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

Douglas W. Elmendorf, Director

December 19, 2009

Honorable Harry Reid
Majority Leader
United States Senate
Washington, DC 20510

Dear Mr. Leader:

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have estimated the direct spending and revenue effects of the Patient Protection and Affordable Care Act (PPACA), Senate Amendment 2786 in the nature of a substitute to H.R. 3590 (as printed in the Congressional Record on November 19, 2009), incorporating the effects of changes proposed in the manager's amendment released on December 19, 2009. This estimate does not include the effects of other amendments adopted during the Senate's consideration of the Patient Protection and Affordable Care Act; it also does not reflect an incremental effect on PPACA from Congressional action on H.R. 3326, the Department of Defense Appropriations Act, 2010, which was cleared on November 19, 2009.[1] Throughout this letter, references to "the legislation" mean the act as originally proposed and incorporating the manager's amendment.

Among other things, the legislation would establish a mandate for most legal residents of the United States to obtain health insurance; set up insurance exchanges through which certain individuals and families could receive federal subsidies to substantially reduce the cost of purchasing that coverage; significantly expand eligibility for Medicaid; substantially reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected under current law); impose an excise tax on insurance plans with relatively high premiums; and make various other changes to the federal tax code, Medicare, Medicaid, and other programs.

CBO and JCT estimate that, on balance, the direct spending and revenue effects of enacting the Patient Protection and Affordable Care Act incorporating the manager's

[1] Section 3112 of the Patient Protection and Affordable Care Act would rescind amounts available in the Medicare Improvement Fund. H.R. 3326, which was cleared by the Senate on December 19, 2009, would reduce the amount in that fund that is available for 2014 by $1.55 billion and increase the amount available for 2015 by $0.55 billion. As a result of those changes, the estimated savings for the PPACA as originally proposed and incorporating the manager's amendment would be reduced by $1 billion over both the 2010–2014 and 2010–2019 periods. That change does not affect the estimated incremental effect of the proposed manager's amendment.

amendment would yield a net reduction in federal deficits of $132 billion over the 2010-2019 period (see Table 1). Approximately $81 billion of that reduction would be on-budget; other effects related to Social Security revenues and spending as well as spending by the U.S. Postal Service are classified as off-budget. CBO has not completed an estimate of the legislation's potential impact on spending that would be subject to future appropriation action.

This estimate incorporates the effects of the manager's amendment, which would make a number of changes to the Patient Protection and Affordable Care Act as originally proposed. The changes with the largest budgetary effects include: expanding eligibility for a small business tax credit; increasing penalties on certain uninsured people; replacing a "public plan" that would be run by the Department of Health and Human Services (HHS) with "multi-state" plans that would be offered under contract with the Office of Personnel Management (OPM); deleting provisions that would increase payment rates for physicians under Medicare; and increasing the payroll tax on higher-income individuals and families. Of the total deficit reduction of $132 billion projected to result from the legislation, the manager's amendment accounts for about $2 billion, and the act as originally proposed accounts for the remaining $130 billion.

CBO and JCT have determined that the legislation contains several intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). The total cost of those mandates to state, local, and tribal governments and the private sector would greatly exceed the thresholds established in UMRA ($69 million and $139 million, respectively, in 2009, adjusted annually for inflation).

CBO and JCT's assessment of the legislation's impact on the federal budget deficit is summarized in Table 1. Table 2 shows federal budgetary cash flows for direct spending and revenues associated with the legislation. Table 3 displays the changes in direct spending and revenues resulting from the provisions in the manager's amendment. Table 4 provides estimates of the resulting changes in the number of nonelderly people in the United States who would have health insurance and presents the primary budgetary effects of the legislation's major provisions related to insurance coverage. Table 5 displays detailed estimates of the costs or savings from other proposed changes (primarily to the Medicare program) that would affect the federal government's direct spending and some aspects of revenues. Detailed estimates of the impact of the tax provisions in Title IX of the legislation are provided by JCT in JCX-61-09 (see www.jct.gov).

This analysis also reviews the main changes included in the manager's amendment, examines the longer-term effects of the legislation on the federal budget, and assesses the effects of the manager's amendment on health insurance premiums.

Table 1. Estimate of the Effects on the Deficit of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
NET CHANGES IN THE DEFICIT FROM INSURANCE COVERAGE PROVISIONS [a,b]												
Effects on the Deficit	2	5	6	3	37	74	109	120	125	133	54	614
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING [c]												
Effects on the Deficit of Changes in Outlays	4	-6	-16	-27	-45	-53	-63	-79	-91	-106	-90	-483
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [d]												
Effects on the Deficit of Changes in Revenues	-1	-6	-10	-30	-27	-32	-35	-38	-41	-42	-75	-264
NET CHANGES IN THE DEFICIT [a]												
Net Increase or Decrease (-) in the Budget Deficit	5	-8	-20	-54	-35	-12	10	3	-7	-16	-111	-132
On-Budget	5	-7	-19	-49	-34	-8	18	13	4	-3	-105	-81
Off-Budget [e]	*	*	*	-5	-1	-4	-8	-10	-11	-13	-6	-52
Memorandum:												
Effects on the Deficit of PPACA as Originally Proposed												
Net Increase or Decrease	2	-14	-28	-58	-38	-11	14	11	1	-8	-136	-130
On-Budget	2	-14	-28	-54	-36	-7	21	20	12	5	-129	-77
Off-Budget [e]	*	*	*	-4	-3	-4	-8	-10	-11	-13	-6	-52
Incremental Effects on the Deficit of Incorporating the Manager's Amendment												
Net Increase or Decrease	3	6	8	5	3	-1	-3	-7	-8	-8	25	-2
On-Budget	3	7	9	5	1	-1	-3	-7	-8	-8	25	-3
Off-Budget [e]	*	*	-1	-1	2	1	*	*	*	*	*	1

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Table 1. Continued.

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

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

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

PPACA = Patient Protection and Affordable Care Act.

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

b. Includes excise tax on high-premium insurance plans.

c. These estimates reflect the effects of provisions affecting Medicare, Medicaid, and other federal health programs, and include the effects of interactions between insurance coverage provisions and those programs.

d. The changes in revenues include effects on Social Security revenues, which are classified as off-budget. The 10-year figure of $264 billion includes $250 billion in revenues from tax provisions (estimated by JCT) apart from receipts from the excise tax on high-premium insurance plans and $14 billion in revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by CBO and JCT). (For JCT's estimates, see JCX-61-09.)

e. Off-budget effects include changes in Social Security spending and revenues as well as spending by the U.S. Postal Service.

Estimated Budgetary Impact

According to CBO and JCT's assessment, enacting the Patient Protection and Affordable Care Act with the manager's amendment would result in a net reduction in federal budget deficits of $132 billion over the 2010–2019 period (see Table 1). In the subsequent decade, the collective effect of its provisions would probably be continued reductions in federal budget deficits if all of the provisions continued to be fully implemented. Those estimates are subject to substantial uncertainty.

The estimate includes a projected net cost of $614 billion over 10 years for the proposed expansions in insurance coverage. That net cost itself reflects a gross total of $871 billion in subsidies provided through the exchanges, increased net outlays for Medicaid and the Children's Health Insurance Program (CHIP), and tax credits for small employers; those costs are partly offset by $149 billion in revenues from the excise tax on high-premium insurance plans and $108 billion in net savings from other sources. Over the 2010–2019 period, the net cost of the coverage expansions would be more than offset by the combination of other spending changes that CBO estimates would save $483 billion and other provisions that JCT and CBO estimate would increase federal revenues by $264 billion.[2]

In total, CBO and JCT estimate that the legislation would increase outlays by $366 billion and increase revenues by $498 billion between 2010 and 2019 (see Table 2).

[2] The 10-year figure of $264 billion includes $250 billion in revenues from tax provisions (estimated by JCT) apart from receipts from the excise tax on high-premium insurance plans and $14 billion in revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by CBO and JCT). (For JCT's estimates, see JCX-61-09.)

Table 2. Estimated Changes in Direct Spending and Revenues Resulting From the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN DIRECT SPENDING (OUTLAYS)												
Health Insurance Exchanges												
Premium and Cost Sharing Subsidies	0	0	0	0	13	31	55	69	76	84	13	329
Start-up Costs	*	*	*	*	*	*	0	0	0	0	2	2
Other Related Spending	0	1	2	2	1	*	*	*	*	0	5	5
Subtotal	*	2	2	2	14	32	55	69	76	84	20	336
Reinsurance and Risk Adjustment Payments [a]	0	0	0	0	12	19	21	21	22	24	12	120
Effects of Coverage Provisions on Medicaid and CHIP	*	-2	-3	-3	28	54	75	79	81	87	20	395
Medicare and Other Medicaid and CHIP Provisions												
Reductions in Annual Updates to Medicare FFS Payment Rates	*	-2	-5	-9	-13	-18	-24	-31	-38	-46	-28	-186
Medicare Advantage Rates Based on Plans' Bids	0	-6	-7	-10	-11	-12	-14	-17	-19	-22	-34	-118
Medicare and Medicaid DSH Payments	0	0	*	*	*	-6	-8	-9	-9	-10	*	-43
Other	1	2	-1	-3	-15	-10	-10	-14	-18	-22	-17	-91
Subtotal	1	-6	-13	-22	-39	-47	-57	-72	-84	-100	-79	-438
Other Changes in Direct Spending												
Community Living Assistance Services and Supports	0	-4	-6	-9	-10	-11	-10	-9	-8	-7	-29	-72
Other	4	4	4	4	4	4	2	*	*	-1	20	26
Subtotal	4	1	-2	-5	-6	-7	-7	-8	-8	-7	-9	-47
Total Outlays	5	-6	-16	-27	8	51	87	88	87	87	-35	366
On-budget	5	-6	-16	-27	8	51	87	88	86	86	-36	362
Off-budget	0	*	*	*	*	*	1	1	1	1	*	4

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Table 2. Continued.

