CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

March 19, 2018

Bipartisan Health Care Stabilization Act of 2018

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SUMMARY

The Bipartisan Health Care Stabilization Act of 2018 (BHCSA) would make several changes to health care laws. It would:

- Change the state innovation waiver process established by the Affordable Care Act (ACA),
- Appropriate a total of $30.5 billion for reinsurance programs or invisible high-risk pools in the nongroup insurance market,
- Appropriate funds for the direct payment for cost-sharing reductions (CSRs) through 2021,
- Allow any enrollee in the nongroup market to purchase a catastrophic plan, and
- Require some existing funding for operations in the health insurance marketplaces to be used specifically for outreach and enrollment activities in 2019 and 2020.

On net, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting the legislation would increase the deficit by $19.1 billion over the 2018-2027 period relative to CBO's baseline. The agencies estimate that the legislation would increase the number of people with health insurance coverage, on net, by fewer than 500,000 people in each year from 2019 through 2022, compared with the baseline projection. Because enacting the legislation would affect direct spending and revenues, 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 BHCSA would impose intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that the costs of those mandates would fall below the annual thresholds established in UMRA for intergovernmental and private-sector mandates ($78 million and $156 million in 2017, respectively, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effects of the Bipartisan Health Care Stabilization Act of 2018 are shown in the following table. The costs of this legislation fall within budget function 550 (health).

BASIS OF ESTIMATE

For this estimate, CBO and JCT assume that the legislation will be enacted in the spring of 2018. The agencies have measured the budgetary effects relative to CBO's most recent baseline (June 2017), incorporating adjustments published in September 2017, as well as adjustments for enacted legislation.[1]

State Innovation Waivers

Under current law, states may apply for waivers from some of the rules governing insurance markets or the programs offering health insurance established by the ACA. Those "state innovation waivers" were established by section 1332 of the ACA. Under current law and this legislation, waivers are required to be budget neutral and to provide comparable levels of insurance coverage, measured in terms of covered benefits, per-enrollee costs, and the number of state residents with health insurance. However, in CBO and JCT's assessment, the actual net budgetary effects of the waiver process are unclear.

1. The most significant adjustment for enacted legislation incorporates the effects of P.L. 115-97, which repealed penalties related to the individual health insurance mandate beginning in 2019 and changed income tax rates.

	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]	*	*	*	*	*	*	*	*	*	*	*	*
Reinsurance and Invisible High-Risk Pools[a]	50	6,866	6,199	9,029	6,024	-1,620	0	0	0	0	28,168	26,548
Waiver Pass-through Recalculation	68	69	70	72	79	*	*	*	*	*	359	359
Funding for CSRs	0	0	0	0	0	0	0	0	0	0	0	0
Copper Plans[a]	0	-71	-99	-88	-85	-87	-91	-93	-94	-97	-343	-805
Total Changes	118	6,864	6,170	9,013	6,019	-1,707	-91	-93	-94	-97	28,184	26,102
INCREASES OR DECREASES (-) IN REVENUES[b]												
State Innovation Waivers[a]	*	*	*	*	*	*	*	*	*	*	*	*
Reinsurance and Invisible High-Risk Pools[a]	0	802	1,501	2,160	1,986	520	0	0	0	0	6,449	6,970
Funding for CSRs	0	0	0	0	0	0	0	0	0	0	0	0
Copper Plans[a]	0	3	4	5	5	5	5	5	6	7	17	44
Total Changes	*	805	1,505	2,165	1,991	525	5	5	6	7	6,466	7,014
On-Budget	*	665	1,234	1,777	1,632	432	5	5	6	7	5,308	5,763
Off-Budget[c]	*	140	271	388	359	94	*	*	*	*	1,158	1,251
NET INCREASE OR DECREASE (-) IN THE DEFICIT FROM INCREASES OR DECREASES (-) IN DIRECT SPENDING AND REVENUES												
Impact on Deficit	118	6,059	4,665	6,848	4,028	-2,232	-96	-98	-100	-104	21,718	19,088
On-Budget	118	6,199	4,936	7,236	4,387	-2,138	-96	-98	-100	-104	22,875	20,339
Off-Budget[c]	*	-140	-271	-388	-359	-94	*	*	*	*	-1,158	-1,251

Notes: Budget authority is equal to outlays; 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.
b. For revenues, a positive number indicates an increase (reducing the deficit) and a negative number indicates a decrease (adding to the deficit).
c. All off-budget effects would come from changes in Social Security revenues.

