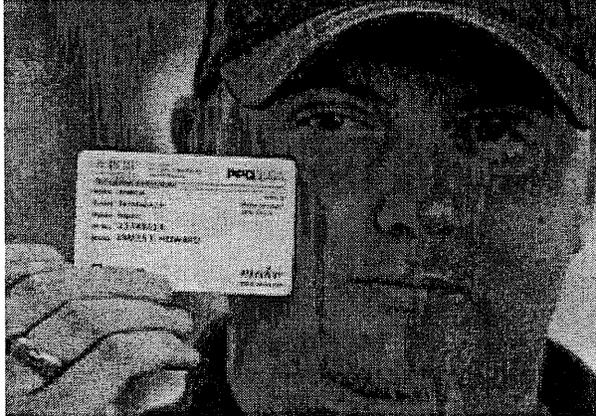


Health reform: The politics of pre-existing conditions

JAN 13, 2011 10:25 EST

Mark Miller

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Public opinion on healthcare reform is divided — Gallup says 46 percent of Americans back Republican efforts to repeal the law, 40 percent want it to stand and 14 percent have no opinion.

Some Americans oppose the law on ideological grounds. But the poll numbers also reflect an enthusiasm gap stemming from the simple fact that the most important provisions of the Affordable Care Act (ACA) won't kick in for another three years — an eternity in our hyperactive political culture.

Pre-existing conditions offer an instructive example. In the current health insurance marketplace, it's very difficult for people with pre-existing conditions to buy a quality policy at an affordable price. The problem disproportionately affects people over age 50, since so many of them have chronic conditions that lead health insurance companies to turn them down.

A recent report by the Commonwealth Fund found that 15 percent of all Americans age 50 to 64 were uninsured in 2009; their ranks grew by 1.1 million that year, to 8.6 million. Meanwhile, another 9.7 million in this age group had coverage with such high deductibles that they were considered “effectively underinsured.” Starting in 2014, the ACA will get these folks covered through expansion of Medicaid and the creation of new private insurance exchanges.

In the meantime, the ACA put a Band-Aid on the problem by setting aside \$5 billion to fund a pre-existing insurance program (PCIP) that operates until the end of 2013, when enrollees will shift to coverage via the new exchanges.

The PCIP gave states the option of using federal dollars to administer their own programs, or to allow the federal government to offer coverage. Twenty-seven states are offering their own plans.

But the PCIP plans barely made a dent last year. Around 8,000 people enrolled nationwide, and most of those were in a handful of big states with very active plans — Pennsylvania, California, Illinois and Ohio.

The weak start was due partly to the short ramp-up time available after the ACA became law, according to Jean Hall, an associate research professor at the University of Kansas who

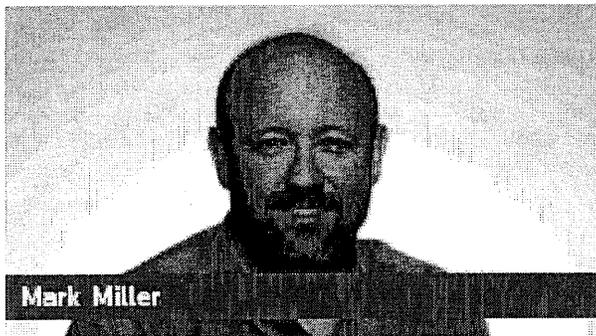
specializes in healthcare. Hall also notes that the plans offered in many states simply weren't great deals. Premiums often were more than \$1,000 per month, with annual deductibles of \$2,500. Finally, enrollees must be uninsured for six months prior to coverage in order to be eligible — a rule that further reduced sign-ups.

But noteworthy improvements are being rolled out to PCIPs this year that will make them worth checking out for those struggling to find insurance.

Premiums will be lower in many states. Moreover, the federal program will offer three plan options, two of which feature lower deductibles for prescription coverage. New child-only premium options also are being offered to reduce the cost of covering children with pre-existing condition.

