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

Douglas W. Elmendorf, Director

July 14, 2009

Honorable Charles B. Rangel
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have completed a preliminary analysis of the specifications related to health insurance coverage that are reflected in draft legislation called America's Affordable Health Choices Act, which was released by the House tri-committee majority group on July 14, 2009.[1] Among other things, those specifications would establish a mandate for most legal residents to obtain insurance, significantly expand eligibility for Medicaid, and set up insurance "exchanges" through which certain individuals and families could receive federal subsidies to substantially reduce the cost of purchasing that coverage. The analysis presented here does not take into account other parts of the proposal that would raise taxes or reduce other spending (particularly in the Medicare program) in an effort to offset the federal costs of implementing those coverage specifications.

The attached tables summarize our preliminary assessment of the coverage specifications' budgetary effects and their likely impact on rates and sources of insurance coverage for the nonelderly population. According to that assessment, enacting legislation that embodied those specifications would result in a net increase in federal budget deficits of $1,042 billion over the 2010–2019 period. By 2019, CBO and the JCT staff estimate, the number of nonelderly people without health insurance would be reduced by about 37 million, leaving about 17 million nonelderly residents uninsured (nearly half of whom would be unauthorized immigrants). It is important to note, however, that those estimates are based on specifications provided by the tri-committee group rather than an analysis of the language released today. For that reason and others outlined below, those figures do *not* represent a formal or complete cost estimate for the coverage provisions of the draft legislation.

---

[1] The House tri-committee group consists of the Committee on Ways and Means, the Committee on Energy and Commerce, and the Committee on Education and Labor.

Key Specifications Related to Health Insurance Coverage

The specifications provided by the tri-committee group would take several steps to increase the number of legal U.S. residents who have health insurance. Starting in 2013, nonelderly people with income below 133 percent of the federal poverty level (FPL) who were not already eligible for Medicaid would be made eligible for that program, and the federal government would pay all of the costs of covering people who became newly eligible. (States would also be required to maintain their current eligibility levels for Medicaid indefinitely.) In addition, the federal government would establish insurance exchanges throughout the country and, more importantly, would subsidize the purchase of health insurance through those exchanges for individuals and families with income between 133 percent and 400 percent of the federal poverty level, also starting in 2013. In that year, the proposal would also establish a requirement for legal residents to obtain insurance and would impose a financial penalty on most people who did not do so (the size of which would generally vary with their income).

The proposal would also impose a "play-or-pay" requirement on employers, who would either have to offer qualifying insurance to their employees and contribute a substantial share toward the premiums, or pay a fee to the federal government that would generally equal 8 percent of their payroll. Small employers (those with an annual payroll of less than $250,000) would be exempt from those requirements. As a rule, full-time employees with a qualifying offer of coverage from their employer would not be eligible to obtain subsidies via the exchanges, but an exception to that "firewall" would be allowed for workers who had to pay more than 11 percent of their income for their employer's insurance. In that case, the employers would have to pay an amount equal to the per-worker fee due for firms subject to the "play-or-pay" penalty. Firms with relatively few employees and relatively low average wages would also be eligible for tax credits to cover up to half of their contributions toward health insurance premiums.

The proposal would also establish a "public plan" available only through the insurance exchanges. That plan would be set up and run by the Secretary of Health and Human Services (HHS). On average, it would pay Medicare rates plus 5 percent to physicians and other practitioners (and those rates would not be determined by the sustainable growth rate formula that is used to set rates for physicians in Medicare but instead would be increased over time using an index of physicians' input costs). On average, the public plan would pay Medicare rates for hospital and other services and supplies on fee schedules, and negotiated rates for drugs or other items or services not on a fee schedule. Providers would not be required to participate in the public plan in order to participate in Medicare. (A more detailed summary of the proposal's key provisions is attached.)

