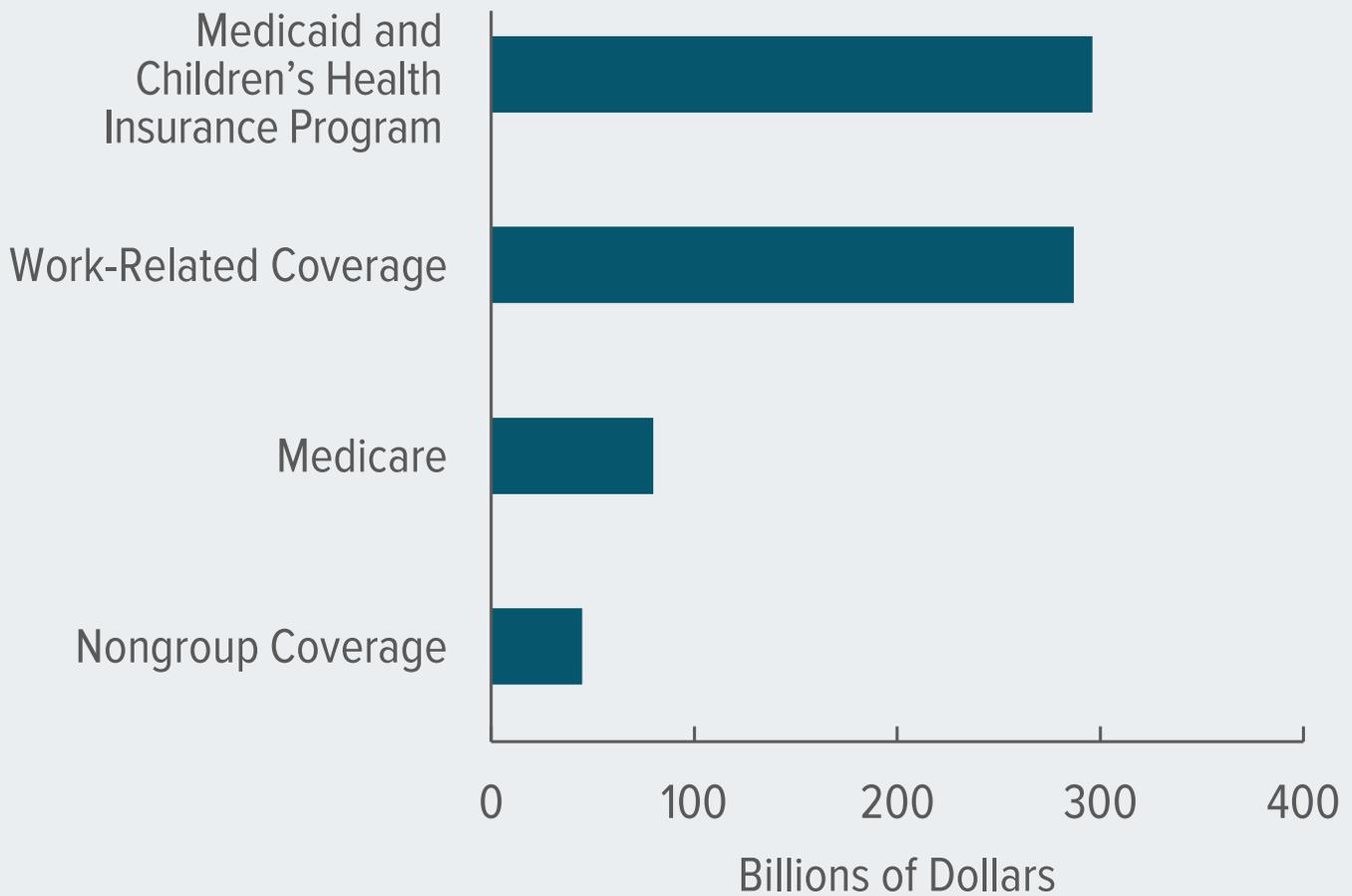


CBO

Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027

Health Insurance Subsidies in 2017 for People Under Age 65



Notes

As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148), the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and the effects of subsequent judicial decisions, statutory changes, and administrative actions.

Numbers in the tables and figures may not add up to totals because of rounding.

Unless the report indicates otherwise, all years referred to in describing estimates of spending and revenues are federal fiscal years, which run from October 1 to September 30 and are designated by the calendar year in which they end.

Estimates of health insurance coverage reflect average monthly enrollment during a calendar year and include spouses and dependents covered under family policies. Those estimates are for the noninstitutionalized civilian population under age 65.

Supplemental data for this report are available on CBO's website (www.cbo.gov/publication/53091).



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Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027

Summary

The federal government subsidizes health insurance for most Americans through a variety of programs and tax provisions. In 2017, net subsidies for people under age 65 will total \$705 billion, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimate.

In order to project the future cost to the federal government of providing those subsidies, CBO and JCT have projected the number of people under age 65 with health insurance of various kinds. They have then projected the federal costs associated with each kind of subsidy under current law, including the cost of preferential tax treatment for employment-based coverage, the cost of providing Medicaid coverage to people under age 65, and the size of government payments for other kinds of health insurance coverage—such as plans purchased through the marketplaces established under the Affordable Care Act (ACA). (The government also bears significant costs for health insurance for people age 65 or older, mostly through Medicare and Medicaid, as CBO has reported elsewhere.)

CBO has used these new estimates to adjust its current baseline budget projections, which incorporate the assumption that current law generally remains in place. Specifically, CBO has updated its baseline projections of the federal cost of subsidizing health insurance purchased through the marketplaces, of spending to subsidize insurance provided through the Basic Health Program, and of net spending and revenues associated with stabilizing premiums for insurance purchased by individuals and small employers. Because of the extensive work required to analyze pending legislation over the past eight months, CBO and JCT did not have time to prepare these new estimates before CBO published the most recent report about its baseline budget projections for the federal budget as a whole in June 2017.¹

CBO's most recent report comparable to this one was published in March 2016; it described the projections underlying CBO's March 2016 baseline.² For 2026, the agencies' projection of the number of people obtaining subsidized coverage through the marketplaces is now 4 million smaller, and the projected number of uninsured people is now 3 million larger, than they were in CBO's March 2016 baseline projections. The projection of net federal subsidies for health insurance from 2017 to 2026 is \$88 billion lower. The largest contributor to that decrease involves subsidies for nongroup coverage (that is, insurance purchased individually) and the Basic Health Program, which are now projected to cost \$137 billion less than the agencies projected in March 2016.

How Many People Under Age 65 Are Projected to Have Health Insurance?

According to CBO and JCT's estimates, a monthly average of about 244 million noninstitutionalized civilians under age 65 will have health insurance in 2017. Almost two-thirds of them will have coverage through an employer, and about a quarter will be enrolled in Medicaid or the Children's Health Insurance Program (CHIP). A smaller number will have nongroup coverage, coverage that is provided by Medicare, or coverage obtained from various other sources. On average, about 28 million people—10 percent of all noninstitutionalized civilians younger than 65—will be uninsured in 2017, CBO and JCT estimate (see Figure 1). Between 2017 and 2018, the number of uninsured people rises by 2 million in the agencies' projections, mainly because premiums in the nongroup market are expected to be higher.