Under a waiver, states receive federal funding (known as "pass-through funds") to implement the waiver in an amount equal to the Administration's estimate of federal subsidies that would have otherwise been paid in the absence of the waiver.[2] 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. 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. However, that equality might not occur for several reasons. 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 that reduced net costs by more than the amounts that would be included in the calculation of pass-through funding; for example, federal tax revenues could increase if state waivers caused premiums for employment-based insurance to fall or fewer employers to offer 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 the Treasury Department 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 significantly alter the net budgetary effect relative to current law.

Reinsurance and Invisible High-Risk Pools

The legislation would appropriate $10 billion per year over the 2019-2021 period to be used for reinsurance programs or invisible high-risk pools in the nongroup insurance market, plus $500 million to be used for state administrative costs, for a total of $30.5 billion. Generally, in order to receive its share of the money, a state would have to apply for a state innovation waiver and establish a reinsurance program or an invisible high-risk pool. However, for 2019 only, the legislation would establish a federal reinsurance program in any state that did not have a waiver related to reinsurance or an invisible high-risk pool. CBO and JCT estimate that, together, those provisions of the legislation would increase the deficit by $19.6 billion over the 2018-2027 period. That increase in the deficit is composed of a spending increase of $26.5 billion, partly offset by an increase in revenues of $7.0 billion.

2. Under current law, those federal subsidies that a state may receive in pass-through funds include subsidies for coverage purchased through a marketplace established by the ACA.

How Reinsurance Programs and Invisible High-Risk Pools Would Work. Reinsurance programs or invisible high-risk pools protect insurers from the risk of high-cost enrollees. A reinsurance program would pay insurers when enrollees incurred particularly high costs for medical claims—that is, costs above a specified threshold and up to a certain maximum. An invisible high-risk pool would allow insurers to pay premiums for selected high-risk enrollees into a pool, which would then cover the claims for those enrollees using the premiums and the federal funding. CBO and JCT estimate that either type of program would result in lower premiums for coverage in the nongroup market because the risk to insurers from high-cost enrollees would be lower.

What Proportion of the Population Would Be Affected. Based on information provided by state governments, insurers, and other outside experts, CBO and JCT estimate that almost all of the U.S. population would live in a state that used the federal default reinsurance program for 2019. Three states already have waivers approved under section 1332 that relate to reinsurance, but the agencies expect that it would be difficult for other states to establish a state-based program in time to affect premiums for 2019. Beginning in 2020, a state would need to establish its own program through a waiver under section 1332 in order to receive federal funds for reinsurance. CBO and JCT expect that about 60 percent of the population would live in a state that received such a waiver for 2020 and that about 80 percent of the country would live in a state that received such a waiver for 2021. The remainder of the population in those years would be without a federally-funded reinsurance program or invisible high-risk pool.

Why the Federal Costs Differ from the Appropriated Amounts. Because the funding would be available until spent, CBO and JCT expect that the money allocated to states that did not obtain a waiver for reinsurance or an invisible high-risk pool in 2020 and 2021 would be available for use by other states in 2022.

In 2019, CBO and JCT estimate, about 60 percent of the federal cost for the default federal reinsurance program would be offset by other sources of savings, mainly by reductions in federal subsidies. The largest amount of offsetting savings would result from lower premiums in the nongroup market. Because premium tax credits for coverage purchased through the marketplaces established under the ACA are directly linked to those premiums, any reductions in nongroup premiums would result in lower federal subsidies.