Important Caveats Regarding This Preliminary Analysis
There are several reasons why the preliminary analysis that is provided in this letter and its attachments does not constitute a comprehensive cost estimate for the coverage provisions of America's Affordable Health Choices Act:

- First, our analysis was based on specifications regarding insurance coverage that were provided by the tri-committee group and that differ in important ways from the "discussion draft" version of legislative language that was released on June 19, 2009. The specifications that we analyzed are supposed to be reflected in the draft language released by the three committees today, but we have not yet been able to analyze that language to determine whether it conforms to those specifications. Our review of that language could have a significant effect on our analysis. More generally, as our understanding of the specifications improves, that also could affect our future estimates.

- Second, some effects of the proposal have not yet been fully captured in our analysis. In particular, we have not yet estimated the administrative costs to the federal government of implementing the specified policies, nor have we accounted for all of the proposal's likely effects on spending for other federal programs. We expect to include those effects in the near future, but we also expect that they will not have a sizable impact on our analysis.

- Third, the budgetary information shown in the attached table reflects many of the major cash flows that would affect the federal budget as a result of implementing the specified policies, and it provides our preliminary assessment of the proposal's net effects on the federal budget deficit (subject to the caveats listed above). Some additional cash flows would appear in the budget—either as outlays and offsetting receipts or outlays and revenues—but would net to zero and thus would not affect the deficit. CBO and the JCT staff have not yet estimated all of those cash flows but expect to do so in the near future.[2] Those additional cash flows would include the premiums collected by the public plan and its outlays as well as risk-adjustment transfers from plans with relatively healthy enrollees to plans with relatively unhealthy enrollees.

Likely Effects of the Proposal
The proposal would have significant effects on the number of people who are enrolled in health insurance plans, the sources of that coverage, and the federal budget (as shown in the attached tables).

Effects on Insurance Coverage. Under current law, the number of nonelderly residents (those under age 65) with health insurance coverage will grow from about 217 million in 2010 to about 228 million in 2019, according to CBO's

---

[2] For a discussion of the considerations that affect whether and how various cash flows should be reflected in the federal budget, see Congressional Budget Office, *The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System*, Issue Brief (May 27, 2009).

estimates. Over that same period, the number of nonelderly residents without health insurance at any given point in time will grow from approximately 50 million people to about 54 million people—constituting roughly 19 percent of the nonelderly population. Because the Medicare program covers nearly all legal residents over the age of 65, our analysis has focused on the effects of proposals on the nonelderly population.

People obtain insurance coverage from a variety of sources. According to CBO's estimates, under current law about 150 million nonelderly people will get their primary coverage through an employer in 2010.[3] Similarly, another 40 million people will be covered through the federal/state Medicaid program or the Children's Health Insurance Program (CHIP). Other nonelderly people will be covered by policies purchased individually in the "nongroup" market, or they will obtain coverage from various other sources (including Medicare and the health benefit programs of the Department of Defense).

According to the preliminary analysis conducted by CBO and the JCT staff, once the proposed changes were fully implemented, the number of uninsured people would decline by 35 million to 37 million relative to our projections under current law—leaving about 16 million to 17 million nonelderly residents uninsured. That decline would be the net effect of several changes, which can be illustrated by examining the effects in a specific year. In 2017, for example, the number of uninsured would fall by about 36 million, relative to current-law projections. In that year, an additional 10 million nonelderly individuals would obtain coverage through Medicaid, and another 29 million would be covered by policies purchased through the new insurance exchanges. In that year, the number of nonelderly people who had coverage through an employer would increase by about 3 million, and coverage from other sources would decline by about 6 million (consisting primarily of people who would otherwise have bought a nongroup policy but would buy coverage through the exchanges in order to take advantage of the new subsidies).

Components of the Coverage Estimates. Reflecting those calculations, the share of the nonelderly population that is insured would increase from about 81 percent today to about 94 percent under the proposal, CBO estimates. The 16 million to 17 million people remaining uninsured include several million people who would be eligible for Medicaid but who would not enroll in that program. The ranks of the uninsured also include unauthorized immigrants; all together, insured and uninsured unauthorized immigrants make up about 5 percent of the total nonelderly population in our estimates. With unauthorized immigrants excluded from the calculation, nearly 97 percent of legal nonelderly residents are projected to have insurance under the proposal.