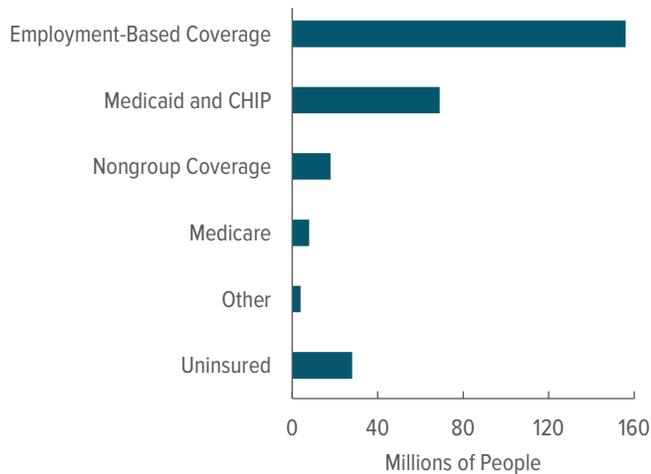
From 2018 through 2027, the number of people with coverage is expected to grow from 242 million to 247 million. But the number of uninsured people is also expected to grow, from 30 million to 31 million, keeping

1. See Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2017 to 2027* (June 2017), www.cbo.gov/publication/52801.

2. Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026* (March 2016), www.cbo.gov/publication/51385.

Figure 1.

Health Insurance Coverage in 2017 for People Under Age 65



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

CHIP = Children's Health Insurance Program.

the uninsured share of the under-65 population stable at 11 percent.

How Large Are the Projected Federal Subsidies, Taxes, and Penalties Associated With Health Insurance?

CBO and JCT currently estimate that in 2017, the federal subsidies, taxes, and penalties associated with health insurance coverage for people under age 65 will result in a net subsidy from the federal government of \$705 billion, which would be equal to 3.7 percent of gross domestic product. That amount is projected to rise at an average annual rate of 5.0 percent between 2017 and 2027, reaching \$1.2 trillion (or 4.1 percent of gross domestic product) in 2027. For the entire 2018–2027 period, the projected net subsidy is \$9.2 trillion. Two types of costs account for most of that amount:

- Federal spending for people under age 65 with full Medicaid and CHIP benefits (excluding people who reside in a nursing home or other institution) is projected to amount to \$4.0 trillion. That amount includes \$1.0 trillion for people who would be made eligible for Medicaid by the ACA.
- Federal subsidies of work-related coverage for people under age 65, which stem mainly from the exclusion of most premiums for such coverage from income and payroll taxes, are projected to equal \$3.9 trillion.

Other projected subsidy costs are smaller:

- Medicare benefits for noninstitutionalized beneficiaries under age 65 (net of their premium payments and other offsetting receipts) are projected to amount to \$1.0 trillion. Such spending is primarily for people who are disabled.
- Subsidies for coverage obtained through the marketplaces or through the Basic Health Program are estimated to total \$0.8 trillion.

In the agencies' projections, the costs of the subsidies are offset to a small extent, \$0.5 trillion, by taxes and penalties collected from health insurance providers, uninsured people, and employers.

How Stable Is the Nongroup Health Insurance Market Projected to Be?

CBO and JCT expect the nongroup health insurance market to be stable in most areas of the country. Preliminary data for 2018 show that insurers will offer coverage in all or almost all areas. Although premiums have been increasing, most subsidized enrollees buying health insurance through the marketplaces are insulated from those increases because their out-of-pocket payments for premiums are based on a percentage of their income; the federal government pays the difference between that percentage and the premium for a benchmark plan. (A benchmark plan is the second-lowest-cost silver plan in an area; a silver plan, in turn, is one that pays an average of 70 percent of the costs of covered health care services to certain beneficiaries.) Those subsidies—combined with the effects of the individual mandate, which requires most people to have insurance or pay a penalty, and other factors—are anticipated to result in demand for insurance by enough people, including people with low health care expenditures, that the number of insurers in the marketplaces would stabilize and insurers would be willing to sell nongroup policies in almost all areas of the country throughout the next decade.

What Are Premiums in the Nongroup Health Insurance Market Projected to Be?

CBO and JCT expect premiums for benchmark plans—which are the basis for determining subsidies—to increase by an average of 5 percent per year between 2017 and 2027. In 2018, the agencies project, the average benchmark premium will be roughly 15 percent higher than it was in 2017, largely because of short-term market uncertainty—in particular, insurers' uncertainty about whether federal funding for certain subsidies that

are currently available will continue to be provided—and an increase in the percentage of the population living in areas with only one insurer in the marketplace. Following the laws that govern the construction of its baseline, CBO has included funding for those subsidies in its baseline projections.³ Because of the assumed continuation of those payments, the agencies project that insurers' uncertainty about the payments would be resolved before 2019 and that insurers would set 2019 premiums at levels that are not affected by similar uncertainty. As a result, the projected average premiums for benchmark plans are slightly lower in 2019 than in 2018.

Projected Health Insurance Coverage

CBO and JCT project that, on average during 2017, 90 percent of the noninstitutionalized civilian population under age 65 will have health insurance, mostly from employment-based plans and Medicaid. Other sources of coverage include CHIP, nongroup policies, and Medicare. Over the 2018–2027 period, a slightly lower percentage of that population is projected to be insured.

Employment-Based Coverage

The most common source of health insurance for the noninstitutionalized civilian population under age 65 is a current or former employer—either one's own or a family member's. CBO and JCT estimate that in 2017, a monthly average of about 156 million people (or about 57 percent of the population under age 65) will have employment-based coverage (see Table 1). That number is projected to decline to 151 million, or about 55 percent of the population under age 65, in 2027.

Most of the projected reduction in employment-based coverage is attributable to the ACA. The agencies expect that as a result of the ACA, some employers will decline to offer coverage and some employees will elect to forgo offers of employment-based coverage in favor of other sources, such as Medicaid. Another factor is a gradual decline in enrollment in employment-based coverage that started well before the ACA took effect, caused in

part by health insurance premiums' growing faster than wages over the long term.⁴

Medicaid and CHIP

The next-largest source of coverage among people under age 65 is Medicaid. In 2017, CBO estimates, a monthly average of 63 million noninstitutionalized people will receive full Medicaid benefits.⁵ By 2027, that number is projected to grow to 70 million people (17 million who would be made eligible through the ACA's optional state expansion of Medicaid coverage, and 53 million who would be otherwise eligible).

CBO estimates that 6 million people, mostly children but also a few pregnant women, will be enrolled in CHIP in 2017, on average. That number falls to about 2 million in 2027, as CHIP funding projected in CBO's baseline declines sharply.⁶ (Most of the decline in coverage through CHIP is projected to be offset by increased enrollment in Medicaid or in insurance purchased through the marketplaces or offered by an employer.) Together, Medicaid and CHIP are projected to provide insurance coverage for about one-quarter of the population under age 65 in 2027.

CBO's estimates of Medicaid enrollment over the next decade reflect the agency's expectations that additional states will expand Medicaid eligibility and that more people will enroll in the program in states that have already done so. Under the ACA, states are permitted to

3. CBO constructs its baseline in accordance with provisions of the Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99-177) and the Congressional Budget and Impoundment Control Act of 1974 (P.L. 93-344).

4. For discussion of that factor, see Employee Benefits Research Institute, *Employment-Based Health Benefits: Trends in Access and Coverage, 1997–2010*, Issue Brief 370 (April 2012), <http://tinyurl.com/bvsvrbf>; and Fredric Blavin and others, *A Decade of Coverage Losses: Implications for the Affordable Care Act* (Urban Institute, February 2012), <http://tinyurl.com/ycnfv4k6>.

5. Some enrollees receive only partial benefits from Medicaid. They include Medicare enrollees who receive only assistance with out-of-pocket payments and Medicare premiums, people who receive only family planning services, and unauthorized immigrants who receive only emergency services.

6. In fiscal year 2017, spending for CHIP will reach \$16 billion, CBO estimates, but at the end of that year, federal funding for the program expires. Following the rules that govern baseline projections for expiring programs, CBO projects budget authority for CHIP after 2017 at about \$6 billion per year, and the estimates of enrollment given here are based on that projected amount of funding. However, CBO anticipates that if lawmakers did not provide additional funding for subsequent years, all state CHIP programs would terminate at some point during fiscal year 2018.

Table 1.

Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Total Population Under Age 65	272	273	273	274	274	275	276	276	276	277	277
Employment-Based Coverage	156	157	156	154	154	154	153	153	152	151	151
Medicaid and CHIP ^a											
Made eligible for Medicaid by the ACA	13	13	13	13	14	14	15	15	16	17	17
Otherwise eligible for Medicaid	50	51	52	52	52	52	52	52	53	53	53
CHIP	6	5	2	3	3	3	3	3	2	2	2
Subtotal	69	68	67	68	68	69	70	70	71	72	73
Nongroup Coverage and the Basic Health Program											
Nongroup coverage purchased through marketplaces ^b											
Subsidized	8	9	10	10	10	10	10	10	10	10	10
Unsubsidized	2	2	2	2	2	2	2	2	2	3	3
Subtotal	10	11	12	12	12	12	12	13	12	12	12
Nongroup coverage purchased outside marketplaces	6	5	5	5	5	5	5	5	5	5	5
Total, nongroup coverage	17	16	17	18	18	18	18	18	18	18	18
Coverage through the Basic Health Program ^c	1	1	1	1	1	1	1	1	1	1	1
Medicare ^d	8	8	8	8	9	9	9	9	9	9	9
Other Coverage ^e	4	5	5	5	5	5	5	5	5	6	6
Uninsured ^f	28	30	31	31	31	31	31	31	31	31	31
Memorandum:											
Number of Insured People	244	242	243	243	243	244	245	245	246	246	247
Insured as a Percentage of the Population											
Including all U.S. residents	90	89	89	89	89	89	89	89	89	89	89
Excluding unauthorized immigrants	92	91	91	91	91	91	91	91	91	91	91

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

Estimates include noninstitutionalized civilian residents of the 50 states and the District of Columbia who are younger than 65. The components do not sum to the total population because some people report multiple sources of coverage. CBO and JCT estimate that in most years, 10 million to 11 million people (or 4 percent of insured people) have multiple sources of coverage, such as employment-based coverage and Medicaid.

Estimates reflect average monthly enrollment over the course of a year and include spouses and dependents covered under family policies.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation.

- Includes noninstitutionalized enrollees with full Medicaid benefits. Estimates are adjusted to account for people enrolled in more than one state.
- Under the ACA, many people can purchase subsidized health insurance coverage through marketplaces (sometimes called exchanges), which are operated by the federal government, state governments, or partnerships between the federal and state governments.
- The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.
- Includes noninstitutionalized Medicare enrollees under age 65. Most Medicare-eligible people under age 65 qualify for Medicare because they participate in the Social Security Disability Insurance program.
- Includes people with other kinds of insurance, such as student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.
- Includes unauthorized immigrants, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid who do not enroll; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

expand eligibility for Medicaid to adults under age 65 whose income is no more than 138 percent of the federal poverty guidelines (also known as the federal poverty level, or FPL). The federal government pays a larger share of the costs for those people than it pays for those who would have been eligible otherwise. In 2014, 26 states and the District of Columbia expanded their Medicaid programs under the ACA. Three more states did so in 2015, and two more followed suit the following year. By the end of 2016, about half of the people in the country who met the new eligibility criteria resided in those states.

In the near term, CBO expects, states' uncertainty about the availability of funds to support Medicaid expansions will make further expansions unlikely. But over time, in the agency's assessment, states will be much likelier to expand eligibility than to contract it, in large part because the federal government would pay at least 90 percent of the cost and because states have historically expanded Medicaid much more often than they have contracted it. (Continued interest in expansion is demonstrated by votes to do so by two more state legislatures, though those measures were vetoed by the states' governors.) In addition, CBO anticipates that states' uncertainty would dissipate over time, provided that current law did not change. CBO's baseline incorporates the assumption that current law generally remains in place—and in the past, the longer a law has been in place, the more likely it has been that states believe it will remain in place. During the next few years, the agency expects that some states will work with the federal government to develop, review, and approve expansions. In CBO's baseline, more states are projected to expand coverage starting in 2020. By 2027, about 70 percent of the people who meet the new eligibility criteria will live in states that have expanded Medicaid coverage, CBO projects.

Nongroup Coverage and the Basic Health Program

Nongroup insurance covers a much smaller share of the population under age 65 than employment-based coverage or Medicaid does. In 2017, a monthly average of about 17 million people under age 65 are expected to have such coverage, most of whom will have purchased it through the marketplaces established under the ACA. (Nongroup policies can be purchased either through the marketplaces—with or without government subsidies—or elsewhere.) An additional 1 million people are estimated to be participating in the Basic Health Program, which allows states to offer subsidies to certain low-income people that are based on the subsidies available through the marketplaces.

Health Insurance Marketplaces. The marketplaces are operated by the federal government, state governments, or partnerships between the federal and state governments. People meeting certain criteria may receive federal subsidies for coverage purchased through those marketplaces.

In 2017, a total of 12 million people selected plans through the marketplaces by the close of the open-enrollment period established by the ACA; however, CBO and JCT estimate that during that year, an average of about 10 million people will be covered each month by insurance purchased through the marketplaces.⁷ The agencies estimate that 8 million of those people will receive subsidies to purchase their coverage.

CBO and JCT expect average enrollment to continue to increase—to 11 million people in 2018 and to 12 million people in almost every year from 2019 to 2027. In 2018, about 9 million of those people are expected to receive subsidies for purchasing that insurance, and that number is expected to be about 10 million in each year from 2019 to 2027.

The projected increase in enrollment in 2018 stems mainly from three factors:

- On the basis of recent research, CBO and JCT expect that some people who are eligible for subsidies through the marketplaces are forgoing the subsidies and enrolling in nongroup coverage outside the marketplaces.⁸ As premiums rise, the agencies expect, some of those people will enroll in subsidized coverage through the marketplaces instead.

7. CBO and JCT also estimate that average monthly enrollment during the year will be lower than the total number of people who will have coverage at some point during the year. The reason for the differences is that some people are covered for only part of the year—because those who experience a qualifying life event (such as a change in income or family size or the loss of employment-based insurance) are allowed to purchase coverage later in the year, or because some people stop paying the premiums or leave their marketplace-based coverage as they become eligible for insurance through other sources.

8. See Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "About 2.5 Million People Who Currently Buy Coverage Off-Marketplace May Be Eligible for ACA Subsidies," *ASPE Data Point* (October 4, 2016), <https://go.usa.gov/xRFhm> (PDF, 330 KB); and John H. Goddeeris, Stacey McMorrow, and Genevieve M. Kenney, "Off-Marketplace Enrollment Remains an Important Part of Health Insurance Under the ACA," *Health Affairs*, vol. 36, no. 8 (August 2017), pp. 1489–1494, <http://dx.doi.org/10.1377/hlthaff.2017.0085>.

- Some children are projected to obtain subsidized coverage through the marketplaces because funding for CHIP projected in CBO's baseline declines sharply at the end of 2017.⁹
- Some people who, in 2017, are enrolled in certain plans that are offered outside the marketplaces and that do not comply with the ACA's requirements are expected to newly enroll in subsidized marketplace coverage in 2018, partly because some of those plans will no longer be available.

That increase in enrollment in 2018 is limited by projected premium increases due to near-term market uncertainty and by announced reductions in federal advertising, outreach, the enrollment period, and other enrollment efforts, which push enrollment down.

In later years, enrollment is expected to be relatively stable as a result of two largely offsetting effects. On the one hand, CBO's expectation that additional states will expand eligibility for Medicaid reduces the number of people projected to obtain coverage through the marketplaces, because people who are eligible for Medicaid are not permitted to receive subsidies for such coverage. On the other hand, over the next few years, more employers are expected to respond to the availability of coverage through the marketplaces by declining to offer insurance to their employees. As a result, some of their employees are expected to obtain coverage through the marketplaces.