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN REVENUES												
Coverage-Related Provisions												
Exchange Premium Credits	0	0	0	0	-4	-9	-17	-22	-24	-26	-4	-102
Reinsurance and Risk Adjustment Collections	0	0	0	0	13	18	21	21	23	25	13	121
Small Employer Tax Credit	-2	-4	-5	-6	-5	-3	-3	-3	-4	-4	-21	-38
Penalty Payments by Employers and Uninsured Individuals	0	0	0	0	2	5	7	9	10	10	2	43
Excise Tax on High-Premium Plans	0	0	0	7	13	17	22	26	30	35	20	149
Associated Effects of Coverage Provisions on Revenues	*	*	-1	-5	-3	3	12	16	18	20	-9	61
Other Provisions												
Fees on Certain Manufacturers and Insurers [b]	2	6	8	10	12	12	12	13	14	14	37	101
Additional Hospital Insurance Tax	0	0	0	13	6	10	13	14	15	15	19	87
Other Revenue Provisions [c]	-1	1	2	7	9	10	10	11	13	13	19	76
Total Revenues	*	2	4	27	44	63	77	85	94	103	76	498
On-budget	-1	1	4	22	42	59	69	75	82	89	69	443
Off-budget	*	*	*	5	1	4	8	11	12	14	7	55
NET IMPACT ON THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES [d]												
Net Change in the Deficit	5	-8	-20	-54	-35	-12	10	3	-7	-16	-111	-132
On-budget	5	-7	-19	-49	-34	-8	18	13	4	-3	-105	-81
Off-budget	*	*	*	-5	-1	-4	-8	-10	-11	-13	-6	-52

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

Notes: Does not include effects on spending subject to future appropriation. Components may not sum to totals because of rounding.

* = between $0.5 billion and -$0.5 billion.

CHIP = Children's Health Insurance Program; FFS = Fee-for-service; DSH = Disproportionate Share Hospital.

a. Risk adjustment payments lag revenues shown later in the table by one quarter. Reinsurance payments total $20 billion over the 10-year period.

b. Amounts include fees on manufacturers and importers of branded drugs and certain medical devices as well as fees on health insurance providers.

c. Amounts include $62 billion in increased revenues, as estimated by JCT, for tax provisions other than those broken out separately in the table. In addition, this line includes an increase in revenues of about $14 billion for other provisions shown in Table 5.

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

Provisions Regarding Insurance Coverage

The legislation would take several steps designed to increase the number of legal U.S. residents who have health insurance. Starting in 2014, the legislation would establish a requirement for such residents to obtain insurance and would in many cases impose a financial penalty on people who did not do so. The bill also would establish new insurance exchanges and would subsidize the purchase of health insurance through those exchanges for individuals and families with income between 133 percent and 400 percent of the federal poverty level (FPL). Policies purchased through the exchanges (or directly from insurers) would have to meet several requirements: In particular, insurers would have to accept all applicants, could not limit coverage for preexisting medical conditions, and could not vary premiums to reflect differences in enrollees' health. The options available in the insurance exchanges would include private health insurance plans and could include two national or multi-state plans operated under contract with OPM.

Starting in 2014, most nonelderly people with income below 133 percent of the FPL would be made eligible for Medicaid. The federal government would pay all of the costs of covering newly eligible enrollees through 2016; in subsequent years, the federal share of spending would vary somewhat from year to year but would average about 90 percent by 2019. (Under current rules, the federal government usually pays about 57 percent, on average, of the costs of Medicaid benefits.) In addition, states would be required to maintain current coverage levels for all Medicaid beneficiaries until the exchanges were fully operational; coverage levels for children under Medicaid and CHIP would have to be maintained through 2019. Beginning in 2014, states would receive higher federal reimbursement for CHIP beneficiaries, increasing from an average of 70 percent to 93 percent. The legislation would also provide states with additional CHIP funding in 2014 and 2015.

The legislation contains a number of other key provisions related to insurance coverage. In general, firms with more than 50 workers that did not offer coverage would have to pay a penalty of $750 for each full-time worker if any of their workers obtained subsidized coverage through the insurance exchanges; that dollar amount would be indexed. As a rule, full-time workers who were offered coverage from their employer would not be eligible to obtain subsidies via the exchanges. However, an exception to that "firewall" would be allowed for workers who had to pay more than a specified percentage of their income for their employer's insurance—9.8 percent in 2014, indexed over time—in which case the employer would be penalized. Under certain circumstances, firms with relatively few employees and relatively low average wages would also be eligible for tax credits to cover up to half of their contributions toward health insurance premiums. Beginning in 2013, insurance policies with relatively high total premiums would be subject to a 40 percent excise tax on the amount by which the premiums exceeded a specified threshold. That threshold would be set initially at $8,500 for single

policies and $23,000 for family policies (with certain exceptions); after 2013, those amounts would be indexed to overall inflation plus 1 percentage point.

Effects of Insurance Coverage Provisions
CBO and JCT estimate that provisions affecting health insurance coverage would result in a net increase in federal deficits of $614 billion over fiscal years 2010 through 2019 (see Table 4). That estimate includes $395 billion in additional net federal outlays for Medicaid and CHIP.[3] It also includes $436 billion in federal subsidies that would be provided to purchase coverage through the new insurance exchanges and related spending.[4] The other main element of the coverage provisions that would increase federal deficits is the tax credit for certain small employers who offer health insurance, which is estimated to cost $40 billion over 10 years. Those costs would be partly offset by receipts or savings, totaling $257 billion over the 10-year budget window, from four sources: net revenues from the excise tax on high-premium insurance plans, totaling $149 billion; penalty payments by uninsured individuals, which would amount to $15 billion; penalty payments by employers whose workers received subsidies via the exchanges, which would total $28 billion; and other budgetary effects, mostly on tax revenues, associated with the expansion of federally subsidized insurance, which would reduce deficits by $65 billion.[5]

By 2019, CBO and JCT estimate, the number of nonelderly people who are uninsured would be reduced by about 31 million, leaving about 23 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under the legislation, the share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 94 percent. Approximately 26 million people would purchase their own coverage through the new insurance exchanges, and there would be roughly 15 million more enrollees in Medicaid and CHIP than is projected under current law. Relative to currently projected levels, the number of people purchasing individual coverage outside the exchanges would decline by about 5 million. Under the legislation, certain employers could allow all of their workers to choose among the plans available in the exchanges, but those enrollees would not be eligible to receive subsidies via the exchanges (and thus are shown in Table 4 as enrollees in employment-based

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[3] CBO estimates that state spending on Medicaid and CHIP would increase by about $26 billion over the 2010–2019 period as a result of the provisions affecting coverage reflected in Table 4. That estimate reflects states' flexibility to make programmatic and other budgetary changes to Medicaid and CHIP.

[4] Related spending includes the administrative costs of establishing the exchanges as well as $5 billion for high-risk pools and the net budgetary effects of proposed payments and receipts for reinsurance and risk adjustment.

[5] Changes in the extent of employment-based health insurance affect federal revenues because most payments for that coverage are tax-preferred. If employers increase or decrease the amount of compensation they provide in the form of health insurance (relative to current-law projections), CBO and JCT assume that offsetting changes will occur in wages and other forms of compensation—which are generally taxable—to hold total compensation roughly the same. Such effects also arise with respect to specific elements of the proposal (such as the tax credits for small employers), and those effects are included within the estimates for those elements.

coverage rather than as exchange enrollees). Approximately 5 million people would obtain coverage in that way in 2019, bringing the total number of people enrolled in exchange plans to about 30 million in that year.

The number of people obtaining coverage through their employer would be about 4 million lower in 2019 under the legislation, CBO and JCT estimate. The net change in employment-based coverage is the result of several flows, which can be illustrated using the estimates for 2019:

- About 6 million people would be covered by an employment-based plan under the proposal who would not be covered by one under current law (largely because the mandate for individuals to be insured would increase workers' demand for coverage through their employers).

- Between 8 million and 9 million other people who would be covered by an employment-based plan under current law would not have an offer of such coverage under the proposal. Firms that would choose not to offer coverage as a result of the proposal would tend to be smaller employers and employers that predominantly employ lower-wage workers—people who would be eligible for subsidies through the exchanges—although some workers who would not have employment-based coverage because of the proposal would not be eligible for such subsidies. Whether those changes in coverage would represent the dropping of existing coverage or a lack of new offers of coverage is difficult to determine.

- In addition, between 1 million and 2 million people who could be covered by their employer's plan (or a plan offered to a family member) would instead obtain coverage in the exchanges, either because the employer's offer would be deemed unaffordable and they would therefore be eligible to receive subsidies in the exchanges, or because the "firewall" for those with an offer of employer coverage would be imperfectly enforced. (Those people are counted as enrollees in the exchanges.)

The proposal would call on OPM to contract for two national or multi-state health insurance plans—one of which would have to be nonprofit—that would be offered through the insurance exchanges. Whether insurers would be interested in offering such plans is unclear, and establishing a nationwide plan comprising only nonprofit insurers might be particularly difficult. Even if such plans were arranged, the insurers offering them would probably have participated in the insurance exchanges anyway, so the inclusion of this provision did not have a significant effect on the estimates of federal costs or enrollment in the exchanges.

Provisions Affecting Medicare, Medicaid, and Other Programs

Other components of the legislation would alter spending under Medicare, Medicaid, and other federal programs. The legislation would make numerous changes to payment rates and payment rules in those programs (the budgetary effects of which are summarized in Table 1 and detailed in Table 5). In total, CBO estimates that enacting those provisions would reduce net direct spending by $483 billion over the 2010–2019 period.[6] The provisions that would result in the largest budget savings include these:

- Permanent reductions in the annual updates to Medicare's payment rates for most services in the fee-for-service sector (other than physicians' services), yielding budgetary savings of $186 billion over 10 years. (That calculation excludes interactions between those provisions and others—namely, the effects of those changes on payments to Medicare Advantage plans and collections of Part B premiums.)

- Setting payment rates in the Medicare Advantage program on the basis of the average of the bids submitted by Medicare Advantage plans in each market, yielding savings of an estimated $118 billion (before interactions) over the 2010–2019 period.

- Reducing Medicaid and Medicare payments to hospitals that serve a large number of low-income patients, known as disproportionate share hospitals (DSH), by about $43 billion—composed of roughly $19 billion from Medicaid and $24 billion from Medicare DSH payments.