---

[3] Those estimates of coverage levels by their source are "point-in-time" enrollment figures and thus represent annual averages. Also, some people have coverage from multiple sources at the same time (for example, Medicare and employment-based coverage), in which case they are assigned a primary source of coverage for purposes of analysis.

The change in employment-based coverage that is shown on the attached table is itself the net result of several flows, which can also be illustrated using the estimates for 2017. For that year, under the proposal, CBO and the JCT staff estimate that about 165 million people would have their primary insurance coverage through an employer, or about 3 million more than under current law. We estimate that about 12 million people would be covered by an employment-based plan who would not be covered by one under current law (largely because the mandate for individuals to be insured would increase workers' demand for insurance coverage through their employers). However, nearly 3 million people who would be covered by their employer's plan (or a plan offered to a family member) under current law—and who could be covered by that plan under the proposal—would choose instead to obtain coverage in the exchanges because the employer's offer would be deemed unaffordable and they would therefore be eligible to receive subsidies in the exchanges. (Those people are counted as enrollees in the exchanges.)

In addition, CBO and the JCT staff estimate that nearly 6 million other people who would be covered by an employment-based plan under current law would not have such coverage under the proposal. That figure includes part-time employees, who could receive subsidies via an exchange even though they have an employer's offer of coverage, and about 3 million people who would not have an employer's offer of coverage under the proposal. Firms that would choose not to offer coverage as a result of the proposal would tend to be smaller employers and those that predominantly employ lower-wage workers—people who would be eligible for subsidies through the exchanges—although some workers who were not eligible for subsidies through the exchanges also would not have coverage available through their employers. Whether those changes in coverage would represent the dropping of existing coverage or a lack of offers of new coverage is difficult to determine.

Another significant feature of the insurance exchanges is that they would include a public plan that largely pays Medicare-based rates for medical goods and services. CBO estimates that the premiums for that plan would generally be lower than the premiums of the private plans against which it would be competing. Because all plans offered in the exchanges would vary their premiums to reflect the costs incurred in each area, the difference in premiums between private plans and the public plan would vary geographically—but on average the public plan would be about 10 percent cheaper than a typical private plan offered in the exchanges. That difference in premiums is itself the net effect of differences in the major factors that affect all insurance plans' premiums, including their payment rates to providers, their administrative costs, the degree of benefit management they apply to control spending, and the pool of enrollees they attract (the effects of which would be partly offset by the risk-adjustment provisions described above).

Enrollment in the public plan would also depend on the number of providers who chose to participate in it. Providers would not be required to participate in the public plan in order to participate in Medicare, and CBO assumed that some providers would elect not to participate in the public plan because its payment rates would be lower, on average, than private rates. Even so, CBO's judgment is that a substantial number of providers would elect to participate in the public plan, in part because they would expect a plan run by HHS to attract substantial enrollment. Taking into account both the access to providers in the public plan and the relative premiums its enrollees would pay, CBO estimates that roughly one-third of the people obtaining subsidized coverage through the insurance exchanges would be enrolled in the public plan—so enrollment in that plan would be about 9 million or 10 million once the proposal was fully implemented.[4] Given all of the factors in play, however, that estimate is subject to an unusually high degree of uncertainty.

Budgetary Impact of Insurance Coverage Provisions. On a preliminary basis, CBO and the JCT staff estimate that the proposal's provisions affecting health insurance coverage would result in a net increase in federal deficits of $1,042 billion for fiscal years 2010 through 2019. That estimate primarily reflects $438 billion in additional federal outlays for Medicaid and $773 billion in federal subsidies that would be provided to purchase coverage through the new insurance exchanges. Not all enrollees in the exchanges would receive subsidies, but the average subsidy among those who would be subsidized is projected to rise from roughly $4,800 in 2015 to roughly $6,000 in 2019. The other main element of the proposal that would increase federal deficits is the tax credit for small employers who offer health insurance, which is estimated to reduce revenues by $53 billion over 10 years.