Stability in the Marketplaces. Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on the proportion of people who live in areas with participating insurers and on the likelihood that premiums will not rise in an unsustainable spiral. In the marketplaces, where premiums cannot be based on enrollees' health status, the market for insurance would be unstable if, for example, 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 for insurers.

Although premiums have been increasing, most subsidized enrollees purchasing health insurance coverage

9. Again, in accordance with the rules governing baseline projections, CBO projects funding for CHIP after 2017 at an annualized amount of \$6 billion. If funding was at that level, significantly fewer people would be able to enroll in CHIP.

through the marketplaces are insulated from those increases because of the subsidies. Those subsidies—combined with the effects of the individual mandate, the rules requiring insurers to offer coverage of preexisting medical conditions, the relative ease of comparison shopping in the marketplaces, and other factors—are anticipated to produce sufficient demand for nongroup insurance, including among people with low health care expenditures, to attract at least one insurer almost everywhere. As a result, in each of the next 10 years, the agencies expect fewer than one-half of one percent of people in the country to live in areas where no insurers participate in the nongroup market.

Moreover, data about insurers' profitability in the first quarter in 2017 are consistent with the market's being stable.¹⁰ Insurers' profitability, as measured by the share of premiums that goes toward their administrative costs and profits rather than paying for claims, has increased in 2017 to move closer to pre-ACA levels. That evidence suggests that the premium increases in 2017 were a sufficient adjustment by insurers to account for the underlying health risk of the nongroup population.

Nevertheless, preliminary data indicate that a greater percentage of people will be living in areas with only one or two insurers in the marketplaces in 2018, following a large jump in that percentage in 2017. Several factors may have led insurers to withdraw from those markets, including low enrollment, lack of profitability, uncertainty about the enforcement of the individual mandate, and uncertainty about the federal government's future payments for cost-sharing reductions (CSRs). Those payments are currently provided to insurers that, following current law, reduce the out-of-pocket payments required from people who enroll in certain plans through the marketplaces and whose income is generally between 100 percent and 250 percent of the FPL; however, the outcome of a lawsuit challenging the legality of CSR payments has yet to be determined, and it is unclear whether the Administration will continue to make them.¹¹ Still, with steady demand for insurance in

10. See Cynthia Cox and Larry Levitt, *Individual Insurance Market Performance in Early 2017* (Kaiser Family Foundation, July 2017), <https://tinyurl.com/y8m68ghz>.

11. For an analysis under CBO's March 2016 baseline of what would happen if CSR payments were terminated, see Congressional Budget Office, *The Effects of Terminating Payments for Cost-Sharing Reductions* (August 2017), www.cbo.gov/publication/53009.

the marketplaces, the agencies expect that the number of insurers in the marketplaces would stabilize after 2018.

Premiums in the Marketplaces. CBO and JCT estimate that the average benchmark premiums for a 21-year-old, a 45-year-old, and a 64-year-old who buy health insurance coverage through the marketplaces are about \$3,400, \$4,800, and \$9,800, respectively, in calendar year 2017. Those estimates represent a national average, reflecting the agencies' projections of the geographic distribution of people who currently have coverage through the marketplaces.

The agencies expect insurers to raise premiums for marketplace plans in 2018 by an average of roughly 15 percent, largely because of uncertainty about whether the federal government will continue to fund CSR payments and because of an increase in the percentage of the population living in areas with only one insurer. Following the laws that govern its baseline, however, CBO has included that funding in its baseline projections. Because of the continuation of those payments, under that assumption in the baseline, the agencies expect that by 2019 the uncertainty surrounding CSR payments would be resolved and insurers would set 2019 premiums at levels that did not include the 2018 uncertainty increase; therefore, average premiums (and consequently subsidies) are projected to be lower in 2019 than in 2018. Between 2017 and 2027, the average benchmark premium is projected to grow by an average of 5 percent per year on the basis of CBO's projections of increases in disposable income and other factors that have historically been associated with growth in premiums.¹²

Other Nongroup Coverage. Outside the marketplaces, 6 million people are expected to purchase nongroup coverage in 2017, and 5 million people are projected to do so in 2027.¹³ CBO and JCT estimate that in most years, roughly 1 million people will be eligible for

marketplace subsidies but instead enroll in unsubsidized coverage outside the marketplaces.

Basic Health Program. Under the ACA, states have the option to establish a Basic Health Program, which is primarily for people whose income is between 138 percent and 200 percent of the FPL. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would have been eligible through a marketplace. States can use those funds, in addition to funds from other sources, to offer health insurance that covers a broader set of benefits or requires smaller out-of-pocket payments than coverage in the marketplaces does.¹⁴ So far, Minnesota and New York have each created a Basic Health Program. In total, about 1 million people are projected to be enrolled in such a plan in each year from 2017 through 2027.

Medicare and Other Coverage

Although Medicare is best known for providing coverage for people age 65 or older, it also covers some people who are under age 65. Many of those younger enrollees receive that coverage because they have qualified for Social Security Disability Insurance benefits. (In general, people become eligible for Medicare two years after they qualify for Disability Insurance.) Between 8 million and 9 million people under age 65 are projected to be covered by Medicare in 2017 and in each year over the 2018–2027 period.

Other miscellaneous sources of coverage account for 4 million to 6 million people each year from 2017 to 2027. Those sources include student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.

Uninsured

An average of 28 million people under age 65 are projected to be uninsured in 2017. (In this report, CBO and JCT consider people uninsured if they would not be covered by a policy or enrolled in a government program that provides financial protection from major medical risks.)

12. For discussion of how CBO and JCT project premiums, see Congressional Budget Office, *Private Health Insurance Premiums and Federal Policy* (February 2016), pp. 9–11, www.cbo.gov/publication/51130.

13. Nongroup plans offered through the marketplaces and nongroup plans purchased directly from insurers are generally subject to the same requirements. Also, in general, insurers must consider all enrollees in nongroup plans that comply with the ACA's requirements as members of a single risk pool.

14. For more information about the Basic Health Program, see Centers for Medicare & Medicaid Services, "Basic Health Program" (accessed September 13, 2017), www.medicare.gov/basic-health-program/index.html.

Between 2017 and 2018, the number of uninsured people rises by 2 million in the agencies' projections, mainly because premiums in the nongroup market are expected to be higher. Over the next decade, roughly 1 out of every 10 residents under age 65 is projected to be uninsured each year, and the number of people who are uninsured is projected to be 31 million in 2027 (see Table 1).¹⁵ In that year, according to CBO and JCT's estimates, about 30 percent of those uninsured people would be unauthorized immigrants and thus ineligible for subsidies through a marketplace or for most Medicaid benefits; about 10 percent would be ineligible for Medicaid because they lived in a state that had not expanded coverage; about 20 percent would be eligible for Medicaid but would not enroll; and the remaining 40 percent would not purchase insurance to which they had access through an employer, through the marketplaces, or directly from insurers.

Projected Subsidies for Health Insurance Coverage

The federal government encourages people to obtain health insurance by making it less expensive than it would be otherwise. For people under age 65, the government subsidizes health insurance coverage in four main ways:

- Giving tax benefits for work-related coverage,
- Providing roughly two-thirds of all funding for Medicaid (while requiring states to provide the remainder),
- Offering tax credits and other subsidies to certain people who purchase coverage through the health insurance marketplaces, and

- Providing coverage through the Medicare program to people under age 65 who receive Disability Insurance or who meet certain other criteria.

The costs of those subsidies are partly offset by taxes and penalties related to health insurance coverage that the federal government collects. They include excise taxes on high-premium insurance plans, penalty payments from people who do not obtain coverage, excise taxes on providers of health insurance, and penalty payments from large employers that do not offer health insurance that meets certain standards.

Provided that current law did not change, the net federal subsidy for health insurance coverage for people under age 65—that is, the cost of all the subsidies minus the taxes and penalties—would be about \$705 billion in 2017 and would total \$9.2 trillion over the 2018–2027 period, CBO and JCT estimate (see Table 2). Those sums reflect projections by the agencies about choices that people would make about obtaining health insurance.