The legislation also would establish an Independent Payment Advisory Board, which would be required, under certain circumstances, to recommend changes to the Medicare program to limit the rate of growth in that program's spending. Those recommendations would go into effect automatically unless blocked by subsequent legislative action. Such recommendations would be required if the Chief Actuary for the Medicare program projected that the program's spending per beneficiary would grow more rapidly than a measure of inflation (the average of the growth rates of the consumer price index for medical services and the overall index for all urban consumers). The provision would place a number of limitations on the actions available to the board, including a prohibition against modifying eligibility or benefits, so its recommendations probably would focus on:

- Reductions in subsidies for non-Medicare benefits offered by Medicare Advantage plans; and

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

- Changes to payment rates or methodologies for services furnished in the fee-for-service sector by providers other than hospitals, physicians, hospices, and suppliers of durable medical equipment that is offered through competitive bidding.[7]

The board would develop its first set of recommendations during 2013 for implementation in 2015. CBO expects that the board would be fairly effective at meeting the savings targets during the 2015–2019 period. As a result, CBO estimates that—given all of the reductions that would result from other provisions—this arrangement would reduce Medicare spending by an additional $28 billion over that period. That estimate represents the expected value of the 10-year savings from the arrangement, reflecting CBO's judgment that most, but not all, of the targeted savings would be achieved through this process. The board would also be required to make recommendations regarding changes to nonfederal health care programs that would slow the growth of national health expenditures. Those recommendations would be non-binding.

The legislation includes a number of other provisions with a significant budgetary effect. They include the following:

- Community Living Assistance Services and Supports (CLASS) provisions, which would establish a voluntary federal program for long-term care insurance. Active workers could purchase coverage, usually through their employer. Premiums would be set to cover the full cost of the program as measured on an actuarial basis. However, the program's cash flows would show net receipts for a number of years, followed by net outlays in subsequent decades. In particular, the program would pay out far less in benefits than it would receive in premiums over the 10-year budget window, reducing deficits by about $72 billion over that period, including about $2 billion in savings to Medicaid.

- Requirements that the Secretary of HHS adopt and regularly update standards for electronic administrative transactions that enable electronic funds transfers, claims management processes, and verification of eligibility, among other administrative tasks. These provisions would result in about $11 billion in federal savings in Medicaid and reduced subsidies paid through the insurance exchanges. In addition, these standards would result in an increase in revenues of about $8 billion as an indirect effect of reducing the cost of private health insurance plans.

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[7] The proposal would authorize the board to recommend changes that would affect hospitals and hospices beginning in 2020.

- A mandatory appropriation of $15 billion to establish a Prevention and Public Health Fund. CBO estimates that outlays of those funds would total about $13 billion over the 2010–2019 period.

- Mandatory funding of $10 billion for community health centers and the National Health Service Corps. CBO estimates that outlays of those funds would total about $10 billion over the 2010–2019 period.

- An abbreviated approval pathway for biosimilar biological products (biological products that are highly similar to or interchangeable with their brand-name counterparts), which would reduce direct spending by an estimated $7 billion over the 2010–2019 period.

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

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

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

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

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

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

Changes Made in the Patient Protection and Affordable Care Act by the Manager's Amendment

On November 18, 2009, CBO transmitted an analysis by CBO and JCT of the legislation as originally proposed. The estimates provided here differ from the ones in that analysis because they incorporate the effects of the manager's amendment. Relative to the provisions included in the PPACA as originally proposed, key examples of the changes that would be made by the manager's amendment are as follows:

- The tax credit for small businesses would be made available to firms paying somewhat higher average wages, and it would first take effect in 2010 rather than 2011.

- The penalty for not having insurance would be the greater of a flat dollar amount per person or a percentage of the individual's income, which would increase the amount of penalties collected.

- The provision establishing a public plan that would be run by HHS was replaced with a provision for multi-state plans that would be offered under contract with OPM.

- Certain workers would have the option of obtaining tax-free vouchers from their employers equal in value to the contributions their employers would make to their health insurance plans. The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. (CBO and JCT estimate that about 100,000 workers would take advantage of that option.)

- Several provisions regulating insurers were added, including a requirement for an insurer to provide rebates if its share of premiums going to administrative costs exceeds specified levels and a general prohibition on imposing annual limits on the amount of benefits that would be covered.

- Additional federal funding for CHIP would be provided to states in 2014 and 2015.

- A provision that would increase Medicare's payment rates for physicians' services by 0.5 percent for 2010 was eliminated. Instead, the 21 percent reduction in those payment rates that is scheduled to occur in 2010 under current law would take effect.

- The measure of Medicare spending that would be used to set savings targets for the Independent Payment Advisory Board was modified.

- The increment to the Hospital Insurance portion of the payroll tax rate for individuals with income above $200,000 and for families with income above $250,000 was raised from 0.5 percent to 0.9 percent.

- The 5 percent excise tax on cosmetic surgery was eliminated, and a 10 percent excise tax on indoor tanning services was added.

- Community health centers and the National Health Service Corps would receive an additional $10 billion in mandatory funding.

- Revisions to and extensions of the Indian Health Care Improvement Act were added.

Table 3. Estimate of the Incremental Effects on the Deficit of Incorporating the Manager's Amendment to the Patient Protection and Affordable Care Act, as Originally Proposed

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN DIRECT SPENDING												
Change in Outlays	-7	-1	4	3	4	6	4	-1	-1	-2	3	10
On-Budget	-7	-1	4	3	4	6	4	-1	-1	-2	3	10
Off-Budget	0	0	*	*	*	*	*	*	*	*	*	*
CHANGES IN REVENUES												
Change in Revenues	-9	-8	-4	-1	1	7	7	7	7	6	-22	12
On-Budget	-10	-8	-5	-2	3	8	7	7	7	6	-22	13
Off-Budget	*	*	1	1	-2	-1	*	*	*	*	*	-1
NET IMPACT ON THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES [a]												
Net Change in the Deficit	3	6	8	5	3	-1	-3	-7	-8	-8	25	-2
On-Budget	3	7	9	5	1	-1	-3	-7	-8	-8	25	-3
Off-Budget	*	*	-1	-1	2	1	*	*	*	*	*	1

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

Notes: Does not include effects on spending subject to future appropriation. Components may not sum to totals because of rounding.

* = between $0.5 billion and -$0.5 billion.

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

Relative to the savings projected for the original proposal, the manager's amendment would reduce the deficit by another $2 billion over 10 years (see Table 3). During this period, the amendment would increase direct spending by about $10 billion and increase revenues by about $12 billion.

The increase in funding for CHIP would raise enrollment and spending in CHIP for several years, with partially offsetting reductions in other sources of coverage. Expanding the small business tax credit would increase the gross cost of the coverage expansion by about $13 billion. Increasing the penalty for not having insurance would increase penalty collections by about $7 billion on net. Several other provisions of the manager's amendment also would affect enrollment and spending in Medicaid, CHIP, and the exchanges. By 2019, the changes related to insurance coverage would slightly increase enrollment in employment-based plans and the exchanges, and they would slightly reduce the number of uninsured people and the number of people enrolled in Medicaid. CBO and JCT estimate that the gross cost of the proposed expansions in insurance coverage would be roughly $23 billion higher as a result of the manager's amendment than they would be under the act as originally proposed ($871 billion compared with $848 billion). The net cost of the proposed insurance expansions would be about $15 billion higher than under the PPACA as originally proposed.

Other provisions included in the manager's amendment would increase federal revenues by about $26 billion (mostly from the change in the payroll tax) and would reduce the savings in Medicare, Medicaid, and other direct spending by about $8 billion on net.

Effects of the Legislation Beyond the First 10 Years

Although CBO does not generally provide cost estimates beyond the 10-year budget projection period (2010 through 2019 currently), Senate rules require some information about the budgetary impact of legislation in subsequent decades, and many Members have requested CBO analyses of the long-term budgetary impact of broad changes in the nation's health care and health insurance systems. A detailed year-by-year projection for years beyond 2019, like those that CBO prepares for the 10-year budget window, would not be meaningful because the uncertainties involved are simply too great. Among other factors, a wide range of changes could occur—in people's health, in the sources and extent of their insurance coverage, and in the delivery of medical care (such as advances in medical research, technological developments, and changes in physicians' practice patterns)—that are likely to be significant but are very difficult to predict, both under current law and under any proposal.

Effects on the Deficit. CBO has developed a rough outlook for the decade following the 10-year budget window by grouping the elements of the legislation into broad categories and assessing the rate at which the budgetary impact of each of those broad categories is likely to increase over time. The categories are as follows:

- The gross cost of the coverage expansions, consisting of exchange subsidies, the net costs of expanded eligibility for Medicaid, and tax credits for employers: Those provisions have an estimated cost of $199 billion in 2019, and that cost is growing at about 8 percent per year toward the end of the 10-year budget window. As a rough approximation, CBO assumes continued growth at about that rate during the following decade.

- The excise tax on high-premium insurance plans: JCT estimates that the provision would generate about $35 billion in additional revenues in 2019 and expects that receipts would grow by roughly 10 percent to 15 percent per year in the following decade.

- Other taxes and other effects of coverage provisions on revenues: Increased revenues from those provisions are estimated to total $74 billion in 2019 and are growing at about 7 percent per year toward the end of the budget window. As a rough approximation, CBO assumes continued growth at about that rate during the following decade.

- Changes to the Medicare program and changes to Medicaid and CHIP other than those associated directly with expanded insurance coverage: Savings from those provisions are estimated to total $106 billion in 2019, and CBO expects that, in combination, they would increase by nearly 15 percent per year in the next decade.

All told, the legislation incorporating the manager's amendment would reduce the federal deficit by $16 billion in 2019, CBO and JCT estimate. In the decade after 2019, the gross cost of the coverage expansion would probably exceed 1 percent of gross domestic product (GDP), but the added revenues and cost savings would probably be greater. Consequently, CBO expects that the legislation, if enacted, would reduce federal budget deficits over the ensuing decade relative to those projected under current law—with a total effect during that decade that is in a broad range around one-half percent of GDP. The imprecision of that calculation reflects the even greater degree of uncertainty that attends to it, compared with CBO's 10-year budget estimates. The expected reduction in deficits would represent a small share of the total deficits that would be likely to arise in that decade under current policies.[8]

Relative to the legislation as originally proposed, the expected reduction in deficits during the 2020–2029 period is larger for the legislation incorporating the manager's amendment. Most of that difference arises because the manager's amendment would lower the threshold for Medicare spending growth that would trigger recommendations for spending reductions by the Independent Payment Advisory Board. Such

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[8] See Congressional Budget Office, *The Long-Term Budget Outlook* (June 2009).

recommendations would be required, in the legislation as originally proposed, if projected growth in Medicare spending per beneficiary exceeded the rate of increase in national health expenditures per capita—and in the legislation incorporating the manager's amendment, if it exceeded the average of the growth rates of the consumer price index for medical services and the overall index for all urban consumers. Because other elements of the proposal would sharply reduce the growth rate of Medicare spending in the next two decades relative to growth in the past two decades—from roughly 4 percent to roughly 2 percent on an inflation-adjusted per-beneficiary basis—CBO expects that the full amount of targeted savings would become more difficult to achieve over time. Even so, this element of the manager's amendment would probably augment the reduction in Medicare spending under the proposal significantly in the decade beyond the 10-year budget window.

