CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

May 3, 2006

S. 1955
Health Insurance Marketplace Modernization and Affordability Act of 2006

As reported by the Senate Committee on Health, Education, Labor, and Pensions on April 27, 2006

SUMMARY

S. 1955 would amend the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act to establish national standards for regulating and administering health insurance. Enacting S. 1955 would increase federal revenues from payroll and income taxes, and it would reduce net federal spending for Medicaid. In addition, the bill would expand the roles of the Department of Labor (DOL) and the Department of Health and Human Services (HHS) in overseeing health insurers.

The increase in revenues would result from a reduction in the total amount spent on employer-sponsored health insurance. Consequently, enacting the bill would reduce the share of compensation that is tax-advantaged (health insurance premiums) and increase the share that is taxable (wages and salaries). CBO estimates that such a shift would increase federal revenues by $1.0 billion over the 2007-2011 period and $3.3 billion over the 2007-2016 period. Social Security payroll taxes, which are off-budget, account for about 35 percent of those amounts.

The decrease in federal Medicaid spending would result primarily from the enrollment in employer-sponsored insurance plans of people who, under current law, would be covered by Medicaid. The estimate also reflects additional enrollment in Medicaid by people who would lose private coverage under the bill and increased Medicaid payments for certain individuals who would face reductions in private coverage. On net, CBO estimates that enacting S. 1955 would reduce direct spending for the federal share of Medicaid expenditures by $235 million over the 2007-2011 period and $790 million over the 2007-2016 period. In addition, the bill would result in estimated Medicaid savings to states totaling $180 million over the 2007-2011 period and $600 million over the 2007-2016 period.

CBO estimates that additional discretionary costs to DOL and HHS would total $2 million in 2007 and $30 million over the 2007-2011 period, assuming appropriation of the necessary amounts.

S. 1955 would preempt a range of state laws governing insurance regulation and administration, and those preemptions would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). Generally, the preemptions in the bill would not impose duties on states that would result in additional spending except for the preemption of state administrative laws relating to certain process standards. Complying with those requirements may require states to revise procedures. CBO estimates, however, that those costs would be small and well below the threshold established in UMRA ($64 million in 2006, adjusted annually for inflation). S. 1955 contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 1955 is shown in the following table. The costs of this legislation fall within budget function 550 (health) and 600 (income security). This estimate assumes that S. 1955 would be enacted by October 1, 2006.

	By Fiscal Year, in Millions of Dollars									
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
CHANGES IN REVENUES										
Income and HI Payroll Taxes (on-budget)	15	75	135	190	260	285	295	300	305	310
Social Security Payroll Taxes (off-budget)	10	40	75	105	140	150	155	155	160	160
Total Changes in Revenues	25	115	210	295	400	435	450	455	465	470
CHANGES IN DIRECT SPENDING										
Estimated Budget Authority	-15	-25	-45	-65	-85	-95	-100	-110	-120	-130
Estimated Outlays	-15	-25	-45	-65	-85	-95	-100	-110	-120	-130
CHANGES IN SPENDING SUBJECT TO APPROPRIATION										
Estimated Authorization Level	4	5	7	7	8	8	8	9	9	9
Estimated Outlays	2	6	7	7	8	8	8	9	9	9

Note: HI = Hospital Insurance (Part A of Medicare).

BASIS OF ESTIMATE

S. 1955 would define federal rules for regulating and administering health insurance in three areas: rating restrictions for small-group health insurance, benefit mandates, and procedures and operations of state health insurance commissioners. For each of those three areas, states would be defined either as "adopting states," if they adopted the federal rules, or non-adopting states. In non-adopting states, insurers would have the option of operating under the federal rules, in which case state law would be preempted. Health insurers, however, would still be subject to state licensing requirements.

