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Office of the Actuary

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SUBJECT: Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Passed by the Senate on December 24, 2009

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

This memorandum summarizes the Office of the Actuary's estimates of the financial and coverage effects through fiscal year 2019 of selected provisions of the "Patient Protection and Affordable Care Act" (PPACA) as passed by the Senate on December 24, 2009 (H.R. 3590, as amended). Included are the estimated net Federal expenditures in support of expanded health insurance coverage, the associated numbers of people by insured status, the changes in Medicare and Medicaid expenditures and revenues, and the overall impact on total national health expenditures. Except where noted, we have not estimated the impact of the various tax and fee proposals or the impact on income and payroll taxes due to economic effects of the legislation. Similarly, the impact on Federal administrative expenses is excluded. A summary of the data, assumptions, and methodology underlying our estimates of national health reform proposals is available in the appendix to our October 21 memorandum on H.R. 3200.[1]

Summary

The table shown on page 2 presents financial impacts of the selected PPACA provisions on the Federal Budget in fiscal years 2010-2019. We have grouped the provisions of the bill into six major categories:

(i) Coverage proposals, which include the mandated coverage for health insurance, the expansion of Medicaid eligibility to those with incomes at or under 133 percent of the Federal poverty level (FPL), and the additional funding for the Children's Health Insurance Program (CHIP);

(ii) Medicare provisions;

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

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

[1] This memorandum is available at http://www.cms.hhs.gov/ActuarialStudies/Downloads/HR3200_2009-10-21.pdf.

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

(vi) Immediate health insurance reforms.

The estimated costs and savings shown in the table are based on the effective dates specified in the bill as passed. Additionally, we assume that employers and individuals would take roughly 3 to 5 years to fully adapt to the insurance coverage provisions and that the enrollment of additional individuals under the Medicaid coverage expansion would be completed by the third year of implementation. Because of these transition effects and the fact that most of the coverage provisions would be in effect for only 6 of the 10 years of the budget period, the cost estimates shown in this memorandum do not represent a full 10-year cost for the proposed legislation.

Estimated Federal Costs (+) or Savings (−) under Selected Provisions of the Patient Protection and Affordable Care Act as Passed by the Senate
(in billions)

	Fiscal Year										Total,
Provisions	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-19
Total*	$11.6	$0.1	−$14.8	−$32.8	$14.7	$63.0	$71.4	$60.9	$55.8	$49.7	$279.5
Coverage†	4.7	6.6	1.7	—	86.5	128.0	150.1	156.4	167.9	180.7	882.5
Medicare	2.2	−3.6	−12.1	−23.4	−62.6	−55.1	−70.2	−87.6	−104.6	−123.7	−540.7
Medicaid/CHIP	−0.4	−0.1	0.2	−3.8	−3.1	−3.8	−3.9	−4.1	−4.0	−3.9	−27.1
Cost trend‡	—	—	—	—	−0.0	−0.1	−0.2	−0.4	−0.6	−0.9	−2.3
CLASS program	—	−2.8	−4.5	−5.6	−5.9	−6.0	−4.3	−3.4	−2.8	−2.4	−37.8
Immediate reforms	5.0	—	—	—	—	—	—	—	—	—	5.0

* Excludes Title IX revenue provisions except for section 9015, certain provisions with limited impacts, and Federal administrative costs.

† Includes expansion of Medicaid eligibility and additional funding for CHIP.

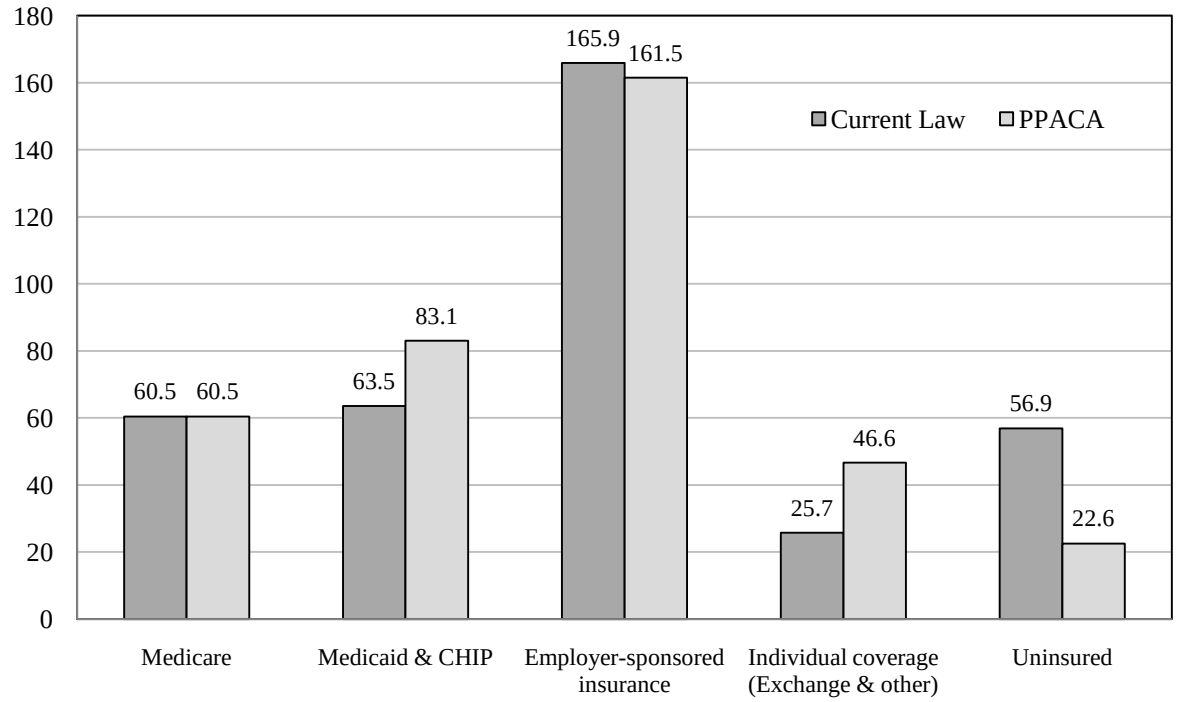
‡ Includes estimated non-Medicare Federal savings from provisions for comparative effectiveness research, prevention and wellness, fraud and abuse, and administrative simplification. Excludes impacts of other provisions that would affect cost growth rates, such as the productivity adjustments to Medicare payment rates, which are reflected in the Medicare line.

As indicated in the table above, the provisions in support of expanding health insurance coverage (including the Medicaid eligibility changes and additional CHIP funding) are estimated to cost $882 billion through fiscal year 2019. The net savings from the Medicare, Medicaid, growth-trend, and CLASS proposals are estimated to total about $603 billion, leaving a net cost for this period of $279 billion before consideration of additional Federal administrative expenses and the increase in Federal revenues that would result from the excise tax on high-cost employer-sponsored health insurance coverage and other revenue provisions. (The additional Hospital Insurance payroll tax income under section 9015 of the PPACA is included in the estimated Medicare savings shown here.) The Congressional Budget Office and Joint Committee on Taxation have estimated that the total net amount of Medicare savings and additional tax and other revenues would somewhat more than offset the cost of the national coverage provisions, resulting in an overall reduction in the Federal deficit through 2019.

The chart shown below summarizes the estimated impacts of the PPACA on insurance coverage. The mandated coverage provisions, which include new responsibilities for both individuals and employers, and the creation of the Health Benefit Exchanges (hereafter referred to as the "Exchanges"), would lead to shifts across coverage types and a substantial overall reduction in the number of uninsured, as many of these individuals become covered through their employers, Medicaid, or the Exchanges.

By calendar year 2019, the mandates, coupled with the Medicaid expansion, would reduce the number of uninsured from 57 million, as projected under current law, to an estimated 23 million under the PPACA. The additional 34 million people who would become insured by 2019 reflect the net effect of several shifts. First, an estimated 18 million would gain primary Medicaid coverage as a result of the expansion of eligibility to all legal resident adults under 133 percent of the FPL.[2] (In addition, roughly 2 million people with employer-sponsored health insurance would enroll in Medicaid for supplemental coverage.) Another 21 million persons (most of whom are currently uninsured) would receive individual insurance coverage through the newly created Exchanges, with the majority of these qualifying for Federal premium and cost-sharing subsidies. Finally, we estimate that the number of individuals with employer-sponsored health insurance would decrease overall by about 4 million, reflecting both gains and losses in such coverage under the PPACA.

Estimated Effect of the Patient Protection and Affordable Care Act, as Passed by the Senate, on 2019 Enrollment by Insurance Coverage
(in millions)



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

[2] This proposal would extend eligibility to two significant groups: (i) individuals who would meet current Medicaid eligibility requirements, for example as disabled adults, but who have incomes in excess of the existing State thresholds but less than 133 percent of the FPL; and (ii) people who live in households with incomes below 133 percent of the FPL but who have no other qualifying factors that make them eligible for Medicaid under current law, such as being under age 18, age 65 or older, disabled, pregnant, or parents of eligible children.

As described in more detail in a later section of this memorandum, we estimate that overall national health expenditures under this bill would increase by an estimated total of $222 billion (0.6 percent) during calendar years 2010-2019, principally reflecting the net impact of (i) greater utilization of health care services by individuals becoming newly covered (or having more complete coverage), (ii) lower prices paid to health providers for the subset of those individuals who become covered by Medicaid, and (iii) lower payments and payment updates for Medicare services, together with net Medicaid savings from provisions other than the coverage expansion. Although several provisions would help to reduce health care cost growth, their impact would be more than offset through 2019 by the higher health expenditures resulting from the coverage expansions.

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

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

Effects of Coverage Proposals on Federal Expenditures and Health Insurance Coverage

Federal Expenditure Impacts

The estimated Federal costs of the coverage provisions in the PPACA are provided in table 1, attached, for fiscal years 2010 through 2019. We estimate that Federal expenditures would increase by a net total of $279 billion during this period—a combination of $882 billion in net costs associated with coverage provisions, $541 billion in net savings for the Medicare provisions, a net savings of $27 billion for the Medicaid/CHIP provisions (excluding the expansion of Medicaid eligibility and the additional CHIP funding), $2 billion in savings from proposals intended to help reduce the rate of growth in health spending, $38 billion in net savings from the CLASS proposal, and $5 billion in costs for the immediate insurance reforms. These latter five impact categories are discussed in subsequent sections of this memorandum.

Of the estimated $882 billion net increase in Federal expenditures related to the coverage provisions of the PPACA, about 45 percent ($394 billion) can be attributed to expanding Medicaid coverage for all adults who live in households with incomes below 133 percent of the FPL. This cost reflects the fact that newly eligible persons would be covered with a 100-percent Federal Medical Assistance Percentage (FMAP) for the first 3 years and approximately 90 percent thereafter; that is, the Federal government would bear a significantly greater proportion of the cost of the newly eligible enrollees than is the case for current Medicaid beneficiaries.[3] Also included in this cost is the additional funding for the CHIP program for

[3] The FMAP for a State for fiscal year 2017 and later would be increased by about 30 to 40 percentage points compared to current law, depending on the year, whether the State has already expanded coverage to certain low-income adult populations, and other considerations. We estimate that, once the provision is fully phased in, the average FMAP across all States would be 90 percent. In addition, the estimated cost includes new Medicaid enrollments by previously eligible individuals as a result of the publicity, enrollment assistance through the Exchanges, and reduced stigma associated with Federal assistance for health care. Also included here are the Medicaid costs associated with the provision to extend Medicaid coverage to individuals up to age 26 who were previously in foster care.