Those estimates of subsidies are not equal to the savings that the federal government would realize if lawmakers eliminated the subsidies. Estimates of such savings would have to incorporate expected changes in individual decisions and other behavioral responses to such a change in law.

Work-Related Coverage

Health insurance that people receive from employers is the most common source of subsidized coverage for people under age 65. Employers' payments for workers' health insurance coverage are a form of compensation, but unlike cash compensation, those payments are excluded from income and payroll taxes. In most cases, the amounts paid by workers themselves for their share of the cost of employment-based coverage are also excluded from income and payroll taxes. Another work-related subsidy is the income tax deduction for health insurance premiums that can be used by self-employed people, including sole proprietors and workers in partnerships (who may purchase insurance individually or as part of a group). In addition, certain small employers that provide health insurance to their employees are eligible to receive a tax credit of up to 50 percent of the cost of that insurance.

JCT estimates that subsidies for work-related coverage will total about \$287 billion in 2017 (see Figure 2). That

15. The sum of the estimates of the number of people enrolled in health insurance plans and the number of people who are uninsured exceeds CBO and JCT's estimate of the total population under age 65 by 10 million to 11 million people in most years, because some people will have multiple sources of coverage. A common example is people who report having both employment-based coverage and Medicaid. To arrive at the estimates given here, CBO and JCT did not assign a primary source of coverage to people who reported multiple sources; the resulting amounts align better with estimates of spending as well as with information about health insurance coverage from household surveys. (By contrast, when CBO and JCT have estimated changes in the sources of insurance coverage stemming from proposed legislation, the agencies have used only people's primary source of coverage to count them, an approach that has generally proven more useful for that purpose.)

amount is estimated to grow to \$487 billion in 2027 and to total \$3.9 trillion over the 2018–2027 period. The amount of the tax subsidy for work-related coverage is very large because the number of people with such coverage is large. It is important to note that the estimated subsidies are not equal to the tax revenues that would be collected if those subsidies were eliminated, because in that event, many people would adjust their behavior to reduce the tax liability created by the change.

Medicaid and CHIP

Outlays for all noninstitutionalized Medicaid and CHIP enrollees under age 65 who receive full benefits are estimated to amount to \$296 billion in 2017.¹⁶ Over the 2018–2027 period, estimated outlays total \$4 trillion—\$1 trillion (or 26 percent of the total) for people whom the ACA would make eligible for Medicaid and roughly \$3 trillion (or 74 percent) for people who would be eligible for Medicaid or CHIP otherwise. Medicaid spending for the noninstitutionalized population under age 65 accounts for roughly 80 percent of total projected Medicaid spending for medical services over the 2018–2027 period.

Nongroup Coverage and the Basic Health Program

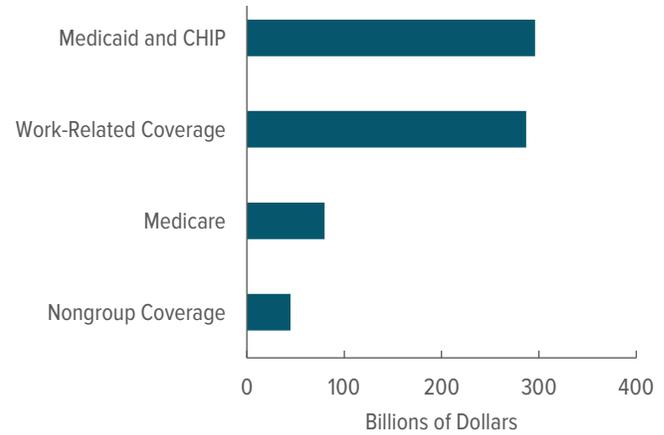
In 2017, subsidies for nongroup coverage obtained through the marketplaces, related spending and revenues—that is, premium tax credits, cost-sharing reductions, net spending and revenues related to risk adjustment and reinsurance, and grants to states—and Basic Health Program payments will total \$45 billion, CBO and JCT estimate. Over the 2018–2027 period, such costs are projected to total \$773 billion and to consist of the following main components:

- Outlays of \$531 billion and a reduction in revenues of \$75 billion for premium tax credits (which cover a portion of eligible people’s health insurance premiums), totaling \$605 billion;
- Outlays of \$99 billion for CSRs (which reduce out-of-pocket payments for low-income enrollees);
- Outlays of \$69 billion for the Basic Health Program; and
- Outlays of \$65 billion and revenues of the same amount related to payments and collections for risk adjustment and reinsurance.

16. Spending for enrollees who receive partial assistance is excluded from these estimates.

Figure 2.

Health Insurance Subsidies in 2017 for People Under Age 65



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

CHIP = Children’s Health Insurance Program.

Combined, the subsidies for nongroup coverage through the marketplaces and the Basic Health Program are projected to average \$5,550 per subsidized enrollee in calendar year 2017 and to rise to about \$8,600 in 2027. Subsidies for insurance obtained through the marketplaces depend on the number of people who purchase such coverage; the premiums for benchmark plans; and certain characteristics of enrollees, such as age, family size, and income. The subsidies fall into two categories: premium tax credits and CSRs. The first category is primarily available to people with income between 100 percent and 400 percent of the FPL who meet certain other conditions, and the second is generally available to people who are eligible for premium tax credits, have a household income below 250 percent of the FPL, and enroll in an eligible plan.

The risk-adjustment and reinsurance programs were established under the ACA to stabilize premiums in the nongroup and small-group insurance markets by reducing the likelihood that particular insurers with a disproportionate share of less healthy enrollees would bear especially high costs.¹⁷ The programs, which were implemented in 2014, make payments to insurers with less healthy enrollees; those payments are financed by

17. The small-group insurance market is for health insurance generally purchased by or through employers with up to 50 employees; starting in 2016, states could expand the definition to include employers with up to 100 employees.

Table 2.

Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65

Billions of Dollars, by Fiscal Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	Total, 2018- 2027
Work-Related Coverage												
Tax exclusion for employment-based coverage ^{a,b}	279	297	314	329	345	365	385	407	428	451	475	3,796
Income tax deduction for self-employed health insurance ^c	7	7	8	8	8	9	9	10	10	11	11	91
Small-employer tax credits ^b	1	1	1	1	1	1	1	1	1	1	1	10
Subtotal	287	306	323	338	354	374	395	417	439	463	487	3,897
Medicaid and CHIP^d												
Made eligible for Medicaid by the ACA	72	76	79	82	88	95	104	111	122	134	143	1,036
Otherwise eligible for Medicaid	209	225	241	256	271	285	298	314	327	341	358	2,917
CHIP	16	13	6	6	6	6	6	6	6	6	6	64
Subtotal	296	315	326	344	365	386	408	431	455	480	508	4,017
Nongroup Coverage and the Basic Health Program												
Premium tax credit outlays	27	41	47	49	51	53	54	57	58	60	62	531
Premium tax credit revenue reductions	6	6	6	7	7	7	8	8	8	8	9	75
Subtotal, premium tax credits	34	47	53	55	58	60	62	64	66	68	71	605
Cost-sharing outlays	7	9	9	10	10	10	10	10	10	11	11	99
Outlays for the Basic Health Program	5	5	6	6	6	7	7	7	8	8	9	69
Collections for risk adjustment and reinsurance	-9	-5	-5	-6	-6	-6	-7	-7	-7	-8	-8	-65
Payments for risk adjustment and reinsurance	9	5	5	5	6	6	7	7	7	8	8	65
Marketplace grants to states	*	*	0	0	0	0	0	0	0	0	0	*
Subtotal	45	62	68	71	74	77	78	82	85	86	90	773
Medicare^e	80	81	84	89	94	98	103	108	112	119	124	1,011

Continued

collecting funds from insurers with healthier enrollees in the case of risk adjustment and by an assessment on a broad range of insurers in the case of reinsurance. The payments under the risk-adjustment and reinsurance programs are recorded in the budget as mandatory outlays, and the collections are recorded as revenues. In CBO's projections for the 2018–2027 period, risk-adjustment and reinsurance payments and collections each total about \$65 billion; almost all of that amount is for risk adjustment, as the last claims eligible for the reinsurance program are from plan year 2016. (Collections and payments ultimately offset each other exactly, but because of differences in the timing of collections and payments, slight discrepancies between the two will occur in any given period.)