"I do believe the new federal options represent a significant change for consumers," Hall says. "People can get prescription costs covered sooner, which is potentially very important for many people with chronic conditions. Also, adding the child-only premiums creates a significant savings for families who have children with chronic conditions."

The federal website for the ACA has a page that describes the state plans, and lists contact information where consumers can get current information on 2011 insurance options.



Mark Miller is a journalist and author who writes about trends in retirement and aging. He has a special focus on how the baby boomer generation is revising its approach to careers, money and lifestyle after age 50. Mark is the author of *The Hard Times Guide to Retirement Security: Practical Strategies for Money, Work and Living* (John Wiley & Sons/Bloomberg Press, 2010); he writes the syndicated column "Retire Smart" and edits RetirementRevised.com. Mark is the former editor of Crain's Chicago Business, and former Sunday editor of the Chicago Sun-Times.

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THE COMMONWEALTH FUND
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Washington Health Policy Week in Review Health Law Spending: What's Mandatory and What's Not?

By John Reichard, CQ HealthBeat Editor

December 22, 2010 -- With Republicans arriving in force on Capitol Hill next month, sharp scrutiny of spending under the health law will surely follow—with a GOP eye toward blocking whatever can be blocked.

So what spending is mandatory and what is discretionary under the law? To the extent spending is discretionary, Republicans will have much more power to block it, given their large majority in the House and their big gains in the Senate.

At first glance, the health law (PL 111-148, PL 111-152) appears to require huge sums of discretionary spending if the overhaul is to be implemented in full. At second glance, not so much—but still enough to be a big headache for the Obama administration.

Earlier this year, the Congressional Budget Office (CBO) estimated potential discretionary spending under the health law would be a minimum of \$115 billion over 10 years. "Discretionary" means that the money will have to be approved by Congress as part of the annual appropriations process, while "mandatory" means the spending is automatic.

Then-House Minority Leader John A. Boehner, R-Ohio, said the \$115 billion estimate for discretionary spending costs "provides ample cause for alarm" and would nearly wipe out "the purported deficit reduction in the law."

But much of that \$115 billion is for existing programs and reflects current spending levels. Among those programs are the Indian Health Service, the National Health Service Corps and community health centers.

CBO estimated that spending for existing programs, including those three, would account for at least \$86 billion of the \$115 billion in discretionary funding. Presumably Republicans would be less likely to go after that money.

But that still leaves a pretty big chunk of change. Prominent among the remaining discretionary spending needs under the law is money for the Department of Health and Human Services and the Internal Revenue Service to implement the measure.

If the agencies don't get it, implementation could be delayed.

CBO noted earlier this year that "the administrative and other costs for federal agencies to implement the act's provisions will be funded through the appropriations process; sufficient discretionary funding will be essential to implement this legislation in the time frame called for."

CBO said the IRS will need \$5 billion to \$10 billion over 10 years to implement "the eligibility determination, documentation and verification processes for premium and cost-sharing credits."

HHS will need at least that much to make changes under the law to Medicare, Medicaid, the Children's Health Insurance Program and the private insurance market, CBO added.

A former GOP congressional aide noted that Democrats will be trying to get discretionary funding for those agencies in March after a stopgap spending measure has just run out and Congress is beginning to turn its attention to debating a budget resolution.

Discussions of another bill to continue funding of the government, including implementation money for HHS and IRS, "will be closer and closer to the budget debate, which is going to be so framed by the debt limit," the former aide commented. "The electorate is so engaged about the size of the debt right now. I think it's one of many things that will be a difficult negotiation" for Democrats, the aide said.

White House officials wouldn't comment specifically on the difficulty of getting implementation money for HHS and the IRS. "We look forward to working with Congress to get the funding necessary to implement the programs and initiatives critical to the American people," said Kenneth Baer, communications director at the White House Office of Management and Budget.

The Congressional Research Service (CRS) has issued reports detailing both the discretionary and mandatory spending provisions of the health law.