2014 and 2015, which would increase such expenditures by the $29 billion allocated for this purpose. The remaining costs of the coverage provisions arise from the refundable tax credits and reduced cost-sharing requirements for low-to-middle-income enrollees purchasing health insurance through the Exchanges ($547 billion) and credits for small employers who choose to offer insurance coverage ($13 billion). The increases in Federal expenditures would be partially offset by the penalties paid by affected individuals who choose to remain uninsured and employers who opt not to offer coverage; such penalties together total $72 billion through fiscal year 2019, reflecting the relatively low penalty amounts specified in the legislation.[4]

The refundable premium tax credits in section 1401 of the PPACA would limit the premiums paid by individuals between 100 percent and 400 percent of the FPL to a range of 2.0 to 9.8 percent of their income and would cost an estimated $511 billion through 2019. An estimated 29 million Exchange enrollees (81 percent) would receive these Federal premium subsidies. The cost-sharing credits would reimburse individuals and families with incomes up to 400 percent of the FPL for a portion of the amounts they pay out-of-pocket for health services, as specified in section 1402. These credits are estimated to cost $36 billion through 2019.[5]

The PPACA changes the basis for future Exchange premium subsidies in such a way that the reduced premiums payable by those with incomes below 400 percent of FPL would maintain the same share of total premiums over time. As a result, the Federal premium subsidies for a qualifying individual would grow at the same pace as per capita health care costs. Because the cost-sharing assistance is based on a percentage of health care costs incurred by qualifying individuals and families, average Federal expenditures for such assistance would also increase at the same rate as per capita health care costs.

As noted, the Federal costs resulting from the coverage expansion provisions are somewhat offset by the individual and employer penalties stipulated by the PPACA. We estimate that individual penalties would provide $34 billion in revenue to the Federal government in fiscal years 2014-2019, taking into account the time lag associated with collecting the penalty amounts through the Federal income tax system. (A discussion of the estimated number of individuals who would choose to remain uninsured is provided below.) Additionally, for firms that do not offer health insurance and are subject to the "play or pay" penalties, we estimate that the penalties would total $37 billion in 2014-2019.

The penalty amounts for noncovered individuals and non-offering employers would be indexed over time by the CPI (or, for individuals above roughly 300 percent of the FPL, by growth in income) and would normally increase more slowly than health care costs. As a result, penalty revenues for nonparticipating individuals and employers are estimated to grow more slowly than the Federal expenditures for the premium assistance credits.

The Senate health reform bill specifies maximum out-of-pocket limits in 2014 equal to the corresponding maximums as defined in the Internal Revenue Code for high-deductible health

[4] Employer penalties would be $750 per employee in 2014, which is substantially less than the cost of providing health insurance coverage. The relationship between penalties and premiums is much more complicated for individuals than for employers; still, for many individuals with incomes above roughly 300 percent of the FPL, the applicable penalty would be considerably smaller than the cost of coverage.

[5] The estimated expenditures for these cost-sharing subsidies are significantly lower than shown previously for the PPACA as introduced by the Senate Majority Leader on November 18, 2009. The difference in estimates is attributable to a clarification in our interpretation of section 1402 and not to a specification change for this provision.

plans. We estimate that these limits would be $6,645 for an individual and $13,290 for a family with qualified creditable coverage (including employer-sponsored health insurance). For future years, the limits are indexed to the growth in the average health insurance premium in the U.S. Under this approach, the proportion of health care costs above the out-of-pocket maximum would be relatively stable over time. For the basic "bronze" benefit plan for individuals, with an actuarial value of 60 percent, we estimate that the cost-sharing percentage applicable before the out-of-pocket maximum is reached would be about 76 percent in 2014 and later. The corresponding cost-sharing rate for family coverage is 64 percent. For the "silver" benefit package, the individual and family cost-sharing rates below the out-of-pocket maximums would be about 47 percent and 40 percent, respectively. For the more comprehensive "gold" and "platinum" benefit packages authorized through the Exchanges, these initial cost-sharing levels would be significantly lower.

Health Insurance Coverage Impacts

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

Of the additional 34 million people who are estimated to be insured in 2019 as a result of the PPACA, a little more than one-half (18 million) would receive Medicaid coverage due to the expansion of eligibility to adults under 133 percent of the FPL. (Included in the total are an estimated 50,000 individuals who would gain Medicaid coverage as former children in foster care programs and who could be covered up to age 26 under the Senate-passed bill.) We anticipate that the intended enrollment facilitation under the PPACA—i.e., that the Health Benefits Exchanges help people determine which insurance plans are available and identify whether individuals qualify for Medicaid coverage, premium subsidies, etc.—would result in a high percentage of eligible persons becoming enrolled in Medicaid. We further believe that the great majority of such persons (15 million) would become covered in the first year, 2014, with the rest covered by 2016. Another 2 million people who currently have employer-sponsored health insurance are estimated to enroll in Medicaid as a supplement to their existing coverage.

An additional 21 million people are estimated to receive health coverage in 2019 through the newly created Exchanges under the PPACA. (Another 15 million, who currently have individual health insurance policies, are also expected to switch to Exchange plans.) We modeled the choice to purchase coverage from the Exchanges as a function of individuals' and families' expected health expenditures relative to the cost of coverage if they were insured (taking account of applicable premium subsidies). We also considered the required penalty associated with the individual mandate if they chose to remain uninsured, along with other factors.[6] Our model

[6] Such other factors include age, gender of head of household, race, children, marital status, health status, and employment status (for both the head of household and the spouse), as well as adjustments to reflect the availability of health insurance on a guaranteed-issue basis and at community-rated, group insurance premium rates. Finally, we also considered the general desire to comply with the intent of the law, even in the significant number of cases in which the penalty amount would be small or would not apply.

indicated that roughly 67 percent of those eligible for the Exchanges would choose to take such coverage, with the principal incentive being the level of premium assistance available. For many individuals, the penalty amounts for not having insurance coverage were not sufficiently large to have a sizable impact on the coverage decision. Also, in this regard, individuals or families would not be subject to a penalty for failing to enroll in an Exchange plan if the "bronze" premium level (reduced by the premium tax credit, if applicable) would exceed 8 percent of income. We estimate that this provision would exempt individuals and families with incomes between about 365 percent and 493 percent of the FPL, representing about 16 percent of the non-aged population.

The proposed legislation would require the Office Personnel Management to arrange for at least two private, multi-State health plans to be offered through each health insurance Exchange. The multi-State plans would generally meet the same benefit, cost-sharing, network, and other requirements applicable to private Exchange plans and would negotiate payment rates with providers. (A State could enact a requirement for additional benefits in the multi-State plans, beyond the essential benefits specified for a qualified plan, but would have to make payments on behalf of eligible individuals to defray the cost of the additional benefits.) We estimate that the multi-State plans would have costs that were very similar to those for other Exchange plans.

Employer-sponsored health insurance has traditionally been the largest source of coverage in the U.S., and we anticipate that it would continue to be so under the PPACA. By 2019, an estimated 13 million workers and family members would become newly covered as a result of additional employers offering health coverage, a greater proportion of workers enrolling in employer plans, and an extension of dependent coverage up to age 26. However, a number of workers who currently have employer coverage would likely become enrolled in the expanded Medicaid program or receive subsidized coverage through the Exchanges. For example, some smaller employers would be inclined to terminate their existing coverage, and companies with low average salaries might find it to their—and their employees'—advantage to end their plans, thereby allowing their workers to qualify for heavily subsidized coverage through the Exchanges. Somewhat similarly, many part-time workers could obtain coverage more inexpensively through the Exchanges or by enrolling in the expanded Medicaid program. Finally, as noted previously, the per-worker penalties assessed on nonparticipating employers are very low compared to prevailing health insurance costs. As a result, the penalties would not be a significant deterrent to dropping or forgoing coverage. We estimate that such actions would collectively reduce the number of people with employer-sponsored health coverage by about 17 million, or somewhat more than the number newly covered through existing and new employer plans under the PPACA. As indicated in table 2, the total number of persons with employer coverage in 2019 is estimated to be 4 million lower under the reform package than under current law.

For the estimated 23 million people who would remain uninsured in 2019, roughly 5 million are undocumented aliens who would be ineligible for Medicaid or the Exchange coverage subsidies under the proposed legislation. The balance of 18 million would choose not to be insured and to pay the penalty (if applicable) associated with the individual mandate. For the most part, these would be individuals with relatively low health care expenses for whom the individual or family insurance premium would be significantly in excess of any penalty and their anticipated health benefit value. In other instances, as appears to happen under current law, some people would not

enroll in their employer plans (or take advantage of the Exchange opportunities) even though it would be in their best financial interest to do so.

Impact on Medicare and Medicaid

Medicare

The estimated financial impacts of the Medicare provisions in the PPACA are provided in detail in table 3, attached, which is organized by section of the proposed legislation.[7] Net Medicare savings are estimated to total $541 billion for fiscal years 2010-2019. Substantial savings are attributable to provisions that would, among other changes, reduce Part A and Part B payment levels and adjust future "market basket" payment updates for productivity improvements ($226 billion); eliminate the Medicare Improvement Fund ($27 billion); reduce disproportionate share (DSH) payments ($47 billion); reduce Medicare Advantage payment benchmarks and extend the authority to adjust for coding intensity ($101 billion); freeze the income thresholds for the Part B income-related premium for 9 years ($8 billion); implement an Independent Payment Advisory Board together with strict Medicare expenditure growth rate targets ($56 billion); and increase the HI payroll tax rate by 0.9 percentage point for individuals with incomes above $200,000 and families above $250,000 ($68 billion). Other provisions would generate relatively smaller amounts of savings, through such means as reporting physician quality measures, reducing payments in cases involving hospital-acquired infections, reducing readmissions, refining imaging payments, increasing Part D premiums for higher-income beneficiaries, and implementing evidence-based coverage of preventive services.

These savings are slightly offset by the costs of extensions of a number of special payment provisions scheduled to expire, such as the postponement of therapy caps ($5 billion) and by the costs for improving preventive health services and access to primary care ($7 billion).

Based on the estimated savings for Part A of Medicare, the assets of the Hospital Insurance trust fund would be exhausted in early 2027 compared to 2017 under current law—an extension of almost 10 years. The combination of lower Part A costs and higher tax revenues results in a lower Federal deficit based on budget accounting rules. However, trust fund accounting considers the same lower expenditures and additional revenues as extending the exhaustion date of the HI trust fund. In practice, the improved HI financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions.

It is important to note that the estimated savings shown in this memorandum for one category of Medicare proposals may be unrealistic. The PPACA would introduce permanent annual productivity adjustments to price updates for most providers (such as hospitals, skilled nursing facilities, and home health agencies), using a 10-year moving average of economy-wide productivity gains. While such payment update reductions would provide a strong incentive for providers to maximize efficiency, it is doubtful that many could improve their own productivity

[7] For ease of interpretation, we have incorporated the Medicare and Medicaid provisions of the Manager's Amendment, as specified in Title X of the PPACA, into the corresponding provisions of Titles II through VII and Title IX. For example, the savings shown for section 3403 (Independent Payment Advisory Board) represent the impact of this provision from the original bill as amended by section 10320.

to the degree achieved by the economy at large.[8] Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the providers' costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries). Simulations by the Office of the Actuary suggest that roughly 20 percent of Part A providers would become unprofitable within the 10-year projection period as a result of the productivity adjustments.[9] Although this policy could be monitored over time to avoid such an outcome, changes would likely result in smaller actual savings than shown here for these provisions.

A related concern is posed by the requirements that would be placed on the Independent Payment Advisory Board. The Board would be charged with recommending changes to certain Medicare payment categories in an effort to prevent per-beneficiary Medicare costs from increasing faster than the average of the CPI and the CPI-medical for "implementation years" 2015 through 2019.[10] The Secretary of HHS would be required to implement the Board's recommendations unless the statutory process was overridden by new legislation.