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

CBO has not extrapolated estimates further into the future, because the uncertainties surrounding them are magnified even more. However, in view of the projected net savings during the decade following the 10-year budget window, CBO anticipates that the legislation would probably continue to reduce budget deficits relative to those under current law in subsequent decades, assuming that all of its provisions would continue to be fully implemented. Pursuant to section 311 of S. Con. Res. 70, CBO estimates that enacting the legislation would not cause a net increase in deficits in excess of $5 billion in any of the four 10-year periods beginning after 2019.

Other Measures. Many Members have expressed interest in the effects of reform proposals on various other measures of spending on health care. One such measure is the "federal budgetary commitment to health care," a term that CBO uses to describe the sum of net federal outlays for health programs and tax preferences for health care—providing a broad measure of the resources committed by the federal government that includes both its spending for health care and the subsidies for health care that are conveyed through reductions in federal taxes (for example, through the exclusion of payments for employment-based health insurance from income and payroll taxes).[9]

[9] For additional discussion of this term, see Congressional Budget Office, letter to the Honorable Max Baucus regarding different measures for analyzing current proposals to reform health care (October 30, 2009).

Under the legislation, federal outlays for health care would increase during the 2010–2019 period, as would the federal budgetary commitment to health care. The net increase in that commitment would be about $200 billion over that 10-year period, driven primarily by the gross cost of the coverage expansions (including increases in both outlays and tax credits). That cost would be partly offset by reductions in the federal commitment from changes to net spending for Medicare, Medicaid, CHIP, and other federal health programs; revenues generated by the excise tax on high-premium insurance plans; and changes to existing law regarding tax preferences for health care and effects of other provisions on tax expenditures for health care. Under the legislation as originally proposed, the net increase in the federal budgetary commitment to health care during the next 10 years was estimated to be about $160 billion. The difference between those figures largely reflects the difference in the gross cost of the coverage expansions.

In subsequent years, the effects of the proposal that would tend to decrease the federal budgetary commitment to health care would grow faster than those that would increase it. As a result, CBO expects that the proposal would generate a reduction in the federal budgetary commitment to health care during the decade following the 10-year budget window. By comparison, CBO expected that the legislation as originally proposed would have no significant effect on that commitment during the 2020-2029 period; most of the difference in CBO's assessment arises because the manager's amendment would lower the threshold for Medicare spending growth that would trigger recommendations for spending reductions by the Independent Payment Advisory Board. The range of uncertainty surrounding these assessments is quite wide.

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

Key Considerations. These longer-term calculations assume that the provisions are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation. For example, the sustainable growth rate (SGR) mechanism governing Medicare's payments to physicians has frequently been modified (either through legislation or administrative action) to avoid reductions in those payments, and legislation to do so again is currently under consideration in the Congress.

The legislation would maintain and put into effect a number of procedures that might be difficult to sustain over a long period of time. Under current law and under the proposal, payment rates for physicians' services in Medicare would be reduced by about 21 percent in 2010 and then decline further in subsequent years. At the same time, the legislation includes a number of provisions that would constrain payment rates for other providers of

Medicare services. In particular, increases in payment rates for many providers would be held below the rate of inflation (in expectation of ongoing productivity improvements in the delivery of health care). The projected longer-term savings for the legislation also assume that the Independent Payment Advisory Board is fairly effective in reducing costs beyond the reductions that would be achieved by other aspects of the legislation.

Based on the extrapolation described above, CBO expects that Medicare spending under the legislation would increase at an average annual rate of roughly 6 percent during the next two decades—well below the roughly 8 percent annual growth rate of the past two decades (excluding the effect of establishing the Medicare prescription drug benefit). Adjusting for inflation, Medicare spending per beneficiary under the legislation would increase at an average annual rate of less than 2 percent during the next two decades—about half of the roughly 4 percent annual growth rate of the past two decades. It is unclear whether such a reduction in the growth rate could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or would reduce access to care or diminish the quality of care.

The long-term budgetary impact could be quite different if key provisions of the legislation were ultimately changed or not fully implemented. If those changes arose from future legislation, CBO would estimate their costs when that legislation was being considered by the Congress.

Effects on Health Insurance Premiums

On November 30, CBO released an analysis prepared by CBO and JCT of the expected impact on average premiums for health insurance in different markets of the legislation as originally proposed.[10] Although CBO and JCT have not updated the estimates provided in that letter, the effects on premiums of the legislation incorporating the manager's amendment would probably be quite similar. Replacing the provisions for a public plan run by HHS with provisions for a multi-state plan under contract with OPM is unlikely to have much effect on average insurance premiums because the existence of that public plan would not substantially change the average premiums that would be paid in the exchanges.[11] The provisions contained in the manager's amendment to regulate the share of premiums devoted to administrative costs would tend to lower premiums slightly, and the provisions prohibiting the imposition of annual limits on coverage would tend to raise premiums slightly.

[10] For further description, see Congressional Budget Office, letter to the Honorable Evan Bayh providing an analysis of health insurance premiums under the Patient Protection and Affordable Care Act (November 30, 2009).

[11] The presence of the public plan had a more noticeable effect on CBO's estimates of federal subsidies because it was expected to exert some downward pressure on the premiums of the lower-cost plans to which those subsidies would be tied.

Private-Sector and Intergovernmental Impact

CBO and JCT have determined that the legislation contains private-sector and intergovernmental mandates as defined in the Unfunded Mandates Reform Act.

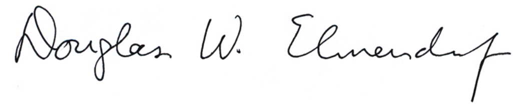
The total cost of mandates imposed on the private sector, as estimated by CBO and JCT, would greatly exceed the threshold established in UMRA for private entities ($139 million in 2009, adjusted annually for inflation)—as was the case for the legislation as originally proposed. The most costly mandates would be the new requirements regarding health insurance coverage that apply to the private sector. The legislation would require individuals to obtain acceptable health insurance coverage, as defined in the legislation. The legislation also would penalize medium-sized and large employers that did not offer health insurance to their employees if any of their workers obtained subsidized coverage through the insurance exchanges. The legislation would impose a number of mandates, including requirements on issuers of health insurance, new standards governing health information, and nutrition labeling requirements.

CBO estimates that the total cost of intergovernmental mandates would greatly exceed the annual threshold established in UMRA for state, local, and tribal entities ($69 million in 2009, adjusted annually for inflation)—as was the case for the legislation as originally proposed. The provisions of the legislation that would penalize those entities—if they did not offer health insurance to their employees and any of their workers obtained subsidized coverage through the insurance exchanges—account for most of the mandate costs. In addition, the legislation would preempt state and local laws that conflict with or are in addition to new federal standards established by the legislation. Those preemptions would limit the application of state and local laws, but CBO estimates that they would not impose significant costs.

As conditions of federal assistance (and thus not mandates as defined in UMRA), the legislation would require state and local governments to comply with “maintenance of effort” provisions associated with high-risk insurance pools. New requirements in the Medicaid program also would result in an increase in state spending. However, because states have significant flexibility to make programmatic adjustments in their Medicaid programs to accommodate changes, the new requirements would not be intergovernmental mandates as defined in UMRA.

I hope this analysis is helpful for the Senate's deliberations. If you have any questions, please contact me or CBO staff. The primary staff contacts for this analysis are Philip Ellis and Holly Harvey.

Sincerely,



Douglas W. Elmendorf
Director

Enclosures

cc: Honorable Mitch McConnell
Republican Leader

Honorable Max Baucus
Chairman
Committee on Finance

Honorable Chuck Grassley
Ranking Member

Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor, and Pensions

Honorable Michael B. Enzi
Ranking Member

Honorable Kent Conrad
Chairman
Committee on the Budget

Honorable Judd Gregg
Ranking Member

TABLE 4. Estimated Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act as Proposed, Incorporating the Manager's Amendment

EFFECTS ON INSURANCE COVERAGE /a (Millions of nonelderly people, by calendar year)		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law Coverage /b	Medicaid & CHIP	40	39	39	38	35	34	35	35	35	35
	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup & Other /c	27	26	25	26	28	29	29	29	30	30
	Uninsured /d	50	51	51	51	51	51	52	53	53	54
	TOTAL	267	269	271	273	274	276	277	279	281	282
Change (+/-)	Medicaid & CHIP	*	-1	-2	-2	8	13	16	15	15	15
	Employer	*	2	2	2	2	-1	-4	-4	-4	-4
	Nongroup & Other /c	*	*	*	*	-2	-3	-5	-5	-5	-5
	Exchanges	0	0	0	0	8	14	23	24	25	26
	Uninsured /d	*	-1	-1	-1	-16	-23	-29	-30	-30	-31
Post-Policy Uninsured Population											
Number of Nonelderly People /d		50	50	50	49	34	28	22	22	23	23
Insured Share of the Nonelderly Population /a											
Including All Residents		81%	81%	82%	82%	88%	90%	92%	92%	92%	92%
Excluding Unauthorized Immigrants		83%	83%	83%	84%	90%	92%	94%	94%	94%	94%
Memo: Exchange Enrollees and Subsidies											
Number w/ Unaffordable Offer from Employer /e						*	1	1	1	1	1
Number of Unsubsidized Exchange Enrollees						2	3	5	5	6	6
Average Exchange Subsidy per Subsidized Enrollee							$4,700	$4,800	$5,000	$5,300	$5,600

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

Note: CHIP = Children's Health Insurance Program; * = fewer than 0.5 million people.

a. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.
b. Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source.
c. Other, which includes Medicare, accounts for about half of current-law coverage in this category; the effects of the proposal are almost entirely on nongroup coverage.
d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.
e. Workers who would have to pay more than a specified share of their income (9.8 percent in 2014) for employment-based coverage could receive subsidies via an exchange.