States that instead established their own reinsurance program or invisible high-risk pool through a waiver under section 1332 would receive most of those offsetting savings as additional “pass-through funds” under the waiver, with the remainder accruing to the federal government. CBO and JCT project that states would use the pass-through funding they receive under a waiver to help finance their state reinsurance program or invisible high-risk pool. Therefore, the agencies estimate that the size of the reinsurance program or invisible high-risk pool, and therefore the magnitude of the premium reductions in the

nongroup market, would be larger in states with a waiver than in states using the federal default program.

How Premiums Would Be Affected. CBO and JCT estimate that premiums for nongroup insurance would be about 10 percent lower in 2019, on average, under the legislation than projected for that year under current law. They also estimate that, in 2020 and 2021, premiums for nongroup insurance would be about 20 percent lower, on average, than estimated for those years under current law in states that applied for a waiver to establish their own reinsurance program or invisible high-risk pool. The reduction in premiums would result in less federal spending on premium tax credits and more federal spending on waiver pass-through funding. In states that did not apply for a waiver, premiums would be the same under current law as under the legislation starting in 2020. The reduction in premiums would mainly affect people with income greater than 400 percent of the federal poverty level (FPL). Most people with lower incomes purchasing nongroup insurance receive premium tax credits and pay a percentage of their income toward the purchase of the plan in their area used for determining the tax credit (referred to here as a benchmark plan) regardless of the gross premium charged for that plan.

The agencies estimate that insurers would lower premiums for coverage in the nongroup market based on the amount of funding they expect to be available for reinsurance programs or invisible high-risk pools. However, insurers would tend to set premiums conservatively to hedge against uncertainty about how the reinsurance program or invisible high-risk pool would be implemented and what their enrollees' ultimate healthcare costs would be. As a result, the agencies expect that total premiums would not be reduced by the entire amount of available federal funding.

How Insurance Coverage Would Be Affected. CBO and JCT estimate that this provision would increase the number of people with health insurance coverage, on net, by fewer than 500,000 people in each year from 2019 through 2022, compared with CBO's baseline projections. The largest portion of that net increase in coverage would come from people with incomes above 400 percent of the FPL who would be uninsured under current law, but who would purchase unsubsidized coverage in the nongroup market under the legislation because the premiums for that coverage would be lower.[3] Because the increase in the number of people with health insurance coverage would primarily occur among the unsubsidized population, the additional federal cost of increased enrollment would be relatively small (and such costs would reduce the size of the pass-through funding that a state would receive).

3. People are generally eligible for subsidies for coverage purchased through the marketplaces if they have incomes between 100 percent and 400 percent of the FPL and do not have another affordable source of insurance coverage, such as employment-based insurance or Medicare.

Waiver Pass-through Recalculation

The legislation would allow states with waivers under section 1332 that were approved before the legislation's enactment to request a recalculation of the pass-through funding they would be owed. The legislation also would modify the methodology for calculating pass-through payments to include reductions in Basic Health Program (BHP) subsidies caused by the terms of a waiver. (The 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. Because Minnesota's reinsurance waiver reduces premiums in the nongroup market, BHP payments are lower because those payments are directly tied to the premiums in the nongroup market. This provision would allow a state to receive the amount of the reduction in BHP payments as pass-through funding for its 1332 waiver.

CBO and JCT expect that Minnesota would request a recalculation, and that it would receive $359 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 for the fourth quarter of calendar year 2017, for certain insurers for plan year 2018, and for all of plan years 2019 through 2021.[4] Because such payments are already in CBO's baseline projections (totaling $25 billion for 2019 through 2021 and $76 billion over the 2018-2027 period), CBO and JCT estimate that the appropriation would not affect direct spending or revenues, relative to that baseline.