The bill would define a set of rules for the small-group insurance market—called Model Small Group Rating Rules (MSGRRs)—that limit the extent to which insurers could vary the premiums they offered in that market. Currently, many states have small-group rating rules that are similar to the MSGRRs; some states have stricter rules (less variation allowed in the premiums charged to different small groups) and others have looser rules (more variation allowed in the premiums charged to different small groups).

In states that do not adopt the MSGRRs, insurers could, after notifying the Secretary of Labor and the state insurance commissioner, choose to operate under the MSGRRs instead of existing state regulations. In general, insurers face competitive pressures to apply rating principles that result in premiums that reflect the differences in expected claims among different small groups. Therefore, CBO assumes that insurers in states with small-group rating rules that are stricter than MSGRRs would choose to operate under the MSGRRs, while insurers in states with small-group rating rules that are looser than MSGRRs would continue to operate under those existing state rules. S. 1955 would effectively loosen the small-group rating restrictions in those states that currently have relatively strict rating rules. That loosening of rating rules would tend to reduce health insurance premiums for small firms with workers who have relatively low expected costs for health care and increase premiums for firms with workers who have relatively high expected costs.

S. 1955 also would define federal rules relating to health insurance benefits, services, and provider mandates that would apply to all health insurance products offered in both group and non-group markets. The bill would allow a health insurer to offer a plan that does not comply with one or more state mandates even in states that do not adopt the federal rules, so long as the insurer also offers an "enhanced option" plan. That enhanced option plan must, at a minimum, include the same covered benefits, services, and categories of providers as one of the plans offered to state employees in one of the five most populous states. The effect of those benefit mandates provisions in S. 1955 on health insurance coverage would depend on whether and to what extent firms and individuals prefer plans that do not comply with current benefit mandates over plans that do. CBO expects that some firms and individuals

would prefer plans that do not comply with current state benefit mandates and that have a reduced level of benefits and premiums.

The bill also would define fully insured group health plans sponsored by certain types of associations as Small Business Health Plans (SBHPs). Each SBHP would operate as a separate risk pool for the purpose of setting premiums and would otherwise be subject to the same rating rules as non-SBHP plans. CBO expects that some small businesses, including self-employed individuals, could pay lower health insurance premiums by purchasing such coverage through SBHPs rather than through the traditional market for small employer health insurance; other small businesses could pay higher premiums.

S. 1955 would require the Secretary of HHS to create a standards board, which would define a set of process standards—referred to as "harmonized standards"— for state regulation and oversight of firms and products in the market for fully insured health insurance. Any insurer operating in a state that does not adopt the harmonized standards would be able to pursue a cause of action in U.S. district court to require the state to implement the harmonized standards. CBO expects that the implementation of harmonized standards would reduce insurers' administrative costs by streamlining insurers' interactions with state insurance commissioners and making it simpler for insurers to comply with state insurance regulations.

Under the bill, premiums in the small-group market are expected to average about 2 percent to 3 percent lower than otherwise. That reduction represents the net effect of savings from the benefit mandate exemption, administrative cost savings, the costs of other benefits added by firms and changes in cost-sharing in response to savings in other areas. Premium changes among firms would vary widely depending on a number of factors, including the state the firm is located in, the average health status of the employees of the particular firm, and that firm's choice of a benefit package. CBO estimates that about three-quarters of policyholders in small firms would pay lower premiums than under current law, while the rest would pay higher premiums.

In estimating the effects of this bill, CBO used an analytical model designed to simulate how firms, their employees, and self-employed individuals would respond to the bill's various provisions. The model incorporates assumptions that characterize economic behavior in the individual, small-group, and large-group health insurance markets. Those assumptions include: the responsiveness of firms and their employees to changes in the price and comprehensiveness of health insurance; the variation in health insurance premiums likely to occur under S. 1955 compared with premium variation as it exists today; and savings arising from the exemption from state-mandated benefits in both the group and individual markets, and from changes in insurers' administrative expenses.