Average Medicare costs per beneficiary usually increase over time as a function of (i) medical-specific price growth, (ii) more utilization of services by beneficiaries, and (iii) greater "intensity" or average complexity of these services. In general, limiting cost growth to a level below medical price inflation alone would represent an exceedingly difficult challenge. Actual Medicare cost growth per beneficiary was below the target level in only 4 of the last 25 years, with 3 of those years immediately following the Balanced Budget Act of 1997; the impact of the BBA prompted Congress to pass legislation in 1999 and 2000 moderating many of the BBA provisions. As an additional comparison, during the last 25 years the average increase in the target growth rate has been 0.33 percent per year below the average increase in nominal GDP per capita—which is approximately the target level for the physician sustainable growth rate (SGR) payment system. Congress has overridden the SGR-based payment reductions for each of the last 7 years.

The Board's efforts would be further complicated by provisions that prohibit increases in cost-sharing requirements and that exempt broad categories of Medicare expenditures from

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

[9] The simulations were based on actual fiscal year 2007 Medicare and total facility margin distributions for hospitals, skilled nursing facilities, and home health agencies. Provider revenues and expenditures were projected using representative growth rates and the Office of the Actuary's best estimates of achievable productivity gains for each provider type, and holding all other factors constant. Sensitivity analysis suggested the conclusions drawn from the simulations would not change significantly under different provider behavior assumptions.

[10] Maximum growth rate reductions of 0.5, 1.0, and 1.25 percentage points would apply to 2015-2017, respectively, and the maximum would be 1.5 percentage points thereafter. After implementation year 2019, the target growth amount would be based on the increase in per capita GDP plus 1 percentage point.

consideration. The necessary savings would have to be achieved primarily through changes affecting physician services, Medicare Advantage payments, and Part D. We have estimated the savings for section 3403 under the assumption that the provision would be implemented as specified; in particular, we have not assumed that Congress would pass subsequent legislation to prevent implementation of the Board's recommendations. Although the savings from the other Medicare provisions in the PPACA are quite substantial, they would not be sufficient to meet the growth rate targets specified in conjunction with the Advisory Board. We estimate that meeting the growth rate targets in 2015-2019 would require changes that would reduce Medicare growth rates by another 0.6 percent per year, on average, in addition to the impacts of the productivity adjustments, MA and DSH reductions, and other provisions in the PPACA.

After 2019, further Advisory Board recommendations for growth rate reductions would generally not be required. The other Medicare savings provisions, if permitted to continue, would normally reduce expenditure growth rates to slightly below the post-2019 target level based on per capita GDP growth plus 1 percent. Even if Medicare growth rates exceeded the targets, recommendations might not be required if the projected Medicare growth rate were less than that for overall national health expenditures on a per capita basis—which would tend to be the case, given the continuing Medicare savings. (This exemption from the requirement to make recommendations could not be applied in 2 successive years.) Although the Advisory Board process would not be required after 2019 based on the specific assumptions underlying these estimates, it would still serve as a brake during any periods of unusually rapid spending growth.

Section 3201 of the PPACA would transition Medicare Advantage benchmarks from their current statutory basis (generally in the range of 100 to 140 percent of fee-for-service costs) to the weighted average of the bids for each plan's service area (competitive benchmarks). Additionally, the MA rebates paid by CMS to most plans would be based on quality measures and the existence of care coordination programs, instead of the current basis equal to 75 percent of the difference between the risk-adjusted benchmark and bid. For plans offered in the two largest metropolitan areas and in certain specified counties, transitional rebate funding of $5 billion would be available. For a minority of plans offered in "grandfathered" counties, the MA rebates would be tied to the amounts occurring in 2011, decreased by 5 percent per year beginning in 2013. Lower benchmarks would reduce MA rebates to plans and thereby result in less generous benefit packages.[11] We estimate that in 2015, when the competitive benchmarks would be fully phased in, enrollment in MA plans would decrease by about 33 percent (from a projected level of 13.7 million under current law to 9.2 million under the proposal).

As noted above, the shift from current-law MA benchmarks in calendar year 2011, to competitive benchmarks with bonus payments in 2014, would result in lower rebates for non-grandfathered counties that are not eligible for transitional rebate payments. For plans in these counties, the average ratio of rebates to risk-adjusted bids is expected to be 4.4 percent in 2011, 2.7 percent in 2012, 1.2 percent in 2013, and 4.3 percent in 2014, compared to a level of 8.9 percent for 2010 under current law. The relatively low rebate for 2013 is a function of (i) the benchmark transition formula (based one-third on current law and two-thirds on the competitive bid average) and (ii) the current-law rebate formula (75 percent of the difference of the risk-adjusted benchmark

[11] MA plans use rebate revenues to reduce Medicare coinsurance requirements, add extra benefits such as vision or dental care, and/or reduce enrollee premiums for Part B or Part D of Medicare. Section 3203 (coding intensity adjustment during the payment transition) would also reduce MA plan revenues.

and the bid). Rebates as a percentage of bids would be somewhat higher during the transition period in conjunction with a change to Medicare physician payment updates; for example, with 0-percent SGR updates, the rebate percentages would be 8.6 percent in 2011, 5.9 percent in 2012, 3.1 percent in 2013, and 4.3 percent in 2014. Even so, the 2013 rebate would still be lower than the fully phased-in competitive benchmarks with bonus payments.

Medicaid/CHIP

The estimated Federal financial effects of the Medicaid and CHIP provisions in the PPACA are shown in table 4, attached. As noted previously, the costs associated with the expansion of Medicaid eligibility to individuals and families with incomes below 133 percent of the FPL and to children previously in foster care are included with the national coverage proposals shown in table 1. The additional funding for the CHIP program is also included in table 1 with the other coverage provisions.

The total net savings of the other Medicaid and CHIP provisions are estimated to be $27 billion in fiscal years 2010-2019 and reflect numerous cost increases and decreases under the individual provisions. Proposals with significant Federal savings include higher minimum manufacturer rebates for prescription drugs ($9 billion), extension of statutory rebates to drugs used by managed care enrollees ($9 billion), and reductions in Medicaid DSH expenditures ($33 billion). Interactions with other provisions, such as the lower Medicare Part B premiums under the PPACA, contribute an additional $11 billion in reduced Medicaid outlays.

The key provisions that would increase Medicaid and CHIP costs are the Medicaid "Community First Choice Option" and other proposals to encourage home and community-based services ($27 billion).

Impact of Proposals on the Rate of Growth in Health Care Costs

The PPACA includes a number of proposals that are intended, in part, to help control health care costs and to change the overall trend in health spending growth. Many of these proposals are specific to the Medicare program, as discussed previously, and their estimated financial effects are shown in table 3. While some of the Medicare proposals would have a largely one-time impact on the *level* of expenditures (for example, the shift to MA benchmarks based on the average plan bid), others would have an effect on expenditure *growth rates*. Examples of the latter include the productivity adjustments to Medicare payment updates for most categories of providers, which would reduce overall Medicare cost growth by roughly 0.6 to 0.7 percent per year, and the Independent Payment Advisory Board process, which would further reduce Medicare growth rates during 2015-2019 by about 0.6 percent per year. As noted previously, however, the growth rate reductions from productivity adjustments are unlikely to be sustainable on a permanent annual basis, and meeting the CPI-based target growth rates prior to 2020 would be very challenging as well.

The Independent Payment Advisory Board would also be required to periodically submit recommendations to Congress and the President regarding methods of slowing the growth of non-Federal health care programs. In many cases, Federal or State legislation would need to be enacted to implement these recommendations. In other cases, they could be adopted voluntarily by private health insurance plans or by health providers or introduced administratively by

government entities. Because the nature of these broader recommendations is not known and there is no mandate to adopt them, we have not estimated an explicit impact on health care spending growth.

Another provision that would tend to moderate health care cost growth rates is the excise tax on high-cost employer-sponsored health insurance coverage (section 9001), which is described in more detail in the section of this memorandum on national health expenditures. In reaction to the tax, many employers would reduce the scope of their health benefits. The resulting reductions in covered services and/or increases in employee cost-sharing requirements would induce workers to use fewer services. Because plan benefit values would generally increase faster than the threshold amounts for defining high-cost plans (which are indexed by the CPI plus 1 percent), over time additional plans would become subject to the excise tax, prompting many of those employers to scale back coverage. This continuing cycle would have a moderate impact on the overall growth of expenditures for employer-sponsored insurance. It should be noted, however, that under current law an estimated 22 percent of insured workers in 2019 would be in employer plans with benefit values in excess of the thresholds and that this percentage would continue to increase thereafter. The effect of the excise tax on reducing health care cost growth would depend on its ongoing application to an expanding share of employer plans and on an increasing scope of benefit reductions for affected plans. Since this provision is characterized as affecting high-cost employer plans, its broader and deeper impact could become an issue.

Certain other provisions of the PPACA are also intended to help control health care costs more generally, through promotion of comparative effectiveness research, greater use of prevention and wellness measures, administrative simplification, and augmented fraud and abuse enforcement. For fiscal years 2010 through 2019, we estimate a relatively small reduction in non-Medicare Federal health care expenditures of $2 billion for these provisions, all of which is associated with the comparative effectiveness research.

Comparative Effectiveness Research

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

Our interpretation of the CER provisions in the PPACA, which allow the Secretary of HHS to use evidence and findings from CER within defined limits in making coverage determinations under Medicare, is consistent with a low level of influence, translating into an estimated total reduction in national health expenditures of $8 billion for calendar years 2010 through 2019, and Federal savings of about $4 billion for fiscal years 2010 through 2019 (including Medicare). We anticipate that such savings would develop gradually, as changes in provider practice and culture evolved over time. Expert input on this subject suggests that the full impact of comparative effectiveness research, together with dissemination and application of its results, would take many years to develop.

Other Provisions

We show a negligible financial impact over the next 10 years for the other proposals intended to help control future health care cost growth. There is no consensus in the available literature or among experts that prevention and wellness efforts result in lower costs. Several prominent studies conclude that such provisions—while improving the quality of individuals' lives in important ways—generally increase costs overall. For example, while it is possible that savings can be achieved for many people by diagnosing diseases in early stages and promoting lifestyle and behavioral changes that reduce the risk for serious and costly illnesses, additional costs are incurred as a result of increased screenings, preventive care, and extended years of life.[12]

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

CLASS Program

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

As shown in the table on page 2, we estimate a net Federal savings for the CLASS program of $38 billion during the first 9 years of operations—the first 5 of which are prior to the commencement of benefit payments. After 2015, as benefits were paid, the net savings from this program would decline; in 2025 and later, projected benefits exceed premium revenues, resulting in a net Federal cost in the longer term.[13]

We estimate that roughly 2.8 million persons would participate in the program by the third year. This level represents about 2 percent of potential participants, compared to a participation rate of 4 percent for private long-term care insurance offered through employers. Factors affecting participation in CLASS include the program's voluntary nature, the lack of a Federal subsidy, a minimal premium for students and individuals with incomes under 100 percent of the FPL

[12] Title IV in the PPACA would create a Prevention and Public Health Fund and would authorize the appropriation of $15 billion for these purposes. We consider these expenditures to be primarily administrative in nature and thus have not included them as program costs in this memorandum.

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

(initially $5 per month), a relatively high premium for all other participants as a result of adverse selection and the effect of subsidizing participants paying the $5 premium, a new and unfamiliar benefit, and the availability of lower-priced private long-term care insurance for many.