Those costs would be partly offset by receipts or savings from three sources: payments of play-or-pay fees by employers that do not make a qualifying offer of health insurance to their workers, which would reduce projected deficits by $163 billion over 10 years; payments to the exchanges by employers who do make qualifying offers but whose workers end up receiving coverage via the exchanges nevertheless, which would total $45 billion over 10 years; and penalty payments by uninsured individuals, which would amount to $29 billion in the 2010–2019 period.

The proposal would not change the tax treatment of health insurance premiums. Nevertheless, changes in the number of people receiving employment-based

---

[4] Under the proposal, small employers could allow their workers to choose among the plans available in the exchanges—including the public plan—but those enrollees would not be eligible to receive subsidies via the exchanges (and thus are counted as enrollees in employment-based coverage rather than as exchange enrollees). Approximately 6 million people would obtain coverage in that way, with roughly a third choosing the public plan, so total enrollment in the public plan would equal about 11 million or 12 million, counting both individually purchased policies and employer-sponsored enrollees.

health insurance coverage and in the cost of that insurance—relative to current-law projections—would affect the government's tax revenues. Because total compensation costs are determined by market forces, CBO and the JCT staff estimate that wages and other forms of compensation would rise or fall by roughly the amount of any changes in employers' health insurance costs. Employers' payments for health insurance are tax-preferred, but most of those offsetting changes in compensation would come in the form of taxable wages and salaries—and the applicable income tax rate would depend on the total income of the affected individuals and their families.

Initially, the net increase in employment-based coverage that is estimated to result from the proposal would increase the federal deficit by several billion dollars per year because it would shift compensation toward tax-preferred health insurance. Over time, however, the net impact on employment-based coverage would diminish, and the resulting impact on the budget would be smaller. Throughout the period, federal deficits would also be reduced modestly as some employers purchased lower-cost coverage through an insurance exchange—which accounts for the estimated revenue gains (and reductions in deficits) that would occur after 2015. Largely as a result of those changes in the mix of compensation, changes in tax revenues are projected to increase deficits by a net $15 billion over the 2010–2019 period.[5]

Effects on State Outlays for Medicaid and CHIP. Medicaid and CHIP are financed jointly by the federal government and states; currently, the average federal reimbursement for medical services is 57 percent under Medicaid and 70 percent under CHIP. As noted above, the proposal's coverage provisions include several specifications that would affect Medicaid—including a substantial expansion of eligibility for that program and requirements that the federal government cover all of the costs of those newly eligible enrollees and that states maintain their current eligibility levels for Medicaid indefinitely. In addition, states would have to maintain their current eligibility levels for CHIP through 2013, but the program would then be terminated. CBO estimates that state spending on Medicaid and CHIP in the 2010–2019 period would be reduced by about $10 billion under the proposal, but that estimate is subject to substantial uncertainty for several reasons.

As a general matter, estimates of the impact on state spending depend heavily on the share of costs that the federal government assumes for such coverage expansions and on whether the federal government would assume any added share of the costs for existing Medicaid and CHIP coverage. In addition, states have considerable flexibility under current law to defray costs in Medicaid and

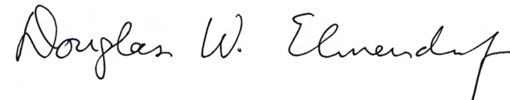
---

[5] As indicated in the attached tables, the provisions regarding tax credits for small employers and play-or-pay penalties on employers would also affect the mix of taxable and nontaxable compensation and, therefore, federal revenues; the revenue effects of both provisions are accounted for separately.

CHIP by modifying their programs (for example, by reducing the scope of covered benefits). The estimate for this proposal represents its approximate impact on state budgets after accounting for anticipated state responses to coverage changes included in the proposal.[6] States also have access to a variety of financing mechanisms, which CBO has not considered, that can be used to increase the effective state share of spending for Medicaid and CHIP. The degree to which states took advantage of such options would affect both federal and state costs under the proposal.

I hope this preliminary analysis is helpful for your consideration of America's Affordable Health Choices Act. If you have any questions, please contact me or CBO staff. The primary staff contacts for this analysis are Philip Ellis and Holly Harvey.