On net, CBO estimates that, by 2011, when the legislation is assumed to have its full impact, about 600,000 more people would have health insurance coverage than under current law. The majority of those newly insured would be employees of small firms and their dependents enrolling in employer-sponsored coverage. Some individuals would become newly insured by purchasing insurance in the non-group market. The net increase in the number of people with health insurance by 2011 reflects:

- New coverage for about 700,000 people who would be uninsured under current law; and

- Loss of coverage for about 100,000 people who would have private health insurance under current law.

In addition, CBO estimates that about 135,000 people who will be enrolled in Medicaid under current law would enroll in private health insurance if S. 1955 is enacted.

In general, the people who would be uninsured under current law and gain private health insurance would tend to have lower health costs than those who would lose private health insurance under S. 1955. In addition, some individuals might find it more difficult to find coverage for conditions or services that had previously been mandated under their state laws, though they would not necessarily lose insurance coverage altogether.

Effects on Federal Revenues

Because S. 1955 would alter regulations relating to health insurance and because health care benefits generally are excluded from taxable incomes, enacting S. 1955 would affect federal tax revenues by changing the share of employee compensation furnished as tax-excluded health benefits rather than as taxable wages and salaries.

S. 1955 would increase federal tax revenues because the share of employee compensation paid in the form of taxable wages and salaries would increase as employers and employees spent less on tax-excluded health benefits. Increases in such wages and salaries lead to increases in both federal income tax and payroll taxes for Social Security and Medicare.

The expected decrease in net spending on health benefits (by employers and employees) is the result of factors that move in different directions. The savings would come from a reduction in the average premium per covered individual resulting from the exemption from certain benefit requirements, reduced administrative costs, and a change in the composition of the insured toward healthier individuals, on average. At the same time, the reduction in the average premium would tend to increase the number of individuals covered by private

health insurance both in group and non-group markets, which would increase spending on health benefits.

CBO estimates that the net effect of those changes would be a small decrease in total spending on employer-sponsored health insurance. By reducing spending for employer-sponsored health insurance, S. 1955 would reduce the share of employees' compensation that is tax-advantaged (health insurance premiums) and would increase the share that is taxable (wages and salaries). By 2011, CBO estimates that S. 1955 would reduce annual spending on employer-sponsored health insurance by about $2 billion out of approximately $1 trillion in total spending on employer-sponsored health insurance. Some of the resulting increase in taxable income from wages and salaries would be offset by higher deductions for certain taxpayers. Affected taxpayers would include individuals that lose employer-sponsored insurance or experience a reduction in health benefits and who spend more than 7.5 percent of their adjusted gross income on health care and health insurance. (At the same time, some taxpayers would gain new health benefits and thus may have lower deductions.)

As a result, CBO estimates that enacting S. 1955 would increase federal revenues by $25 million in 2007, by $1 billion over the 2007-2011 period, and by $3.3 billion over the 2007-2016 period. About 35 percent of the 10-year revenue gain would be in Social Security payroll taxes, which are classified as off-budget revenues.

The size and direction of the predicted change in employer spending on health insurance are sensitive to assumptions about the purchase of health insurance by small firms and the effect of the new federal rules on the average premium per covered individual. For example, if more firms offer coverage for their employees under the new federal rules than CBO has estimated, federal revenues could decrease because aggregate spending by employers on health insurance could rise as otherwise-uninsured employees gain private coverage.

Effects on Medicaid Spending

Some people who acquire private health insurance coverage under S. 1955 would otherwise be covered by Medicaid. Likewise, some people who lose private health insurance coverage under the bill would enroll in Medicaid. On net, CBO estimates that enacting S. 1955 would reduce federal spending in the Medicaid program by $15 million in 2007, by $235 million over the 2007-2011 period, and by $790 million over the 2007-2016 period.