Compounding this situation would be the probable participation of a significant number of individuals who would already meet the functional limitation requirements to qualify for benefits. In the sixth year of the program (2016), these participants would begin to receive benefits, along with others who had developed such limitations in the interim. We estimate that an initial average premium level of about $240 per month would be required to adequately fund CLASS program costs for this level of enrollment, adverse selection, and premium inadequacy for students and low-income participants. (Except for those paying the $5 premium, individuals enrolling in a given year would pay a constant premium amount throughout their participation, unless trust fund deficits necessitated a premium increase. Premiums would vary by age at enrollment and by year of enrollment.)

In general, voluntary, unsubsidized, and non-underwritten insurance programs such as CLASS face a significant risk of failure as a result of adverse selection by participants. Individuals with health problems or who anticipate a greater risk of functional limitation would be more likely to participate than those in better-than-average health. Setting the premium at a rate sufficient to cover the costs for such a group further discourages persons in better health from participating, thereby leading to additional premium increases. This effect has been termed the "classic assessment spiral" or "insurance death spiral." The problem of adverse selection would be intensified by requiring participants to subsidize the $5 premiums for students and low-income enrollees. Although Title VIII includes modest work requirements in lieu of underwriting, and specifies that the program is to be "actuarially sound" and based on "an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period," there is a very serious risk that the problem of adverse selection would make the CLASS program unsustainable.[14]

Immediate Insurance Reforms

A number of provisions in the PPACA would have an immediate effect on insurance coverage. Most of these proposals, however, would not have a direct impact on Federal expenditures. (A discussion of their impact on national health expenditures is included in the following section of this memorandum.) Section 1101 of the PPACA authorizes the expenditure of up to $5 billion in support of a temporary national insurance pool for high-risk individuals without other health insurance.

National Health Expenditure Impacts

The estimated effects of the PPACA on overall national health expenditures (NHE) are shown in table 5. In aggregate, we estimate that for calendar years 2010 through 2019, NHE would increase by $222 billion, or 0.6 percent, over the updated baseline projection that was released on

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

June 29, 2009.[15] Year by year, the relative increases are largest in 2016, when the coverage expansions would be fully phased in (1.7 percent), and gradually decline thereafter to 0.5 percent in 2019, as the effects of the Medicare market basket reductions compound and as the excise tax on high-cost employer health plans affects more policies. The NHE share of GDP is projected to be 20.9 percent in 2019, compared to 20.8 percent under current law.

The increase in total NHE is estimated to occur primarily as a net result of the substantial expansions in coverage under the PPACA, together with the expenditure reductions for Medicare. Numerous studies have demonstrated that individuals and families with health insurance use more health services than otherwise-similar persons without insurance. Under the health reform legislation, as noted above, an estimated 34 million currently uninsured people would gain comprehensive coverage through the health insurance Exchanges, their employers, or Medicaid. The availability of coverage would typically result in a fairly substantial increase in the utilization of health care services, with a corresponding impact on total health expenditures. These higher costs would be partially offset by the sizable discounts imposed on providers by State Medicaid payment rules, as well as the significant discounts negotiated by private health insurance plans. We estimate that the net effect of the utilization increases and price reductions arising from the coverage provisions of the PPACA would increase NHE in 2019 by about 3.4 percent.

The PPACA would also affect aggregate NHE through the Medicare savings provisions. We estimate that these impacts would reduce NHE by roughly 2.5 percent in 2019, assuming that the productivity adjustments to Medicare payment updates and the impacts of the Independent Payment Advisory Board could be sustained through this period. The bill would have only a slight impact on the utilization of health care services by Medicare beneficiaries (subject to the caveat mentioned previously regarding possible access issues under the proposal to permanently reduce annual provider payment updates by economy-wide productivity gains). Medicaid outlays for health care would increase under some provisions and decrease under others; excluding the coverage expansion, the net decrease in such costs overall would reduce total U.S. health expenditures in 2019 by about 0.1 percent.

The immediate insurance reforms in Title I would affect national health expenditures as well, although by relatively small amounts. We estimate that the creation of a national high-risk insurance pool would result in roughly 375,000 people gaining coverage in 2010, increasing national health spending by $4 billion. By 2011 and 2012 the initial $5 billion in Federal funding for this program would be exhausted, resulting in substantial premium increases to sustain the program; we anticipate that such increases would limit further participation. Beginning in 2010, qualified child dependents below age 26 who are uninsured would be allowed to enroll under dependent coverage. An estimated 485,000 dependent children would gain insurance coverage through their parents' private group health plans, increasing national health spending by $0.9 billion. These impacts are expected to persist through 2013. Additionally, because this provision would not expire when the Medicaid expansion, individual mandate, and Exchanges start in 2014, we anticipate that these individuals would continue to remain covered as dependents even though they may be newly eligible for other coverage. Finally, we did not estimate NHE coverage or cost impacts for the other immediate reform

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

provisions, such as prohibiting limitations on pre-existing conditions or elimination of lifetime aggregate benefit limits. We believe that each of these provisions would have only a relatively minor upward impact on national health spending.

Section 9001 of the PPACA would place an excise tax on employer-sponsored health insurance coverage with a benefit value above specified levels (generally $8,500 for individuals and $23,000 for families in 2013, adjusted in future years by growth in the CPI plus 1 percentage point).[16] The tax would be 40 percent of the excess benefit value above these thresholds. We estimate that, in aggregate, affected employers would reduce their benefit packages in such a way as to eliminate about three-quarters of the current excess benefit value. The resulting higher cost-sharing requirements for employees would have an initial, significant impact on the overall level of health expenditures. Moreover, because health care costs would generally increase faster than the CPI plus 1 percent, we anticipate additional, incremental benefit coverage reductions in future years to prevent an increase in the share of employer coverage subject to the excise tax. These further adjustments would contribute to a small reduction in the growth in total health care costs (but an increase in out-of-pocket costs) for affected employees through at least 2019.[17] In 2019, these impacts would reduce total NHE by an estimated 0.3 percent, assuming that the provision would continue to operate as specified—as noted previously, by 2019 coverage for an estimated 22 percent of all insured workers would have to be reduced to avoid the tax.

Sections 9008, 9009, and 9010 would impose collective annual fees on (i) manufacturers and importers of brand-name prescription drugs, (ii) manufacturers and importers of medical devices, and (iii) health insurance plans. For manufacturers and importers of brand-name prescription drugs, the fee is $2.3 billion per year beginning in 2010. For medical devices and insurers, the annual fee level for each industry is phased in starting in 2011, ultimately reaching an annual level of $3.0 billion in 2018 for manufacturers and importers of medical devices and $10.0 billion in 2017 for insurers. In each case, the total annual fee amount would be assessed on the specified industry as a whole; the share of the fee payable by any given firm in that industry would be determined based on market share and sales (for manufacturers and importers of drugs and devices) and on net premiums (in the case of insurers), with some limited exemptions. We anticipate that such fees would generally be passed through to health consumers in the form of higher drug and device prices and higher insurance premiums, with an associated increase in overall national health expenditures ranging from $5.8 billion in 2011 to $13.8 billion in 2019.

Although, compared to current law, the *level* of total national health expenditures is estimated to be higher through 2019 under the PPACA, two particular provisions of the legislation would help reduce NHE *growth rates* after 2016. Specifically, the productivity adjustments to most Medicare payment updates would reduce NHE growth by about 0.10 to 0.15 percent per year. In addition, the excise tax on high-cost employer health plans (with benefit thresholds indexed by the CPI plus 1 percent) would exert a further decrease in NHE growth rates of an estimated 0.05 percent per year. Although these growth rate differentials are not large, over time they

[16] Plans in the 17 States with the highest employer health care costs would have higher thresholds over a 3-year transition period. A higher threshold would permanently apply in the case of qualified retirees and individuals in high-risk occupations.

[17] As noted previously, we have not included the excise taxes under this provision in the estimated financial effects of the PPACA shown in this memorandum. Similarly, the indirect impacts on Federal income taxes and social insurance payroll taxes are not shown.

would have a noticeable downward effect on the level of national health expenditures. Such an outcome, however, would depend critically on the sustainability of both provisions. As previously noted, the Medicare productivity adjustments could become unsustainable even within the next 10 years, and over time the reductions in the scope of employer-sponsored health insurance could also become an issue. For these reasons, the estimated reductions in NHE growth rates after 2016 may not be fully achievable.

Underlying the overall moderate effects of the PPACA on NHE would be various changes by payer. Based on the net impact of (i) the substantial coverage expansions, (ii) the significant cost-sharing subsidies for low-to-middle-income persons, (iii) the maximum out-of-pocket limitations associated with the qualified health benefit, and (iv) the increases in workers' cost-sharing obligations in plans affected by the excise tax on high-cost employer-sponsored health insurance coverage, we estimate that overall out-of-pocket spending would be reduced significantly by the PPACA (a net total decline of $141 billion in calendar years 2010-2019).[18]

Public spending would increase under the PPACA as a result of the expansion of the Medicaid program and additional CHIP funding but be reduced by the net Medicare savings and other Medicaid savings from the bill. Private expenditures would decrease somewhat because of the net reduction in the number of persons with employer-sponsored health insurance and the reduced benefits for plans affected by the excise tax on high-cost employer coverage. The sizable growth in health insurance coverage through Exchange plans would also affect NHE amounts by payer, although the classification of such spending is not straightforward. Based on current law, public expenditures (principally Medicare and Medicaid) are estimated to represent 52 percent of total NHE in 2019. Under the PPACA, the public share would be between 51 and 56 percent, depending on how health expenditures by Exchange plans were classified. Similarly, expenditures from private health insurance, which are estimated to be 31 percent of NHE under current law, would fall in the range of 28 to 33 percent.[19]

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[18] Beginning with this memorandum, we are reducing the aggregate out-of-pocket expenditures shown in table 5 by the amount of Federal cost-sharing subsidies and increasing national health expenditures through Exchange plans by the same amount ($38 billion in total for calendar years 2014-2019). In previous analyses, the cost-sharing subsidies were included with out-of-pocket expenditures due to classification challenges of the sort described in footnote 19.

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

(i) The Exchanges would be government entities, with a role in setting minimum benefit standards, but they would not directly provide health insurance coverage. The same situation would apply to the multi-State Exchange plans arranged by the Office of Personnel Management.

(ii) All Exchange plans would be private health insurance.

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

(iv) The premium subsidies would vary between zero and 100 percent from one person to another, and the cost-sharing subsidies from zero to 67 percent on an insurance-value basis.

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

Caveats and Limitations of Estimates

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

- These financial and coverage impacts are based on the provisions of the PPACA as passed by the Senate on December 24, 2009 and do not pertain to other versions of the bill.
- Many of the provisions, particularly the coverage proposals, are unprecedented or have been implemented only on a smaller scale (for example, at the State level). Consequently, little historical experience is available with which to estimate the potential impacts.
- The behavioral responses to changes introduced by national health reform legislation are impossible to predict with certainty. In particular, the responses of individuals, employers, insurance companies, and Exchange administrators to the new coverage mandates, Exchange options, and insurance reforms could differ significantly from the assumptions underlying the estimates presented here.
- The nominal dollar amounts of costs and savings under national health reform are sensitive to the assumed trajectory of future health cost trends. Relative measures, such as the cost as a percentage of GDP, are less sensitive.
- Due to the very substantial challenges inherent in modeling national health reform proposals, our estimates will vary from those of other experts and agencies. Differences in results from one estimating entity to another may tend to cause confusion among policy makers. These differences, however, provide a useful reminder that all such estimates are uncertain and that actual future impacts could differ significantly from the estimates of any given organization. Indeed, the future costs and coverage effects could lie outside of the range of estimates provided by the various estimators.
- The existing number of uninsured persons in the U.S. is difficult to measure, and the number of uninsured persons who are undocumented aliens is considerably more uncertain. Medicaid coverage and Exchange premium subsidies under the PPACA are not available to undocumented aliens. As a result of these measurement difficulties, the actual costs under the PPACA and the reduction in the number of uninsured persons may be somewhat higher or lower than estimated in this memorandum.
- Certain Federal costs and savings were not included in our estimates if (i) a provision would have no, or only a minor, impact; (ii) the legislative language did not provide sufficient detail with which to estimate a provision's impact; or (iii) the estimates are outside of the scope of the Office of the Actuary's expertise and will be prepared by other agencies. In particular, we did not include any Federal savings pertaining to the excise tax on high-cost employer-sponsored health insurance coverage, the fees on drugs, devices, and plans, and other non-Medicare revenue provisions of the PPACA, as those estimates are provided by the Department of the Treasury. (In contrast, the impacts of these provisions on national health expenditures are reflected.) Similarly, Federal administrative expenses associated with the

PPACA are not included here and will be estimated separately. As noted previously, the Congressional Budget Office and Joint Committee on Taxation have estimated that the total amount of Medicare savings and additional excise tax and other revenues would somewhat more than offset the cost of the national coverage provisions, resulting in an overall small reduction in the Federal deficit through 2019, and probably for the following 10 years as well, if all of the provisions continued to be fully implemented.