TABLE 4. Estimated Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act as Proposed, Incorporating the Manager's Amendment

EFFECTS ON THE FEDERAL DEFICIT / a,b (Billions of dollars, by fiscal year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Medicaid & CHIP Outlays /c	0	-2	-3	-3	28	54	75	79	81	87	395
Exchange Subsidies & Related Spending /d	0	2	2	2	17	42	73	90	100	109	436
Small Employer Tax Credits /e	2	4	5	6	5	4	3	3	4	4	40
Gross Cost of Coverage Provisions	2	4	5	6	50	99	151	172	184	199	871
Penalty Payments by Uninsured Individuals	0	0	0	0	0	-1	-2	-4	-4	-4	-15
Penalty Payments by Employers /e	0	0	0	0	-2	-4	-5	-5	-6	-6	-28
Excise Tax on High-Premium Insurance Plans /e	0	0	0	-7	-13	-17	-22	-26	-30	-35	-149
Other Effects on Tax Revenues and Outlays /f	0	1	1	5	2	-3	-13	-17	-19	-22	-65
NET COST OF COVERAGE PROVISIONS	**2**	**5**	**6**	**3**	**37**	**74**	**109**	**120**	**125**	**133**	**614**

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

Note: CHIP = Children's Health Insurance Program.

a. Does not include several billion dollars in federal administrative costs that would be subject to appropriation.
b. Components may not sum to totals because of rounding; positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
c. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2010-2019 period would increase by about $26 billion as a result of the coverage provisions.
d. Includes $5 billion in spending for high-risk pools and the net budgetary effects of proposed collections and payments for reinsurance and risk adjustment.
e. The effects on the deficit of this provision include the associated effects of changes in taxable compensation on tax revenues.
f. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about $3 billion over the 2010-2019 period, and that the coverage provisions would have negligible effects on outlays for other federal programs.

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Changes in Direct Spending Outlays												
TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS												
Subtitle A—Immediate Improvements in Health Care Coverage for All Americans												
1001 Amendments to the Public Health Service Act	Included in estimate for expanding health insurance coverage.											
1002 Helping Consumers Receive Quality Accountable Coverage	*	*	*	0	0	0	0	0	0	0	*	*
Subtitle B—Immediate Assistance to Preserve and Expand Coverage												
1101 Temporary High Risk Health Insurance Pool	Included in estimate for expanding health insurance coverage.											
1102 Reinsurance for Early Retirees	3.0	2.0	0	0	0	0	0	0	0	0	5.0	5.0
1103 Immediate Assistance to Consumers in Identifying Affordable Coverage Options	Included in estimate for expanding health insurance coverage.											
1104 Administrative Simplification												
Effects on Medicaid spending	*	*	-0.1	-0.1	-0.2	-0.4	-0.8	-1.7	-1.8	-2.0	-0.4	-7.1
Effects on exchange subsidies	0	0	0	0	-0.1	-0.3	-0.6	-1.0	-1.2	-1.2	-0.1	-4.3
Subtitle C—Effective Coverage for All Americans	Included in estimate for expanding health insurance coverage.											
Subtitle D—Available Coverage for All Americans	Included in estimate for expanding health insurance coverage.											
Subtitle E—Affordable Coverage for All Americans	Included in estimate for expanding health insurance coverage.											
Subtitle F—Shared Responsibility for Health Care	Included in estimate for expanding health insurance coverage.											
Subtitle G—Miscellaneous Provisions												
1556 Equity for Certain Eligible Survivors	*	*	*	*	*	*	*	*	*	*	*	*
Sections 1551-1555 and 1557-1562	Included in estimate for expanding health insurance coverage.											

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
TITLE II—ROLE OF PUBLIC PROGRAMS													
Subtitle A—Improved Access to Medicaid													
2001	Medicaid Coverage for the Lowest Income Populations	Included in estimate for expanding health insurance coverage.											
2002	Income Eligibility for Nonelderly Determined Using Modified Gross Income	Included in estimate for expanding health insurance coverage.											
2003	Requirement to Offer Premium Assistance for Employer-Sponsored Insurance	Included in estimate for expanding health insurance coverage.											
2004	Medicaid Coverage for Former Foster Care Children	Included in estimate for expanding health insurance coverage.											
2005	Payments to Territories	0	0.1	0.1	0.1	0.7	0.7	0.8	0.8	0.9	1.0	1.0	5.3
2006	Special Adjustment to FMAP Determination for Certain States Recovering from a Major Disaster	0	0.1	0	0	0	0	0	0	0	0	0.1	0.1
2007	Medicaid Improvement Fund Rescission	0	0	0	0	-0.1	-0.2	-0.2	-0.2	-0.2	0	-0.1	-0.7
Subtitle B—Enhanced Support for the Children's Health Insurance Program													
2101	Additional Federal Financial Participation for CHIP	Included in estimate for expanding health insurance coverage.											
2102	Technical Corrections	0	0	0	0	0.1	*	*	0	0	0	0.1	0.1
Subtitle C—Medicaid and CHIP Enrollment Simplification		Included in estimate for expanding health insurance coverage.											
Subtitle D—Improvements to Medicaid Services													
2301	Coverage for Freestanding Birth Center Services	*	*	*	*	*	*	*	*	*	*	*	*
2302	Concurrent Care for Children	*	*	*	*	*	*	*	*	*	*	0.1	0.2
2303	State Eligibility Option for Family Planning Services	0	0	0	0	0	0	0	0	0	0	0	0
2304	Clarification of Definition of Medical Assistance	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle E—New Options for States to Provide Long-Term Services and Supports													
2401	Community First Choice Option	0	0.1	0.2	0.3	0.7	0.8	0.9	1.1	1.2	1.5	1.3	6.9
2402	Removal of Barriers to Providing Home and Community-Based Services	0	0.1	0.1	0.1	0.2	0.3	0.3	0.4	0.4	0.4	0.5	2.3
2403	Money Follows the Person Rebalancing Demonstration	0	0	0	*	0.1	0.2	0.3	0.4	0.3	0.3	0.2	1.7
2404	Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment	0	0	0	0	0.2	0.3	0.3	0.3	0.3	0.2	0.2	1.5
2405	Expand State Aging and Disability Resource Centers	*	*	*	*	*	*	*	*	0	0	*	0.1
2406	Sense of the Senate Regarding Long-Term Care	0	0	0	0	0	0	0	0	0	0	0	0
	Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes	0	*	0.1	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.6	1.6

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Subtitle F—Medicaid Prescription Drug Coverage		-0.8	-2.6	-3.2	-3.3	-3.7	-4.1	-4.7	-5.0	-5.3	-5.7	-13.5	-38.4
Subtitle G—Medicaid Disproportionate Share Hospital Payments		0	0	*	*	*	-2.8	-3.7	-3.9	-4.0	-4.1	*	-18.5
Subtitle H—Improved Coordination for Dual Eligible Beneficiaries													
2601	5-Year Period for Demonstration Projects	0	0	0	0	0	0	0	0	0	0	0	0
2602	Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle I—Improving the Quality of Medicaid for Patients and Providers													
2701	Adult Health Quality Measures	*	*	*	0.1	0.1	*	*	*	*	0	0.2	0.3
2702	Payment Adjustment for Health Care-Acquired Conditions	0	0	*	*	*	*	*	*	*	*	*	*
2703	State Option to Provide Health Homes for Enrollees With Chronic Conditions	0	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.7
2704	Demonstration Project to Evaluate Integrated Care Around a Hospitalization	0	0	0	0	0	0	0	0	0	0	0	0
2705	Medicaid Global Payment System Demonstration Project	0	0	0	0	0	0	0	0	0	0	0	0
2706	Pediatric Accountable Care Organization Demonstration Project	0	0	0	0	0	0	0	0	0	0	0	0
2707	Medicaid Emergency Psychiatric Demonstration Project	0	*	*	*	*	*	0	0	0	0	0.1	0.1
Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)		*	*	0	0	0	0	0	0	0	0	*	*
Subtitle K—Protections for American Indians and Alaska Natives													
2901	Special Rules Relating to Indians												
	No Cost Sharing for Indians with Income at or Below 300 Percent of Poverty Enrolled in Coverage Through a State Exchange	Included in estimate for expanding health insurance coverage.											
	Payer of Last Resort and Express-Lane Option	0	0	0	0	0	0	0	0	0	0	0	0
2902	Elimination of Sunset for Payment for Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics	0	*	*	*	*	*	*	*	*	*	0.1	0.2
	Indian Health Improvement Act	*	*	*	*	*	*	*	*	*	*	*	*

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
SUBTITLE F—MATERNAL AND CHILD HEALTH SERVICES													
2951	Maternal, Infant, and Early Childhood Home Visiting Programs	*	0.1	0.3	0.4	0.4	0.2	0.1	*	0	0	1.2	1.5
2952	Support, Education, and Research for Postpartum Depression	0	0	0	0	0	0	0	0	0	0	0	0
2953	Personal Responsibility Education	*	*	0.1	0.1	0.1	0.1	*	*	*	0	0.3	0.4
2954	Restoration of Funding for Abstinence Education	*	*	*	*	*	*	*	*	*	0	0.1	0.1
2955	Inclusion of Information About The Importance of Having a Health-Care Power of Attorney in Transition Planning for Children Aging Out of Foster Care and Independent Living Programs	0	0	0	0	0	0	0	0	0	0	0	0
	Support for Pregnant and Parenting Teens and Women	*	*	*	*	*	*	*	*	*	*	0.1	0.2
TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE													
Subtitle A—Transforming the Health Care Delivery System													
PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM													
3001	Hospital Value-Based Purchasing Program	0	0	0	0	0	0	0	0	0	0	0	0
3002	Improvements to the Physician Quality Reporting System												
	Physicians' Services	0	0	0.2	0.2	0.2	0.3	-0.1	-0.2	-0.2	-0.2	0.6	0.3
	PPO Stabilization Fund	0	0	0	0	-0.1	*	0	0	0	0	-0.1	-0.2
3003	Improvements to the Physician Feedback Program	0	0	0	0	0	0	0	0	0	0	0	0
3004	Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs	0	0	0	0	*	*	*	*	*	*	*	-0.2
3005	Quality Reporting for PPS-Exempt Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
3006	Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies	0	0	0	0	0	0	0	0	0	0	0	0
3007	Value-based Payment Modifier Under the Physician Fee Schedule	0	0	0	0	0	0	0	0	0	0	0	0
3008	Payment Adjustment for Conditions Acquired in Hospitals	0	0	0	0	0	-0.3	-0.3	-0.3	-0.3	-0.3	0	-1.5
PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY													
3011	National Strategy	0	0	0	0	0	0	0	0	0	0	0	0
3012	Interagency Working Group on Health Care Quality	0	0	0	0	0	0	0	0	0	0	0	0
3013	Quality Measure Development	0	0	0	0	0	0	0	0	0	0	0	0
3014	Quality Measurement	*	*	*	*	*	*	0	0	0	0	0.1	0.1
3015	Data Collection; Public Reporting	0	0	0	0	0	0	0	0	0	0	0	0
	Interaction of Quality-Measure Development/Endorsement Provisions	0	0	0	0	*	*	*	*	*	*	*	*