A number of discretionary items seek "to address concerns about the current size, specialty mix, and geographic distribution of the health care workforce," the Sept. 2 CRS report on discretionary funding noted.

The administration says more doctors will be needed to meet the health care needs of the newly insured. But Republicans may block the expansion of treatment capacity if they block the discretionary funding required.

The report lists other discretionary items such as improvements in measuring and reporting quality of care; disseminating

innovative strategies for improving health care; improving the coordination of care for people with chronic illnesses; and combining primary care and mental health care services so they are located in the same treatment centers. They also include programs to prevent elder abuse; expand trauma services; better coordinate emergency services; and test alternatives to the current medical malpractice litigation system.

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For the full report issued by the Congressional Budget Office mentioned in this article, go to:

www.cbo.gov/ftpdocs/114xx/doc11490/LewisLtr_HR3590.pdf

For the full report issued by the Congressional Research Office mentioned in this article, go to:

www.nacbhdd.org/content/CRS%20Rpt%20on%20Discretionary%20Funding%20in%20PPACA%209%202010.pdf



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

Douglas W. Elmendorf, Director

January 6, 2011

Honorable John Boehner
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

The Congressional Budget Office (CBO) has reviewed H.R. 2, the Repealing the Job-Killing Health Care Law Act, as introduced on January 5, 2011. That bill would repeal the Patient Protection and Affordable Care Act (PPACA, Public Law 111-148) and the provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) that are related to health care. Both of those laws were enacted in March 2010.

Among other things, PPACA and the provisions of the Reconciliation Act that are related to health care will do the following: establish a mandate for most legal residents of the United States to obtain health insurance; create insurance exchanges through which certain individuals and families will receive federal subsidies to substantially reduce the cost of purchasing health insurance coverage; significantly expand eligibility for Medicaid; permanently reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected under prior law); impose an excise tax on certain health insurance plans with relatively high premiums; impose certain taxes on individuals and families with relatively high incomes; and make various other changes to the federal tax code, Medicare, Medicaid, and other programs.

CBO has not yet developed a detailed estimate of the budgetary impact of repealing that legislation, although it is working with the staff of the Joint Committee on Taxation (JCT) to complete such an estimate in the near future. Because Congressional deliberations on H.R. 2 could begin very soon, CBO is providing in this letter a less-detailed preliminary analysis of that legislation. CBO and JCT estimated that the March 2010 health care legislation would reduce budget deficits over the 2010–2019 period and in

subsequent years; consequently, we expect that repealing that legislation would increase budget deficits.

The projected increase in deficits will not be exactly the same as the reduction in deficits that was originally estimated to result from the enacted legislation. As will be discussed in the detailed estimate that is forthcoming, a number of developments have occurred since CBO and JCT produced the cost estimate for the March 2010 legislation (shortly before it was enacted). In particular:

- The original estimate was based on the projections of economic conditions, health care costs, federal spending and revenues, and other factors that CBO published in March 2009. The economic outlook is now somewhat different, and CBO has made a number of technical changes to its spending and revenue projections related to health care programs.¹
- Some of the funding provided by the legislation enacted last March has been obligated or spent, and some regulations implementing aspects of that legislation have been promulgated. The budgetary impact of repealing that legislation depends on the extent to which repeal would affect those actions; because an estimate of repeal would assume enactment around the end of this fiscal year, no significant budgetary effects would occur in fiscal year 2011. (However, such effects would occur if H.R. 2 was enacted well before the end of the fiscal year.)
- Subsequent legislation has already modified the laws enacted last March. Specifically, the Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309) increased the amount that could be recovered from enrollees in insurance exchanges whose actual income in a year differed from the figure used to determine their tax credit for health insurance premiums. That legislation was estimated to reduce net

¹ For example, in *The Budget and Economic Outlook: An Update* that was published in August 2010, CBO noted that identifiable changes in the estimated effects of some of the provisions of the legislation had reduced projected outlays over the 2010–2019 period by about \$11 billion and increased projected revenues by about the same amount (see Box 1-1 on page 6). For many aspects of the legislation, however, distinguishing the effects of economic and technical updates on the budgetary impact of PPACA and the Reconciliation Act from their effects on the projections that would have been made under prior law is difficult. Therefore, developing the baseline projections in August did not automatically result in an estimate of the effect of PPACA and the Reconciliation Act under the economic and technical assumptions of that baseline.

federal payments for subsidies through the health insurance exchanges.