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

  The latter possibility is especially likely in the case of the substantially higher volume of Medicaid services, where provider payment rates are well below average. Therefore, it is reasonable to expect that a significant portion of the increased demand for Medicaid would be difficult to meet, particularly over the first few years.

  We have not attempted to model that impact or other plausible supply and price effects, such as supplier entry and exit or cost-shifting towards private payers. A specific estimate of these potential outcomes is impracticable at this time, given the uncertainty associated with both the magnitude of these effects and the interrelationships among these market dynamics. We may incorporate such factors in future estimates, should we determine that they can be estimated with a reasonable degree of confidence. For now, we believe that consideration should be given to the potential consequences of a significant increase in demand for health care meeting a relatively fixed supply of health care providers and services.

- As noted in the section on Medicare estimates, reductions in payment updates to health care providers, based on economy-wide productivity gains, are unlikely to be sustainable on a permanent annual basis. If these reductions were to prove unworkable within the 10-year period 2010-2019 (as appears probable for significant numbers of hospitals, skilled nursing facilities, and home health agencies), then the actual Medicare savings from these provisions would be less than shown in this memorandum. Similarly, the further reductions in Medicare growth rates mandated for 2015 through 2019 through the Independent Payment Advisory Board may be difficult to achieve in practice.

- In estimating the financial impact of the Medicaid eligibility expansion, we assumed that existing and new Medicaid enrollees would be appropriately classified for FMAP purposes.

- As discussed in the section on the CLASS program, we believe that there is a very serious risk that the program, as currently specified, would not be sustainable because of adverse selection.

Conclusions

The national health care reform proposals in the Senate "Patient Protection and Affordable Care Act" would make far-reaching changes to the health sector, including mandated coverage for most people, required payments by most employers not offering insurance, expanded eligibility for Medicaid, Federal premium and cost-sharing subsidies for many individuals and families, a new system of health benefits exchanges for facilitating coverage, and a new Federal insurance program in support of long-term care. Additional provisions would reduce Medicare outlays, make other Medicaid modifications, provide additional funding for the CHIP program, add certain benefit enhancements for these programs, and combat fraud and abuse. Federal revenues would be increased through an excise tax on high-cost insurance plans; fees on drugs, devices, and health plans; and other provisions.

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

- The total Federal cost of the national insurance coverage provisions would be about $882 billion during fiscal years 2010 through 2019.

- By 2019, an additional 34 million U.S. citizens and other legal residents would have health insurance coverage meeting the essential-benefit requirements.

- Total net savings in 2010-2019 from Medicare provisions would offset about $541 billion of the Federal costs for the national coverage provisions. The Medicaid and CHIP provisions, excluding the expansion of Medicaid and additional CHIP funding, would decrease costs by $27 billion. Additional Federal revenues would further offset the coverage costs; however, the Office of the Actuary does not have the expertise necessary to estimate such impacts. The Congressional Budget Office and the Joint Committee on Taxation have estimated an overall reduction in the Federal budget deficit through 2019 under the PPACA.

- The proposed Community Living Assistance Services and Supports (CLASS) insurance program would produce an estimated total net savings of $38 billion through fiscal year 2019. This result, however, is due to the initial 5-year period during which no benefits would be paid. Over the longer term, expenditures would exceed premium receipts, and there is a very serious risk that the program would become unsustainable as a result of adverse selection by participants.

- Total national health expenditures in the U.S. during 2010-2019 would increase by about 0.6 percent. The additional demand for health services could be difficult to meet initially with existing health provider resources and could lead to price increases, cost-shifting, and/or changes in providers' willingness to treat patients with low-reimbursement health coverage.

- The proposed reductions in Medicare payment updates for providers, the actions of the Independent Payment Advisory Board, and the excise tax on high-cost employer-sponsored

health insurance would have a downward impact on future health care cost growth rates. During 2010-2019, however, these effects would be outweighed by the increased costs associated with the expansions of health insurance coverage. Also, the longer-term viability of the Medicare update reductions is doubtful. Other provisions, such as comparative effectiveness research, are estimated to have a relatively small effect on expenditure growth rates.

We hope that the information presented here will be of value to policy makers as they continue to develop and debate the many facets of health reform legislation.

Richard S. Foster, FSA, MAAA
Chief Actuary

Attachments: 5

Table 1 — Estimated Federal Costs (+) or Savings (-) under the Patient Protection and Affordable Care Act, as Passed by the Senate, in billions

	Fiscal Year										Total, FY
Provisions	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total*	$11.6	$0.1	-$14.8	-$32.8	$14.7	$63.0	$71.4	$60.9	$55.8	$49.7	$279.5
Coverage Provisions:	4.7	6.6	1.7	0.0	86.5	128.0	150.1	156.4	167.9	180.7	882.5
Medicaid Expansion and CHIP Funding	—	—	—	—	37.7	61.7	77.3	68.6	72.0	77.0	394.3
Credits:	4.7	6.6	1.7	0.0	51.0	70.8	81.9	103.7	115.3	124.2	559.8
Individual Exchange Subsidies:	—	—	—	—	51.0	70.8	81.9	103.7	115.3	124.2	546.9
Refundable Premium Tax Credits	—	—	—	—	47.5	66.4	77.1	96.7	107.4	115.7	510.7
Reduced Cost-Sharing Requirements	—	—	—	—	3.5	4.4	4.8	7.1	7.9	8.5	36.2
Small Employer Credits	4.7	6.6	1.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	12.9
Penalties:	—	—	—	—	-2.2	-4.4	-9.2	-16.0	-19.3	-20.6	-71.6
Individual Penalties	—	—	—	—	0.0	-0.8	-3.7	-8.5	-10.3	-10.9	-34.2
Employer Penalties	—	—	—	—	-2.2	-3.6	-5.5	-7.5	-9.0	-9.6	-37.4
Medicare	2.2	-3.6	-12.1	-23.4	-62.6	-55.1	-70.2	-87.6	-104.6	-123.7	-540.7
Medicaid/CHIP (Excluding Coverage Expansions)	-0.4	-0.1	0.2	-3.8	-3.1	-3.8	-3.9	-4.1	-4.0	-3.9	-27.1
Cost Trend Proposals:	—	—	—	—	0.0	-0.1	-0.2	-0.4	-0.6	-0.9	-2.3
Comparative Effectiveness Research†	—	—	—	—	0.0	-0.1	-0.2	-0.4	-0.6	-0.9	-2.3
Prevention and Wellness	—	—	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Fraud and Abuse	—	—	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Administrative Simplification	—	—	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Additional Proposals:	5.0	-2.8	-4.5	-5.6	-5.9	-6.0	-4.3	-3.4	-2.8	-2.4	-32.8
CLASS Program	—	-2.8	-4.5	-5.6	-5.9	-6.0	-4.3	-3.4	-2.8	-2.4	-37.8
Immediate Reforms	5.0	—	—	—	—	—	—	—	—	—	5.0

* Excludes Title IX revenue provisions except for section 9015 (additional HI payroll tax), certain provisions with limited impacts, and Federal administrative costs.

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

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.
January 8, 2010

Table 2 — Estimated Effects of the Patient Protection and Affordable Care Act, as Passed by the Senate, on Enrollment by Insurance Coverage, in millions

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

	Calendar Year									
Proposed — PPACA	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare	46.9	48.0	49.4	50.9	52.4	53.9	55.4	57.1	58.7	60.5
Medicaid/CHIP	59.2	60.5	61.6	62.0	82.7	83.7	83.3	81.3	82.0	83.1
Other Public	12.6	12.6	12.9	13.2	13.6	13.9	14.2	14.6	14.9	15.2
Employer-sponsored Private Health Insurance	164.3	163.7	164.9	165.5	166.9	167.6	164.9	162.3	160.7	161.5
Other Private Health Insurance*	26.1	25.3	25.5	25.6	13.3	13.0	12.5	12.0	11.6	11.1
Exchanges	—	—	—	—	18.4	20.6	27.7	33.3	35.3	35.5
Private Plans (Local and Multi-state)	—	—	—	—	18.4	20.6	27.7	33.3	35.3	35.5
Public Plan	—	—	—	—	—	—	—	—	—	—
Uninsured	47.5	48.1	47.4	47.6	24.1	22.3	20.4	21.5	22.2	22.6
Insured Share of US Population†	84.7%	84.6%	85.0%	85.0%	92.5%	93.1%	93.8%	93.5%	93.3%	93.3%

	Calendar Year									
Impact of PPACA	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare	—	—	—	—	—	—	—	—	—	—
Medicaid/CHIP	—	—	—	—	22.1	23.4	22.2	19.4	19.3	19.5
Other Public	0.4	—	—	—	—	—	—	—	—	—
Employer-sponsored Private Health Insurance	0.5	0.5	0.5	0.5	0.8	1.0	-1.5	-3.9	-5.3	-4.4
Other Private Health Insurance*	—	—	—	—	-12.5	-12.8	-13.3	-13.8	-14.2	-14.6
Exchange	—	—	—	—	18.4	20.6	27.7	33.3	35.3	35.5
Private Plans (Local and Multi-state)	—	—	—	—	18.4	20.6	27.7	33.3	35.3	35.5
Public Plan	—	—	—	—	—	—	—	—	—	—
Uninsured	-0.9	-0.5	-0.5	-0.5	-25.9	-29.4	-32.7	-32.9	-33.4	-34.3
Insured Share of US Population†	0.3%	0.2%	0.2%	0.2%	8.1%	9.1%	10.0%	10.0%	10.1%	10.2%

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

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

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.
January 8, 2010

Table 3—Estimated Effects of the Patient Protection and Affordable Care Act, as Passed by the Senate, on Medicare