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS													
3021	Establishment of Center for Medicare and Medicaid Innovation	*	0.1	0.2	0.2	0.2	0.2	*	-0.3	-0.7	-1.2	0.7	-1.3
3022	Medicare Shared Savings Program	*	*	*	-0.1	-0.3	-0.6	-0.7	-0.9	-1.0	-1.2	-0.5	-4.9
3023	National Pilot Program on Payment Bundling	0	0	0	*	*	*	*	*	*	*	*	*
3024	Independence at Home Demonstration Program	*	*	*	*	*	*	0	0	0	0	*	*
3025	Hospital Readmissions Reduction Program	0	0	0	-0.1	-0.3	-1.1	-1.3	-1.3	-1.4	-1.5	-0.5	-7.1
3026	Community-Based Care Transitions Program	0	*	0.1	0.1	0.1	0.1	0.1	0	0	0	0.3	0.5
3027	Extension of Gainsharing Demonstration	*	*	*	*	*	0	0	0	0	0	*	*
Subtitle B—Improving Medicare for Patients and Providers													
PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES													
3101	Increase in the Physician Payment Update	0	0	0	0	0	0	0	0	0	0	0	0
3102	Extension of the Work Geographic Index Floor and Revisions to the Practice Expense Geographic Adjustment	0.7	0.9	0.3	0	0	0	0	0	0	0	1.8	1.8
3103	Extension of Exceptions Process for Medicare Therapy Caps	0.6	0.2	0	0	0	0	0	0	0	0	0.8	0.8
3104	Extension of Payment for Technical Component of Certain Physician Pathology Services	0.1	*	0	0	0	0	0	0	0	0	0.1	0.1
3105	Extension of Ambulance Add-Ons	0.1	*	0	0	0	0	0	0	0	0	0.1	0.1
3106	Extension of Certain Payment Rules for Long-Term Care Hospital Services and of Moratorium on the Establishment of Certain Hospitals and Facilities	0	0.1	0.1	*	0	0	0	0	0	0	0.2	0.2
3107	Extension of Physician Fee Schedule Mental Health Add-On	*	*	0	0	0	0	0	0	0	0	*	*
3108	Permitting Physician Assistants to Order Post-Hospital Extended Care Services	*	*	*	*	*	*	*	*	*	*	*	*
3109	Exemption of Certain Pharmacies From Accreditation Requirements	0	0	0	0	0	0	0	0	0	0	0	0
3110	Part B Special Enrollment Period for Disabled TRICARE Beneficiaries	*	*	*	*	*	*	*	*	*	*	*	*
3111	Payment for Bone Density Tests	0.1	0.1	*	0	0	0	0	0	0	0	0.1	0.1
3112	Revision to the Medicare Improvement Fund	0	0	0	0	-16.7	-5.6	0	0	0	0	-16.7	-22.3
3113	Treatment of Certain Complex Diagnostic Laboratory Tests	0	*	*	*	0	0	0	0	0	0	0.1	0.1
3114	Improved Access for Certified-Midwife Services	0	*	*	*	*	*	*	*	*	*	*	*

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PART II—RURAL PROTECTIONS													
3121	Extension of Outpatient Hold Harmless Provision	0.1	*	0	0	0	0	0	0	0	0	0.2	0.2
3122	Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas	*	*	0	0	0	0	0	0	0	0	*	*
3123	Extension of the Rural Community Hospital Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0
3124	Extension of the Medicare-Dependent Hospital Program	0	0	*	*	0	0	0	0	0	0	*	*
3125	Payment Adjustment for Low-Volume Hospitals	0	0.1	0.2	*	0	0	0	0	0	0	0.3	0.3
3126	Demonstration Project on Community Health Integration Models in Certain Rural Counties	0	0	0	0	0	0	0	0	0	0	0	0
3127	MedPAC Study on Adequacy of Medicare Payments for Health Care Providers Serving in Rural Areas	0	0	0	0	0	0	0	0	0	0	0	0
3128	Technical Correction Related to Critical Access Hospital Services	0	0	0	0	0	0	0	0	0	0	0	0
3129	Medicare Rural Hospital Flexibility Program	0	0	0	0	0	0	0	0	0	0	0	0
PART III—IMPROVING PAYMENT ACCURACY													
3131	Payment Adjustments for Home Health Care (includes effect of section 3401)	-0.1	-0.5	-0.8	-1.1	-1.8	-3.2	-5.2	-7.4	-9.0	-10.3	-4.3	-39.4
3132	Hospice Reform	0	*	*	*	*	*	*	*	*	*	*	-0.1
3133	Medicare Disproportionate Share Hospital Payments	0	0	0	0	0	-3.6	-4.4	-5.6	-5.0	-5.8	0	-24.4
3134	Misvalued Codes Under the Physician Fee Schedule	0	0	0	0	0	0	0	0	0	0	0	0
3135	Modification of Equipment Utilization Factor for Advanced Imaging Services	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-1.1	-3.0
3136	Revision of Payment for Power-Driven Wheelchairs	0	-0.4	-0.1	*	*	*	*	-0.1	-0.1	-0.1	-0.6	-0.8
3137	Hospital Wage Index Improvement	0.2	*	0	0	0	0	0	0	0	0	0.3	0.3
3138	Treatment of Certain Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
3139	Payment for Biosimilar Biological Products	Included in estimate for title VII, subtitle A.											
3140	Medicare Hospice Concurrent Care Demonstration Program	0	0	*	*	*	*	0	0	0	0	*	*
3141	Application of Budget Neutrality on a National Basis in the Calculation of the Medicare Hospital Wage Index Floor	0	0	0	0	0	0	0	0	0	0	0	0
3142	HHS Study on Urban Medicare-Dependent Hospitals	0	0	0	0	0	0	0	0	0	0	0	0

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Subtitle C—Provisions Relating to Part C													
3201	Medicare Advantage Payment	0	-6.2	-6.7	-10.4	-11.1	-12.4	-14.0	-16.8	-19.0	-21.6	-34.4	-118.1
3202	Benefit Protection and Simplification	0	0	0	0	0	0	0	0	0	0	0	0
3203	Application of Coding Intensity Adjustment During Payment Transition for Medicare Advantage	0	-0.6	-0.8	-0.5	0	0	0	0	0	0	-1.9	-1.9
3204	Simplification of Annual Beneficiary Election Periods	*	*	*	*	*	*	*	*	*	*	*	*
3205	Extension for Specialized Medicare Advantage Plans for Special Needs Individuals	0	0.2	0.2	0.2	0.1	0.1	*	*	*	*	0.7	0.9
3206	Extension of Reasonable Cost Contracts	0	*	*	*	0	0	0	0	0	0	*	*
3207	Technical Correction to MA Private Fee-for-Service Plans	0	*	*	*	*	*	*	*	*	*	0.1	0.1
3208	Making Senior Housing Facility Demonstration Permanent	Included in estimate for section 3205.											
3209	Authority to Deny Plan Bids	Included in estimate for section 3201.											
3210	Development of New Standards for Certain Medigap Plans	0	0	0	0	0	*	*	*	*	*	0	-0.1
Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans													
3301	Medicare Coverage Gap Discount Program	0	2.5	1.9	1.4	1.6	1.8	2.2	2.4	2.5	3.2	7.4	19.5
3302	Improvement in Determination of Medicare Part D Low-Income Benchmark Premium	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.7
3303	Voluntary de Minimis Policy for Subsidy Eligible Individuals Under Prescription Drug Plans and MA–PD Plans	0	*	*	*	*	*	*	0.1	0.1	0.1	0.1	0.4
3304	Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance	0	*	*	*	*	*	*	*	*	*	0.1	0.2
3305	Improved Information for Subsidy Eligible Individuals Reassigned to Prescription Drug Plans and MA–PD Plans	0	0	0	0	0	0	0	0	0	0	0	0
3306	Funding Outreach and Assistance for Low-Income Programs	*	*	*	0	0	0	0	0	0	0	*	*
3307	Formulary Requirements With Respect to Certain Categories or Classes of Drugs	0	0	0	0	0	0	0	0	0	0	0	0
3308	Part D Premiums for High-Income Beneficiaries	0	-0.4	-0.5	-0.7	-0.9	-1.1	-1.3	-1.6	-2.0	-2.4	-2.4	-10.7
3309	Elimination of Cost Sharing for Certain Dual-Eligible Individuals	0	0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	1.1
3310	Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-Term Care Facilities	0	0	-0.1	-0.3	-0.5	-0.8	-1.0	-1.0	-0.9	-1.1	-1.0	-5.7
3311	Prescription Drug Plan Complaint System	0	0	0	0	0	0	0	0	0	0	0	0
3312	Uniform Exceptions and Appeals Process	0	0	0	0	0	0	0	0	0	0	0	0
3313	Office of the Inspector General Studies and Reports	0	0	0	0	0	0	0	0	0	0	0	0
3314	Including Costs Incurred by AIDS Drug Assistance Programs and Indian Health Service in Providing Prescription Drugs Toward the Annual Out-of-Pocket Threshold Under Part D	0	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
3315	Immediate Reduction in Coverage Gap in 2010	Included in estimate for section 3301.											
	Part D Medication Therapy Management Programs	0	0	0	0	0	0	0	0	0	0	0	0