- The original estimate covered 2010 through 2019, the period used for Congressional budget enforcement procedures when the legislation was being considered (in calendar year 2009 and early 2010). CBO has nearly completed new baseline projections through 2021 that will be published later this month. As a result, CBO's estimate of the budgetary effect of repealing last March's legislation will cover a later period than that spanned by the original estimate.

The changes noted above will affect many elements of a detailed estimate of the impact of H.R. 2, but they will probably not have a major effect on the overall budgetary impact of the bill through 2019. Moreover, in its ongoing monitoring of developments, CBO has seen no evidence to date that the steps that will be taken to implement the March legislation—or the ways in which participants in the health care and health financing systems will respond to that legislation—will yield overall budgetary effects that differ significantly from the ones that CBO and JCT projected earlier. As a result, for the 2012–2019 period, the forthcoming detailed cost estimate for H.R. 2 will probably not differ substantially from the result that would be obtained by reversing the signs of the net changes in deficits that were shown in the cost estimate for PPACA and the Reconciliation Act that CBO issued on March 20, 2010.²

The remainder of this letter describes—in broad terms and on a preliminary basis—CBO's assessment of the effects that repealing PPACA and the relevant provisions of the Reconciliation Act would have on federal budget deficits, the federal government's budgetary commitment to health care, the number of people with health insurance, and health insurance premiums in the private market. (Repealing the provisions of that legislation would also have a variety of other effects on the health care and health insurance systems that this letter, like previous CBO cost estimates, does not address.)

² See Congressional Budget Office, letter to the Honorable Nancy Pelosi about the budgetary effects of H.R. 4872, the Reconciliation Act of 2010 (March 20, 2010). That letter and the other CBO documents cited in this letter are available on CBO's Web site (www.cbo.gov) and are contained in CBO's December 2010 report *Selected CBO Publications Related to Health Care Legislation, 2009–2010*.

Impact on the Federal Budget in the First Decade

As a result of changes in direct spending and revenues, CBO expects that enacting H.R. 2 would probably increase federal budget deficits over the 2012–2019 period by a total of roughly \$145 billion, plus or minus the effects of technical and economic changes that CBO and JCT will include in the forthcoming estimate. That figure consists of the following two components:

- About \$130 billion, representing the net reduction in deficits over the 2012–2019 period expected to result from the health care provisions of the enacted legislation (as estimated by CBO and JCT last March),³ plus
- About \$15 billion, representing the reduction brought about by the Medicare and Medicaid Extenders Act of 2010 in the estimated cost of subsidies to be provided through the insurance exchanges through 2019.

The forthcoming, more-detailed estimate will also reflect changes that CBO and JCT will make to reflect economic developments since the legislation was enacted and technical revisions to baseline projections and the previous estimate (including adjustments to reflect the passage of time and to incorporate the effects of administrative actions that have been taken to implement the laws). We cannot predict whether those changes will increase or decrease the estimated impact of H.R. 2 on federal deficits.

Though the amounts may differ somewhat, the net increase in deficits from enacting H.R. 2 would have the same three major components as the net decrease in deficits estimated to result from enacting PPACA and the Reconciliation Act. The March health care legislation contained a set of provisions designed to expand health insurance coverage, which CBO and JCT estimated would have a gross cost of about \$930 billion and a net cost (after accounting for certain related changes in outlays and revenues) of about \$780 billion over the 2012–2019 period. Repealing that legislation would eliminate such costs. But PPACA and the Reconciliation Act also included a number of provisions to reduce federal outlays (primarily for

³ The \$130 billion figure reflects about \$124 billion in net savings estimated in March for the health care and revenue provisions over the 2010–2019 period but excludes about \$7 billion in estimated net costs of the enacted legislation in 2010 and 2011—during which the proposed repeal would have no budgetary effect if it was enacted near the end of fiscal year 2011. The \$130 billion in savings is the result of projected increases of about \$520 billion in revenues and about \$390 billion in outlays.