(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	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 IN THE MEDICARE PROGRAM												
3001	Hospital Value-Based Purchasing	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
3002	Physician Quality Reporting Initiative	0	0	0	210	120	-190	-390	-580	-560	-530	330	-1,920
3003	Expansion of 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	-30	-30	-30	-30	-20	-20	-30	-160
3005	Quality Reporting for PPS-exempt Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
3006	Value-based Purchasing for SNF, HHA, & ASC	0	0	0	0	0	0	0	0	0	0	0	0
3007	Value-based Payment Modifer under 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	-520	-610	-660	-700	-750	0	-3,240
	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 and Efficiency Measurement	0	0	0	0	0	0	0	0	0	0	0	0
3015	Data Collection; Public Reporting	0	0	0	0	0	0	0	0	0	0	0	0
	PART III-ENCOURAGING DEVELOPMENT OF THE NEW PATIENT CARE MODELS												
3021	CMS Innovation Center	0	0	0	0	0	0	0	0	0	0	0	0
3022	Medicare Shared Savings Program	0	0	0	0	0	0	0	0	0	0	0	0
3023	National Pilot Program on Payment Bundling	0	0	0	0	0	0	0	0	0	0	0	0
3024	Independence at Home Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0
3025	Hospital Readmissions Reduction Program	0	0	0	-530	-630	-1,180	-1,320	-1,410	-1,510	-1,620	-1,160	-8,200
3026	Community-Based Care Transitions Program												
	Part A	0	100	100	100	100	100	0	0	0	0	400	500
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
3027	Extension of Gainsharing Demonstration	0	0	0	0	0	0	0	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 Physician Payment Update	0	0	0	0	0	0	0	0	0	0	0	0
3102	Extension of Floor on Medicare Work Geographic Adjustment	620	720	200	0	0	0	0	0	0	0	1,540	1,540
3103	Extension of Exceptions for Therapy Caps	520	1,160	500	10	10	20	20	20	20	20	2,200	2,300
3104	Extension of Treatment of Certain Physician Pathology Services	40	80	40	0	0	0	0	0	0	0	160	160
3105	Extension of Ambulance Add-ons	20	10	0	0	0	0	0	0	0	0	30	30
3106	Extension of Long-Term Care Hospital Provisions	30	440	530	140	10	0	0	0	0	0	1,150	1,150
3107	Extension of Physician Fee Schedule Mental Health Add-on	40	20	0	0	0	0	0	0	0	0	60	60

Table 3—Estimated Effects of the Patient Protection and Affordable Care Act, as Passed by the Senate, on Medicare

(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
3108	Permitting Physician Assistants to Order Post-Hospital Extended Care Services	0	0	0	0	0	0	0	0	0	0	0	0
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 for Disabled TRICARE	0	10	20	30	40	40	40	40	50	50	100	320
3111	Bone Density Tests	20	40	20	0	0	0	0	0	0	0	80	80
3112	Revision to Medicare Improvement Fund												
	Part A	0	0	0	0	-15,350	0	0	0	0	0	-15,350	-15,350
	Part B	0	0	0	0	-11,890	0	0	0	0	0	-11,890	-11,890
3113	Treatment of Certain Complex Diagnostic Lab Tests	0	0	0	0	0	0	0	0	0	0	0	0
3114	Improved Access for Certified Midwife Services	0	0	0	0	0	0	0	0	0	0	0	0
	PART II-RURAL PROTECTIONS												
3121	Extend of Outpatient Hold Harmless Provision	50	20	0	0	0	0	0	0	0	0	70	70
3122	Extend Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
3123	Extend Rural Community Hospital Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0
3124	Extend Medicare Dependent Hospital Program	0	0	100	10	0	0	0	0	0	0	110	110
3125	Improvements to Hospital Payments for Low-volume Hospitals	0	100	110	10	0	0	0	0	0	0	220	220
3126	Demonstration Project on Community Health Integration Models	0	0	0	0	0	0	0	0	0	0	0	0
3127	MEDPAC Study on Payments in Rural Areas	0	0	0	0	0	0	0	0	0	0	0	0
3128	Technical Correction to Critical Access Hospital Services	0	0	0	0	0	0	0	0	0	0	0	0
3129	Medicare Rural Hospital Flexibilty Program	0	0	0	0	0	0	0	0	0	0	0	0
	PART III-IMPROVING PAYMENT ACCURACY												
3131	Payment Adjustment for Home Health Care												
	Part A	20	-220	-370	-410	-690	-1,140	-1,710	-2,340	-2,700	-2,900	-1,670	-12,460
	Part B	20	-260	-450	-510	-860	-1,410	-2,120	-2,900	-3,350	-3,600	-2,060	-15,440
3132	Hospice Reform	0	0	0	0	0	0	0	0	0	0	0	0
3133	Improvement to Medicare DSH Payments	0	0	0	0	0	-6,350	-8,460	-10,170	-10,740	-11,290	0	-47,010
3134	Misvalued Codes under Physician Fee Schedule	0	0	0	0	0	0	0	0	0	0	0	0
3135	Equipment Utilization Factor for Advanced Imaging Services	-100	-260	-340	-420	-550	-620	-660	-700	-740	-770	-1,670	-5,160
3136	Revision of Payment for Power Wheelchairs	0	-40	-50	-50	-50	-60	-70	-70	-80	-80	-190	-550
3137	Hospital Wage Index Improvement	260	30	0	0	0	0	0	0	0	0	290	290
3138	Treatment of Certain Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
3139	Payment for Biosimilar Biological Products												
	Part B	0	0	0	10	20	-350	-810	-960	-1,150	-1,360	30	-4,600
	Part D	0	0	0	10	-20	-80	-130	-150	-180	-220	-10	-770
3140	Hospice Concurrent Care Demonstration	0	0	0	0	0	0	0	0	0	0	0	0
3141	Budget Neutrality in Calculation of Hospital Wage Index Floor	0	0	0	0	0	0	0	0	0	0	0	0
3142	Study on Urban Medicare-dependent Hospitals	0	0	0	0	0	0	0	0	0	0	0	0

Table 3—Estimated Effects of the Patient Protection and Affordable Care Act, as Passed by the Senate, on Medicare

(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	SUBTITLE C-PROVISIONS RELATING TO PART C												
3201	Medicare Advantage Payment												
	Part A	0	-870	-2,690	-5,230	-4,850	-6,620	-7,130	-7,700	-8,240	-8,790	-13,640	-52,120
	Part B	0	-580	-1,770	-3,440	-3,150	-4,370	-4,840	-5,350	-5,940	-6,440	-8,940	-35,880
3202	Benefit Protection and Simplification	0	0	0	0	0	0	0	0	0	0	0	0
3203	Coding Intensity Adjustment During MA Payment Transition												
	Part A	0	-2,120	-2,120	-1,200	-1,320	-940	0	0	0	0	-7,700	-7,700
	Part B	0	-1,400	-1,400	-790	-860	-620	0	0	0	0	-4,450	-5,070
3204	Simplification of Annual Beneficiary Election Periods	0	0	0	0	0	0	0	0	0	0	0	0
3205	Specialized MA Plans for Special Needs Individuals	0	0	0	0	0	0	0	0	0	0	0	0
3206	Extension of Reasonable Cost Contracts	0	0	0	0	0	0	0	0	0	0	0	0
3207	Technical Correction to MA Private FFS Plans	0	0	0	0	0	0	0	0	0	0	0	0
3208	Making Senior Housing Facility Demonstration Permanent	0	0	0	0	0	0	0	0	0	0	0	0
3209	Authority to Deny Plan Bids	0	0	0	0	0	0	0	0	0	0	0	0
3210	Development of New Standards for Certain Medigap Plans												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	-50	-70	-80	-90	-90	0	-380
	SUBTITLE D-MEDICARE PART D IMPROVEMENTS FOR PRESCRIPTION DRUG PLANS AND MA-PD PLANS												
3301	Medicare Coverage Gap Discount Program	140	150	130	150	170	190	230	230	240	290	740	1,920
3302	Improving the Determination of Part D Low-Income Benchmarks	0	90	120	130	140	140	150	170	180	190	480	1,310
3303	Voluntary De Minimus Policy for Low-Income Subsidy Plans	0	20	20	20	20	30	30	30	30	30	80	230
3304	Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance	0	0	0	0	0	0	0	0	0	0	0	0
3305	Improved Information for Subsidy Eligible Individuals	0	0	0	0	0	0	0	0	0	0	0	0
3306	Funding Outreach and Assistance of Low-Income Programs	45	45	45	0	0	0	0	0	0	0	135	135
3307	of Drugs	0	0	0	0	0	0	0	0	0	0	0	0
3308	Reducing the Part D Premium Subsidy for High-Income Beneficiaries	0	-390	-590	-670	-760	-860	-980	-1,110	-1,260	-1,430	-2,410	-8,050
3309	Elimination of Cost Sharing for Certain Dual Eligible Individuals	0	0	0	0	0	0	0	0	0	0	0	0
3310	Reducing Wasteful Dispensing of Outpatient Prescription Drugs	0	0	0	0	0	0	0	0	0	0	0	0
3311	Improved Plan Complaint System	0	0	0	0	0	0	0	0	0	0	0	0
3312	Uniform Exception and Appeals Process	0	0	0	0	0	0	0	0	0	0	0	0
3313	OIG Studies and Reports	0	0	0	0	0	0	0	0	0	0	0	0
3314	Cost Incurred by AIDS Drug Assistance and HIS	0	50	70	70	80	90	100	110	120	130	270	820
3315	Immediate Reduction in Coverage Gap in 2010	1,050	350	0	0	0	0	0	0	0	0	1,400	1,400

Table 3—Estimated Effects of the Patient Protection and Affordable Care Act, as Passed by the Senate, on Medicare

(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	SUBTITLE E-ENSURING MEDICARE SUSTAINABILITY												
3401	Market Basket Revisions and Productivity Adjustments												
	Skilled Nursing Faciltities	0	-30	-440	-1,000	-1,560	-2,160	-2,920	-3,700	-4,530	-5,660	-3,030	-22,000
	Long-Term Care Hospitals	-10	-50	-120	-220	-330	-440	-580	-720	-880	-1,080	-730	-4,430
	Inpatient Rehabilitation Facilities	-10	-40	-130	-250	-380	-520	-690	-860	-1,050	-1,300	-810	-5,230
	Hospitals Paid Under the Inpatient Prospective Payment System	-280	-870	-2,670	-4,930	-7,460	-10,150	-13,640	-17,220	-21,000	-26,130	-16,210	-104,350
	Inpatient Psychiatric Facilities--Productivity Adjustments	-10	-30	-100	-190	-290	-390	-520	-650	-790	-980	-620	-3,950
	Inpatient Psychiatric Facilities--Quality Reporting	0	0	0	0	-10	-10	-10	-10	-10	0	-10	-50
	Hospice	0	0	0	-220	-450	-690	-980	-1,330	-1,700	-2,120	-670	-7,490
	Hospital Outpatient Services	0	0	-820	-1,280	-1,790	-2,310	-2,930	-3,690	-4,580	-5,600	-3,890	-23,000
	Durable Medical Equipment	0	-20	-50	-80	-110	-140	-180	-230	-280	-330	-260	-1,420
	All Other Part B Fee Schedules, Except Physicians' Services	0	-100	-300	-520	-750	-1,010	-1,310	-1,680	-2,100	-2,600	-1,670	-10,370
	Home Health--Part A	0	-60	-160	-290	-350	-440	-610	-780	-970	-1,230	-860	-4,890
	Home Health--Part B	0	-70	-180	-320	-380	-490	-680	-870	-1,080	-1,370	-950	-5,440
3402	Temporary Adjustment to Calculation of Part B Premiums												
	Part B Income (additional premiums)	0	-70	-190	-320	-510	-740	-990	-1,320	-1,700	-2,300	-1,090	-8,140
	Part B Benefits	0	0	0	-10	-10	-10	-20	-20	-50	-70	-20	-190
3403	Independent Payment Advisory Board												
	Part A	0	0	0	0	0	-1,200	-3,040	-5,330	-8,110	-10,890	0	-28,570
	Part B	0	0	0	0	0	-760	-1,940	-3,430	-5,270	-7,170	0	-18,570
	Part D	0	0	0	0	0	-320	-840	-1,520	-2,390	-3,330	0	-8,400
	Medicare Coverage for Individuals Exposed to Environmental Health Hazards												
	Part A	10	10	10	10	10	20	20	20	20	20	50	150
	Part B	0	10	10	10	10	10	10	10	10	20	40	100
	Protection for Frontier States												
	Part A	0	190	230	250	260	280	300	320	340	370	930	2,540
	Part B	0	80	150	170	170	190	200	230	240	280	570	1,710
	Delay Implementation of RUG-IV	0	0	0	0	0	0	0	0	0	0	0	0
	Pilot Testing for Pay-for-Performance	0	0	0	0	0	0	0	0	0	0	0	0
	Improvments to Physician Quality Reporting System												
	Part A	0	0	0	-80	-110	-70	-50	-50	-50	-50	-190	-460
	Part B	0	0	0	60	40	100	130	-30	-40	-40	100	220
	Improvments to Part D Medication Therapy Management												
	Methodology to Assess Health Plan Value	0	0	0	0	0	0	0	0	0	0	0	0
	Modernizing CMS Computer and Data System	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
	Availability of Medicare Data for Perfomance Measurement	0	0	0	0	0	0	0	0	0	0	0	0

