CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

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American Health Care Act

Budget Reconciliation Recommendations of the House Committees on Ways and Means and Energy and Commerce, March 9, 2017

SUMMARY

The Concurrent Resolution on the Budget for Fiscal Year 2017 directed the House Committees on Ways and Means and Energy and Commerce to develop legislation to reduce the deficit. The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have produced an estimate of the budgetary effects of the American Health Care Act, which combines the pieces of legislation approved by the two committees pursuant to that resolution. In consultation with the budget committees, CBO used its March 2016 baseline with adjustments for subsequently enacted legislation, which underlies the resolution, as the benchmark to measure the cost of the legislation.

Effects on the Federal Budget

CBO and JCT estimate that enacting the legislation would reduce federal deficits by $337 billion over the 2017-2026 period. That total consists of $323 billion in on-budget savings and $13 billion in off-budget savings. Outlays would be reduced by $1.2 trillion over the period, and revenues would be reduced by $0.9 trillion.

The largest savings would come from reductions in outlays for Medicaid and from the elimination of the Affordable Care Act's (ACA's) subsidies for nongroup health insurance. The largest costs would come from repealing many of the changes the ACA made to the Internal Revenue Code—including an increase in the Hospital Insurance payroll tax rate for high-income taxpayers, a surtax on those taxpayers' net investment income, and annual fees imposed on health insurers—and from the establishment of a new tax credit for health insurance.

Pay-as-you-go procedures apply because enacting the legislation would affect direct spending and revenues. CBO and JCT estimate that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2027.

Effects on Health Insurance Coverage

To estimate the budgetary effects, CBO and JCT projected how the legislation would change the number of people who obtain federally subsidized health insurance through Medicaid, the nongroup market, and the employment-based market, as well as many other factors.

CBO and JCT estimate that, in 2018, 14 million more people would be uninsured under the legislation than under current law. Most of that increase would stem from repealing the penalties associated with the individual mandate. Some of those people would choose not to have insurance because they chose to be covered by insurance under current law only to avoid paying the penalties, and some people would forgo insurance in response to higher premiums.

Later, following additional changes to subsidies for insurance purchased in the nongroup market and to the Medicaid program, the increase in the number of uninsured people relative to the number under current law would rise to 21 million in 2020 and then to 24 million in 2026. The reductions in insurance coverage between 2018 and 2026 would stem in large part from changes in Medicaid enrollment—because some states would discontinue their expansion of eligibility, some states that would have expanded eligibility in the future would choose not to do so, and per-enrollee spending in the program would be capped. In 2026, an estimated 52 million people would be uninsured, compared with 28 million who would lack insurance that year under current law.

Stability of the Health Insurance Market

Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on having insurers participating in most areas of the country and on the likelihood of premiums' not rising in an unsustainable spiral. The market for insurance purchased individually (that is, nongroup coverage) would be unstable, for example, if the people who wanted to buy coverage at any offered price would have average health care expenditures so high that offering the insurance would be unprofitable. In CBO and JCT's assessment, however, the nongroup market would probably be stable in most areas under either current law or the legislation.

Under current law, most subsidized enrollees purchasing health insurance coverage in the nongroup market are largely insulated from increases in premiums because their out-of-pocket payments for premiums are based on a percentage of their income; the government pays the difference. The subsidies to purchase coverage combined with the penalties paid by uninsured people stemming from the individual mandate are anticipated to cause sufficient demand for insurance by people with low health care expenditures for the market to be stable.

Under the legislation, in the agencies' view, key factors bringing about market stability include subsidies to purchase insurance, which would maintain sufficient demand for insurance by people with low health care expenditures, and grants to states from the Patient and State Stability Fund, which would reduce the costs to insurers of people with high health care expenditures. Even though the new tax credits would be structured differently from the current subsidies and would generally be less generous for those receiving subsidies under current law, the other changes would, in the agencies' view, lower average premiums enough to attract a sufficient number of relatively healthy people to stabilize the market.

Effects on Premiums

The legislation would tend to increase average premiums in the nongroup market prior to 2020 and lower average premiums thereafter, relative to projections under current law. In 2018 and 2019, according to CBO and JCT's estimates, average premiums for single policyholders in the nongroup market would be 15 percent to 20 percent higher than under current law, mainly because the individual mandate penalties would be eliminated, inducing fewer comparatively healthy people to sign up.

Starting in 2020, the increase in average premiums from repealing the individual mandate penalties would be more than offset by the combination of several factors that would decrease those premiums: grants to states from the Patient and State Stability Fund (which CBO and JCT expect to largely be used by states to limit the costs to insurers of enrollees with very high claims); the elimination of the requirement for insurers to offer plans covering certain percentages of the cost of covered benefits; and a younger mix of enrollees. By 2026, average premiums for single policyholders in the nongroup market under the legislation would be roughly 10 percent lower than under current law, CBO and JCT estimate.

Although average premiums would increase prior to 2020 and decrease starting in 2020, CBO and JCT estimate that changes in premiums relative to those under current law would differ significantly for people of different ages because of a change in age-rating rules. Under the legislation, insurers would be allowed to generally charge five times more for older enrollees than younger ones rather than three times more as under current law, substantially reducing premiums for young adults and substantially raising premiums for older people.

Uncertainty Surrounding the Estimates

The ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by the legislation are all difficult to predict, so the estimates in this report are uncertain. But CBO and JCT

have endeavored to develop estimates that are in the middle of the distribution of potential outcomes.

Macroeconomic Effects

Because of the magnitude of its budgetary effects, this legislation is “major legislation,” as defined in the rules of the House of Representatives.[1] Hence, it triggers the requirement that the cost estimate, to the greatest extent practicable, include the budgetary impact of its macroeconomic effects. However, because of the very short time available to prepare this cost estimate, quantifying and incorporating those macroeconomic effects have not been practicable.

Intergovernmental and Private-Sector Mandates

JCT and CBO have reviewed the provisions of the legislation and determined that they would impose no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA).

JCT and CBO have determined that the legislation would impose private-sector mandates as defined in UMRA. On the basis of information from JCT, CBO estimates the aggregate cost of the mandates would exceed the annual threshold established in UMRA for private-sector mandates ($156 million in 2017, adjusted annually for inflation).

MAJOR PROVISIONS OF THE LEGISLATION

Budgetary effects related to health insurance coverage would stem primarily from the following provisions:

- Eliminating penalties associated with the requirements that most people obtain health insurance coverage and that large employers offer their employees coverage that meets specified standards.

- Reducing the federal matching rate for adults made eligible for Medicaid by the ACA to equal the rate for other enrollees in the state, beginning in 2020.

- Capping the growth in per-enrollee payments for most Medicaid beneficiaries to no more than the medical care component of the consumer price index starting in 2020.

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1. Cl. 8 of Rule XIII of the Rules of the House of Representatives, H.R. Res. 5, 115th Congress (2017).

- Repealing current-law subsidies for health insurance coverage obtained through the nongroup market—which include refundable tax credits for premium assistance and subsidies to reduce cost-sharing payments—as well as the Basic Health Program, beginning in 2020.

- Creating a new refundable tax credit for health insurance coverage purchased through the nongroup market beginning in 2020.

- Appropriating funding for grants to states through the Patient and State Stability Fund beginning in 2018.

- Relaxing the current-law requirement that prevents insurers from charging older people premiums that are more than three times larger than the premiums charged to younger people in the nongroup and small-group markets. Unless a state sets a different limit, the legislation would allow insurers to charge older people five times more than younger ones, beginning in 2018.

- Removing the requirement, beginning in 2020, that insurers who offer plans in the nongroup and small-group markets generally must offer plans that cover at least 60 percent of the cost of covered benefits.

- Requiring insurers to apply a 30 percent surcharge on premiums for people who enroll in insurance in the nongroup or small-group markets if they have been uninsured for more than 63 days within the past year.

Other parts of the legislation would repeal or delay many of the changes the ACA made to the Internal Revenue Code that were not directly related to the law's insurance coverage provisions. Those with the largest budgetary effects include:

- Repealing the surtax on certain high-income taxpayers' net investment income;

- Repealing the increase in the Hospital Insurance payroll tax rate for certain high-income taxpayers;

- Repealing the annual fee on health insurance providers; and

- Delaying when the excise tax imposed on some health insurance plans with high premiums would go into effect.

In addition, the legislation would make several changes to other health-related programs that would have smaller budgetary effects.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

CBO and JCT estimate that, on net, enacting the legislation would decrease federal deficits by $337 billion over the 2017-2026 period (see Table 1). That change would result from a $1.2 trillion decrease in direct spending, partially offset by an $883 billion reduction in revenues.

BASIS OF ESTIMATE

For this estimate, CBO and JCT assume that the legislation will be enacted by May 2017. Costs and savings are measured relative to CBO's March 2016 baseline projections, with adjustments for legislation that was enacted after that baseline was produced.

The largest budgetary effects would stem from provisions in the recommendations from both committees that would affect insurance coverage. Those provisions, taken together, would reduce projected deficits by $935 billion over the 2017-2026 period. Other provisions would increase deficits by $599 billion, mostly by reducing tax revenues. All told, deficits would be reduced by $337 billion over that period, CBO and JCT estimate. (See Table 2 for the estimated budgetary effects of each major provision.)

Budgetary Effects of Health Insurance Coverage Provisions

The $935 billion in estimated deficit reduction over the 2017-2026 period that would stem from the insurance coverage provisions includes the following amounts (shown in Table 3):

- A reduction of $880 billion in federal outlays for Medicaid;

- Savings of $673 billion, mostly stemming from the elimination of the ACA's subsidies for nongroup health insurance—which include refundable tax credits for premium assistance and subsidies to reduce cost-sharing payments—in 2020;

- Savings of $70 billion mostly associated with shifts in the mix of taxable and nontaxable compensation resulting from net decreases in the number of people estimated to enroll in employment-based health insurance coverage; and

- Savings of $6 billion from the repeal of a tax credit for certain small employers that provide health insurance to their employees.

Those decreases would be partially offset by:

- A cost of $361 billion for the new tax credit for health insurance established by the legislation in 2020;

- A reduction in revenues of $210 billion from eliminating the penalties paid by uninsured people and employers;

- An increase in spending of $80 billion for the new Patient and State Stability Fund grant program; and

- A net increase in spending of $43 billion under the Medicare program stemming from changes in payments to hospitals that serve a disproportionate share of low-income patients.