Medicare) and to increase federal revenues (mostly by increasing the Hospital Insurance payroll tax and imposing fees on certain manufacturers and insurers); in March, CBO and JCT estimated that those provisions unrelated to insurance coverage would, on balance, reduce direct spending by about \$500 billion and increase revenues by about \$410 billion over the 2012–2019 period.⁴ If that legislation was repealed, such reductions in spending and increases in revenues would not occur. Thus, H.R. 2 would, on net, increase federal deficits over that period.

The difference in the time horizons for the cost estimates will also differentiate the estimate for H.R. 2 from that for PPACA and the Reconciliation Act. The budgetary horizon for legislation considered in 2011 will span the fiscal years from 2011 through 2021, two years beyond the period covered by the cost estimate for the enacted legislation. Extrapolating the budgetary effects for 2019 of PPACA and the health care provisions of the Reconciliation Act, CBO anticipates that enacting H.R. 2 would increase federal budget deficits by a total of roughly \$80 billion to \$90 billion over the 2020–2021 period. Consequently, over the 2012–2021 period, the effect of H.R. 2 on federal deficits as a result of changes in direct spending and revenues is likely to be an increase in the vicinity of \$230 billion, plus or minus the effects of technical and economic changes to CBO's and JCT's projections for that period.

Effects on Discretionary Spending. Those projections do not include any savings associated with lower discretionary spending under H.R. 2. The cost estimate issued last March focused on direct spending and revenues because those effects are relevant for pay-as-you-go rules and will occur without any additional legislative action (in contrast with discretionary spending, which is subject to future appropriation action). However, the cost estimate noted that additional funding would be necessary for agencies to carry out the responsibilities required of them by the legislation and that the legislation also included explicit authorizations for a variety of grants and other programs.⁵

⁴ Those figures exclude the impact of the provisions of the Reconciliation Act related to education programs (which were estimated to reduce deficits by \$19 billion over the 2010–2019 period).

⁵ For more information, see CBO's March 20, 2010, letter to the Honorable Nancy Pelosi cited earlier (in particular, pages 10 and 11); Congressional Budget Office, letter to the Honorable Jerry Lewis about potential effects of the Patient Protection and Affordable Care Act on discretionary spending (May 11, 2010); and "Additional Information about the Potential Discretionary Costs of Implementing PPACA" (May 12, 2010).

By CBO's estimates, repeal of the health care legislation would probably reduce the appropriations needed by the Internal Revenue Service by between \$5 billion and \$10 billion over 10 years. Similar savings would accrue to the Department of Health and Human Services.

In addition, H.R. 2 would repeal a number of authorizations for future appropriations, which, if left in place, might or might not result in additional appropriations. CBO estimated that such provisions authorizing specific amounts, if fully funded, would result in appropriations of \$106 billion over the 2010–2019 period. However, most of those authorizations, for more than \$86 billion, were for activities that were already being carried out under prior law or that were previously authorized and that PPACA authorized for future years; for example, that amount includes an estimated \$39 billion for ongoing activities of the Indian Health Service and \$34 billion for continued grants to federally qualified health centers. Consequently, just as the authorizations in PPACA of an estimated \$106 billion over the 2010–2019 period will not necessarily lead to an increase of that amount in total discretionary spending, the repeal of those PPACA authorizations would not necessarily result in discretionary savings of that amount.