Medicare

Net outlays for Medicare coverage for noninstitutionalized people under age 65 are projected to be \$80 billion in 2017 and to total \$1 trillion over the 2018–2027

period. That amount is about one-eighth of total projected net spending for the Medicare program.

Taxes and Penalties

Taxes and penalties related to health insurance coverage are expected to reduce the total amount of federal subsidies for such coverage by \$3 billion in 2017. Under current law, those taxes and penalties would total \$453 billion over the 2018–2027 period, CBO and JCT estimate.

Excise Tax on High-Premium Insurance Plans. An excise tax on certain high-cost employment-based coverage is scheduled to be imposed beginning in 2020. The tax was originally supposed to take effect in 2018, but the Consolidated Appropriations Act, 2016 (Public Law 114-113), delayed its implementation by two years. In CBO and JCT's current projections, collections of that tax total \$29 billion over the 2018–2027 period.

Table 2.

Continued

Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65

Billions of Dollars, by Fiscal Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	Total, 2018- 2027
Taxes and Penalties Related to Coverage												
Gross collections of excise tax on high-premium insurance plans ^f	0	0	0	-1	-3	-3	-3	-4	-5	-5	-6	-29
Penalty payments by uninsured people	-3	-4	-4	-5	-5	-5	-5	-5	-6	-6	-6	-51
Net receipts from tax on health insurance providers ^g	0	-13	-14	-14	-15	-16	-17	-18	-19	-20	-21	-166
Gross collections of employer penalties ^f	0	-12	-20	-22	-17	-19	-20	-22	-23	-25	-27	-207
Subtotal	-3	-28	-38	-42	-40	-43	-46	-49	-52	-56	-59	-453
Net Subsidies	705	735	763	800	847	892	938	989	1,039	1,093	1,150	9,245
Memorandum:												
Average Subsidy per Subsidized Marketplace or Basic Health Program Enrollee (Dollars)	5,550	6,370	6,140	6,310	6,680	6,870	7,090	7,530	7,830	8,150	8,610	
Collections of Excise Tax on High-Premium Insurance Plans, Including the Associated Effects on Revenues of Changes in Taxable Compensation	0	0	0	-4	-7	-9	-11	-14	-17	-20	-24	-106

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

Positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

This table excludes outlays made by the federal government in its capacity as an employer.

ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program; JCT = Joint Committee on Taxation; * = between zero and \$500 million.

- a. Includes the effect on tax revenues of the exclusion of premiums for people under age 65 with employment-based insurance from federal income and payroll taxes and includes the effects on taxable wages of the excise tax on high-cost plans and employer penalties. JCT made this projection; it differs from JCT’s estimate of the tax expenditure for the exclusion of employer-paid health insurance because effects stemming from the exclusion for people over age 65 are excluded here and because the Federal Insurance Contributions Act tax exclusion for employer-paid health insurance is included here.
- b. Includes increases in outlays and reductions in revenues.
- c. JCT made this projection; it does not include effects stemming from the deduction for people over age 65.
- d. For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits. Also, the federal government covers a larger share of costs for Medicaid enrollees whom the ACA made eligible for the program than for people otherwise eligible for Medicaid; the government therefore tracks those groups separately.
- e. For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.
- f. Excludes the associated effects on revenues of changes in taxable compensation, which are included in the estimate of the tax exclusion for employment-based insurance. If those effects were included, net revenues stemming from the excise tax would total \$106 billion over the 2018–2027 period, and revenues from penalty payments by employers would total \$157 billion over that 10-year period.
- g. Net receipts include effects of the excise tax on individual and corporate tax receipts.

The excise tax is expected to cause some employers and workers to shift to health plans with lower premiums in order to avoid paying the tax entirely or to reduce their tax liability. However, those shifts will generally increase income tax revenues, CBO and JCT estimate, because affected workers will receive less of their income in nontaxable health benefits and more in taxable wages. Including those increases in income tax revenues, JCT

estimates that receipts stemming from the imposition of the excise tax will total \$106 billion over the coming decade.¹⁸

18. That amount is shown as a memorandum item in Table 2. If workers’ wages were instead held constant, their total compensation would be reduced by the amount of the premium change. Their employers would have smaller deductions for compensation costs and hence more taxable income—and the resulting total revenues would be similar.

Penalty Payments by Uninsured People. Under the individual mandate, most U.S. citizens and noncitizens who lawfully reside in the country must either obtain health insurance, obtain an exemption, or pay a penalty. The penalty equals the greater of two amounts: a fixed dollar amount assessed for each uninsured person in a household, or 2.5 percent of the difference between the household's adjusted gross income and its income threshold for tax filing. The fixed dollar amount per uninsured adult is \$695 in 2017; the penalty per child is half as large. Both penalties are subject to a cap, and people who are uninsured for only part of the year face a smaller penalty.

Although most legal residents are subject to the individual mandate, a number of exemptions apply. For example, people who would have to pay more than a certain share of their income to acquire health insurance do not face a penalty; that share is 8.16 percent in 2017 and is scheduled to grow over time. People may also obtain exemptions for having income below the tax-filing threshold, experiencing certain hardships, and belonging to certain religious groups. CBO and JCT expect that a substantial majority of the roughly 28 million people estimated to be uninsured in 2017 will be exempt. In CBO and JCT's projections, penalty payments collected from uninsured people amount to \$3 billion in 2017 and total \$51 billion over the 2018–2027 period.

Tax on Health Insurance Providers. Health insurers are subject to an excise tax (though legislation eliminated it for calendar year 2017). The law specifies the total amount of tax to be assessed, and that total is divided among insurers according to their share of total applicable premiums charged in the previous year. Some health insurers, such as firms operating self-insured plans and certain state government entities and tax-exempt providers, are fully or partly exempt from the tax.¹⁹ Under current law, net revenues from the tax would be \$13 billion in 2018 and increase steadily to about \$21 billion by 2027, for a total of \$166 billion over the decade, CBO and JCT estimate.

Employer Penalties. Some large employers that do not offer health insurance coverage that meets certain standards under the ACA will owe a penalty if they have any full-time employees who receive a subsidy through

a health insurance marketplace.²⁰ The requirement generally applies to employers with at least 50 full-time-equivalent employees. In CBO and JCT's projections, payments of those penalties total \$207 billion over the 2018–2027 period. However, the increased costs for employers that pay the penalties are projected to reduce other revenues by about \$50 billion, because employers would generally shift the costs of the penalties to workers by lowering taxable wages. Once that shift is taken into account, the net reduction in the deficit would be \$157 billion.

Changes in the Estimates of Insurance Coverage and Subsidies Since March 2016

In CBO and JCT's current projections for 2026, an average of 7 million fewer people obtain nongroup coverage, and 3 million more people are uninsured, than the agencies estimated in March 2016. For the 2017–2026 period (which is covered by both last year's projections and the current ones), the agencies have decreased their estimate of the net federal subsidies associated with health insurance coverage for people under age 65 from \$8.9 trillion to \$8.8 trillion (see Table 3).

Changes in the Estimates of Insurance Coverage

For the 2017–2026 period, CBO has slightly lowered its projection of the total noninstitutionalized population under age 65, which affects the number of people projected to have all types of insurance coverage. Using those population projections as a starting point, the agencies have lowered their projections of subsidized and unsubsidized nongroup coverage and increased their projections of the number of uninsured people. In addition, the agencies have increased their projections of enrollment in employment-based coverage in the near term (but decreased them slightly by 2026) and have increased their projections of total Medicaid enrollment in most years.