Methodology. The legislation would change the pricing of nongroup insurance and the eligibility for and the amount of subsidies to purchase that insurance. It would also lead to changes in Medicaid eligibility and per capita spending. The legislation's effects on health insurance coverage would depend in part on how responsive individuals are to changes in the prices, after subsidies, they would have to pay for nongroup insurance; on changes in their eligibility for public coverage; and on their underlying desire for such insurance. Effects on coverage would also stem from how responsive firms are to changes in those post subsidy prices and in the attractiveness of other aspects of nongroup alternatives to employment-based insurance.

To capture those complex interactions, CBO uses a microsimulation model to estimate how rates of coverage and sources of insurance would change as a result of alterations in eligibility and subsidies for—and thus the net cost of—various insurance options. Based on survey data, that model incorporates a wide range of information about a representative sample of individuals and families, including their income, employment, health status, and health insurance coverage. The model also incorporates information from the research literature about the responsiveness of individuals and employers to price changes and the responsiveness of individuals to changes in eligibility for public coverage. CBO regularly updates the model so that it incorporates information from the most recent administrative data on insurance coverage and premiums. CBO and JCT use that model—in combination with models of tax revenues, models of Medicaid spending and actions by states, projections of trends in early retirees' health insurance coverage, and other available information—to inform their estimates of the numbers of people with certain types of coverage and the associated federal budgetary costs.[2]

2. For additional information, see Congressional Budget Office, "Methods for Analyzing Health Insurance Coverage" (accessed March 13, 2017), www.cbo.gov/topics/health-care/methods-analyzing-health-insurance-coverage.

Effects of Repealing Mandate Penalties. Eliminating the penalties associated with two requirements, while keeping the requirements themselves in place, would affect insurance coverage in various ways. Those two requirements are that most people obtain health insurance coverage (also called the individual mandate) and that large employers offer their employees health insurance coverage that meets specified standards (also called the employer mandate). Eliminating their associated penalties would reduce federal revenues starting in 2017, but CBO and JCT estimate that doing so would also substantially reduce the number of people with health insurance coverage and, accordingly, would reduce the costs incurred by the federal government in subsidizing some health insurance coverage. The estimated savings stemming from fewer people enrolling in Medicaid, in health insurance obtained through the nongroup market, and in employment-based health insurance coverage would exceed the estimated loss of revenues from eliminating mandate penalties.

CBO and JCT estimate that repealing the individual mandate penalties would also result in higher health insurance premiums in the nongroup market after 2017.[3] Insurers would still be required to provide coverage to any applicant, would not be able to vary premiums to reflect enrollees' health status or to limit coverage of preexisting medical conditions, and would be limited in how premiums could vary by age. Those features are most attractive to applicants with relatively high expected costs for health care, so CBO and JCT expect that repealing the individual mandate penalties would tend to reduce insurance coverage less among older and less healthy people than among younger and healthier people. Thus, the agencies estimate that repealing those penalties, taken by itself, would increase premiums. Nevertheless, CBO and JCT anticipate that a significant number of relatively healthy people would still purchase insurance in the nongroup market because of the availability of government subsidies.

Major Changes to Medicaid. CBO estimates that several major provisions affecting Medicaid would decrease direct spending by $880 billion over the 2017-2026 period. That reduction would stem primarily from lower enrollment throughout the period, culminating in 14 million fewer Medicaid enrollees by 2026, a reduction of about 17 percent relative to the number under current law. Some of that decline would be among people who are currently eligible for Medicaid benefits, and some would be among people who CBO projects would be made eligible as a result of state actions in the future under current law (that is, from additional states adopting the optional expansion of eligibility authorized by the ACA). Some decline in spending and enrollment would begin immediately, but most of the changes would begin in 2020, when the legislation would terminate the enhanced federal matching rate for new enrollees under the ACA's expansion of Medicaid and would place a per capita-based cap on the federal government's payments to states for medical

3. CBO and JCT expect that insurers would not be able to change their 2017 premiums because those premiums have already been set.

assistance provided through Medicaid. By 2026, Medicaid spending would be about 25 percent less than what CBO projects under current law.

Changes Before 2020. Under current law, the penalties associated with the individual mandate apply to some Medicaid-eligible adults and children. (For example, the penalties apply to single individuals with income above about 90 percent of the federal poverty guidelines, also known as the federal poverty level, or FPL). CBO estimates that, without those penalties, fewer people would enroll in Medicaid, including some who are not subject to the penalties but might think they are. Some people might be uncertain about what circumstances trigger the penalty and others might be uncertain about their annual income. The estimated lower enrollment would result in less spending for the program. Those effects on enrollment and spending would continue throughout the 2017-2026 period.

Termination of Enhanced Federal Matching Funds for New Enrollees From Expanding Eligibility for Medicaid. Under current law, states are permitted, but not required, to expand eligibility for Medicaid to adults under 65 whose income is equal to or less than 138 percent of the FPL (referred to here as “newly eligible”). The federal government pays a larger share of the medical costs for those people than it pays for those who were previously eligible. Beginning in 2020, the legislation would reduce the federal matching rate for newly eligible adults from 90 percent of medical costs to the rate for other enrollees in the state. (The federal matching rate for other enrollees ranges from 50 percent to 75 percent, depending on the state, with an average of about 57 percent.) The lower federal matching rate would apply only to those newly enrolled after December 31, 2019.

The 31 states and the District of Columbia that have already expanded Medicaid to the newly eligible cover roughly half of that population nationwide. CBO projects that under current law, additional states will expand their Medicaid programs and that, by 2026, roughly 80 percent of newly eligible people will reside in states that have done so. Under the legislation, largely because states would pay for a greater share of enrollees’ costs, CBO expects that no additional states would expand eligibility, thereby reducing both enrollment in and spending for Medicaid. According to CBO’s estimates, that effect would be modest in the near term, but by 2026, on an average annual basis, 5 million fewer people would be enrolled in Medicaid than would have been enrolled under current law (see Figure 1).

CBO also anticipates some states that have already expanded their Medicaid programs would no longer offer that coverage, reducing the share of the newly eligible population residing in a state with expanded eligibility to about 30 percent in 2026. That estimate reflects different possible outcomes without any explicit prediction about which states would make which choices. In considering the possible outcomes, CBO took into account several factors: the extent of optional coverage provided to the newly eligible population and other groups before the ACA’s enactment (as a measure of a state’s willingness to

provide coverage above statutory minimums), states' ability to bear costs under the legislation, and potential methods to mitigate those costs (such as changes to benefit packages and payment rates). Some states might also begin to take action prior to 2020 in anticipation of future changes that would result from the legislation to avoid abrupt changes to eligibility and other program features. How individual states would ultimately respond is highly uncertain.

Because the lower federal matching rate would apply only to those newly enrolled after December 31, 2019 (or who experience a break in eligibility after that date), CBO estimates that reductions in spending for the newly eligible would increase over several years, as "grandfathered" enrollees would cycle off the program and be replaced by new enrollees. On the basis of historical data (and taking into account the increased frequency of eligibility redeterminations required by the legislation), CBO projects that fewer than one-third of those enrolled as of December 31, 2019, would have maintained continuous eligibility two years later. Under the legislation, the higher federal matching rate would apply for fewer than 5 percent of newly eligible enrollees by the end of 2024, CBO estimates.

Per Capita-Based Cap on Medicaid Payments for Medical Assistance. Under current law, the federal government and state governments share in the financing and administration of Medicaid. In general, states pay health care providers for services to enrollees, and the federal government reimburses states for a percentage of their expenditures. All federal reimbursement for medical services is open-ended, meaning that if a state spends more because enrollment increases or costs per enrollee rise, additional federal payments are automatically generated.

Under the legislation, beginning in 2020, the federal government would establish a limit on the amount of reimbursement it provides to states. That limit would be set by calculating the average per-enrollee cost of medical services for most enrollees who received full Medicaid benefits in 2016 for each state. The Secretary of Health and Human Services would then inflate the average per-enrollee costs for each state by the growth in the consumer price index for medical care services (CPI-M). The final limit on federal reimbursement for each state for 2020 and after would be the average cost per enrollee for five specified groups of enrollees (the elderly, disabled people, children, newly eligible adults, and all other adults), reflecting growth in the CPI-M from 2016 multiplied by the number of enrollees in each category in that year. If a state spent more than the limit on federal reimbursement, the federal government would provide no additional funding to match that spending.

The limit on federal reimbursement would reduce outlays because (after the changes to the Medicaid expansion population have been accounted for) Medicaid spending would grow on a per-enrollee basis at a faster rate than the CPI-M, according to CBO's projections: at an average annual rate of 4.4 percent for Medicaid and 3.7 percent for the CPI-M over the

2017-2026 period. With less federal reimbursement for Medicaid, states would need to decide whether to commit more of their own resources to finance the program at current-law levels or whether to reduce spending by cutting payments to health care providers and health plans, eliminating optional services, restricting eligibility for enrollment, or (to the extent feasible) arriving at more efficient methods for delivering services. CBO anticipates that states would adopt a mix of those approaches, which would result in additional savings to the federal government. (Other provisions affecting Medicaid are discussed below.)

Changes to Subsidies and Market Rules for Nongroup Health Insurance Before 2020. Under the legislation, existing subsidies for health insurance coverage purchased in the nongroup market would largely remain in effect until 2020—but the premium tax credits would differ by the age of the individual in 2019. Aside from the changes in enrollment and premiums as a result of eliminating the individual mandate penalties (mentioned earlier), the other changes discussed in this section would have small effects on coverage and federal subsidies in the nongroup market.

Nongroup Market Subsidies. Subsidies under current law fall into two categories: subsidies to cover a portion of participants' health insurance premiums (which take the form of refundable tax credits) and subsidies to reduce their cost-sharing amounts (out-of-pocket payments required under insurance policies). The first category of subsidies, also called premium tax credits, is generally available to people with income between 100 percent and 400 percent of the FPL, with certain exceptions. The second category, also called cost-sharing subsidies, is available to those who are eligible for premium tax credits, generally have a household income between 100 percent and 250 percent of the FPL, and enroll in an eligible plan.