Table 3—Estimated Effects of the Patient Protection and Affordable Care Act, as Passed by the Senate, on Medicare

(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	Community Based Collaborative Care Networks	0	0	0	0	0	0	0	0	0	0	0	0
	Minority Health	0	0	0	0	0	0	0	0	0	0	0	0
	Technical Correction to Hospital Value-based Purchasing	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
	SUBTITLE F-HEALTH CARE QUALITY IMPROVEMENTS												
3501	Health Care Delivery System Research	0	0	0	0	0	0	0	0	0	0	0	0
3502	Support Patient-Sentered Medical Home	0	0	0	0	0	0	0	0	0	0	0	0
3503	Medication Management Services	0	0	0	0	0	0	0	0	0	0	0	0
3504	Regionalized Systems for Emergency Care	0	0	0	0	0	0	0	0	0	0	0	0
3505	Trauma Care Centers	0	0	0	0	0	0	0	0	0	0	0	0
3506	Shared Decisionmaking	0	0	0	0	0	0	0	0	0	0	0	0
3507	Prescription Drug Benefit and Risk Information	0	0	0	0	0	0	0	0	0	0	0	0
3508	Demonstration to Integrate Quality Care and Patient Safety	0	0	0	0	0	0	0	0	0	0	0	0
3509	Improving Woman's Health	0	0	0	0	0	0	0	0	0	0	0	0
3510	Patient Navigator Program	0	0	0	0	0	0	0	0	0	0	0	0
3511	Authorization of Appropriations	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE III		2,475	-3,755	-12,535	-21,560	-54,300	-46,030	-60,030	-76,470	-92,590	-110,740	-89,675	-475,535
	TITLE IV-PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH												
	SUBTITLE A-MODERNINZING DISEASE PREVENTION AND PUBLIC HEALTH SYSTEMS												
4001-4004		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE B-INCREASING ACCESS TO CLINICAL PREVENTIVE SERVICES												
4103	Annual Wellness Visit Providing a Personalized Plan	0	230	380	380	390	420	470	530	590	650	1,380	4,040
4104	Removing Barriers to Preventive Services	0	110	190	200	210	230	250	270	300	330	710	2,090
4105	Evidence-Based Coverage of Preventive Services	-60	-140	-160	-170	-170	-180	-200	-220	-240	-260	-700	-1,800
	SUBTITLE C-CREATING HEALTHIER COMMUNITIES												
4201-4207		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE D-SUPPORT FOR PREVENTION AND PUBLIC HEALTH INNOVATION												
4301-4306		0	0	0	0	0	0	0	0	0	0	0	0
	Additional Provisions	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE E-MISCELLENEOUS PROVISIONS												
4401-4402		0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE IV		-60	200	410	410	430	470	520	580	650	720	1,390	4,330

Table 3—Estimated Effects of the Patient Protection and Affordable Care Act, as Passed by the Senate, on Medicare

(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	TITLE V-HEALTH CARE WORKFORCE												
	SUBTITLE A-PURPOSE AND DEFINITIONS												
5001-5002		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE B-INNOVATIONS IN HEALTH CARE WORKFORCE												
5101-5103		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE C- INCREASING THE SUPPLY OF THE HEALTH CARE WORKFORCE												
5201-5210		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE D-EHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING												
5301-5315		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE E-SUPPORTING THE EXISTING HEALTH CARE WORKFORCE												
5401-5405		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE F-STRENGTHENING PRIMARY CARE AND OTHER WORKFORCE IMPROVEMENTS												
5501	Expanding Access to Primary Care/General Surgery Services	0	170	260	260	260	270	110	0	0	0	950	1,330
5502	Medicare Federally Qualified Health Center Improvements	0	10	10	20	20	70	90	100	100	110	60	530
5503	Distribution of Additional Residency Positions	0	0	0	0	0	0	0	0	0	0	0	0
5504	Counting Resident Time in Outpatient Setting	0	0	0	0	0	0	0	0	0	0	0	0
5505	Rules for Counting Resident Time for Didactic/Scholarly Activities	0	0	0	0	0	0	0	0	0	0	0	0
5506	Preservation of Resident Cap Positions	0	0	0	0	0	0	0	0	0	0	0	0
5507	Demonstration to Address Health Professions Workforce Needs	0	0	0	0	0	0	0	0	0	0	0	0
5508	Increasing Teaching Capacity	0	0	0	0	0	0	0	0	0	0	0	0
5509	Graduate Nurse Education Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE G-IMPROVING ACCESS TO HEALTH CARE SERVICES												
5601-5605		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE H-GENERAL PROVISIONS												
5701	Reports	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE V		0	180	270	280	280	340	200	100	100	110	1,010	1,860

Table 3—Estimated Effects of the Patient Protection and Affordable Care Act, as Passed by the Senate, on Medicare

(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	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	0	0	0	0	0	0	0	0	0	0	0
6002	Transparency Reports on Physician Ownership	0	0	0	0	0	0	0	0	0	0	0	0
6003	Disclosure Requirements for in-Office Ancillary 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												
6101-6121		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE C-NATIONWIDE PROGRAM FOR BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS												
6201	Nationwide Program for Background Checks	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE D-PATIENT CENTERED OUTCOMES RESEARCH												
6301	Patient Centered Outcomes Research	0	0	0	0	0	0	0	0	0	0	0	0
6302	Federal Coordinating Council for CER	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE E-MEDICARE, MEDICAID, AND CHIP PROGRAM INTEGRITY												
6401	Provider Screening and Other Enrollment Requirements												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	-10	-20	-20	-30	-30	-30	-30	-30	-40	-40	-110	-280
6402	Enhanced Program Integrity Provisions												
	Part A	0	0	-10	-20	-30	-30	-30	-40	-40	-40	-60	-240
	Part B	0	0	-10	-10	-20	-20	-20	-20	-20	-20	-40	-140
6403	Elimination of Duplication between Data Banks												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
6404	Maximum Period for Submission of Medicare Claims to Not More Than 12 Months												
	Part A	0	60	70	70	80	80	90	100	100	110	280	760
	Part B	0	50	50	50	50	60	60	70	70	80	200	540
6405	Physicians Required to Be Enrolled Physicians												
	Part A	-10	-20	-20	-20	-30	-30	-30	-30	-30	-40	-100	-260
	Part B	-30	-50	-50	-50	-60	-60	-60	-70	-70	-80	-240	-580
6406	Documentaion on Referrals to Programs at High Risk of Waste and Abuse												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0

Table 3—Estimated Effects of the Patient Protection and Affordable Care Act, as Passed by the Senate, on Medicare

(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
6407	Face to Face Encounter with Patient Required Before Physician May Certify for HHA or DME												
	Part A	-50	-70	-70	-80	-80	-90	-100	-100	-110	-120	-350	-870
	Part B	-70	-110	-120	-130	-140	-150	-160	-170	-180	-190	-570	-1,420
6408	Enhanced Penalties												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
6409	Medicare Self-referral Disclosure Protocal												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
	Adjustments to DME, Prosthetics, Orthotics, and Supplies												
6410	Competitive Acquisition Program												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	-10	-20	-20	-20	-20	-80	-120	-130	-140	-70	-560
6411	Expansion of Recovery Audit Contractor (RAC) program												
	Part A	0	-20	-30	-40	-40	-40	-50	-50	-50	-60	-130	-380
	Part B	0	0	-10	-10	-10	-10	-10	-10	-10	-10	-30	-80
	Part D	0	-10	-20	-30	-30	-30	-30	-40	-40	-50	-90	-280
	SUBTITLE G-ADDITIONAL PROGRAM INTEGRITY PROVISIONS												
6601	Prohibition on false Statements and Representations	0	0	0	0	0	0	0	0	0	0	0	0
6602	Clarifying Definition	0	0	0	0	0	0	0	0	0	0	0	0
6603	Development of Model Uniform Report Form	0	0	0	0	0	0	0	0	0	0	0	0
6604	Applicability of State Law to Combat Fraud and Abuse	0	0	0	0	0	0	0	0	0	0	0	0
6605	Administrative Summary Cease and Desist Orders	0	0	0	0	0	0	0	0	0	0	0	0
6606	MEWA Plan Registration	0	0	0	0	0	0	0	0	0	0	0	0
6607	Permitting Evidentiary Privilege and Confidential Communications	0	0	0	0	0	0	0	0	0	0	0	0
	Additional Provisions	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE H-ELDER JUSTICE ACT												
6701	Short Title of Subtitle	0	0	0	0	0	0	0	0	0	0	0	0
6702	Definitions	0	0	0	0	0	0	0	0	0	0	0	0
6703	Elder Justice	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE I-SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE												
6801	Sense of the Senate Regarding Medical Malpractice	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE VI		-170	-200	-260	-320	-360	-370	-450	-510	-550	-600	-1,310	-3,790

Table 3—Estimated Effects of the Patient Protection and Affordable Care Act, as Passed by the Senate, on Medicare

(Amounts in millions)

Sec.	Provision	Fiscal year										Total,	
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
	TITLE IX-REVENUE PROVISIONS												
9015	Additional hospital insurance tax on high-income taxpayers[1]	0	0	0	-2,165	-8,682	-9,559	-10,444	-11,306	-12,240	-13,214	-10,847	-67,609
	TOTAL IMPACT, III-VI and IX	2,245	-3,575	-12,115	-23,355	-62,632	-55,149	-70,204	-87,606	-104,630	-123,724	-99,432	-540,744

[1] Preliminary estimate, prepared by the Office of the Chief Actuary, Social Security Administration.

Notes: The effects of the Manager's Amendments in Title X on provisions in other titles have been incorporated with the estimates shown for those titles.
New proposals included in Title X have been group with the corresponding category of proposal in the estimates shown for earlier titles.
The provisions affecting Medicare Part B are net of premium offset.
The Medicare provisions that affect fee-for-service benefits also reflect interactions with payments to managed care plans.