Total Population Under Age 65. CBO has lowered its projection of the total noninstitutionalized population under age 65 in each year—a change first incorporated in CBO's January 2017 baseline. In CBO's current projections, 277 million noninstitutionalized people under age 65 are expected to reside in the United States

19. A self-insured firm essentially acts as its own insurer and bears most or all of the financial risk of providing coverage to its workers.

20. To meet the standards, the cost to employees for self-only coverage must not exceed a specified share of their income (which is 9.69 percent in 2017 and is scheduled to grow over time), and the plan must pay at least 60 percent of the cost of covered benefits.

in 2026, whereas in the March 2016 projections, that number was 280 million. The main reason is that CBO now projects less immigration than it did in March 2016.²¹

Nongroup Coverage and the Basic Health Program.

Average monthly enrollment in the nongroup market from 2018 to 2026 is currently projected to be 7 million to 10 million people lower than it was in March 2016. In the current projections, subsidized enrollment through the marketplaces is lower by 4 million to 5 million people, unsubsidized enrollment through the marketplaces is lower by 1 million to 2 million, and enrollment outside the marketplaces is lower by 2 million to 3 million. Enrollment in the Basic Health Program is not noticeably different.

The agencies' reduction in projected enrollment in the nongroup market incorporates administrative data indicating lower enrollment in all three parts of that market during the past few years than the agencies had estimated in March 2016. (Most of those data were first incorporated in CBO's January 2017 baseline.) Survey data suggest that one reason for the difference is that more employers are offering coverage to their employees than CBO and JCT had anticipated.²² Also, the agencies expect lower enrollment because of announced reductions in federal advertising, outreach, the enrollment period, and other enrollment efforts and, in 2018, because of higher premiums resulting from insurers' uncertainty about federal funding of CSR payments; those factors were not incorporated into the March 2016 projections.

In the past, CBO and JCT's projections of nongroup enrollment turned out to be too high, particularly for 2016. The agencies have had difficulty ascertaining the extent to which those overpredictions occurred because responses to incentives from the ACA to enroll were slower than anticipated (with significant gains still to

occur in the future) and the extent to which the overpredictions were caused by factors that would persist over the longer term. CBO and JCT have now concluded that such persistent factors are probably more significant. One such factor might have been less interest by consumers in enrolling than the agencies expected; another might have been less inclination by employers to cease offering coverage to their employees because of new options in the nongroup market. Furthermore, after examining new data from the Census Bureau's Current Population Survey, CBO and JCT now estimate that more people with annual income that would make them eligible for subsidized nongroup insurance will instead qualify for and enroll in Medicaid coverage on the basis of their monthly income.

Now that the marketplaces have been operating for four years, the agencies expect further net changes in enrollment to be small. Specifically, during the projection period, they currently project changes in average monthly enrollment in each of the three parts of the nongroup market to be no larger than 1 million people—changes of about the same size as projected in March 2016 for the 2018–2026 period, but from a much lower starting point.

CBO and JCT currently project subsidized enrollment through the health insurance marketplaces to average 8 million people per month in 2017 and between 9 million and 10 million people in later years.²³ In March 2016, the agencies estimated that the monthly average would be 12 million people in 2017 and between 14 million and 16 million people in later years.

For unsubsidized plans purchased through the marketplaces, the agencies now estimate monthly enrollment averaging 2 million to 3 million in each year from 2017 to 2027. In March 2016, they estimated that in each of the next 10 years, a monthly average of 3 million to 4 million people would be enrolled.

21. For more information, see Congressional Budget Office, *The 2017 Long-Term Budget Outlook* (March 2017), Appendix A, www.cbo.gov/publication/52480.

22. The data are from the Medical Expenditure Panel Survey's insurance component. For discussion of the 2014 data, see Jean Abraham, Anne B. Royalty, and Coleman Drake, "Employer-Sponsored Insurance Offers: Largely Stable in 2014 Following ACA Implementation," *Health Affairs*, vol. 35, no. 11 (November 2016), pp. 2133–2137, <http://dx.doi.org/10.1377/hlthaff.2016.0631>.

23. Most of that change occurred in CBO's January 2017 baseline projections, in which the agencies lowered their estimate of subsidized enrollment in 2026 from 14 million people to 11 million. In this report, CBO and JCT have further lowered that estimate to about 10 million people. See Congressional Budget Office, "Baseline Projections for Selected Programs: Federal Subsidies for Health Insurance (Includes Effects of the Affordable Care Act)" (January 2017), www.cbo.gov/publication/51298.

Table 3.

Comparison of Current and Previous Estimates of Health Insurance Coverage and Net Federal Subsidies for People Under Age 65

	March 2016 Baseline	September 2017 Baseline	Difference
Change in Insurance Coverage in Calendar Year 2026 (Millions of people)^a			
Total Population	280	277	-3
Employment-Based Coverage	152	151	-1
Medicaid and CHIP ^b			
Made eligible for Medicaid by the ACA	15	17	2
Otherwise eligible for Medicaid or CHIP	56	55	-1
Total	71	72	1
Nongroup Coverage and the Basic Health Program			
Subsidized nongroup	14	10	-4
Unsubsidized nongroup	11	8	-3
Total	25	18	-7
Coverage through the Basic Health Program ^c	1	1	*
Medicare ^d	9	9	-1
Other Coverage ^e	6	6	*
Uninsured ^f	28	31	3
Effects on the Cumulative Federal Deficit, Fiscal Years 2017 to 2026^g (Billions of dollars)			
Work-Related Coverage			
Tax exclusion for employment-based coverage ^h	3,620	3,600	-20
Income tax deduction for self-employed health insurance ⁱ	53	87	33
Small-employer tax credits	9	9	1
Subtotal	3,683	3,696	14
Medicaid and CHIP ^j			
Made eligible for Medicaid by the ACA	969	964	-4
Otherwise eligible for Medicaid or CHIP	2,821	2,841	20
Subtotal	3,790	3,806	16
Nongroup Coverage and the Basic Health Program			
Premium tax credits	672	568	-104
Cost-sharing outlays	130	95	-35
Outlays for the Basic Health Program	63	65	2
Subtotal	866	729	-137
Medicare ^k	979	966	-13

Continued

For nongroup coverage outside the marketplaces, the current projection is a monthly average of 5 million people during the 2018–2026 period. In March 2016, the agencies projected that a monthly average of 7 million to 8 million people would be enrolled in in each of those years.

Uninsured. CBO and JCT’s projections of the number of uninsured people are 2 million to 4 million higher

in each year from 2017 to 2026 than they were in March 2016. The agencies increased their estimate for 2017 by 2 million people to reflect recent data from surveys.²⁴ It is unclear why more people were

24. For discussion of the data that CBO and JCT use, see Jared Maeda and Susan Yeh Beyer, “How Does CBO Define and Estimate Health Insurance Coverage for People Under Age 65?” *CBO Blog* (December 20, 2016), www.cbo.gov/publication/52352.

Table 3.

Continued

Comparison of Current and Previous Estimates of Health Insurance Coverage and Net Federal Subsidies for People Under Age 65

	March 2016 Baseline	September 2017 Baseline	Difference
Effects on the Cumulative Federal Deficit, Fiscal Years 2017 to 2026^g (Continued) (Billions of dollars)			
Taxes and Penalties Related to Coverage			
Gross collections of excise tax on high-premium insurance plans ^l	-18	-24	-5
Penalty payments by uninsured people	-38	-48	-10
Net receipts from tax on health insurance providers ^m	-145	-145	**
Gross collections of employer penalties ^l	-228	-181	47
Subtotal	-429	-397	32
Net Subsidies^m	8,888	8,800	-88

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

ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program; JCT = Joint Committee on Taxation; * = between -500,000 and zero; ** = between -\$500 million and zero.