Under current law, those subsidies can be obtained only by purchasing nongroup coverage through a health insurance marketplace. Under the legislation, premium tax credits—but not cost-sharing subsidies—would also be available for most plans purchased in the nongroup market outside of marketplaces beginning in 2018. However, the tax credits for those plans could not be advanced and could only be claimed on a person's tax return. CBO and JCT estimate that roughly 2 million people who are expected to enroll in plans purchased in the nongroup market outside of marketplaces in 2018 and 2019 under current law would newly receive premium tax credits for that coverage under the legislation.

The premium tax credits would differ by the age of the individual for one year in 2019, while cost-sharing subsidies would remain unchanged prior to 2020. For those with household income exceeding 150 percent of the FPL, the legislation would generally reduce the percentage of income that younger people had to pay toward their premiums and increase that percentage for older people.[4] CBO and JCT expect that roughly 1 million

4. For families, the age of the oldest taxpayer would be used to determine the age-adjusted percentage of income that must be paid toward the premiums. As under current law, the premium tax credits would cover the amount by

more people would enroll in coverage obtained through the nongroup market as a result of the change in the structure of premium tax credits. That increase would be the net result of higher enrollment among younger people and lower enrollment among older people.

Patient and State Stability Fund Grants. Beginning in 2018 and ending after 2026, the federal government would make a total of $100 billion in allotments to states that they could use for a variety of purposes, including reducing premiums for insurance in the nongroup market. CBO and JCT estimate that federal outlays for grants from the Patient and State Stability Fund would total $80 billion over the 2018-2026 period.

By the agencies' estimates, the grants would reduce premiums for insurance in the nongroup market in many states. CBO and JCT expect that states would use those grants mostly to reimburse insurers for some of the costs of enrollees with claims above a threshold. For states that did not develop plans to spend the funds, the federal government would make payments to insurers in the individual market who have enrollees with relatively high claims. Before 2020, CBO expects, the Secretary of Health and Human Services would make payments to insurers on the behalf of most states because most would not have enough time to set up their own programs before insurers had to set premiums for 2018. As a result, CBO estimates that most states would rely on the federal default program for one or more years until they had more time to establish their own programs.

Continuous Coverage Provisions. Insurers would be required to impose a penalty on people who enrolled in insurance in the nongroup or small-group markets if they had been uninsured for more than 63 days within the past year. When they purchased insurance in the nongroup or small-group market, they would be subject to a surcharge equal to 30 percent of their monthly premium for up to 12 months. The requirement would apply to people enrolling during a special enrollment period in 2018 and, beginning in 2019, to people enrolling at any time during the year.

CBO and JCT expect that increasing the future price of insurance through the surcharge for people who do not have continuous coverage would increase the number of people with insurance in 2018 and reduce that number in 2019 and later years. By the agencies' estimates, roughly 1 million people would be induced to purchase insurance in 2018 to avoid possibly having to pay the surcharge in the future. In most years after 2018, however, roughly 2 million fewer people would purchase insurance because they would either have to pay the surcharge or provide documentation about previous health insurance coverage. The people deterred from purchasing coverage would tend to be healthier than those who would not be deterred and would be willing to pay the surcharge.

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which the reference premium—that is, the premium for the second-lowest-cost "silver" plan that covers the eligible people in the household in the area in which they reside—exceeds that percentage of income. A silver plan covers about 70 percent of the costs of covered benefits.

Age Rating Rules. Beginning in 2018, the legislation would expand the limits on how much insurers in the nongroup and small-group markets can vary premiums on the basis of age. However, CBO and JCT expect that the provision could not be implemented until 2019 because there would be insufficient time for the federal government, states, and insurers to incorporate the changes and then set premiums for 2018. Under current law, a 64-year-old can generally be charged premiums that cost up to three times as much as those offered to a 21-year-old. Under the legislation, that allowable difference would shift to five times as much unless a state chose otherwise. That change would tend to reduce premiums for younger people and increase premiums for older people.

However, CBO and JCT estimate that the structure of the premium tax credits before 2020 would limit how changes in age rating rules affected the number of people who would enroll in health insurance coverage in the nongroup market. People eligible for subsidies in the nongroup market are now largely insulated from changes in premiums: A person receiving a premium tax credit pays a certain percentage of his or her income toward the reference premium, and the tax credit covers the difference between the premium and that percentage of income. Consequently, despite the changes in premiums for younger and older people, the person's out-of-pocket payments would not be affected much. Therefore, CBO and JCT estimate that the increase in the number of people enrolled in coverage through the nongroup market as a result of changes in age rating rules would be less than 500,000 in 2019 and would be the net result of higher enrollment among younger people and lower enrollment among older people. The small increase would mostly stem from net changes in enrollment among people who had income high enough to be ineligible for subsidies and who would face substantial changes in out-of-pocket payments for premiums.

Changes to Subsidies and Market Rules for Nongroup Health Insurance Beginning in 2020. Beginning in 2020, the current premium tax credits and cost-sharing subsidies would both be repealed. That same year, the legislation would create new refundable tax credits for insurance purchased in the nongroup market. In addition to making the market changes discussed thus far (eliminating mandate penalties, providing grants to states to help stabilize the nongroup market, establishing a requirement for continuous coverage, and changing the age rating rules), the legislation would relax the current requirements about the share of benefits that must be covered by a health insurance plan.

Many rules governing the nongroup market would remain in effect as under current law. For example, insurers would be required to accept all applicants during specified open-enrollment periods, could not vary people's premiums on the basis of their health, and could not restrict coverage of enrollees' preexisting health conditions. Insurers would also still be required to cover specified categories of health care services, and the amount of costs for covered services that enrollees have to pay out of pocket would remain limited to a specified threshold. Prohibitions on annual and lifetime maximum benefits would still apply. Also, the risk adjustment program—which transfers funds from plans that attract a

relatively small proportion of high-risk enrollees (people with serious chronic conditions, for example) to plans that attract a relatively large proportion of such people—would remain in place.

Because the new tax credits are designed primarily to be paid in advance on behalf of enrollees to insurers, procedures would need to be in place to enable the Internal Revenue Service and the Department of Health and Human Services to verify that the credits were being paid to eligible insurers who were offering qualified insurance as defined under federal and state law on behalf of eligible enrollees. CBO and JCT's estimates reflect an assumption that adequate resources would be made available through future appropriations to those executive branch agencies to ensure that such systems were put in place in a timely manner. To the extent that they were not, enrollment and compliance could be negatively affected.

Changes to Actuarial Value Requirements. Actuarial value is the percentage of total costs for covered benefits that the plan pays when covering a standard population. Under current law, most plans in the nongroup and small-group markets must have an actuarial value that is in one of four tiers: about 60 percent, 70 percent, 80 percent, or 90 percent. Beginning in 2020, the legislation would repeal those requirements, potentially allowing plans to have an actuarial value below 60 percent. However, plans would still be required to cover 10 categories of health benefits that are defined as "essential" under current law, and the total annual out-of-pocket costs for an enrollee would remain capped. In CBO and JCT's estimation, complying with those two requirements would significantly limit the ability of insurers to design plans with an actuarial value much below 60 percent.

Nevertheless, CBO and JCT estimate that repealing the actuarial value requirements would lower the actuarial value of plans in the nongroup market on average. The requirement that insurers offer both a plan with an actuarial value of 70 percent and one with an actuarial value of 80 percent in order to participate in the marketplace would no longer apply under the legislation. As a result, an insurer could choose to sell only plans with lower actuarial values. Many insurers would find that option attractive because they could offer a plan priced closer to the amount of the premium tax credit so that a younger person would have low out-of-pocket costs for premiums and would be more likely to enroll. Insurers might be less likely to offer plans with high actuarial values out of a fear of attracting a greater proportion of less healthy enrollees to those plans, although the availability of the Patient and State Stability Fund grants in most states would reduce that risk. The continuation of the risk adjustment program could also help limit insurers' costs from high-risk enrollees.

Because of plans' lower average actuarial values, CBO and JCT expect that individuals' cost-sharing payments, including deductibles, in the nongroup market would tend to be higher than those anticipated under current law. In addition, cost-sharing subsidies would be repealed in 2020, significantly increasing out-of-pocket costs for nongroup insurance for many lower-income enrollees. The higher costs would make the plans less attractive

than those available under current law to many potential enrollees, especially people who are eligible for the largest subsidies under current law.

Changes in the Ways the Nongroup Market Would Function. Under the legislation, some of the ways that the nongroup market functions would change for consumers. The current actuarial value requirements help people compare different insurance plans, because all plans in a tier cover the same share of costs, on average. CBO and JCT expect that, under the legislation, plans would be harder to compare, making shopping for a plan on the basis of price more difficult.

Another feature of the nongroup market under current law is that there is one central website through the state or federal marketplace where people can shop for all the plans in their area that are eligible for subsidies. Under the legislation, insurers participating in the nongroup market would no longer have to offer plans through the marketplaces in order for people to receive subsidies toward those plans; therefore, CBO and JCT estimate that fewer would do so. With more plans that are eligible for subsidies offered directly from insurers or directly through agents and brokers and not through the marketplaces' central websites, shopping for and comparing plans could be harder, depending on insurers' decisions about how to market their plans.

Changes in Nongroup Market Subsidies. With the repeal in 2020 of the current premium tax credits and the cost-sharing subsidies, different refundable tax credits for insurance purchased in the nongroup market would become available.[5] The new tax credits would vary on the basis of age by a factor of 2 to 1: Someone age 60 or older would be eligible for a tax credit of $4,000, while someone younger than age 30 would be eligible for a tax credit of $2,000. People would generally be eligible for the full amount of the tax credit if their adjusted gross income was below $75,000 for a single tax filer and below $150,000 for joint filers and if they were not eligible for certain other types of insurance coverage.[6] The credits would phase out for people with income above those thresholds. The tax credits would be refundable if the size of the credit exceeded a person's tax liability. They could also be advanced to insurers on a monthly basis throughout the year on behalf of an enrollee. Finally, tax credits could be used for most health insurance plans purchased through a marketplace or directly from an insurer.