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

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Subtitle E—Ensuring Medicare Sustainability													
3401	Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates that do not Already Incorporate Such Improvements (effect of productivity adjustment for home health services included in estimate for section 3131)	-0.2	-1.1	-3.9	-7.4	-11.2	-15.0	-19.1	-23.8	-29.3	-36.0	-23.7	-147.0
3402	Temporary Adjustment to the Calculation of Part B Premiums	0	-1.3	-1.9	-1.9	-2.5	-2.6	-2.8	-3.2	-4.0	-4.9	-7.5	-25.0
3403	Independent Medicare Advisory Board	0	0	*	*	*	-1.5	-4.0	-5.6	-7.7	-9.4	*	-28.2
Subtitle F—Health Care Quality Improvements		0	0	0	0	0	0	0	0	0	0	0	0
	Medicare Coverage For Individuals Exposed To Environmental Health Hazards	*	*	*	*	*	*	*	*	*	*	0.1	0.3
	Protections for Frontier States	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.8	2.0
	Delay Implementation of RUG-IV	0	0	0	0	0	0	0	0	0	0	0	0
	Pilot Testing of Pay-for-Performance	0	0	0	0	0	0	0	0	0	0	0	0
	Methodology to Assess Health Plan Value	0	0	0	0	0	0	0	0	0	0	0	0
	Modernizing CMS Computer and Data Systems	0	0	0	0	0	0	0	0	0	0	0	0
	Public Reporting of Performance Information	0	0	0	0	0	0	0	0	0	0	0	0
	Medicare Data	0	0	0	0	0	0	0	0	0	0	0	0
	Community-Based Collaborative Care Networks	0	0	0	0	0	0	0	0	0	0	0	0
	Report On Access To High-Quality Dialysis Services	0	0	0	0	0	0	0	0	0	0	0	0

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TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH													
SUBTITLE A—MODERNIZING DISEASE PREVENTION AND PUBLIC HEALTH SYSTEMS													
4002	Prevention and Public Health Fund	0.1	0.6	0.8	1.0	1.3	1.6	1.8	1.9	2.0	2.0	3.7	12.9
	Sections 4001, 4003, 4004	0	0	0	0	0	0	0	0	0	0	0	0
SUBTITLE B—INCREASING ACCESS TO CLINICAL PREVENTIVE SERVICES													
4101	School-Based Health Centers	0	*	*	*	*	*	0	0	0	0	0.1	0.1
4102	Oral Healthcare Prevention Activities	0	0	0	0	0	0	0	0	0	0	0	0
4103	Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan	0.2	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.5	1.6	3.7
4104	Removal of Barriers to Preventive Services in Medicare	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
4105	Evidence-Based Coverage of Preventive Services in Medicare	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.7
4106	Improving Access to Preventive Services for Eligible Adults in Medicaid	0	0	0	*	*	*	*	*	*	*	*	0.1
4107	Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid	0	0	0	*	*	*	*	*	*	*	*	-0.1
4108	Incentives for Prevention of Chronic Diseases in Medicaid	0	*	0.1	*	*	0	0	0	0	0	0.1	0.1
SUBTITLE C—CREATING HEALTHIER COMMUNITIES													
4201	Community Transformation Grants	0	0	0	0	0	0	0	0	0	0	0	0
4202	Healthy Aging, Living Well; Evaluation of Community-Based Prevention and Wellness Programs in Medicare	*	*	*	0	0	0	0	0	0	0	0.1	0.1
4203	Removing Barriers and Improving Access to Wellness for Individuals With Disabilities	0	0	0	0	0	0	0	0	0	0	0	0
4204	Immunizations	*	0	0	0	0	0	0	0	0	0	*	*
4205	Nutrition Labeling at Chain Restaurants	0	0	0	0	0	0	0	0	0	0	0	0
4206	Demonstration Project Concerning Individualized Wellness Plan	0	0	0	0	0	0	0	0	0	0	0	0
4207	Reasonable Break Time for Nursing Mothers	0	0	0	0	0	0	0	0	0	0	0	0

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SUBTITLE D—SUPPORT FOR PREVENTION AND PUBLIC HEALTH INNOVATION													
4301	Research On Optimizing The Delivery of Public Health Services	0	0	0	0	0	0	0	0	0	0	0	0
4302	Understanding Health Disparities: Data Collection and Analysis	0	0.1	0.1	0.1	0	0	0	0	0	0	0.2	0.2
4303	CDC and Employer-Based Wellness Programs	0	0	0	0	0	0	0	0	0	0	0	0
4304	Epidemiology-Laboratory Capacity Grants	0	0	0	0	0	0	0	0	0	0	0	0
4305	Advancing Research and Treatment for Pain-Care Management	0	0	0	0	0	0	0	0	0	0	0	0
4306	Funding for Childhood Obesity Demonstration Project	*	*	*	*	*	0	0	0	0	0	*	*
	Better Diabetes Care	0	0	0	0	0	0	0	0	0	0	0	0
	Grants for Workplace Wellness	0	0	0	0	0	0	0	0	0	0	0	0
	Cures Acceleration Network	0	0	0	0	0	0	0	0	0	0	0	0
	Centers of Excellence for Depression	0	0	0	0	0	0	0	0	0	0	0	0
	Programs Relating to Congenital Heart Disease	0	0	0	0	0	0	0	0	0	0	0	0
	Automated Defibrillation	0	0	0	0	0	0	0	0	0	0	0	0
	Young Women's Breast Health	0	0	0	0	0	0	0	0	0	0	0	0
SUBTITLE E—MISCELLANEOUS PROVISIONS		0	0	0	0	0	0	0	0	0	0	0	0
TITLE V—HEALTH CARE WORKFORCE													
Subtitle A—Purpose and Definitions		0	0	0	0	0	0	0	0	0	0	0	0
Subtitle B—Innovations in the Health Care Workforce		0	0	0	0	0	0	0	0	0	0	0	0
	Alaska Task Force	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle C—Increasing the Supply of the Health Care Workforce		0	0	0	0	0	0	0	0	0	0	0	0
Subtitle D—Enhancing Health Care Workforce Education and Training													
	Sections 5301-5314	0	0	0	0	0	0	0	0	0	0	0	0
5315	United States Public Health Sciences Track	Included in estimate for section 4002.											
	Community Health Workforce	0	0	0	0	0	0	0	0	0	0	0	0
	Physician Assistant Education Programs	0	0	0	0	0	0	0	0	0	0	0	0
	Family Nurse Practitioner Training Programs	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle E—Supporting the Existing Health Care Workforce		0	0	0	0	0	0	0	0	0	0	0	0
	Residents	0	0	0	0	0	0	0	0	0	0	0	0

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

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Subtitle F—Strengthening Primary Care and Other Workforce Improvements													
5501	Expanding Access to Primary Care Services and General Surgery Services	0	0.4	0.6	0.7	0.7	0.8	0.3	0	0	0	2.5	3.5
5502	Medicare Federally Qualified Health Centers	0	*	*	*	*	0.1	0.1	0.1	0.1	0.1	*	0.4
5503-5506	Medicare Graduate Medical Education Policies	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.4	1.2
5507	Demonstration Projects to Address Health Professions Workforce Needs; Extension of Family-To-Family Health Information Centers	*	0.1	0.1	0.1	0.1	0.1	*	*	0	0	0.4	0.4
5508	Increasing Teaching Capacity	0	*	*	*	*	*	*	*	*	*	0.2	0.2
5509	Graduate Nurse Education Demonstration Program	0	0	*	0.1	0.1	0.1	*	0	0	0	0.1	0.2
Subtitle G—Improving Access to Health Care Services		0	0	0	0	0	0	0	0	0	0	0	0
	Funding for Community Health Centers and the National Health Service Corps	0	0.5	1.8	1.4	1.7	2.6	1.5	0.2	*	0	5.5	9.8
	State Grants to Providers	0	0	0	0	0	0	0	0	0	0	0	0
	Medical Training in Underserved Communities	0	0	0	0	0	0	0	0	0	0	0	0
	Preventive Medicine and Public Health Training Program	0	0	0	0	0	0	0	0	0	0	0	0
	Scholarship and Loan Program	0	0	0	0	0	0	0	0	0	0	0	0
	Infrastructure to Expand Access to Care	0	0.1	*	*	0	0	0	0	0	0	0.1	0.1
	Demonstration Program to Provide Access to Affordable Care	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle H—General Provisions		0	0	0	0	0	0	0	0	0	0	0	0

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY													
Subtitle A—Physician Ownership and Other Transparency													
6001	Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals	*	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5
6002	Transparency Reports and Reporting of Physician Ownership or Investment Interests	0	0	0	0	0	0	0	0	0	0	0	0
6003	Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services	0	0	0	0	0	0	0	0	0	0	0	0
6004	Prescription Drug Sample Transparency	0	0	0	0	0	0	0	0	0	0	0	0
6005	Pharmacy Benefit Managers Transparency Requirements	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle B—Nursing Home Transparency and Improvement		0	0	0	0	0	0	0	0	0	0	0	0
Subtitle C—Nationwide Program for National and State Background Checks on Direct		*	*	*	0	0	0	0	0	0	0	0.1	0.1
Subtitle D—Patient-Centered Outcomes Research													
6301	Patient-Centered Outcomes Research												
	Medicare	0	0	*	*	*	*	*	*	-0.1	-0.2	0.1	-0.3
	Non-Medicare	*	*	0.1	0.1	0.2	0.3	0.4	0.4	0.4	0.5	0.4	2.5
6302	Federal Coordinating Council for Comparative Effectiveness Research	0	0	0	0	0	0	0	0	0	0	0	0

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By fiscal year, in billions of dollars.