Uncertainty Surrounding the Estimates. The projections of the bill's budgetary impact are quite uncertain, both because CBO has not completed a detailed estimate of the effects of H.R. 2 and because assessing the effects of making broad changes in the nation's health care and health insurance systems—or of reversing scheduled changes—requires assumptions about a broad array of technical, behavioral, and economic factors. However, CBO's staff, in consultation with outside experts, has devoted a great deal of care and effort to the analysis of health care legislation in the past few years, and the agency strives to develop estimates that are in the middle of the distribution of possible outcomes. As a result, CBO believes that its estimates of the net budgetary effects of health care legislation have a roughly equal chance of turning out to be too high or too low.

As with all of CBO's cost estimates, those estimates reflect an assumption that the provisions of current law would otherwise remain unchanged throughout the projection period and that the legislation being considered would be enacted and implemented in its current form. CBO's responsibility to the Congress is to estimate the effects of proposals as written and not to forecast future legislation. The budgetary impact of repealing PPACA and the provisions of the Reconciliation Act related to health care could be quite different if key provisions of that original

legislation would have subsequently been changed or not fully implemented.

Impact on the Federal Budget Beyond the First 10 Years

Relative to current law, enacting H.R. 2 would, CBO estimates, increase federal budget deficits in the decade following 2019; similarly, the legislation would increase budget deficits in the decade following 2021 and in subsequent years.

Although CBO does not generally provide cost estimates beyond the 10-year projection period, certain Congressional rules require some information about the budgetary impact of legislation in subsequent decades, and many Members requested CBO's analysis of the long-term budgetary impact of proposed broad changes in the health care and health insurance systems. Therefore, in the course of analyzing such proposals, CBO developed rough assessments for the decade following the 10-year projection period by grouping the elements of legislation into broad categories and assessing the rate at which the budgetary impact of each of those broad categories would increase over time.

Last March, CBO estimated that enacting PPACA and the Reconciliation Act would reduce federal deficits in the decade after 2019, with a total effect during that decade in a broad range around one-half percent of gross domestic product (GDP). The imprecision of the calculation reflects the even greater degree of uncertainty that attends to it, compared with CBO's 10-year estimates. Correspondingly, CBO estimates that enacting H.R. 2 would increase federal deficits in the decade after 2019 by an amount that is in a broad range around one-half percent of GDP, plus or minus the effects of technical and economic changes that CBO and JCT will include in the forthcoming estimate. For the decade beginning after 2021, the effect of H.R. 2 on federal deficits as a share of the economy would probably be somewhat larger.

CBO has not extrapolated estimates further into the future because the uncertainties surrounding them are magnified even more. However, in view of the projected budgetary effects during the decade following the 10-year budget window, CBO anticipates that enacting H.R. 2 would probably continue to increase budget deficits relative to those under current law in subsequent decades.

Those calculations incorporate an assumption that the provisions of current law would otherwise remain unchanged throughout the next two decades.

However, current law now includes a number of policies that might be difficult to sustain over a long period of time. For example, PPACA and the Reconciliation Act reduced payments to many Medicare providers relative to what the government would have paid under prior law. On the basis of those cuts in payment rates and the existing “sustainable growth rate” mechanism that governs Medicare’s payments to physicians, CBO projects that Medicare spending (per beneficiary, adjusted for overall inflation) will increase significantly more slowly during the next two decades than it has increased during the past two decades. If those provisions would have subsequently been modified or implemented incompletely, then the budgetary effects of repealing PPACA and the relevant provisions of the Reconciliation Act could be quite different—but CBO cannot forecast future changes in law or assume such changes in its estimates.⁶

Effects on the Federal Budgetary Commitment to Health Care

Last March, CBO estimated that enacting PPACA and the relevant provisions of the Reconciliation Act would increase the “federal budgetary commitment to health care” by about \$400 billion over the 2010–2019 period; CBO uses that term to describe the sum of net federal outlays for health programs and tax preferences for health care.⁷ In contrast, CBO estimated that enacting that legislation would reduce the federal budgetary commitment to health care during the decade after 2019. The impact in the second decade was estimated to be different than that in the first decade because the effects of those provisions that would tend to decrease the federal budgetary commitment to health care would grow faster than the effects of provisions that would tend to increase it. Correspondingly, by repealing all of those provisions, H.R. 2 would roughly reverse those outcomes, thereby diminishing the federal budgetary commitment to health care over the next decade and increasing it in subsequent years.