Sincerely,



Douglas W. Elmendorf
Director

Attachments

Identical letter sent to the Honorable Henry A. Waxman and the Honorable George Miller.

cc: Honorable Dave Camp
Ranking Member

---

[6] This preliminary analysis does not consider how federal or state budgets would be affected by other changes to Medicaid that are contained in other sections of the draft legislation.

A Summary of the Specifications for Health Insurance Coverage Provided by the House Tri-Committee Group

July 14, 2009

- The proposal's major provisions—including the establishment of an individual mandate to obtain insurance, an expansion of eligibility for the Medicaid program, and the creation of new insurance exchanges through which certain people could purchase subsidized coverage—would be implemented beginning in 2013.

- All legal residents would be required to enroll in a health insurance plan meeting certain minimum standards or face a tax penalty (described below). Individuals not required to file a tax return would be exempt from the penalty; exemptions for hardship and other reasons would be determined by a new and independent federal agency overseeing the health insurance exchanges (also described below).

- The penalty assessed on people who would be subject to the mandate but did not obtain insurance would equal 2.5 percent of the difference between their adjusted gross income (modified to include tax-exempt interest and certain other sources of income) and the tax filing threshold. The amount of the penalty could not exceed the national average premium for plans offered in the exchanges.

- New health insurance policies sold in the individual and group insurance markets would be subject to several requirements regarding their availability and benefits. Insurers would be required to issue policies to all applicants and could not limit coverage for people with preexisting medical conditions. In addition, premiums for a given plan could not vary because of enrollees' health but could vary because of their age by a factor of two (under a system known as adjusted community rating). Individual policies that were purchased before 2013 and maintained continuously thereafter would be "grandfathered," meaning that they would not have to conform to the new rules but would still fulfill the individual mandate. Existing group policies would have to conform to the new rules by 2017.

- In order to fulfill the individual mandate, policies that were not grandfathered would have to cover a broadly specified minimum benefit package (which was assumed to have the same scope of benefits as seen in a typical employer-sponsored plan) and would have to have a minimum actuarial value of 70 percent and a limit on out-of-pocket costs no greater than $5,000 for individual coverage and $10,000 for family coverage. (A health insurance plan's actuarial value reflects the share of costs for covered services paid by the plan.) After 2013, the maximum levels of those out-of-pocket caps would be indexed to general inflation.

- The proposal would establish a national exchange through which certain individuals and employers could purchase health insurance; states could also opt to operate their own exchanges (either one per state or one covering several states). All insurance plans sold through an exchange would be required to cover the "basic" benefit package described above. "Enhanced" plans would have an actuarial value of 85 percent, and "premium" plans would have an actuarial value of 95 percent.

- Except as specified below, individuals and families who enroll in exchange plans and have income between 133 percent and 400 percent of the federal poverty level (FPL) would be eligible for premium subsidies and cost-sharing subsidies (see table below). Federal premium subsidies in a given area would be tied to the average premium of the three lowest-cost plans providing basic coverage in the exchange in that area. The subsidies would limit an enrollee's contribution to a percentage of income ranging from 1.5 percent to 11.0 percent (see table); those caps would not be indexed over time. The federal government would fully fund cost-sharing subsidies, which would increase the actuarial value of enrollees' coverage to specified tiers based on income.

(Percent)

	Start of Tier		**End of Tier**		
Subsidy Tier	**Income Relative to the FPL**	**Premium Cap as Share of Income**	**Income Relative to the FPL**	**Premium Cap as Share of Income**	**Actuarial Value of Coverage in Tier**
1	133	1.5	150	3	97
2	150	3	200	5	93
3	200	5	250	7	85
4	250	7	300	9	78
5	300	9	350	10	72
6	350	10	400	11	70

- Eligibility for subsidies would be determined on the basis of adjusted gross income (modified to include tax-exempt interest and certain other types of income). Participants would have to provide information from their prior-year tax return during a fall open-enrollment period for coverage during the next calendar year (for example, tax return data on income received in 2011 would be provided when applying in the fall of 2012 for subsidies to be received in 2013). Each exchange would be given authority to obtain such information about taxpayers from the Internal Revenue Service as necessary to verify the information provided on income from the prior year. Individuals who did not qualify for a subsidy on the basis of their prior-year income would be allowed to apply for a subsidy on the basis of specified changes in their circumstances. Individuals receiving subsidies would be required to report changes in income and family composition during the year and, if changes occurred, would have their eligibility redetermined.