Under current law, the size of the premium tax credit depends on household income and the reference premium in an enrollee's rating area. The enrollee pays a certain percentage of his or her income toward the reference premium, and the size of the subsidy varies by

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5. People would also be able to use the new tax credits toward unsubsidized of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

6. The tax credits and the income thresholds would both be indexed each year by the consumer price index for all urban consumers plus 1 percentage point.

geography and age for a given income level. In that way, the enrollee is insulated from variations in premiums by geography and is also largely insulated from increases in the reference premium. An enrollee would pay the difference between the reference premium and the premium for the plan he or she chose, providing some incentive to choose lower-priced insurance. Beginning in 2020, under the legislation, the size of a premium tax credit would vary with age, rather than with income (except for people with income in the phase-out range) or the amount of the premium. The enrollee would be responsible for any premium above the credit amount. That structure would provide greater incentives for enrollees to choose lower-priced insurance and would mean that people living in high-cost areas would be responsible for a larger share of the premium.

Under the legislation, some people would be eligible for smaller subsidies than those under current law, and others would be eligible for larger ones. As a result, by CBO and JCT's estimates, the composition of the population purchasing health insurance in the nongroup market under the legislation would differ significantly from that under current law, particularly by income and age.

For many lower-income people, the new tax credits under the legislation would tend to be smaller than the premium tax credits under current law.[7] In an illustrative example, CBO and JCT estimate that a 21-year-old with income at 175 percent of the FPL in 2026 would be eligible for a premium tax credit of about $3,400 under current law; the tax credit would fall to about $2,450 under the legislation (see Table 4). In addition, because cost-sharing subsidies would be eliminated under the legislation, lower-income people's share of medical services paid in the form of deductibles and other cost sharing would increase. As a result, CBO and JCT estimate, fewer lower-income people would obtain coverage through the nongroup market under the legislation than under current law.

Conversely, the tax credits under the legislation would tend to be larger than current-law premium tax credits for many people with higher income—particularly for those with income above 400 percent of the FPL but below the income cap for a full credit, which is set by the legislation at $75,000 for a single tax filer and $150,000 for joint filers in 2020. For example, CBO and JCT estimate that a 21-year-old with income at 450 percent of the FPL in 2026 would be ineligible for a credit under current law but newly eligible for a tax credit of about $2,450 under the legislation. Lower out-of-pocket payments toward premiums would tend to increase enrollment in the nongroup market among higher-income people.

Enacting the legislation would also result in significant changes in the size of subsidies in the nongroup market according to people's age. For example, CBO and JCT estimate that a

7. People with income below 100 percent of the FPL who are ineligible for Medicaid and meet other eligibility criteria would become newly eligible for a premium tax credit under the legislation.

21-year-old, 40-year-old, and 64-year-old with income at 175 percent of the FPL in 2026 would all pay roughly $1,700 toward their reference premium under current law, even though the reference premium for a 64-year-old is three times larger than that for a 21-year-old in most states. Under the legislation, premiums for older people could be five times larger than those for younger people in many states, but the size of the tax credits for older people would only be twice the size of the credits for younger people. Because of that difference in how much the tax credits would cover, CBO and JCT estimate that, under the legislation, a larger share of enrollees in the nongroup market would be younger people and a smaller share would be older people.

According to CBO and JCT's estimates, total federal subsidies for nongroup health insurance would be significantly smaller under the legislation than under current law for two reasons. First, by the agencies' projections, fewer people, on net, would obtain coverage in the nongroup health insurance market under the legislation. Second, the average subsidy per subsidized enrollee under the legislation would be significantly lower than the average subsidy under current law. In 2020, CBO and JCT estimate, the average subsidy under the legislation would be about 60 percent of the average subsidy under current law. In addition, the average subsidy would grow more slowly under the legislation than under current law. That difference results from the fact that subsidies under current law tend to grow with insurance premiums, whereas subsidies under the legislation would grow more slowly, with the consumer price index for all urban consumers plus 1 percentage point. By 2026, CBO and JCT estimate that the average subsidy under the legislation would be about 50 percent of the average subsidy under current law.

Patient and State Stability Fund Grants. As a condition of the grants, beginning in 2020, states would be required to provide matching funds, which would generally increase from 7 percent of the federal funds provided in 2020 to 50 percent of the federal funds provided in 2026. The agencies expect that the grants' effects on premiums after 2020 would be limited by the share of states that took action and decided to pay the required matching funds in order to receive federal money and by the extent to which states chose to use the money for purposes that did not directly help to lower premiums in the nongroup market. Nevertheless, CBO and JCT estimate that the grants would exert substantial downward pressure on premiums in the nongroup market in 2020 and later years and would help encourage participation in the market by insurers.

Effects of Changes in the Nongroup Market on Employers' Decisions to Offer Coverage. CBO and JCT estimate that, over time, fewer employers would offer health insurance because the legislation would change their incentives to do so. First, the mandate penalties would be eliminated. Second, the tax credits under the legislation, for which people would be ineligible if they had any offer of employment-based insurance, would be available to people with a broader range of incomes than the current tax credits are. That change could make nongroup coverage more attractive to a larger share of employees. Consequently, in CBO and JCT's estimation, some employers would choose not to offer coverage and

instead increase other forms of compensation in the belief that nongroup insurance was a close substitute for employment-based coverage for their employees.

However, two factors would partially offset employers' incentives not to offer insurance. First, the average subsidy for those who are eligible would be smaller under the legislation than under current law and would grow more slowly than health care costs over time. Second, CBO and JCT anticipate, nongroup insurance under the legislation would be less attractive to many people with employment-based coverage than under current law because nongroup insurance under the legislation would cover a smaller share of enrollees' expenses, on average, and because shopping for and comparing plans would probably be more difficult. In general, CBO and JCT expect that businesses that decided not to offer insurance coverage under the legislation would have, on average, younger and higher-income workforces than businesses that choose not to offer insurance under current law.

CBO and JCT expect that employers would adapt slowly to the legislation. Some employers would probably delay making decisions because of uncertainty about the viability of and regulations for the nongroup market and about implementation of the new law.

Market Stability. CBO and JCT anticipate that, under the legislation, the combination of subsidies to purchase nongroup insurance and rules regulating the market would result in a relatively stable nongroup market. That is, most areas of the country would have insurers participating in the nongroup market, and the market would not be subject to an unsustainable spiral of rising premiums. First and most important, a substantial number of relatively healthy (mostly young) people would continue to purchase insurance in the nongroup market because of the availability of government subsidies. Second, grants from the Patient and State Stability Fund would help stabilize premiums and reduce potential losses to insurers from enrollees with very large claims. Finally, in CBO and JCT's judgment, the risk adjustment program would help protect insurers from losses arising from high-risk enrollees. The agencies expect that all of those factors would encourage insurers to continue to participate in the nongroup market.

However, significant changes in nongroup subsidies and market rules would occur each year for the first three years following enactment, which might cause uncertainty for insurers in setting premiums. As a result of the elimination of the individual mandate penalties, CBO and JCT project that nongroup enrollment in 2018 would be smaller than that in 2017 and that the average health status of enrollees would worsen. A small share of that decline in enrollment would be offset by the onetime effect of the continuous coverage provisions, which would somewhat increase enrollment in the nongroup market in 2018 as people anticipated potential surcharges in 2019. Grants from the Patient and State Stability Fund would begin to take effect in 2018 to help mitigate losses and encourage participation by insurers.

The mix of enrollees in 2019 would differ from that in 2018, because the change to age-rating rules would allow older adults to be charged five times as much as younger adults in many states. In addition, there would be a one-year change to the premium tax credits, which CBO and JCT expect would somewhat increase enrollment among younger adults and decrease enrollment among older adults. Although the combined effect of those two changes would reduce the average age and improve the average health of enrollees in the nongroup market, it might be difficult for insurers to set premiums for 2019 using their prior experience in the market.

In 2020, CBO estimates, grants to states from the Patient and State Stability Fund, once fully implemented, would significantly reduce premiums in the nongroup market and encourage participation by insurers. The grants would help to reduce the risk to insurers of offering nongroup insurance. As a result, CBO expects that those grants would contribute substantially to the stability of the nongroup market.

That effect would occur despite the fact that more major changes taking effect in that year would make it difficult for insurers to predict the mix of enrollees on the basis of their recent experience. The new age-based tax credits would be introduced in 2020 and actuarial value requirements would be eliminated. In response, insurers would have the flexibility to sell different types of plans than they do under current law. The nongroup market is expected to be smaller in 2020 than in 2019 but then is expected to grow somewhat over the 2020-2026 period.

Other Budgetary Effects of Health Insurance Coverage Provisions. Because the insurance coverage provisions of the legislation would increase the number of uninsured people and decrease the number of people with Medicaid coverage relative to the numbers under current law, CBO estimates that Medicare spending would increase by $43 billion over the 2018-2026 period.

Medicare makes additional “disproportionate share hospital” payments to facilities that serve a higher percentage of uninsured patients. Those payments have two components: an increase to the payment rate for each inpatient case and a lump-sum allocation of a pool of funds based on each qualifying hospital’s share of the days of care provided to beneficiaries of Supplemental Security Income and Medicaid.

Under the legislation, the decreased enrollment in Medicaid would slightly reduce the amounts paid to hospitals, CBO estimates. However, the increase in the number of uninsured people would substantially boost the amounts distributed on a lump-sum basis.

Net Effects on Health Insurance Coverage

CBO and JCT expect that under the legislation, the number of people without health insurance coverage would increase but that the increase would be limited initially, because

insurers have already set their premiums for the current year and many people have already made their enrollment decisions for the year. However, in 2017, the elimination of the individual mandate penalties would result in about 4 million additional people becoming uninsured (see Table 5).

In 2018, by CBO and JCT's estimates, about 14 million more people would be uninsured, relative to the number under current law. That increase would consist of about 6 million fewer people with coverage obtained in the nongroup market, roughly 5 million fewer people with coverage under Medicaid, and about 2 million fewer people with employment-based coverage. In 2019, the number of uninsured would grow to 16 million people because of further reductions in Medicaid and nongroup coverage. Most of the reductions in coverage in 2018 and 2019 would stem from repealing the penalties associated with the individual mandate. Some of those people would choose not to have insurance because they choose to be covered by insurance under current law only to avoid paying the penalties. And some people would forgo insurance in response to higher premiums. CBO and JCT estimate that, in total, 41 million people under age 65 would be uninsured in 2018 and 43 million people under age 65 would be uninsured in 2019.