Medicaid savings for people who gain private coverage. Of the people gaining employer-sponsored insurance under S. 1955, CBO estimates that approximately 135,000 would otherwise be enrolled in Medicaid. Of that amount, about three-quarters would be children, many of whose parents would convert individual policies to family policies under

the bill. The balance would be Medicaid-eligible parents and certain other adults who otherwise would fall under one of Medicaid's eligibility categories. Assuming that those children and adults would be less costly than average—because people with high health care costs would be unlikely to switch from Medicaid to private health insurance that offers less generous covered benefits—and that some maintain Medicaid coverage as a wrap-around benefit to private coverage, enacting S. 1955 would decrease federal Medicaid spending by $1.2 billion over the 2007-2016 period as a result of this shift to private health insurance coverage.

Medicaid spending for people who lose private coverage. CBO estimates that about 17,000 people losing employer-sponsored coverage by 2011 would be eligible for and would enroll in Medicaid, and that about two-thirds of those individuals would be children. The balance of new Medicaid enrollees would be non-elderly adults who, CBO expects, are likely to have higher costs than do average Medicaid-eligible individuals. CBO estimates that federal spending for those new Medicaid enrollees would total about $260 million over the 2007-2016 period.

Medicaid spending for additional wrap-around coverage. By law, Medicaid may wrap around private coverage under certain conditions; just over 1 million Medicaid beneficiaries access that wrap-around coverage for at least some part of the year. In cases where health plans reduce benefits under the bill for plans that enroll those individuals, Medicaid would pick up many of the costs of that reduced coverage under wrap-around plans, particularly for children. CBO estimates that federal spending for those Medicaid wrap-around benefits would total about $130 million over the 2007-2016 period.

Spending Subject to Appropriation

The bill also would require additional spending for administrative and regulatory activities, subject to appropriation of the necessary amounts. CBO estimates that DOL would hire an additional 75 workers over the next three years to certify insurers as eligible for exemption from state regulations beginning in 2007. In addition, we expect that HHS would implement federal rules and establish and operate the Health Insurance Consensus Standards Board, which would develop recommendations for harmonizing the operations and procedures of state insurance commissioners. CBO estimates that implementing those provisions would cost $2 million in 2007, $30 million over the 2007-2011 period, and $73 million over the 2007-2016 period, assuming the appropriation of the necessary amounts.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Intergovernmental Mandates

S. 1955 would preempt a range of state laws governing insurance regulation and administration, and those preemptions would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act. The bill would establish national standards for regulating and administering insurance, and if states did not adopt those standards, the bill would preempt state laws that govern rating and pricing regulations, administration, and in some cases, licensing. Any state that attempts to enforce provisions of state laws that would be preempted by the bill would be subject to suit in federal court. The bill also would preempt state laws governing benefit requirements and state laws that would restrict the ability of an insurer to re-enter the insurance market in some cases. Generally, the preemptions in the bill would not impose duties on states that would result in additional spending except for the preemption of state administrative laws that are not in agreement with the "harmonized standards." Complying with those requirements might require states to revise procedures. Any spending, however, would be well below the threshold established in UMRA ($64 million in 2006, adjusted annually for inflation).

Licensing. Insurers that provide coverage to small business health plans would have to be licensed in all states in which they provide coverage, and as licensed insurers, they would be subject to state premium taxes. However, the bill would preempt state licensing requirements if the insurer applies for a license in a state, and the state takes no action on the application within 90 days. At the end of the 90-day period, the state's licensing laws would be preempted, and the applicant would be able to operate in the state, pending approval or denial of the application or a determination that the insurer is in material violation of insurance laws in the state (other than licensing requirements). This preemption might result in some loss of premium tax collections, but CBO expects such losses would be short-lived and probably insignificant.

Harmonized Standards. The bill would establish the Health Insurance Consensus Standards Board, which would be charged with developing standards for state laws governing form filing and rate filing, market conduct review, prompt payment of claims, and internal reviews. The bill would preempt any state laws that differ from those standards and that would have the effect of precluding an eligible insurer from offering coverage in the state. While practices of individual states vary, CBO expects the costs of complying with new national standards to be small. In some cases, the changes would involve administrative adjustments, including changes to computer programming, with a small possibility of hiring additional personnel to speed up reviews of market conduct reports. In other cases, such as internal and external reviews, most states already have uniform procedures in place.