- People not enrolled in other coverage would be allowed to purchase insurance in an exchange at their own expense. Employers meeting specified size requirements would also be allowed to let their workers choose any of the plans available in the exchange (in which case, the workers would not receive subsidies via the exchange but would be subsidized by the tax exclusion for employment-based policies that exists under current law).

- A "public plan," run by the Department of Health and Human Services, would be offered through the exchanges. That plan would pay Medicare rates plus 5 percent for physicians and other practitioners (and those rates would not be determined by the sustainable growth rate formula used in Medicare but instead were assumed to grow with the Medicare economic index); Medicare rates for hospitals and other services and supplies that are on fee schedules; and negotiated rates for drugs and other items and services that are not on a fee schedule. Medicare providers would not be required to participate in the public plan.

- Eligibility for the Medicaid program would be expanded to all nonelderly individuals and families with income at or below 133 percent of the FPL. The federal government would pay 100 percent of the costs of newly eligible enrollees. States would be required to maintain their current eligibility levels for existing groups indefinitely. The federal government would fully subsidize the cost for some parents and childless adults who are currently covered by Medicaid under existing waivers that expand coverage. People eligible for Medicaid could not receive subsidies via an exchange.

- Newborns who would otherwise be uninsured would be automatically enrolled in Medicaid for 60 days (with the federal government paying 100 percent of their costs during that period), at which point there would be a determination of their eligibility for Medicaid or for subsidies provided through an exchange.

- Medicaid payment rates for primary care services would be increased to 80 percent of Medicare rates in 2010, 90 percent in 2011, and 100 percent beginning in 2012. The federal government would pay 100 percent of the cost of those increases.

- There would be a maintenance-of-effort requirement for the Children's Health Insurance Program through 2013, at which point the program would be terminated.

- Firms with an annual employee payroll above $250,000 would be subject to a "play-or-pay" requirement. Employers could "play" by offering coverage that meets the minimum benefit standards described above and making a minimum contribution toward the premiums (72.5 percent for individual premiums and 65 percent for family premiums). Firms that do not meet those requirements would be subject to a payroll tax, with the rate depending on their annual payroll, as follows: 2 percent, for firms with a payroll between $250,000 and $300,000; 4 percent, for firms with a payroll between $300,000 and $350,000; 6 percent, for firms with a payroll between $350,000 and $400,000; and 8 percent, for firms with a payroll above $400,000. Employers could choose to "play" for full-time employees and "pay" for part-time employees and could also make separate

elections for separate lines of business. Employers offering coverage would also be required to automatically enroll workers in single coverage.

- In 2013, full-time employees with an offer of employer-sponsored insurance would not be permitted to receive subsidies via an exchange (under an approach known as a "firewall"). Thereafter, those employees could receive the subsidies only if their contribution for that coverage was deemed unaffordable—which would be defined as exceeding 11 percent of their income. Part-time employees could receive the subsidies with no restrictions. Beginning in 2014, employers offering coverage would be required to pay the exchange a percentage of their average payroll per worker for each employee obtaining coverage with the exchange. The percentage would be the same one that applied if the firm was subject to the play-or-pay penalty (and thus would vary with the firm's total payroll, as described above).

- A tax credit for small employers would be available. It would be permanent, not advanceable or refundable, and would phase out as employers' size and average wages increased. The smallest firms with average wages below $20,000 would receive a credit equal to 50 percent of the employer's share of premiums. The credit would phase out for employers with between 10 and 25 employees and average wages between $20,000 and $40,000 and would not be available for workers with wages above $80,000; those wage amounts would be indexed to the consumer price index.