In 2020, according to CBO and JCT's estimates, as a result of the insurance coverage provisions of the legislation, 21 million more nonelderly people in the United States would be without health insurance than under current law. By 2026, that number would total 24 million, CBO and JCT estimate. Specifically:

- Roughly 9 million fewer people would enroll in Medicaid in 2020; that figure would rise to 14 million in 2026, as states that expanded eligibility for Medicaid discontinued doing so, as states projected to expand Medicaid in the future chose not to do so, and as the cap on per-enrollee spending took effect.

- Roughly 9 million fewer people, on net, would obtain coverage through the nongroup market in 2020; that number would fall to 2 million in 2026. The reduction in enrollment in the nongroup market would shrink over the 2020-2026 period because people would gain experience with the new structure of the tax credits and some employers would respond to those tax credits by declining to offer insurance to their employees.

- Roughly 2 million fewer people, on net, would enroll in employment-based coverage in 2020, and that number would grow to roughly 7 million in 2026. Part of that net reduction in employment-based coverage would occur because fewer employees would take up the offer of such coverage in the absence of the individual mandate penalties. In addition, CBO and JCT expect that, over time, fewer employers would offer health insurance to their workers.

CBO and JCT estimate that 48 million people under age 65, or roughly 17 percent of the nonelderly population, would be uninsured in 2020 if the legislation was enacted. That figure would grow to 52 million, or roughly 19 percent of the nonelderly population, in 2026. (That figure is currently about 10 percent and is projected to remain at that level in each year through 2026 under current law.) Although the agencies expect that the legislation would increase the number of uninsured broadly, the increase would be disproportionately larger among older people with lower income; in particular, people between 50 and 64 years old with income of less than 200 percent of the FPL would make up a larger share of the uninsured (see Figure 2).

Net Effects on Health Insurance Premiums

The legislation would tend to increase average premiums in the nongroup market prior to 2020 and lower average premiums thereafter, relative to the outcomes under current law. (This discussion is focused on premiums before any applicable tax credits and before any surcharges for not maintaining continuous coverage.)

In 2018 and 2019, according to CBO and JCT's estimates, average premiums for single policyholders in the nongroup market would be 15 percent to 20 percent higher than under current law mainly because of the elimination of the individual mandate penalties. Eliminating those penalties would markedly reduce enrollment in the nongroup market and increase the share of enrollees who would be less healthy. CBO and JCT expect that grants from the Patient and State Stability Fund would largely be used for reinsurance programs, particularly in 2018 and 2019, when many states would rely on the federal default before establishing their own programs and, as explained earlier, that those payments would help lower premiums in the nongroup market. The agencies estimate that program would have a relatively small effect on premiums in 2018 because there would not be much time between enactment of the legislation and insurers' deadlines for setting premiums for 2018. By 2019, however, in CBO and JCT's judgment, the Patient and State Stability Fund would have the effect of somewhat moderating the increases in average premiums in the nongroup market resulting from the legislation.

Starting in 2020, the increase in average premiums from repealing the individual mandate penalties would be more than offset by the combination of three main factors. First, the mix of people enrolled in coverage obtained in the nongroup market is anticipated to be younger, on average, than the mix under current law. Second, premiums, on average, are estimated to fall because of the elimination of actuarial value requirements, which would result in plans that cover a lower share of health care costs, on average. Third, reinsurance programs supported by the Patient and State Stability Fund are estimated to reduce premiums. If those funds were devoted to other purposes, then premium reductions would be smaller. By 2026, average premiums for single policyholders in the nongroup market under the legislation would be roughly 10 percent lower than the estimates under current law.

The changes in premiums would vary for people of different ages. The change in age-rating rules, effective in 2019, would directly change the premiums faced by different age groups, substantially reducing premiums for young adults and raising premiums for older people. By 2026, CBO and JCT project, premiums in the nongroup market would be 20 percent to 25 percent lower for a 21-year-old and 8 percent to 10 percent lower for a 40-year-old—but 20 percent to 25 percent higher for a 64-year-old.

Revenue Effects of Other Provisions

JCT estimates that the legislation would reduce revenues by $592 billion over the 2017-2026 period as a result of provisions that would repeal many of the revenue-related provisions of the ACA (apart from provisions related to health insurance coverage discussed above). Those with the most significant budgetary effects include an increase in the Hospital Insurance payroll tax rate for high-income taxpayers, a surtax on those taxpayers' net investment income, and annual fees imposed on health insurers.[8]

Direct Spending Effects of Other Provisions

The legislation would also make changes to spending for other federal health care programs. CBO and JCT estimate that those provisions would increase direct spending by about $7 billion over the 2017-2026 period.

Prevention and Public Health Fund. The legislation would, beginning in fiscal year 2019, repeal the provision that established the Prevention and Public Health Fund and rescind all unobligated balances. The Department of Health and Human Services awards grants through the fund to public and private entities to carry out prevention, wellness, and public health activities. Funding under current law is projected to be $1 billion in 2017 and to rise to $2 billion in 2025 and each year thereafter. CBO estimates that eliminating that funding would reduce direct spending by $9 billion over the 2017-2026 period.

Community Health Center Program. The legislation would increase the funds available to the Community Health Center Program, which provides grant funds to health centers that offer primary and preventive care to patients regardless of their ability to pay. Under current law, the program will receive about $4 billion in fiscal year 2017. The legislation would increase funding for the program by $422 million in fiscal year 2017. CBO estimates that implementing the provision would increase direct spending by $422 million over the 2017-2026 period.

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8. JCT published 10 documents (JCX-7-17 through JCX-16-17) on March 7, 2017, relating to the legislation. For more information, see www.jct.gov/publications.html.

Provision Affecting Planned Parenthood. For a one-year period following enactment, the legislation would prevent federal funds from being made available to an entity (including its affiliates, subsidiaries, successors, and clinics) if it is:

- A nonprofit organization described in section 501(c)(3) of the Internal Revenue Code and exempt from tax under section 501(a) of the code;

- An essential community provider that is primarily engaged in providing family planning and reproductive health services and related medical care;

- An entity that provides abortions—except in instances in which the pregnancy is the result of an act of rape or incest or the woman's life is in danger; and

- An entity that had expenditures under the Medicaid program that exceeded $350 million in fiscal year 2014.

CBO expects that, according to those criteria, only Planned Parenthood Federation of America and its affiliates and clinics would be affected. Most federal funds received by such entities come from payments for services provided to enrollees in states' Medicaid programs. CBO estimates that the prohibition would reduce direct spending by $178 million in 2017 and by $234 million over the 2017-2026 period. Those savings would be partially offset by increased spending for other Medicaid services, as discussed below.

To the extent that there would be reductions in access to care under the legislation, they would affect services that help women avert pregnancies. The people most likely to experience reduced access to care would probably reside in areas without other health care clinics or medical practitioners who serve low-income populations. CBO projects that about 15 percent of those people would lose access to care.

The government would incur some costs for Medicaid beneficiaries currently served by affected entities because the costs of about 45 percent of all births are paid for by the Medicaid program. CBO estimates that the additional births stemming from the reduced access under the legislation would add to federal spending for Medicaid. In addition, some of those children would themselves qualify for Medicaid and possibly for other federal programs. By CBO's estimates, in the one-year period in which federal funds for Planned Parenthood would be prohibited under the legislation, the number of births in the Medicaid program would increase by several thousand, increasing direct spending for Medicaid by $21 million in 2017 and by $77 million over the 2017-2026 period. Overall, with those costs netted against the savings estimated above, implementing the provision would reduce direct spending by $156 million over the 2017-2026 period, CBO estimates.

Repeal of Medicaid Provisions. Under current law, states can elect the Community First Choice option, allowing them to receive a 6 percentage-point increase in their federal

matching rate for some services provided by home and community-based attendants to certain Medicaid recipients. The legislation would terminate the increase in the federal matching funds beginning in calendar year 2020, which would decrease direct spending by about $12 billion over the next 10 years.

Repeal of Reductions to Allotments for Disproportionate Share Hospitals. Under current law, Medicaid allotments to states for payments to hospitals that treat a disproportionate share of uninsured and Medicaid patients are to be cut significantly in each year from 2018 to 2025. The cuts are currently scheduled to be $2 billion in 2018 and to increase each year until they reach $8 billion in 2024 and 2025. The legislation would eliminate those cuts for states that have not expanded Medicaid under the ACA starting in 2018 and for the remaining states starting in 2020, boosting outlays by $31 billion over the next 10 years.

Safety Net Funding for States That Did Not Expand Medicaid. The legislation would provide $2 billion in funding in each year from 2018 to 2021 to states that did not expand Medicaid eligibility under the ACA. Those states could use the funding, within limits, to supplement payments to providers that treat Medicaid enrollees. Such payments to providers would not be subject to the per capita caps also established by the proposed legislation. Any states that chose to expand Medicaid coverage as of July 1 of each year from 2017 through 2020 would lose access to the funding available under this provision in the following year and thereafter. CBO estimates that this provision would increase direct spending by $8 billion over the 2017-2026 period.

Reductions to States' Medicaid Costs. The legislation would make a number of additional changes to the Medicaid program, including these:

- Requiring states to treat lottery winnings and certain other income as income for purposes of determining eligibility;

- Decreasing the period when Medicaid benefits may be covered retroactively from up to three months before a recipient's application to the first of the month in which a recipient makes an application;

- Eliminating federal payments to states for Medicaid services provided to applicants who did not provide satisfactory evidence of citizenship or nationality during a reasonable opportunity period; and

- Eliminating states' option to increase the amount of allowable home equity from $500,000 to $750,000 for individuals applying for Medicaid coverage of long-term services and supports.

Together, CBO estimates, those changes would decrease direct spending by about $7 billion over the 2017-2026 period.

Changes in Spending Subject to Appropriation

CBO has not completed an estimate of the potential impact of the legislation on discretionary spending, which would be subject to future appropriation action.

UNCERTAINTY SURROUNDING THE ESTIMATES

CBO and JCT considered the potential responses of many parties that would be affected by the legislation, including these:

- Federal agencies—which would need to implement major changes in the regulation of the health care system and administration of new subsidy structures and eligibility verification systems in a short time frame;

- States—which would need to decide how to use Patient and State Stability Fund grants, whether to pass new laws affecting the nongroup market, how to respond to the reduction in the federal matching rate for certain Medicaid enrollees, how to respond to constraints from the cap on Medicaid payments, and how to provide information to the federal government about insurers and enrollees;

- Insurers—who would need to decide about the extent of their participation in the insurance market and what types of plans to sell in the face of different market rules and federal subsidies;

- Employers—who would need to decide whether to offer insurance given the different federal subsidies and insurance products available to their employees;

- Individuals—who would make decisions about health insurance in the context of different premiums, subsidies, and penalties than those under current law; and

- Doctors and hospitals—who would need to negotiate contracts with insurers in a new regulatory environment.