- a. Estimates include noninstitutionalized civilian residents of the 50 states and the District of Columbia who are younger than 65. The components do not sum to the total population because some people report multiple sources of coverage. CBO and JCT estimate that in most years, 10 million to 11 million people (or 4 percent of insured people) have multiple sources of coverage, such as employment-based coverage and Medicaid.
- b. Includes noninstitutionalized enrollees with full Medicaid benefits. Estimates are adjusted to account for people enrolled in more than one state.
- c. The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.
- d. Includes noninstitutionalized Medicare enrollees under age 65. Most Medicare-eligible people under age 65 qualify for Medicare because they participate in the Social Security Disability Insurance program.
- e. Includes people with other kinds of insurance, such as student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.
- f. Includes unauthorized immigrants, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid who do not enroll; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.
- g. Positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.
- h. Includes the effect on tax revenues of the exclusion of premiums for people under age 65 with employment-based insurance from federal income and payroll taxes and includes the effects on taxable wages of the excise tax on high-cost plans and employer penalties. JCT made this projection; it differs from JCT’s estimate of the tax expenditure for the exclusion of employer-paid health insurance because effects stemming from the exclusion for people over age 65 are excluded here and because the Federal Insurance Contributions Act tax exclusion for employer-paid health insurance is included here.
- i. JCT made this projection; it does not include effects stemming from the deduction for people over age 65.
- j. For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits. Also, the federal government covers a larger share of costs for Medicaid enrollees whom the ACA made eligible for the program than for people otherwise eligible for Medicaid; the government therefore tracks those groups separately.
- k. For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.
- l. Excludes the associated effects on revenues of changes in taxable compensation, which are included in the estimate of the tax exclusion for employment-based insurance.
- m. Includes the effects of the excise tax on individual and corporate tax receipts. Such effects were not included in the March 2016 edition of this report.

uninsured than the agencies previously projected. For instance, potential enrollees' valuation of being insured compared with being uninsured may have been lower, the individual mandate may have had a smaller effect on people's decisions, and plans—such as those with high deductibles—offered by employers may have been less attractive.

CBO and JCT expect the increase in the number of uninsured people (compared with the earlier estimate) to be larger in later years, partly because a smaller proportion of people who lack an offer of insurance through an employer and who are ineligible for Medicaid are projected to enroll in nongroup insurance than previously expected. That projected change more than offsets the effects of a smaller population and greater Medicaid enrollment (in some years), which would both tend to reduce the number of uninsured people.

Employment-Based Coverage. For most years, CBO and JCT have increased last year's projections of enrollment in employment-based insurance coverage. For example, the current projections for 2018 and 2019 are about 4 million people higher than the previous ones. The size of that change declines in later years, and for 2026, the projection is 1 million people lower than it was last year.

The increases in most years reflect updated projections of wage growth, which increase the number of workers estimated to have income higher than 400 percent of the FPL. That increased proportion of higher-income workers results in a higher estimated proportion of workers with offers of employment-based health insurance and thus more people with such coverage. That increase in coverage results in part from a reduction in the number of employers that are expected to stop offering coverage to their employees—because those workers' income would be too high for them to get subsidized marketplace coverage instead. As a result, although CBO and JCT still project that some employers would stop offering coverage to their workers because of the availability of other coverage options under the ACA, the agencies now estimate that most of that change would occur a few years later and to a lesser extent than previously anticipated. Recent research has found little evidence that there has been a substantial net change so far in the number of employers that offer

coverage.²⁵ But the agencies expect that as employers gain more experience with the ACA's coverage options and as their continued availability makes employers and employees more willing to rely on them, more employers will decline to offer coverage to their employees.

The agencies' projection for 2026 of enrollment in employment-based coverage is lower than it was in March 2016 largely because of the lower total estimated population under age 65.

Medicaid. For most years, CBO has increased the March 2016 projections of enrollment in Medicaid of people made eligible by the ACA by 1 million to 2 million people. The increase is largely driven by higher-than-expected enrollment through 2016—which was the result of a larger share of eligible people's choosing to enroll in the program, CBO estimates. Possible factors increasing that enrollment rate include increased awareness; less burdensome application processes; and responses to penalties, reduced stigma, or changes in social norms related to the individual mandate.

Partly offsetting those increases in Medicaid enrollment, CBO has slowed the rate at which states are projected to expand Medicaid coverage. Previously, the agency estimated that by 2026, about 80 percent of the people who met the new eligibility criteria for Medicaid under the ACA would live in states that had expanded Medicaid coverage. Because fewer states have expanded such coverage by the end of 2017 than anticipated, CBO has reduced that share to 70 percent by 2027 in its current projections.

Also partly offsetting the projected increases in Medicaid enrollment are the agency's higher projections of earnings from wages and salaries. (Those higher earnings were

25. For example, the Employee Benefit Research Institute found no change in the percentage of people under age 65 with employment-based coverage between 2013 and 2014. See Paul Fronstin, *Sources of Health Insurance Coverage: A Look at Changes Between 2013 and 2014 From the March 2014 and 2015 Current Population Survey*, Issue Brief 419 (Employee Benefit Research Institute, October 2015), <http://tinyurl.com/hdz2bc4>. In addition, the *Employer Health Benefits Survey* reported that the percentage of firms that offered coverage to at least some of their employees in 2015 and 2016 was statistically unchanged from 2014. See Gary Claxton and others, *Employer Health Benefits: 2016 Annual Survey* (Kaiser Family Foundation and Health Research and Educational Trust, September 2016), <http://tinyurl.com/yamaox3a>.

first incorporated into Medicaid projections in CBO's January 2017 baseline.) As a result, a smaller share of the population is now projected to have income below 138 percent of the FPL, particularly in the later years of the projection period. CBO and JCT consequently expect a smaller share of the population to be eligible for Medicaid on the basis of their annual income.

Changes in the Estimates of Subsidies

In CBO and JCT's current projections, the net cost to the federal government of subsidizing health insurance coverage is \$88 billion (or about 1 percent) lower over the 2017–2026 period than it was in the agencies' March 2016 projections. That net decrease results mainly from two changes.

First, estimates of the net cost of subsidies for coverage through the marketplaces, along with estimates of related spending and revenues, are now \$137 billion lower. That net reduction results from the agencies' lower projections of subsidized enrollment through the marketplaces, partly offset by an increase in the estimated per-person cost of that coverage and of coverage in the Basic Health Program.

Second, partly offsetting the reduction in estimated subsidies is a \$47 billion decrease in estimated collections of penalty payments from employers that do not offer coverage meeting the ACA's standards. The reason is that more employers are now projected to offer health insurance to their employees in most years from 2017 to 2026.



About This Document

Each year, the Congressional Budget Office issues a series of publications describing its projections of the federal budget. This report provides background information that helps explain some of the projections in the most recent of those publications and also provides updated estimates. In keeping with CBO's mandate to provide objective, impartial analysis, this report makes no recommendations.

Susan Yeh Beyer prepared the report with contributions from Jessica Banthin and Alexandra Minicozzi. Kate Fritzsche, Sean Lyons, Sarah Masi, Eamon Molloy, Romain Parsad, Allison Percy, Ezra Porter, Lisa Ramirez-Branum, Robert Stewart, and the staff of the Joint Committee on Taxation contributed to the analysis. Chad Chirico, Theresa Gullo, Holly Harvey, and David Weaver provided guidance and helpful comments.

Mark Hadley, Jeffrey Kling, and Robert Sunshine reviewed the report; Benjamin Plotinsky edited it; and Jorge Salazar prepared it for publication. The report is available on the agency's website (www.cbo.gov/publication/53091).

A handwritten signature in black ink, appearing to read "Keith Hall".

Keith Hall
Director
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