CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

October 25, 2017

Bipartisan Health Care Stabilization Act of 2017

As posted on the website of the Senate Committee on Health, Education, Labor, and Pensions on October 19, 2017 (version TAM17K02)

SUMMARY

The Bipartisan Health Care Stabilization Act of 2017 would make several changes to the state innovation waiver process established by the Affordable Care Act (ACA), appropriate money for cost-sharing reductions (CSRs) through 2019, require many insurers to pay rebates to individuals and the federal government related to premiums in the nongroup health insurance market for 2018, allow anyone in the nongroup market to purchase a catastrophic plan, and require some existing funding for health insurance marketplace operations to be used specifically for outreach and enrollment activities for 2018 and 2019.

On net, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that implementing the legislation would reduce the deficit by $3.8 billion over the 2018-2027 period relative to CBO's baseline. The agencies estimate that the legislation would not substantially change the number of people with health insurance coverage, on net, compared with that baseline projection. Enacting the legislation would affect direct spending and revenues; therefore, pay-as-you-go procedures apply.

CBO and JCT estimate that enacting the legislation would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

The legislation would impose an intergovernmental and private-sector mandate as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that the cost of the mandates would fall below the annual thresholds established in UMRA ($78 million for intergovernmental mandates and $156 million for private-sector mandates, respectively, in 2017, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effect of the legislation is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By Fiscal Year, in Millions of Dollars											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018-2022	2018-2027
INCREASES OR DECREASES (-) IN DIRECT SPENDING												
State Innovation Waivers[a]												
Estimated Budget Authority	*	*	*	*	*	*	*	*	*	*	*	*
Estimated Outlays	*	*	*	*	*	*	*	*	*	*	*	*
Waiver Pass-through Recalculation												
Estimated Budget Authority	81	84	87	90	95	*	*	*	*	*	436	436
Estimated Outlays	81	84	87	90	95	*	*	*	*	*	436	436
Funding for CSRs												
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	0	0	0	0	0	0	0	0	0	0	0
Rebates Related to CSRs[a]												
Estimated Budget Authority	-311	-1,168	-78	0	0	0	0	0	0	0	-1,557	-1,557
Estimated Outlays	-311	-1,168	-78	0	0	0	0	0	0	0	-1,557	-1,557
Copper Plans[a]												
Estimated Budget Authority	0	-72	-106	-111	-115	-118	-124	-128	-131	-137	-405	-1,042
Estimated Outlays	0	-72	-106	-111	-115	-118	-124	-128	-131	-137	-405	-1,042
Outreach and Assistance Funding[a]												
Estimated Budget Authority	*	*	*	0	0	0	0	0	0	0	*	*
Estimated Outlays	*	*	*	0	0	0	0	0	0	0	*	*
Total Changes												
Estimated Budget Authority	-231	-1,156	-98	-21	-20	-118	-124	-128	-131	-137	-1,526	-2,163
Estimated Outlays	-231	-1,156	-98	-21	-20	-118	-124	-128	-131	-137	-1,526	-2,163
INCREASES OR DECREASES (-) IN REVENUES												
State Innovation Waivers[a]	*	*	*	*	*	*	*	*	*	*	*	*
Funding for CSRs	0	0	0	0	0	0	0	0	0	0	0	0
Rebates Related to CSRs[a]	311	1,168	78	0	0	0	0	0	0	0	1,557	1,557
Copper Plans[a]	0	5	6	7	7	7	7	7	7	7	25	58
Outreach and Assistance Funding[a]	*	*	*	0	0	0	0	0	0	0	*	*
Total Changes	311	1,172	84	7	7	7	7	7	7	7	1,581	1,615
NET DECREASE (-) IN THE DEFICIT FROM INCREASES OR DECREASES (-) IN DIRECT SPENDING AND REVENUES												
Impact on Deficit	-542	-2,328	-182	-28	-27	-125	-130	-134	-137	-144	-3,107	-3,778

Notes: Components may not add to totals because of rounding; * = an increase or decrease of less than $500,000; CSRs = Cost-Sharing Reductions.

a. Policies affect both direct spending and revenues.

BASIS OF ESTIMATE

For this estimate, CBO and JCT assume that the legislation will be enacted near the start of calendar year 2018. The agencies have measured the budgetary effects relative to CBO's June 2017 baseline, incorporating adjustments published in September 2017.

State Innovation Waivers

Under current law, states may apply for waivers of some of the rules governing insurance markets or the programs offering health insurance established by the ACA. The criteria and process for obtaining state innovation waivers were established by Section 1332 of the ACA. Under current law and this legislation, waivers are required to be budget neutral. However, in CBO and JCT's assessment, the actual net budgetary effects of the waiver process are unclear.