Each of those responses is difficult to predict. Moreover, the responses would depend upon how the provisions in the legislation were implemented, such as whether advance payments of the new tax credits were made reliably. And flaws in the determination of eligibility, for instance, could keep subsidies from people who were eligible or provide them to people who were not.

In addition, CBO and JCT's projections under current law itself are inexact, which could also affect the estimated effects. For example, enrollment in the marketplaces under current law could be lower than is projected, which would tend to decrease the budgetary savings of the legislation. Alternatively, the average subsidy per enrollee under current law could be higher than is projected, which would tend to increase the budgetary savings of the legislation.

CBO and JCT have endeavored to develop estimates that are in the middle of the distribution of potential outcomes. One way to assess the range of uncertainty around the estimated effects of the legislation is to compare previous projections with actual results. For example, some aspects of CBO and JCT's projections of health insurance coverage and related spending made in July 2012 (after the Supreme Court issued a decision that essentially made the expansion of the Medicaid program under the ACA an option for states) can be compared with actual results for 2016. Projected spending on people made eligible for Medicaid because of the ACA was about 60 percent of the actual amount. The number of people predicted in 2012 to purchase insurance through the marketplaces in 2016 was more than twice the actual number. The decline in the number of insured people from 2012 to 2016 was projected to be 23 million, and the decline measured in the National Health Interview Survey turned out to be 20 million. CBO and JCT have continued to learn from experience with the ACA and have endeavored to use that experience to improve their modeling.

That comparison of projections with actual results and the great uncertainties surrounding the actions of the many parties that would be affected by the legislation suggest that outcomes of the legislation could differ substantially from some of the estimates provided here. Nevertheless, CBO and JCT are confident about the direction of certain effects of the legislation. For example, spending on Medicaid would almost surely be lower than under current law. The cost of the new tax credit would probably be lower than the cost of the subsidies for coverage through marketplaces under current law. And the number of uninsured people under the legislation would almost surely be greater than under current law.

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2027.

MANDATES ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

JCT and CBO reviewed the provisions of the legislation and determined that they would impose no intergovernmental mandates as defined in the Unfunded Mandates Reform Act. For large entitlement programs like Medicaid, UMRA defines an increase in the stringency of conditions or a cap on federal funding as an intergovernmental mandate if the affected governments lack authority to offset those costs while continuing to provide required services. As discussed earlier in this estimate, the legislation would eliminate the enhanced federal matching rate for some future enrollees, establish new per capita caps in the Medicaid program, and make other changes that would affect Medicaid spending—some of which would provide additional assistance to states.

On net, CBO estimates that states would see an overall decrease in federal assistance, as reflected in estimates of federal savings in the Medicaid program. In response to the caps and other changes, CBO anticipates that states could use existing flexibility allowed in the Medicaid program and additional authorities provided by the legislation to cut payments to health care providers and health plans, eliminate optional services, restrict eligibility for enrollment, or (to the extent feasible) change the way services are delivered to save costs. Because flexibility in the program would allow states to make such changes and still provide statutorily required services, the per capita caps and other changes in Medicaid would not impose intergovernmental mandates as defined in UMRA.

MANDATES ON THE PRIVATE SECTOR

JCT and CBO have determined that the legislation would impose private-sector mandates as defined in UMRA. On the basis of information from JCT, CBO estimates that the aggregate direct cost of the mandates imposed by the legislation would exceed the annual threshold established in UMRA for private-sector mandates ($156 million in 2017, adjusted annually for inflation).

The tax provisions of the legislation contain two mandates. Specifically, the legislation would recapture excess advance payments of premium tax credits (so that the full amount of excess advance payments is treated as an additional tax liability for the individual) and repeal the small business (health insurance) tax credit.

The nontax provisions of the legislation would impose a private-sector mandate as defined in UMRA on insurers that offer health insurance coverage in the individual or small-group market. The legislation would require those insurers to charge a penalty equal to 30 percent of the monthly premium for a period of 12 months to individuals who enroll in insurance in a given year after having allowed their health insurance to lapse for more than 63 days during the previous year. CBO estimates that the costs of complying with the mandate would be largely offset by the penalties insurers would collect.

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Table 1 - SUMMARY OF THE DIRECT SPENDING AND REVENUE EFFECTS OF THE AHCA, THE BUDGET RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEES ON WAYS AND MEANS AND ENERGY AND COMMERCE, MARCH 9, 2017

(Billions of Dollars, by Fiscal Year)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
CHANGES IN DIRECT SPENDING[a]												
Coverage Provisions												
Estimated Budget Authority	-6.6	-12.5	-22.9	-97.6	-139.1	-157.4	-173.8	-186.9	-199.4	-210.5	-278.6	-1,206.7
Estimated Outlays	-6.6	-27.5	-25.6	-92.5	-138.6	-158.5	-175.2	-188.5	-201.3	-212.0	-290.7	-1,226.2
Non Coverage Provisions												
Estimated Budget Authority	0.3	-0.5	-0.7	0.6	1.7	-0.2	1.0	1.1	0.7	0.0	1.3	3.8
Estimated Outlays	-0.1	0.3	-0.1	0.8	1.8	0.5	0.8	1.5	1.3	0.3	2.7	7.1
Total Changes in Direct Spending												
Estimated Budget Authority	-6.3	-13.0	-23.6	-97.1	-137.4	-157.6	-172.8	-185.8	-198.7	-210.5	-277.4	-1,202.8
Estimated Outlays	-6.7	-27.2	-25.7	-91.7	-136.9	-158.0	-174.3	-187.0	-200.0	-211.7	-288.1	-1,219.1
CHANGES IN REVENUES[b]												
Coverage Provisions	-3.8	-13.7	-16.8	-25.5	-33.6	-36.4	-38.9	-40.4	-41.0	-40.7	-93.5	-290.9
Non Coverage Provisions	-2.1	-37.5	-41.8	-57.6	-65.1	-70.2	-76.0	-83.1	-79.7	-78.7	-204.2	-591.9
Total Changes in Revenues	-5.9	-51.2	-58.6	-83.1	-98.7	-106.6	-114.9	-123.5	-120.6	-119.4	-297.6	-882.8
INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING OR REVENUES												
Net Increase or Decrease (-) in the Deficit	-0.8	24.0	33.0	-8.6	-38.2	-51.3	-59.4	-63.5	-79.4	-92.4	9.4	-336.5

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

Notes: The costs of this legislation fall within budget function 550 (health), 570 (Medicare), 600 (Income Security), and 650 (Social Security). AHCA = American Health Care Act; numbers may not add up to totals because of rounding.

a. For outlays, a positive number indicates an increase (adding to the deficit) and a negative number indicates a decrease (reducing the deficit).

b. For revenues, a negative number indicates a decrease (adding to the deficit).

Table 2 - ESTIMATE OF THE DIRECT SPENDING AND REVENUE EFFECTS OF THE AHCA, THE BUDGET RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEES ON WAYS AND MEANS AND ENERGY AND COMMERCE, MARCH 9, 2017

(Billions of Dollars, by Fiscal Year)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
CHANGES IN DIRECT SPENDING[a]												
Coverage Provisions												
Estimated Budget Authority	-6.6	-12.5	-22.9	-97.6	-139.1	-157.4	-173.8	-186.9	-199.4	-210.5	-278.6	-1,206.7
Estimated Outlays	-6.6	-27.5	-25.6	-92.5	-138.6	-158.5	-175.2	-188.5	-201.3	-212.0	-290.7	-1,226.2
On-Budget	*-6.6*	*-27.5*	*-25.6*	*-92.5*	*-138.6*	*-158.2*	*-174.7*	*-187.9*	*-200.7*	*-211.4*	*-290.7*	*-1,223.6*
Off-Budget	*0*	*	*	*	*-0.1*	*-0.2*	*-0.4*	*-0.6*	*-0.6*	*-0.6*	*	*-2.5*
Prevention and Public Health Fund												
Estimated Budget Authority	0	-0.9	-0.9	-1.0	-1.0	-1.5	-1.0	-1.7	-2.0	-2.0	-3.8	-12.0
Estimated Outlays	0	-0.1	-0.4	-0.7	-0.9	-1.0	-1.1	-1.3	-1.4	-1.7	-2.2	-8.8
Community Health Center Program												
Estimated Budget Authority	0.4	0.0	0	0	0	0	0	0	0	0	0.4	0.4
Estimated Outlays	0.1	0.3	0.1	0	0	0	0	0	0	0	0.4	0.4
Provision Affecting Planned Parenthood												
Estimated Budget Authority	-0.2	*	*	*	*	*	*	*	*	*	-0.2	-0.2
Estimated Outlays	-0.2	*	*	*	*	*	*	*	*	*	-0.2	-0.2
Repeal of Medicaid Provisions[b]												
Estimated Budget Authority	0	0	0	-0.8	-1.3	-1.6	-1.9	-2.0	-2.1	-2.2	-2.1	-11.7
Estimated Outlays	0	0	0	-0.8	-1.3	-1.6	-1.9	-2.0	-2.1	-2.2	-2.1	-11.7
Repeal of Medicaid Expansion												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Repeal of Reductions to Allotments for DSH												
Estimated Budget Authority	0	0.6	1.0	1.9	2.8	3.7	4.7	5.7	5.7	5.1	6.3	31.2
Estimated Outlays	0	0.6	1.0	1.9	2.8	3.7	4.7	5.7	5.7	5.1	6.3	31.2
Reductions to States' Medicaid Costs[b]												
Estimated Budget Authority	0	-0.3	-0.6	-0.8	-0.8	-0.8	-0.9	-0.9	-0.9	-1.0	-2.5	-7.1
Estimated Outlays	0	-0.3	-0.6	-0.8	-0.8	-0.8	-0.9	-0.9	-0.9	-1.0	-2.5	-7.1
Safety Net Funding for Non Expansion States												
Estimated Budget Authority	0	2.0	2.0	2.0	2.0	0.0	0.0	0.0	0.0	0.0	8.0	8.0
Estimated Outlays	0	1.8	2.0	2.0	2.0	0.2	0.0	0.0	0.0	0.0	7.8	8.0
Providing Incentives for Increased Frequency of Eligibility Redeterminations												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Per Capita Allotment for Medical Assistance												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											