CBO and JCT have long viewed the requirement that the federal government compensate insurers for CSRs as a form of entitlement authority. The Balanced Budget and Emergency Deficit Control Act of 1985, which specifies rules for constructing the baseline, requires CBO to assume full funding of such entitlement authority.[5] On that basis, in the most recent baseline projections (summer 2017), CBO included the CSR payments as direct spending (that is, spending that does not require appropriation action). After consulting with the Budget Committees, CBO continued to assume in its baseline that CSRs would be funded, even though the Administration announced on October 12, 2017, that it would stop making direct payments for CSRs.

4. CSRs take the form of reduced deductibles, copayments, and other means of cost sharing for eligible individuals enrolled in silver plans through marketplaces.

5. 2 U.S.C. §907(b)(1) (2012). Entitlement authority is authority for federal agencies to incur obligations to make payments to entities that meet the eligibility criteria set in law.

Because CBO's baseline incorporates the assumption that direct payments for CSRs will be made for 2019 through 2021, premiums for those years would not change under the provision, relative to that baseline. To the extent that there would be uncertainty in 2022 about whether CSRs will be directly funded, CBO and JCT expect that insurers would increase premiums in that year relative to the baseline projections. Because CBO's baseline incorporates the funding for CSRs, 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.[6] Most importantly, the August 2017 analysis considered the effects of hypothetical legislation that would terminate direct funding for CSRs, whereas this analysis addresses the effects of legislation that would provide direct funding for CSRs. In both cases, the legislation was compared to a baseline in which CSRs were directly appropriated.

Simply comparing outcomes with and without direct funding for CSRs, CBO and JCT expect that premiums for benchmark plans over the 2019-2021 period would be lower with funding for CSRs than without it, and federal costs would be lower as well. Such effects are explained in CBO's August 2017 report.

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 allow any nongroup enrollee to choose a catastrophic plan (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 are treated separately from other nongroup plans for purposes of the risk-adjustment program.)

CBO and JCT estimate that this provision would not substantially change the total number of people purchasing 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 would be reduced by

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

$849 million over the 2019-2027 period. That decrease in the deficit is composed of a decrease in outlays of $805 million and an increase in revenues of $44 million.

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 conducting outreach and enrollment activities, building and maintaining information technology systems, determining eligibility for subsidies, ensuring proper payments of subsidies, operating a quality rating system, conducting 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 2019 and 2020. That amount is larger than the amount the Administration has previously announced it plans to spend on those activities for the 2018 plan year.

The legislation would designate specific purposes 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 newly specified activities rather than 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. Only on-budget changes to outlays or revenues are subject to pay-as-you-go procedures.

CBO Estimate of Pay-As-You-Go Effects for the Bipartisan Health Care Stabilization Act of 2018

	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 ON-BUDGET DEFICIT												
Statutory Pay-As-You-Go Impact	118	6,199	4,936	7,236	4,387	-2,138	-96	-98	-100	-104	22,875	20,339
Memorandum:												
Changes in Outlays	118	6,864	6,170	9,013	6,019	-1,707	-91	-93	-94	-97	28,184	26,102
Changes in Revenues	0	665	1,234	1,777	1,632	432	5	5	6	7	5,308	5,763

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates 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.

MANDATES

The bill would impose two private-sector mandates as defined in UMRA. It would require insurers to consider catastrophic plans as part of the single risk pool. The bill also would require issuers of short-term, limited duration insurance to notify consumers that such insurance differs from coverage and benefits under qualified health plans. CBO estimates that any incremental administrative costs of those mandates would be small and fall below the annual threshold established in UMRA for private-sector mandates ($156 million in 2017, adjusted annually for inflation). Additionally, the bill would require state insurance commissioners to oversee the consumer notification process. CBO estimates that the costs of that requirement would fall well below the threshold for intergovernmental mandates ($78 million in 2017, adjusted annually for inflation).

PREVIOUS CBO ESTIMATE

On October 25, 2017, CBO transmitted a cost estimate for the Bipartisan Health Care Stabilization Act of 2017. The differences in the estimated costs reflect differences between the two pieces of legislation, primarily the appropriation of funding for reinsurance and invisible high-risk pools, and the effects of legislation that was enacted since the earlier estimate was prepared.

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