Rating Rules, Benefits, and Market Re-entry. The bill would direct the Secretary of HHS to establish Model Small Group Rating Rules that are based on guidelines adopted by the National Association of Insurance Commissioners in 1993. These rating rules would specify how much variation among premiums is allowed within and among classes of business that purchase health insurance. If a state has rating rules that are more favorable to small-group insurers (generally allowing a wider variation among premiums), the insurer could opt to abide by the state rules. However, if a state has rating rules that are more limited, the small-group insurer could choose to abide by the MSGRRs, and the state law as it would apply to them would be preempted.

The bill also would direct the Secretary of HHS to establish benefit choice standards that would preempt all state requirements for covered benefits in health insurance as long as an insurer also offers an enhanced option. An enhanced option would have to provide at least the same covered benefits, services, and categories of providers as those included in a health insurance plan for state employees in one of the five most populous states. The bill would not establish any explicit cost-sharing requirements for such an enhanced option.

Insurers that have voluntarily stopped providing insurance to the small group market in any particular state would be free to resume providing coverage, regardless of any state law to the contrary.

While the preemptions of state laws governing rating rules, required benefits, and market re-entry would limit the application of state law, they would impose no duty on states that would result in additional spending.

Other Impacts on State and Local Governments

The effects of the bill on Medicaid would result in estimated savings to states totaling $180 million over the 2007-2011 period and $600 million over the 2007-2016 period.

Employee health plans for local governments (more so than larger, state governments) would realize some savings from the bill. Because the bill would eliminate benefit requirements for health plans that are offered to employees of local governments, costs of insurance for those plans would go down.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

This bill contains no private-sector mandates as defined in UMRA.

PREVIOUS CBO ESTIMATE

On April 8, 2005, CBO transmitted a cost estimate for H.R. 525, the Small Business Health Fairness Act of 2005, as ordered reported by the House Committee on Education and the Workforce on March 16, 2005. H.R. 525 would establish a regulatory framework and certification process for association health plans (AHPs). Although H.R. 525 and S. 1955 both aim to create vehicles for the purchase of health insurance through groups of related employers, the bills differ in numerous ways. For example, under S. 1955 insurers operating in the non-group, small-group, and large-group markets would be allowed to sell policies that do not comply with a state's benefit mandates (as long as they also offer an enhanced option), while H.R. 525 would allow only federally certified AHPs to offer a package of benefits that does not comply with state benefit mandates in states in which they operate. S. 1955 would allow insurers in the small-group market to follow the MSGRRs, while H.R. 525 would allow associations to vary premiums across small employers in a state to the extent allowed by that state's laws. H.R. 525 specifically would allow self-insured association health plans, while S. 1955 would not. The two bills also have numerous other differences.

The estimated effects of S. 1955 differ from CBO's previous estimate for H.R. 525 for three principal reasons: (1) the provisions of the bills are different (as noted above), (2) the estimate for the Senate bill covers the 2007-2016 period, while last year's estimate for H.R. 525 covered the 2006-2015 period, and (3) CBO has enhanced its modeling capability (as explained below).

Since the transmission of the cost estimate for H.R. 525, CBO has enhanced its ability to model the health insurance market to allow for a more-refined analysis of the flow of individuals between various types of health coverage and to incorporate more recent research findings on the decisions of employers to offer health benefits and the decisions of individuals to take up coverage. That new analysis led to the conclusion that the net increase in the amount of tax-sheltered premiums paid as a result of more people receiving tax-favored coverage (primarily through employers) than under current law would be less than the net reduction in tax-sheltered premiums paid on behalf of those who would have been insured under current law. Hence, total tax-sheltered premiums would fall and competition for workers would lead to a net increase in workers' taxable wages and salaries (and, thus, the increase in federal revenues estimated here).

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