-150	0	-100	-700
1789	Treatment of certain Medicaid brokers	0	0	0	0	0	0	0	0	0	0	0	0	0
1790	Rule for changes requiring State legislation	0	0	0	0	0	0	0	0	0	0	0	0	0
SUBTOTAL		0	2,745	27,352	8,036	2,671	1,832	5,664	6,337	5,619	5,417	2,963	42,636	68,637
	Interaction between drug proposals (1742 & 1743)	0	-220	-260	-280	-290	-320	-360	-370	-380	-430	-440	-1,370	-3,350
	Interaction with Medicaid expansion (1701)	0	0	0	0	338	548	590	628	665	686	711	886	4,165
	Interaction with increased FMAP (1749)	0	0	-73	0	0	0	0	0	0	0	0	-73	-73
	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	3,015	27,809	8,836	3,949	2,171	7,144	7,635	6,694	6,353	3,924	45,779	77,529

*Negligible financial impact

Table 5 - Estimated Impacts of H.R. 3962 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. 3962	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total National Health Expenditures (NHE)	$ 2,632.8	$ 2,773.9	$ 2,914.3	$ 3,142.6	$ 3,343.4	$ 3,606.0	$ 3,856.2	$ 4,123.4	$ 4,417.4	$ 4,731.7	$ 35,541.9
Medicare	503.6	526.3	557.6	584.9	609.2	671.2	719.9	775.2	838.6	908.0	6,694.5
Medicaid/CHIP	446.1	496.0	520.6	610.7	662.9	729.4	792.9	859.8	931.7	1,008.8	7,058.7
Federal	287.9	291.0	297.4	368.2	401.2	437.3	475.4	515.0	557.1	602.3	4,232.8
State & Local	158.1	205.0	223.2	242.5	261.8	292.1	317.5	344.8	374.5	406.4	2,825.9
Other Public	312.3	325.1	343.9	360.7	382.6	407.4	433.7	461.5	490.3	520.3	4,037.8
Out of Pocket (OOP)	283.3	295.2	305.7	305.3	318.1	330.0	346.1	365.5	386.0	407.6	3,342.8
Employer-sponsored Private Health Insurance	847.7	879.3	919.3	966.7	1,026.3	1,082.3	1,146.4	1,212.3	1,291.9	1,376.7	10,748.9
Other Private Health Insurance*	48.4	49.8	53.0	14.1	14.7	15.1	15.4	15.9	16.3	16.5	259.3
Other Private†	191.4	202.3	214.3	222.7	236.5	254.0	272.8	292.4	312.0	333.0	2,531.4
Exchange - Private Plan	—	—	—	59.1	70.7	88.2	97.1	105.6	113.3	121.1	655.3
Exchange - Public Plan	—	—	—	20.5	24.5	30.6	33.7	36.6	39.3	42.0	227.2
NHE as percent of Gross Domestic Product (GDP)‡	17.8%	17.9%	17.9%	18.4%	18.7%	19.2%	19.7%	20.1%	20.6%	21.1%	

Table 5, cont. - Estimated Impacts of H.R. 3962 on National Health Expenditures (NHE), in billions

	Calendar Year										Total, CY
Impact of H.R. 3962	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total National Health Expenditures (NHE)	$ 0.5	-$ 4.8	-$ 30.1	$ 17.2	$ 18.0	$ 54.6	$ 57.7	$ 55.7	$ 58.7	$ 61.1	$ 288.6
Medicare	-12.0	-24.2	-33.4	-49.2	-70.5	-60.9	-70.5	-81.9	-92.2	-102.9	-597.8
Medicaid/CHIP	10.0	23.1	8.2	57.2	69.0	87.6	96.3	103.9	110.0	115.5	680.8
Federal	5.7	13.1	4.7	52.4	63.3	72.9	80.3	87.1	92.6	97.9	570.0
State & Local	4.3	9.9	3.5	4.9	5.7	14.7	16.0	16.8	17.4	17.7	110.8
Other Public	4.6	0.0	0.0	-3.9	-3.9	-3.1	-2.7	-2.5	-2.9	-3.3	-17.7
Out of Pocket (OOP)	-1.8	-2.5	-3.2	-17.0	-22.2	-29.4	-33.0	-34.7	-36.7	-39.1	-219.6
Employer-sponsored Private Health Insurance	0.7	0.3	0.0	0.6	1.8	-6.1	-9.6	-16.3	-13.7	-10.6	-52.9
Other Private Health Insurance*	-0.8	-1.2	-1.6	-43.6	-44.7	-46.4	-48.1	-49.9	-51.9	-54.1	-342.4
Other Private†	-0.2	-0.2	-0.2	-4.5	-4.6	-3.8	-3.6	-3.6	-4.4	-5.2	-30.4
Exchange - Private Plan	—	—	—	59.1	70.7	88.2	97.1	105.6	113.3	121.1	655.3
Exchange - Public Plan	—	—	—	20.5	24.5	30.6	33.7	36.6	39.3	42.0	227.2
NHE as percent of Gross Domestic Product (GDP)‡	0.0%	0.0%	-0.2%	0.1%	0.1%	0.3%	0.3%	0.3%	0.3%	0.3%	

*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.
November 13, 2009