Continued

Table 2 Continued.
(Billions of Dollars, by Fiscal Year)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
Repeal of Cost-Sharing Subsidy												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Patient and State Stability Fund												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Continuous Health Insurance Coverage Incentive												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Increasing Levels of Coverage Options												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Change in Permissible Age Variation												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Recapture Excess Advance Payments of Premium Tax Credits												
Estimated Budget Authority	0	-2.0	-2.2	-0.7	0	0	0	0	0	0	-4.9	-4.9
Estimated Outlays	0	-2.0	-2.2	-0.7	0	0	0	0	0	0	-4.9	-4.9
Additional Modifications to Premium Tax Credit												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Premium Tax Credit												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Small Business Tax Credit												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Individual Mandate												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Employer Mandate												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Total Changes in Direct Spending												
Estimated Budget Authority	-6.3	-13.0	-23.6	-97.1	-137.4	-157.6	-172.8	-185.8	-198.7	-210.5	-277.4	-1,202.8
Estimated Outlays	-6.7	-27.2	-25.7	-91.7	-136.9	-158.0	-174.3	-187.0	-200.0	-211.7	-288.1	-1,219.1
On-Budget	*-6.7*	*-27.2*	*-25.7*	*-91.7*	*-136.8*	*-157.7*	*-173.9*	*-186.4*	*-199.4*	*-211.1*	*-288.0*	*-1,216.6*
Off-Budget	*0*	*	*	*	*-0.1*	*-0.2*	*-0.4*	*-0.6*	*-0.6*	*-0.6*	*	*-2.5*

Continued

Table 2 Continued.

(Billions of Dollars, by Fiscal Year)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
CHANGES IN REVENUES[c]												
Coverage Provisions												
Estimated Revenues	-3.8	-13.7	-16.8	-25.5	-33.6	-36.4	-38.9	-40.4	-41.0	-40.7	-93.5	-290.9
On-Budget	*-4.5*	*-17.0*	*-19.9*	*-27.6*	*-35.5*	*-38.4*	*-41.7*	*-44.7*	*-46.7*	*-48.0*	*-104.5*	*-324.2*
Off-Budget	*0.7*	*3.3*	*3.1*	*2.0*	*1.9*	*2.0*	*2.8*	*4.3*	*5.8*	*7.3*	*11.1*	*33.3*
Recapture Excess Advance Payments of Premium Tax Credits	0	0.6	0.7	0.5	0	0	0	0	0	0	1.8	1.8
Additional Modifications to Premium Tax Credit	*included in estimate of coverage provisions*											
Premium Tax Credit	*included in estimate of coverage provisions*											
Small Business Tax Credit	*included in estimate of coverage provisions*											
Individual Mandate	*included in estimate of coverage provisions*											
Employer Mandate	*included in estimate of coverage provisions*											
Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits[d]	0	0	0	-3.4	-6.9	-8.7	-10.7	-13.6	-5.5	0	-10.3	-48.7
Repeal of Tax on Over-the-Counter Medications	0	-0.4	-0.5	-0.6	-0.6	-0.6	-0.6	-0.7	-0.7	-0.7	-2.1	-5.5
Repeal of Increase of Tax on Health Savings	0	*	*	*	*	*	*	*	*	*	*	-0.1
Repeal of Limitations on Contributions to Flexible Spending Accounts	0	-0.3	-1.2	-1.6	-1.7	-1.8	-2.2	-2.6	-3.3	-4.1	-4.7	-18.6
Repeal of Tax on Prescription Medications	0	-3.1	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-11.2	-24.8
Repeal of Medical Device Excise Tax	0	-1.4	-1.9	-2.0	-2.1	-2.2	-2.3	-2.4	-2.6	-2.7	-7.4	-19.6
Repeal of Health Insurance Tax	0	-12.8	-13.5	-14.3	-15.1	-15.9	-16.8	-17.8	-18.7	-19.7	-55.7	-144.7
Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy	0	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.6	-1.7
Repeal of Increase in Income Threshold for Determining Medical Care Deduction	-0.2	-2.0	-3.2	-3.4	-3.6	-3.9	-4.2	-4.5	-4.8	-5.1	-12.4	-34.9
Repeal of Medicare Tax Increase	-0.4	-6.5	-10.1	-11.4	-12.3	-13.2	-14.1	-15.2	-16.5	-17.6	-40.8	-117.3
Refundable Tax Credit for Health Insurance	*included in estimate of coverage provisions*											
Maximum Contribution Limit to Health Savings	0	-1.0	-1.6	-1.7	-1.9	-2.1	-2.3	-2.5	-2.7	-2.9	-6.2	-18.6
Allow Both Spouses to Make Catch-Up Contributions to the Same Health Savings Account	0	*	*	*	*	*	*	*	-0.1	-0.1	-0.1	-0.4
Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings	0	*	*	*	*	*	*	*	*	*	-0.1	-0.2
Repeal of Tanning Tax	0	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
Repeal of Net Investment Tax	-1.5	-10.5	-7.5	-16.7	-17.8	-18.7	-19.7	-20.7	-21.7	-22.7	-54.1	-157.6
Remuneration	0	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.4
Total Changes in Revenues	-5.9	-51.2	-58.6	-83.1	-98.7	-106.6	-114.9	-123.5	-120.6	-119.4	-297.6	-882.8
On-Budget	*-6.6*	*-53.8*	*-60.8*	*-83.3*	*-98.0*	*-105.5*	*-114.0*	*-123.2*	*-123.3*	*-124.7*	*-302.7*	*-893.5*
Off-Budget	*0.7*	*2.6*	*2.2*	*0.2*	*-0.7*	*-1.2*	*-1.0*	*-0.3*	*2.7*	*5.3*	*5.0*	*10.7*
INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING OR REVENUES												
Net Increase or Decrease (-) in the Deficit	-0.8	24.0	33.0	-8.6	-38.2	-51.3	-59.4	-63.5	-79.4	-92.4	9.4	-336.5
On-Budget	*	*26.6*	*35.1*	*-8.4*	*-38.8*	*-52.3*	*-59.9*	*-63.2*	*-76.0*	*-86.4*	*14.5*	*-323.3*
Off-Budget	*-0.7*	*-2.6*	*-2.2*	*-0.2*	*0.6*	*0.9*	*0.5*	*-0.3*	*-3.3*	*-5.9*	*-5.1*	*-13.2*

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

Notes: The costs of this legislation fall within budget function 550 (health), 570 (Medicare), 600 (Income Security), and 650 (Social Security). Numbers may not add up to totals because of rounding; DSH = Disproportionate Share Hospital; AHCA = American Health Care Act; * = an increase or decrease between zero and $50 million.

a. For outlays, a positive number indicates an increase (adding to the deficit) and a negative number indicates a decrease (reducing the deficit).

b. Estimate interacts with the provision related to the Per Capita Allotment for Medical Assistance.

c. For revenues, a positive number indicates an increase (reducing the deficit) and a negative number indicates a decrease (adding to the deficit).

d. This estimate does not include effects of interactions with other subsidies; those effects are included in estimates of other relevant provisions.

Table 3 - NET BUDGETARY EFFECTS OF THE INSURANCE COVERAGE PROVISIONS OF THE AHCA

(Billions of dollars, by fiscal year)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total, 2017-2026
Medicaid Outlays	-3	-18	-26	-68	-94	-111	-124	-135	-146	-155	-880
Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	-5	-11	-16	-62	-87	-91	-95	-99	-102	-106	-673
Small-Employer Tax Credits[b,c]	*	*	*	*	-1	-1	-1	-1	-1	-1	-6
Tax Credits for Nongroup Insurance[b,d]	0	0	0	30	44	47	52	58	63	68	361
Penalty Payments by Employers[c]	2	16	20	15	16	18	19	20	22	23	171
Penalty Payments by Uninsured People	3	3	3	3	4	4	4	4	4	5	38
Patient and State Stability Fund Grants	0	0	12	15	10	9	9	8	8	8	80
Medicare[e]	0	1	3	4	6	6	6	6	6	6	43
Other Effects on Revenues and Outlays[d,f]	-1	-5	-5	-4	-4	-4	-6	-10	-14	-18	-70
Total Effect on the Deficit	**-3**	**-14**	**-9**	**-67**	**-105**	**-122**	**-136**	**-148**	**-160**	**-171**	**-935**
Memorandum:											
Decreases in Mandatory Spending	-7	-27	-26	-93	-139	-158	-175	-188	-201	-212	-1,226
Decreases in Revenues	-4	-14	-17	-26	-34	-36	-39	-40	-41	-41	-291

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

Except in the memorandum lines, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

Numbers may not add up to totals because of rounding; AHCA = American Health Care Act; * = between -$500 million and zero.

a. Related spending and revenues include spending for the Basic Health Program and net spending and revenues for risk adjustment.

b. Includes effects on outlays and on revenues.

c. Effects on the deficit include the associated effects of changes in taxable compensation on revenues.

d. Includes costs for a new tax credit for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

e. Effects arise mostly from changes in Disproportionate Share Hospital payments.

f. Consists mainly of the effects of changes in taxable compensation on revenues. CBO also estimates that outlays for Social Security benefits would decrease by about $3 billion over the 2017-2026 period.