Effects on the Number of People with Health Insurance

Under H.R. 2, about 32 million fewer nonelderly people would have health insurance in 2019, leaving a total of about 54 million nonelderly people uninsured. The share of legal nonelderly residents with insurance coverage

⁶ For an example of the long-term budgetary effect of altering several key features of PPACA and the Reconciliation Act, see Congressional Budget Office, letter to the Honorable Paul Ryan responding to questions about the preliminary estimate of the reconciliation proposal (March 19, 2010).

⁷ For additional discussion of that term, see Congressional Budget Office, letter to the Honorable Max Baucus regarding different measures for analyzing proposals to reform health care (October 30, 2009).

in 2019 would be about 83 percent, compared with a projected share of 94 percent under current law (and 83 percent currently).

That projected difference of 32 million in the number of uninsured people in 2019 reflects a number of differences relative to circumstances under current law. Approximately 24 million people who would otherwise purchase their own coverage through insurance exchanges would not do so, and Medicaid and the Children's Health Insurance Program would have roughly 16 million fewer enrollees. Partly offsetting those reductions would be net increases, relative to the number projected under current law, of about 5 million people purchasing individual coverage directly from insurers and about 3 million people obtaining coverage through their employer.⁸

Effects on Health Insurance Premiums

On November 30, 2009, CBO released an analysis prepared by CBO and JCT of the impact that PPACA as it was originally proposed would have on average premiums for health insurance in different markets.⁹ Although CBO and JCT have not updated the estimates provided in that letter, the estimated effects of PPACA and the Reconciliation Act as enacted would probably be quite similar, and CBO expects that the effects on premiums of repealing that legislation would be similar to reversing the effects estimated last November.

In particular, if H.R. 2 was enacted, premiums for health insurance in the individual market would be somewhat lower than under current law, mostly because the average insurance policy in this market would cover a smaller share of enrollees' costs for health care and a slightly narrower range of benefits. The effects of those differences would be offset in part by other factors that would tend to raise premiums in the individual market if PPACA was repealed; for example, insurers would probably incur higher administrative costs per policy and enrollees would tend to be less healthy, leading to higher average costs for their health care. Although premiums in the individual market would be lower, on average, under H.R. 2 than under current law, many people would end up paying more for health insurance—because under current law, the majority of enrollees purchasing coverage

⁸ For more information about the effects of PPACA and the Reconciliation Act on the sources of health insurance coverage, see CBO's March 20, 2010, letter to the Honorable Nancy Pelosi cited earlier (in particular, pages 9 and 10).

⁹ See Congressional Budget Office, letter to the Honorable Evan Bayh providing an analysis of health insurance premiums under the Patient Protection and Affordable Care Act (November 30, 2009).

in that market would receive subsidies via the insurance exchanges, and H.R. 2 would eliminate those subsidies.

Premiums for employment-based coverage obtained through large employers would be slightly higher under H.R. 2 than under current law, reflecting the net impact of many relatively small changes. Premiums for employment-based coverage obtained through small employers might be slightly higher or slightly lower (reflecting uncertainty about the impact of the enacted legislation on premiums in that market).

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

Sincerely,

Douglas W. Elmendorf
Director

cc: Honorable Nancy Pelosi
Democratic Leader

Honorable Paul Ryan
Chairman
Committee on the Budget

Honorable Chris Van Hollen
Ranking Member

Honorable Harry Reid
Senate Majority Leader

Honorable Mitch McConnell
Senate Republican Leader

Honorable Kent Conrad
Chairman
Senate Committee on the Budget

Honorable Jeff Sessions
Ranking Member