Table 4— Estimated Impacts of the Patient Protection and Affordable Care Act, as Passed by the Senate, on Medicaid and CHIP (in millions)

Sec.	Provision	Fiscal Year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	TITLE II—ROLE OF PUBLIC PROGRAMS												
	Subtitle A—Improved Access to Medicaid												
2001	Medicaid coverage for the lowest income populations	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
	Equitable support for certain States	0	0	0	0	100	150	160	80	50	60	100	600
2002	Income eligibility for nonelderly determined using modified gross	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2003	Requirement to offer premium assistance for employer-sponsored	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2004	Medicaid coverage for former foster care children	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2005	Payments to territories	0	100	104	108	593	634	677	723	772	823	906	4,535
2006	Special adjustment to FMAP for major disaster recovery	0	255	90	0	0	0	0	0	0	0	345	345
2007	Medicaid Improvement Fund rescission	0	0	0	0	-100	-150	-150	-150	-150	0	-100	-700
	Subtitle B—Enhanced Support for CHIP												
2101	Additional federal financial participation for CHIP	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2102	Technical corrections	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle C—Enrollment Simplification												
2201	Enrollment simplificiation and coordination with State health insurance exchanges	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2202	Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
	Subtitle D—Improvements to Medicaid services												
2301	Coverage for freestanding birth center services	0	0	0	0	0	0	0	0	0	0	0	0
2302	Concurrent care for children	15	15	15	15	20	20	20	25	25	25	80	195
2303	State eligibility option for family planning services	1	0	0	-2	-4	-6	-9	-12	-15	-18	-5	-65
2304	Clarification of definition of medical assistance	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle E—New State Options for Long-term Services & Supports												
2401	Community First Choice Option	0	772	599	1,207	1,642	2,337	2,935	3,687	4,166	4,705	4,221	22,050
2402	Removal of barriers to providing home and community-based services	25	50	80	120	170	190	215	240	270	300	445	1,660
2403	Money Follows the Person Rebalancing Demonstration	0	0	450	450	450	450	450	0	0	0	1,350	2,250
2404	Protection for recipients of home and community-based services against spousal impoverishment	0	0	0	0	125	190	215	240	270	75	125	1,115
2405	Funding to expand State Aging and Disability Resource Centers	10	10	10	10	10	0	0	0	0	0	50	50
2406	Sense of the Senate regarding long-term care	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle F—Medicaid Prescription Drug Coverage												
2501(a)	Increase minimum rebate percentage for brand drugs	-370	-750	-780	-820	-860	-910	-960	-1,020	-1,080	-1,150	-3,580	-8,700
2501(b)	Increase rebate percentage for generic drugs	-30	-60	-60	-60	-60	-70	-70	-80	-80	-90	-270	-660
2501(c)	Extension of prescription drug discounts to enrollees of Medicaid managed care organizations	-580	-720	-720	-770	-820	-870	-930	-990	-1,040	-1,100	-3,610	-8,540
2501(d)	Rebates on new drug formulations	-280	-260	-260	-270	-280	-300	-320	-340	-360	-380	-1,350	-3,050
2501(e)	Maximum rebate amount	0	0	0	0	0	0	0	0	0	0	0	0
2501(f)	Conforming Amendment	0	0	0	0	0	0	0	0	0	0	0	0
2502	Elimination of exclusion of coverage of certain drugs	0	0	0	0	25	30	30	40	45	45	25	215
2503	Providing adequate pharmacy reimbursement	0	140	280	295	310	330	350	370	390	415	1,025	2,880

Table 4— Estimated Impacts of the Patient Protection and Affordable Care Act, as Passed by the Senate, on Medicaid and CHIP (in millions)

Sec.	Provision	Fiscal Year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	Subtitle G—Medicaid Disproportionate Share Hospital Payments												
2551	Disproportionate share hospital payments	0	0	10	-4,350	-4,490	-4,620	-4,720	-4,820	-4,920	-5,030	-8,830	-32,940
	Subtitle H—Dual Eligibles												
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 low-income Medicare beneficiaries	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle I—Medicaid Quality												
2701	Adult health quality measures	40	50	60	70	80	0	0	0	0	0	300	300
2702	Payment Adjustment for Health Care-Acquired Conditions	0	-1	-4	-5	-5	-5	-6	-6	-7	-7	-15	-46
2703	State option to provide health homes for enrollees with chronic	0	35	90	115	145	175	150	135	135	135	385	1,115
2704	Demonstration project to evaluate integrated care around a	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	15	15	15	15	15	0	0	0	0	0	75	75
	Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)												
2801	MACPAC assessment of policies affecting all Medicaid beneficiaries	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle K—American Indians and Alaska Natives												
2901	Special rules relating to Indians	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2902	Elimination of sunset for reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics	0	20	20	20	30	30	30	30	30	30	90	240
	TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE												
	Subtitle B—Improving Medicare for Patients and Providers												
	PART III—Improving payment accuracy												
3139	Payment for biosimilar biological products - Medicaid impact	0	0	0	0	-10	-30	-50	-60	-80	-90	-10	-320
	TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH												
	Subtitle A—Modernizing Disease prevention and Public Health Systems												
4004(i)	Public awareness of preventive and obesity-related services	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	155	200	105	115	125	135	145	160	175	190	700	1,505
4106	Improving access to preventive services for eligible adults	0	0	0	6	9	9	10	11	11	12	15	68
4107	Coverage of comprehensive tobacco cessation services for pregnant	0	0	0	0	-10	-10	-10	-10	-10	-20	-10	-70
4108	Incentives for prevention of chronic disease	0	20	20	20	20	20	0	0	0	0	80	100
	Subtitle D—Support for Prevention and Public Health Innovation												
4302(b)	Addressing health care disparities in Medicaid and CHIP	0	0	0	0	0	0	0	0	0	0	0	0
4306	Funding for Childhood Obesity Demonstration Project	5	5	5	5	5	0	0	0	0	0	25	25
	TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY												
	Subtitle E—Medicare, Medicaid & CHIP Program Integrity Provisions												
6201	Background checks for certain employees of LTC facil.	0	30	20	30	30	30	30	30	30	30	110	260
6401	Provider screening and other enrollment requirements under Medicare, Medicaid & CHIP	0	0	0	0	0	0	0	0	0	0	0	0
6402	Enhanced Medicare and Medicaid program integrity provisions	0	0	0	0	0	0	0	0	0	0	0	0

Table 4— Estimated Impacts of the Patient Protection and Affordable Care Act, as Passed by the Senate, on Medicaid and CHIP (in millions)

Sec.	Provision	Fiscal Year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
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
6407	Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical	0	0	0	0	0	0	0	0	0	0	0	0
6408	Enhanced penalties	0	0	0	0	0	0	0	0	0	0	0	0
6411	Expansion of the Recovery Audit Contractor Program	0	-80	-170	-250	-310	-330	-360	-390	-420	-450	-810	-2,760
	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, clearninghouses, 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	780	0	-60	-65	-70	-75	-80	-85	-95	-100	585	150
6507	Mandatory State use of national correct coding initiative	-10	-25	-40	-45	-55	-75	-85	-90	-95	-100	-175	-620
6508	General effective date	0	0	0	0	0	0	0	0	0	0	0	0
	TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES												
	Subtitle B—More Affordable Medicines for Children and Underserved Communities												
7101(d)	Expanded participation in 340B programs - Medicaid credits	2/	2/	2/	2/	2/	2/	2/	2/	2/	2/	2/	2/
10202[3]	Home and community based services incentives	0	0	800	910	1,030	260	0	0	0	0	2,740	3,000
SUBTOTAL		-224	-178	679	-3,125	-2,140	-2,461	-2,333	-2,282	-1,983	-1,691	-4,988	-15,738
	Interaction - Prescription Drugs	-190	-250	-270	-280	-300	-320	-330	-360	-390	-410	-1,290	-3,100
	Interaction - Medicaid Expansion	0	0	0	0	-214	-318	-391	-410	-435	-465	-214	-2,234
	Interaction with Medicare Premium Provisions	0	310	-250	-430	-490	-700	-870	-1,040	-1,210	-1,370	-860	-6,050
TOTAL		-414	-118	159	-3,835	-3,144	-3,799	-3,924	-4,093	-4,018	-3,937	-7,352	-27,122

[1] Included with Title I impacts.

[2] Insufficient detail for estimation.

[3] New provision of Manager's Amendment

Table 5 — Estimated Impacts of the Patient Protection and Affordable Care Act, as Passed by the Senate, on National Health Expenditures, in billions

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

	Calendar Year										Total, CY
Proposed — PPACA	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total National Health Expenditures (NHE)	$ 2,638.8	$ 2,779.2	$ 2,936.2	$ 3,097.0	$ 3,351.5	$ 3,604.9	$ 3,863.0	$ 4,116.4	$ 4,393.0	$ 4,695.4	$ 35,475.6
Medicare	516.9	545.5	577.3	605.5	628.8	684.0	727.6	778.0	835.2	896.3	6,794.9
Medicaid/CHIP	435.7	472.9	511.5	549.8	647.5	708.6	772.2	828.9	901.2	978.9	6,807.4
Federal	282.0	277.8	292.3	313.8	387.6	427.2	470.3	493.9	535.8	580.5	4,061.3
State & Local	153.7	195.1	219.3	236.0	259.9	281.4	302.0	335.0	365.4	398.4	2,746.1
Other Public	312.3	325.6	344.4	365.1	382.5	407.4	436.3	465.7	496.4	526.8	4,062.2
Out of Pocket	285.1	298.1	308.7	329.9	323.2	335.4	348.7	372.7	396.9	422.9	3,421.6
Employer-Sponsored Private Health Insurance	848.2	882.8	924.6	961.2	1,027.0	1,092.9	1,136.7	1,169.5	1,217.6	1,290.8	10,551.3
Other Private Health Insurance*	49.3	50.9	54.1	57.0	15.9	16.2	16.1	16.0	15.9	15.7	307.1
Other Private†	191.4	203.4	215.6	228.4	236.5	254.1	275.6	296.9	319.0	340.4	2,561.4
Exchange - Private Plan	—	—	—	—	90.2	106.2	150.0	188.9	210.8	223.6	969.6
Exchange - Public Plan	—	—	—	—	—	—	—	—	—	—	—
NHE as percent of Gross Domestic Product (GDP)‡	17.8%	17.9%	18.0%	18.1%	18.7%	19.2%	19.7%	20.0%	20.5%	20.9%	

Table 5, cont. - Estimated Impacts of H.R. 3590 on National Health Expenditures (NHE), in billions

	Calendar Year										Total, CY
Impact of PPACA	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total National Health Expenditures (NHE)	$ 6.6	$ 0.5	-$ 8.2	-$ 28.4	$ 26.1	$ 53.4	$ 64.6	$ 48.7	$ 34.2	$ 24.8	$ 222.3
Medicare	1.4	-5.0	-13.7	-28.6	-50.9	-48.1	-62.8	-79.2	-95.7	-114.6	-497.4
Medicaid/CHIP	-0.4	0.0	-0.8	-3.7	53.6	66.9	75.7	73.0	79.6	85.7	429.5
Federal	-0.3	0.0	-0.5	-2.1	49.7	62.9	75.3	66.1	71.3	76.1	398.4
State & Local	-0.2	0.0	-0.4	-1.6	3.8	4.0	0.4	7.0	8.3	9.6	31.0
Other Public	4.6	0.5	0.5	0.5	-4.1	-3.1	-0.2	1.7	3.2	3.2	6.7
Out of Pocket	-0.1	0.4	-0.2	7.6	-17.1	-24.0	-30.4	-27.4	-25.9	-23.7	-140.8
Employer-Sponsored Private Health Insurance	1.2	3.9	5.3	-4.9	2.5	4.6	-19.3	-59.2	-88.0	-96.6	-250.5
Other Private Health Insurance*	0.1	-0.1	-0.4	-0.7	-43.5	-45.3	-47.5	-49.9	-52.3	-54.9	-294.6
Other Private†	-0.2	1.0	1.1	1.1	-4.6	-3.7	-0.9	0.9	2.6	2.2	-0.4
Exchange - Private Plan	—	—	—	—	90.2	106.2	150.0	188.9	210.8	223.6	969.6
Exchange - Public Plan	—	—	—	—	—	—	—	—	—	—	—
NHE as percent of Gross Domestic Product (GDP)‡	0.0%	0.0%	-0.1%	-0.2%	0.1%	0.3%	0.3%	0.2%	0.2%	0.1%	

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

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

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

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

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