Under a waiver, federal funding (known as "pass-through funds") would be provided for the purpose of implementing the waiver that would be specifically designed to equal the Administration's estimate of certain subsidies that would have been paid in the absence of the waiver. If the amount of pass-through funding equaled the amount that otherwise would have been paid, then the waiver would have no net budgetary effect. However, that equality might not occur for several reasons. In CBO and JCT's assessment, the factors that tend to increase net costs are probably roughly offset by factors that tend to decrease them. For example, approved waivers could increase net costs if states chose to implement waivers only when the Administration's estimate of pass-through funding turned out to be too high and did not implement them when that estimate turned out to be too low. On the other hand, states could implement waivers in a way that reduced net costs by more than the amounts that would be included in the calculation of pass-through funding; for example, revenues could increase if premiums for employment-based insurance were lower or fewer employers offered employment-based coverage under a waiver.

The legislation would make several changes to the rules for state innovation waivers. For example, under the legislation, states would no longer need to enact legislation before submitting a waiver application and the standards by which the Departments of Health and Human Services and Treasury evaluate states' applications would change. CBO and JCT estimate that those changes would increase the number of applications submitted by states and the likelihood that future waiver applications would be approved. However, the agencies do not expect that the changes made to the standards for evaluating new waivers would substantially alter the net budgetary effect relative to current law.

Waiver Pass-through Recalculation

The legislation would allow states with waivers under Section 1332 that were approved before the legislation's date of enactment to request a recalculation of the pass-through funding they would be owed. The legislation would also modify the methodology for calculating pass-through payments to allow reductions in Basic Health Program (BHP) subsidies caused by the terms of a waiver to be included in that calculation (BHP allows states to offer subsidies to certain low-income people that are based on the subsidies available through the marketplaces). Minnesota is the only state with an approved 1332 waiver and a BHP. CBO and JCT expect that Minnesota would request a recalculation, and that it would receive about $436 million more in pass-through funding between 2018 and 2022. CBO and JCT also expect that if other states with an already-approved 1332 waiver but no BHP requested a recalculation, the amount of pass-through funding would not change significantly.

Funding for Cost-Sharing Reductions

The legislation would appropriate such sums as may be necessary to make payments for CSRs through 2019. Because such payments are already in CBO's baseline projections (totaling $18 billion for 2018 and 2019 and $99 billion over the 2018-2027 period), CBO and JCT estimate that the appropriation would not affect direct spending or revenues, relative to that baseline.

The Balanced Budget and Emergency Deficit Control Act of 1985, which specifies rules for constructing the baseline, requires that CBO assume full funding of entitlement authority. CBO and JCT have long viewed the cost-sharing subsidies as a form of entitlement authority—that is, authority for federal agencies to incur obligations to make payments to entities that meet the eligibility criteria set in law.[1] On that basis, in the agencies initial cost estimate for the ACA and in all subsequent baseline projections, they have recorded the CSR payments as direct spending (that is, spending that does not require appropriation action). After consultation with the Budget Committees, CBO has not changed its baseline to reflect the Administration's announcement on October 12, 2017, that it would stop making payments for CSRs.

CBO and JCT assume that this legislation will not be enacted until after open enrollment for insurance for 2018 begins on November 1, 2017. Therefore, premiums for 2018 plans would already have been finalized and enacting the legislation would not affect premiums for that year. Also, health insurance coverage in 2018 would not be affected compared with the baseline.

1. Even if an agency has the authority to incur obligations, they may not have the authority, or funding, to liquidate that obligation.

Because CBO's baseline incorporates the assumption that CSRs will be fully funded for 2019, premiums for 2019 would not change under the legislation, relative to that baseline. To the extent that there is uncertainty in 2020 about whether CSRs will be funded, CBO and JCT expect that insurers would increase premiums in that year relative to the baseline projections. Because CBO's baseline incorporates the assumption of full funding of entitlement authority, however, this cost estimate excludes any effects on premiums of uncertainty about future funding—consistent with the exclusion of effects of providing the funding itself.

This analysis of the effects of CSRs on health insurance coverage and federal costs differs from that which CBO published in August 2017 in various ways.[2] Most importantly, the August 2017 analysis considered the effects of hypothetical legislation that would terminate funding for CSRs, whereas this analysis estimates the effects of legislation that would provide funding for CSRs. In both cases, the legislation was compared to a baseline in which CSRs were fully funded. Simply comparing outcomes with and without funding for CSRs, CBO and JCT expect that federal costs in 2018 would be higher with funding for CSRs because premiums for 2018 have already been finalized and rebates related to CSRs would be less than the CSR payments themselves. In contrast, premiums in 2019 would be lower with funding for CSRs than without it, and federal costs would probably be lower as well.