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions													
6401	Provider Screening and Other Enrollment Requirements	*	*	*	*	*	*	*	*	*	*	*	-0.2
6402	Medicare and Medicaid Program Integrity Provisions	*	-0.2	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-1.3	-3.2
6403	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
6404	Maximum Period for Submission of Medicare Claims	0	0	0	0	0	0	0	0	0	0	0	0
6405	Physicians Who Order Items or Services Required to Be Medicare-Enrolled Physicians or Eligible Professionals	*	*	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.2	-0.4
6406	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
6407	Face to Face Encounter With Patient Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment Under Medicare	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.3	-1.0
6408	Enhanced Penalties	0	0	0	0	0	0	0	0	0	0	0	0
6409	Medicare Self-Referral Disclosure Protocol	0	0	0	0	0	0	0	0	0	0	0	0
6410	Adjustments to the Medicare Competitive Acquisition Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	*	*	*	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-1.4
6411	Expansion of the Recovery Audit Contractor Program	0	*	*	*	*	*	*	*	*	*	*	*
	Health Care Fraud Enforcement	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle F—Additional Medicaid Program Integrity Provisions													
6501	Termination of Provider Participation Under Medicaid if Terminated Under Medicare or Other State Plan	0	0	0	0	0	0	0	0	0	0	0	0
6502	Medicaid Exclusion From Participation Relating to Certain Ownership, Control, and Management Affiliations	0	0	0	0	0	0	0	0	0	0	0	0
6503	Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicaid	0	0	0	0	0	0	0	0	0	0	0	0
6504	Requirement to Report Expanded Set of Data Elements Under MMIS to Detect Fraud and Abuse	0	0	0	0	0	0	0	0	0	0	0	0
6505	Prohibition on Payments to Institutions or Entities Located Outside of the United States	0	0	0	0	0	0	0	0	0	0	0	0
6506	Overpayments	0.1	*	*	*	*	*	*	*	*	*	0.1	0.1
6507	Mandatory State Use of National Correct Coding Initiative	0	*	*	*	*	*	*	*	*	*	-0.1	-0.3
6508	General Effective Date	0	0	0	0	0	0	0	0	0	0	0	0

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Subtitle G—Additional Program Integrity Provisions	0	0	0	0	0	0	0	0	0	0	0	0
State Demonstration Programs: Alternatives to Tort Litigation	0	0	0	0	0	0	0	0	0	0	0	0
Liability Coverage in Free Clinics	0	*	*	*	*	*	*	*	*	*	*	0.1
FDA Labeling Changes	*	*	*	*	*	*	*	*	*	*	*	-0.1
Subtitle H—Elder Justice Act	0	0	0	0	0	0	0	0	0	0	0	0
Subtitle I—Sense of the Senate Regarding Medical Malpractice	0	0	0	0	0	0	0	0	0	0	0	0
TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES												
Subtitle A—Biologics Price Competition and Innovation	0	0	0	*	-0.1	-0.4	-0.7	-1.2	-1.9	-2.7	-0.1	-7.1
Subtitle B—More Affordable Medicines for Children and Underserved Communities												
7101 Expanded Participation in 340B Program	Included in estimate for section 2501.											
7102 Improvements to 340B Program Integrity	0	0	0	0	0	0	0	0	0	0	0	0
7103 GAO Study on Improving the 340B Program	0	0	0	0	0	0	0	0	0	0	0	0
TITLE VIII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS	0	-3.7	-6.4	-8.7	-9.9	-11.2	-9.6	-8.6	-7.5	-6.8	-28.7	-72.5
TITLE IX—REVENUE PROVISIONS	Estimates provided by the Joint Committee on Taxation in a Separate Table											
INTERACTIONS												
Medicare Advantage Interactions	0	1.0	-0.5	-1.1	-1.9	-2.0	-2.4	-2.8	-3.0	-4.0	-2.5	-16.6
Premium Interactions	0	0.1	0.5	1.1	6.1	4.1	3.8	4.8	5.7	6.7	7.9	32.8
Implementation of Medicare Changes	*	*	*	*	*	*	*	*	*	*	*	0.1
Medicare Part D Interactions with Medicare Advantage Provisions	0	0.1	0.1	0.3	0.3	0.4	0.4	0.4	0.4	0.5	0.8	3.0
Medicare Part B Interactions with Medicare Part D Provisions	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.9
Medicaid Interactions with Medicare Part D Provisions	*	*	*	*	*	0.1	0.1	0.1	0.1	0.2	0.1	0.6
Medicare Interaction with 340B	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5
TRICARE Interaction	*	*	-0.1	-0.2	-0.2	-0.3	-0.5	-0.6	-0.8	-0.9	-0.4	-3.5
FEHB Interaction (on-budget)	0	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.4	0.4	1.8
FEHB Interaction (off-budget)	0	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.4	1.0
Total, Changes in Unified-Budget Direct Spending	**4.3**	**-6.1**	**-15.9**	**-26.9**	**-45.5**	**-53.3**	**-63.3**	**-79.0**	**-91.1**	**-106.3**	**-90.0**	**-483.1**

Table 5. Estimate of Effects on Direct Spending and Revenues for Non-Coverage Provisions of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment

By fiscal year, in billions of dollars.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Changes in Revenues												
Transitional Reinsurance - Collections for Early Retirees	0	0	0	0	1.5	1.5	0.8	0	0	0	1.5	3.8
Fraud, Waste, and Abuse (on-budget)	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.9
Effect of Administrative Simplification on Revenues [a]	-0.1	-0.2	-0.2	*	0.5	0.9	1.3	1.9	2.0	2.0	*	8.1
Effect on Revenues of Changes in Health Insurance Premiums as a Result of Comparative Effectiveness Research, Changes in the Medicaid Drug Program, Biosimilar Biological Products, and FDA Labeling												
Income and Medicare payroll taxes (on-budget)	*	*	*	*	*	0.1	0.1	0.2	0.3	0.3	0.1	1.0
Social Security payroll taxes (off-budget)	*	*	*	*	*	*	0.1	0.1	0.1	0.2	*	0.5
Total, Changes in Unified-Budget Revenues	**-0.1**	**-0.1**	**-0.1**	**0.2**	**2.1**	**2.6**	**2.4**	**2.2**	**2.5**	**2.6**	**2.0**	**14.2**
Changes in Unified-Budget Deficits	**4.4**	**-6.0**	**-15.8**	**-27.1**	**-47.5**	**-55.8**	**-65.6**	**-81.2**	**-93.6**	**-108.9**	**-92.1**	**-497.3**
Memorandum:												
Non-scoreable Effects												
Savings from increased HCFAC spending	0	*	*	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4	-0.3	-1.6
Expansion of the Recovery Audit Contractor (RAC) Program in Medicaid	0	*	*	*	*	*	*	*	-0.1	-0.1	-0.1	-0.3

NOTES: * = between -$50 million and $50 million.

AIDS = Acquired Immune-Deficiency Syndrome; CDC = Center for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; FMAP = federal medical assistance percentage; FDA = Food and Drug Administration; GAO = Government Accountability Office; HCFAC = Health Care Fraud and Abuse Control; HHS = Department of Health and Human Services; MA = Medicare Advantage; MA-PD = Medicare Advantage prescription drug plan; MedPAC = Medicare Payment Advisory Commission; MMIS = Medicaid Management Information System; PPO = preferred provider organization; PPS = prospective payment system; RUG-IV = Resource Utilization Group, version four.

a. Includes both on- and off-budget revenues.

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

Douglas W. Elmendorf, Director

December 20, 2009

Honorable Harry Reid
Majority Leader
United States Senate
Washington, DC 20510

Dear Mr. Leader:

The Congressional Budget Office (CBO) has discovered an error in the cost estimate released on December 19, 2009, related to the longer-term effects on direct spending of the manager's amendment to the Patient Protection and Affordable Care Act (PPACA), Senate Amendment 2786 in the nature of a substitute to H.R. 3590 (as printed in the Congressional Record on November 19, 2009).

Correcting that error has no impact on the estimated effects of the legislation during the 2010–2019 period. However, the correction reduces the degree to which the legislation would lower federal deficits in the decade after 2019.

The legislation would establish an Independent Payment Advisory Board, which would be required, under certain circumstances, to recommend changes to the Medicare program to limit the rate of growth in that program's spending. Those recommendations would go into effect automatically unless blocked by subsequent legislative action. In its original estimate, CBO wrote that: "Such recommendations would be required if the Chief Actuary for the Medicare program projected that the program's spending per beneficiary would grow more rapidly than a measure of inflation (the average of the growth rates of the consumer price index for medical services and the overall index for all urban consumers)." That statement is correct for fiscal years 2015 through 2019. After 2019, however, the threshold for Medicare spending growth that would trigger recommendations for spending reductions would be higher—specifically, the rate of increase in gross domestic product (GDP) per capita plus 1 percentage point.

With this corrected reading, savings from changes to the Medicare program (along with other changes to direct spending that are not associated directly with expanded insurance coverage) would increase at a rate that is between 10 percent and 15 percent per year during the 2020–2029 period, compared with a growth rate of nearly 15 percent reported in the initial estimate. The long-run budgetary effects of the other broad categories of the legislation are unchanged from the initial estimate. All told, CBO expects that the legislation, if enacted, would reduce federal budget deficits over the decade after 2019

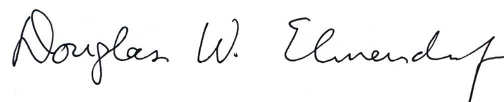
relative to those projected under current law—with a total effect during that decade that is in a broad range between one-quarter percent and one-half percent of GDP. In comparison, the extrapolations in the initial estimate implied a reduction in deficits in the 2020–2029 period that would be in a broad range around one-half percent of GDP. The imprecision of these calculations reflects the even greater degree of uncertainty that attends to them, compared with CBO's 10-year budget estimates. The expected reduction in deficits would represent a small share of the total deficits that would be likely to arise in that decade under current policies.

Relative to the legislation as originally proposed, the expected reduction in deficits during the 2020–2029 period remains somewhat larger for the legislation incorporating the manager's amendment. It also remains that case that most of that difference arises because the manager's amendment would lower the threshold for Medicare spending growth that would trigger recommendations for spending reductions by the Independent Payment Advisory Board. Such recommendations would be required, in the legislation as originally proposed, if projected growth in Medicare spending per beneficiary exceeded the rate of increase in national health expenditures per capita—and in the legislation incorporating the manager's amendment, if it exceeded the rate of increase in GDP plus 1 percentage point.

Based on this extrapolation, CBO expects that Medicare spending under the legislation would increase at an average annual rate of roughly 6 percent during the next two decades—well below the roughly 8 percent annual growth rate of the past two decades (excluding the effect of establishing the Medicare prescription drug benefit). Adjusting for inflation, Medicare spending per beneficiary under the legislation would increase at an average annual rate of roughly 2 percent during the next two decades—well below the roughly 4 percent annual growth rate of the past two decades. It is unclear whether such a reduction in the growth rate could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or would reduce access to care or diminish the quality of care.

I apologize for any confusion created by this error. If you have any questions, please contact me.

Sincerely,



Douglas W. Elmendorf
Director

Enclosures

cc: Honorable Mitch McConnell
Republican Leader

Honorable Max Baucus
Chairman
Committee on Finance

Honorable Chuck Grassley
Ranking Member

Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor, and Pensions

Honorable Michael B. Enzi
Ranking Member

Honorable Kent Conrad
Chairman
Committee on the Budget

Honorable Judd Gregg
Ranking Member