Table 4 - ILLUSTRATIVE EXAMPLE OF SUBSIDIES FOR NONGROUP HEALTH INSURANCE UNDER CURRENT LAW AND THE AHCA, 2026

(Dollars)

	Premium[a]	Premium Tax Credit[b]	Net Premium Paid	Actuarial Value of Plan After Cost-Sharing Subsidies (Percent)[c]
Single Individual With Annual Income of $26,500 (175 percent of FPL)[d]				
Current Law				
21 years old	5,100	3,400	1,700	87
40 years old	6,500	4,800	1,700	
64 years old	15,300	13,600	1,700	
AHCA				
21 years old	3,900	2,450	1,450	65
40 years old	6,050	3,650	2,400	
64 years old	19,500	4,900	14,600	
Single Individual With Annual Income of $68,200 (450 percent of FPL)[d]				
Current Law				
21 years old	5,100	0	5,100	70
40 years old	6,500	0	6,500	
64 years old	15,300	0	15,300	
AHCA				
21 years old	3,900	2,450	1,450	65
40 years old	6,050	3,650	2,400	
64 years old	19,500	4,900	14,600	

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

All dollar figures have been rounded to the nearest $50; AHCA = American Health Care Act; FPL = federal poverty level.

a. For this illustration, CBO projected the average national premiums for a 21-year-old in the nongroup health insurance market in 2026 both under current law and under the AHCA. On the basis of those amounts, CBO calculated premiums for a 40-year-old and a 64-year-old, assuming that the person lives in a state that uses the federal default age-rating methodology, which limits variation of premiums to a ratio of 3 to 1 for adults under current law and 5 to 1 for adults under the AHCA. CBO projects that, under current law, most states will use the default 3-to-1 age-rating curve; under the AHCA, CBO projects, most would use an age-rating curve with a maximum ratio of 5 to 1.

b. Under current law, premium tax credits are calculated as the difference between the reference premium and a specified percentage of income for a person with income at a given percentage of the FPL. The reference premium is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which the person resides. A silver plan covers about 70 percent of the costs of covered benefits. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 for someone with income at 175 percent of the FPL takes into account the probability, estimated in CBO's March 2016 baseline, that additional indexing may apply. Under the AHCA, the premium tax credits offered for nongroup coverage would be indexed to the consumer price index for all urban consumers plus 1 percentage point. In 2026, CBO projects, those tax credits would be about 22 percent higher than the amounts specified in 2020.

c. The actuarial value of a plan is the percentage of costs for covered services that the plan pays. Cost-sharing subsidies are payments made by the federal government to insurers that reduce the cost-sharing amounts (out-of-pocket payments required under insurance policies) for covered people whose income is generally between 100 percent and 250 percent of the FPL. The cost-sharing subsidy amounts in this example would range from $1,100 for a 21-year-old with income at 175 percent of the FPL to $3,350 for a 64-year-old at the same income level. Under current law, cost-sharing subsidies have the effect of increasing the actuarial value of the plan from 70 percent for a typical silver plan to 94 percent for people whose income is between 100 percent and 149 percent of the FPL; 87 percent for people between 150 percent and 199 percent of the FPL; and 73 percent for people between 200 percent and 249 percent of the FPL. People whose income is 250 percent of the FPL or more would receive a standard 70 percent actuarial value when purchasing a silver plan. CBO projects that, under the AHCA, the elimination of required actuarial values and the structure of new tax credits would, by 2026, result in a reduction to about 65 percent in the average actuarial value of plans purchased in the nongroup market.

d. Income levels reflect modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers. CBO projects that in 2026, a modified adjusted gross income of $26,500 would equal 175 percent of the FPL and an income of $68,200 would equal 450 percent of the FPL.

Table 5 - EFFECTS OF THE AHCA ON HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER AGE 65

(Millions of people, by calendar year)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Population Under Age 65	273	274	275	276	276	277	278	279	279	280
Uninsured Under Current Law	26	26	27	27	27	27	27	28	28	28
Change in Coverage Under the AHCA										
Medicaid[a]	-1	-5	-6	-9	-12	-13	-13	-14	-14	-14
Nongroup coverage, including marketplaces[b]	-2	-6	-7	-9	-8	-8	-6	-5	-4	-2
Employment-based coverage	-1	-2	-2	-2	-2	-2	-3	-5	-5	-7
Other coverage[c]	*	*	*	-1	-1	-1	-1	-1	-1	-1
Uninsured	4	14	16	21	23	23	23	24	24	24
Uninsured Under the AHCA	31	41	43	48	50	50	51	51	51	52
Percentage of the Population Under Age 65 With Insurance Under the AHCA										
Including all U.S. residents	89	85	84	83	82	82	82	82	82	81
Excluding unauthorized immigrants	91	87	87	85	84	84	84	84	84	84

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

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect average enrollment over the course of a year among noninstitutionalized civilian residents of the 50 states and the District of Columbia who are under the age of 65, and they include spouses and dependents covered under family policies.

AHCA = American Health Care Act; * = a reduction that falls between zero and 500,000 people.

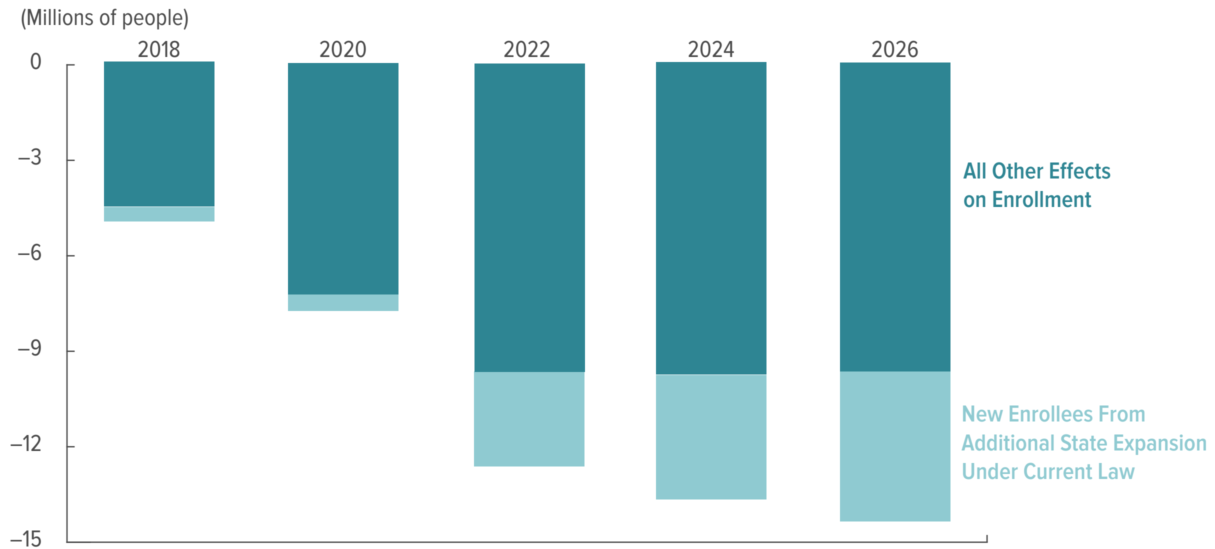
a. Includes noninstitutionalized enrollees with full Medicaid benefits.

b. Under current law, many people can purchase subsidized health insurance coverage through the marketplaces (sometimes called exchanges) operated by the federal government, by state governments, or as partnerships between federal and state governments. People also can purchase unsubsidized coverage in the nongroup market outside of those marketplaces. Under the AHCA, people could receive subsidies for coverage purchased either inside or outside of the marketplaces.

c. Includes coverage under the Basic Health Program, which allows states to establish a coverage program primarily for people whose income is between 138 percent and 200 percent of the federal poverty level. To subsidize that coverage, the federal government provides states with funding that is equal to 95 percent of the subsidies for which those people would otherwise have been eligible by purchasing health insurance through a marketplace. Payments for that program would be rescinded by the AHCA in 2020.

Figure 1.

Changes in Medicaid Enrollment Under the AHCA, Selected Years



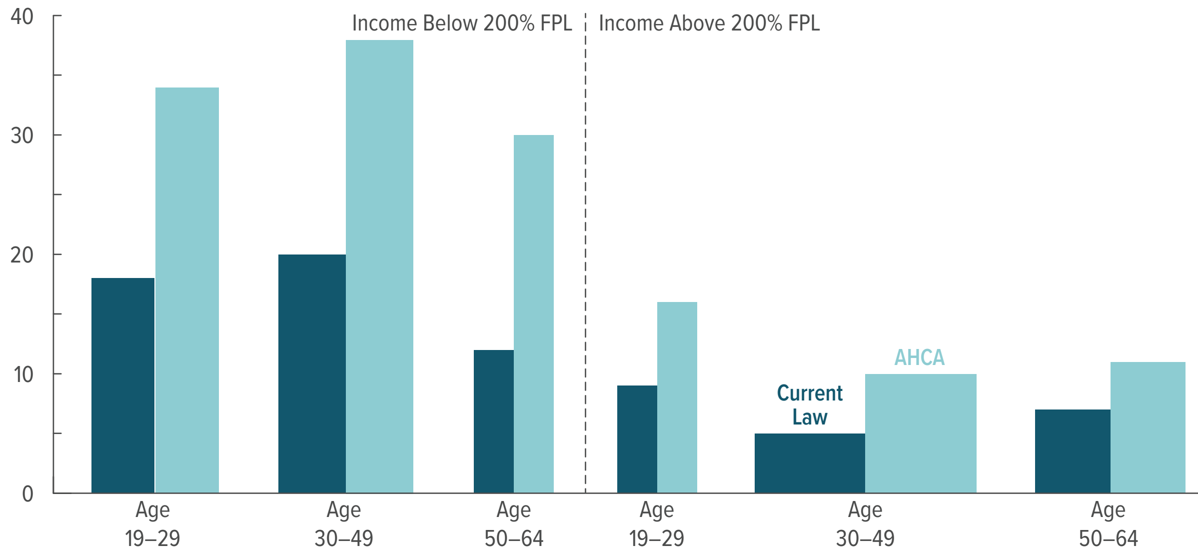
Source: Congressional Budget Office.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect average enrollment over the course of a year. Under CBO's current-law projections, additional states would expand Medicaid eligibility to people who are made newly eligible under the Affordable Care Act (adults under the age of 65 whose income is below 138 percent of the federal poverty level). Enrollment estimates associated with those future expansions are separated in the figure to highlight the change in Medicaid enrollment under the AHCA because CBO anticipates that states that would expand coverage in the future under current law would not do so under the AHCA.

AHCA = American Health Care Act.

Figure 2.

Share of Nonelderly Adults Without Health Insurance Coverage Under Current Law and Under the AHCA, by Age and Income Level, 2026



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

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect the average number of people without insurance coverage over the course of the year in the noninstitutionalized civilian population of the 50 states and the District of Columbia.

The width of each bar represents the relative share of the population in each age and income category. In CBO's projections, 200 percent of the FPL in 2026 would amount to $30,300 for a single person.

AHCA = American Health Care Act; FPL = federal poverty level.