Rebates Related to Cost-Sharing Reductions

The legislation would require states to submit plans for ensuring that each health insurer provides a rebate or other financial benefit to consumers and the federal government in return for receiving payments for CSRs in 2018. As a result, CBO and JCT expect that insurers in almost all areas of the country would be required to issue some form of rebate to individuals and the federal government. Based on information from state insurance regulators and state-based insurance marketplaces, CBO and JCT estimate that the federal government would receive rebates from insurers totaling about $3.1 billion over the 2018-2027 period. There are a variety of ways states could choose to implement the rebates; some would be recorded in the federal budget as an increase in revenues, and others would be recorded in the budget as a decrease in outlays. CBO and JCT estimate that states would adopt a mix of strategies and that the federal savings would be recorded as a mix of changes to outlays and revenues—specifically, half in lower outlays and half in higher revenues.

2. For related discussion, see Congressional Budget Office, The Effects of Terminating Payments for Cost-Sharing Reductions (August 2017), www.cbo.gov/publication/53009.

Copper Plans

Under current law, only certain people, most of whom are under the age of 30, may enroll in a catastrophic plan in the nongroup insurance market. Beginning in 2019, the legislation would newly allow any nongroup enrollee to choose a catastrophic plan (and those plans would be called copper plans). As under current law, subsidies would not be available for that coverage. In addition, the legislation would require that catastrophic plans be included as part of the single risk pool for pricing premiums in the nongroup market, alongside most other plans. (Under current regulations, catastrophic plans can be rated in a separate risk pool from other nongroup plans.)

CBO and JCT estimate that this provision would not substantially change the total number of people with insurance through the nongroup market. However, the agencies estimate that making catastrophic plans part of the single risk pool would slightly lower premiums for other nongroup plans, because the people who enroll in catastrophic plans tend to be healthier, on average, than other nongroup market enrollees. As a result of the slightly lower estimated premiums, CBO and JCT expect that federal costs for subsidies for insurance purchased through a marketplace established under the ACA would decline by about $1.1 billion over the 2019-2027 period.

Outreach and Assistance Funding

Under current law, insurers participating in the federally-facilitated health insurance marketplace must pay a user fee. Those user fees support operations of the marketplace such as outreach and enrollment activities, building and maintaining information technology systems, determining eligibility for subsidies, ensuring proper payments of subsidies, operating a quality rating system, plan certification and oversight, and educating and assisting consumers with the marketplace.

The legislation would require the Department of Health and Human Services to spend $105.8 million of those existing user fees for outreach and enrollment activities related to the federally-facilitated marketplace for each of plan years 2018 and 2019. That amount is higher than the amount the Administration has previously announced it plans to spend on those activities for the 2018 plan year.

The legislation would require a specific purpose for existing funding and would not appropriate additional funds. Funding for outreach and enrollment activities could increase enrollment, increasing the number of people receiving subsidies while potentially improving the average health of enrollees in marketplace plans (and thus lowering average premiums in marketplace plans). However, because CBO and JCT do not have a basis for comparing the effects on enrollment and subsidies of using the funding for those activities to the effects of the funding choices under current law (which

also could affect enrollment and subsidies), the agencies do not have a basis for estimating a net effect on the deficit from enacting the provision.

PAY-AS-YOU-GO CONSIDERATIONS

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays and revenues that are subject to those pay-as-you-go procedures are shown in the following table.

CBO Estimate of Pay-As-You-Go Effects for the Bipartisan Health Care Stabilization Act of 2017, as posted on the website of the Senate Committee on Health, Education, Labor, and Pensions on October 19, 2017

	By Fiscal Year, in Millions of Dollars											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018-2022	2018-2027
NET INCREASE OR DECREASE (-) IN THE DEFICIT												
Statutory Pay-As-You-Go Impact	-542	-2,328	-182	-28	-27	-125	-130	-134	-137	-144	-3,107	-3,778
Memorandum:												
Changes in Outlays	-231	-1,156	-98	-21	-20	-118	-124	-128	-131	-137	-1,526	-2,163
Changes in Revenues	311	1,172	84	7	7	7	7	7	7	7	1,581	1,615

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO and JCT estimate that enacting the legislation would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The legislation would impose an intergovernmental mandate as defined in UMRA on states in which insurers receive federal payments for cost-sharing reductions. The legislation would require insurance regulators in those states to submit a certification and state plan to the Secretary of Health and Human Services that ensures issuers of health plans for 2018 provide a direct financial benefit to enrollees and the federal government. Based on information from state insurance regulators, CBO estimates that the cost to submit a certification and plan would be small for each state. Consequently, CBO

estimates that the aggregate cost of the mandate would fall below the annual threshold established in UMRA for intergovernmental mandates ($78 million in 2017, adjusted annually for inflation).

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The legislation would impose a private-sector mandate as defined in UMRA by requiring insurers to consider catastrophic plans as part of the single risk pool. CBO estimates that any incremental administrative costs would be small and fall below the annual threshold established in UMRA for private-sector mandates ($156 million in 2017, adjusted annually for inflation).

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