Preliminary Analysis of the Insurance Coverage Specifications Provided by the House Tri-Committee Group

EFFECTS ON INSURANCE COVERAGE /a
(Millions of nonelderly people, by calendar year)

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law	Medicaid/CHIP	40	39	39	38	35	34	35	35	35	35
Coverage /b	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup	13	12	12	12	13	14	14	14	14	15
	Other /c	14	14	14	14	14	15	15	15	15	16
	Uninsured /d	50	51	51	51	51	51	52	53	53	54
	TOTAL	267	269	271	273	274	276	277	279	281	282
Change (+/-)	Medicaid/CHIP	*	-1	-2	6	4	9	10	10	11	11
	Employer	*	*	1	10	7	4	3	3	2	2
	Nongroup/Other /c	*	*	*	-3	-4	-6	-6	-6	-6	-6
	Exchanges	0	0	0	11	20	27	28	29	29	30
	Uninsured /d	*	1	1	-23	-28	-35	-35	-36	-37	-37
Post-Policy Insurance Coverage											
Number of Uninsured People /d		51	52	52	27	23	16	16	17	17	17
Insured Share of the Nonelderly Population											
Including All Residents		81%	81%	81%	90%	92%	94%	94%	94%	94%	94%
Excluding Unauthorized Immigrants		83%	83%	83%	92%	94%	97%	97%	97%	97%	97%
Memo: Exchange Enrollees and Subsidies											
Number w/ Unaffordable Offer from Employer /e					*	*2*	*2*	*2*	*3*	*3*	*3*
Number of Unsubsidized Exchange Enrollees					*1*	*2*	*3*	*3*	*3*	*3*	*3*
Approximate Average Subsidy per Subsidized Enrollee						*$4,600*	*$4,800*	*$5,100*	*$5,300*	*$5,700*	*$6,000*

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

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

a. Components may not sum to totals because of rounding.
b. Figures reflect average annual enrollment. Individuals reporting mutiple sources of coverage are assigned a primary source.
c. Includes Medicare, TRICARE, and other sources; the effects of the proposal are almost entirely on nongroup coverage.
d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.
e. Full-time workers who would have to pay more than 11 percent of their income for employment-based coverage could receive subsidies via an exchange (see text).

Preliminary Analysis of the Insurance Coverage Specifications Provided by the House Tri-Committee Group

EFFECTS ON THE FEDERAL DEFICIT / a,b,c (Billions of dollars, by fiscal year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Medicaid/CHIP Outlays /d,e	3	4	1	29	42	58	66	72	78	84	438
Exchange Subsidies	0	0	0	33	72	105	123	134	146	160	773
Payments by Employers to Exchanges /f,g	0	0	0	0	-3	-6	-8	-8	-9	-11	-45
Associated Effects on Tax Revenues /f	*	*	*	10	10	3	-1	-1	-2	-4	15
Subtotal	3	4	1	72	122	160	180	196	213	230	1,182
Small Employer Credits /h	0	0	0	4	7	8	8	8	10	10	53
Payments by Uninsured Individuals	0	0	0	0	-6	-5	-4	-5	-5	-5	-29
"Play-or-Pay" Payments by Employers /f,h	0	0	0	-7	-16	-21	-26	-29	-31	-33	-163
NET IMPACT OF COVERAGE SPECIFICATIONS	**3**	**4**	**1**	**69**	**107**	**141**	**158**	**171**	**187**	**202**	**1,042**

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

Note: CHIP = Children's Health Insurance Program; * = less than $0.5 billion.

a. Does not include federal administrative costs or account for all effects on other federal programs.
b. Components may not sum to totals because of rounding.
c. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
d. Includes effects of coverage provisions and the proposed increase in Medicaid payment rates for primary care physicians (see text).
e. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2010-2019 period would be reduced by about $10 billion under the proposal (see text).
f. Increases in tax revenues reduce the deficit.
g. Employers would generally have to pay 8 percent of their average payroll per worker for each employee who received subsidies via an exchange (see text).
h. The effects on the deficit shown for this provision include the associated effects of changes in taxable compensation on tax revenues.