



Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026

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Summary

The federal government subsidizes health insurance for most Americans through a variety of federal programs and tax preferences. In 2016, those subsidies for people under age 65 will total more than \$600 billion, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimate. (The government also bears significant costs for health insurance for people 65 or older, mostly through Medicare and Medicaid.)

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 otherwise indicated, all years referred to in describing estimates of mandatory 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 enrollment in any given month of 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/51385).

In preparing the March 2016 baseline budget projections, CBO and JCT updated their estimates of the number of people under age 65 who have health insurance from various sources as well as their projections of the federal subsidies associated with that coverage. Those projections encompass a broad set of budgetary effects that operate under current law, including the effects of providing preferential tax treatment for employment-based coverage, costs for providing Medicaid coverage to people under age 65, and payments stemming directly from the Affordable Care Act (ACA). In this report, CBO and JCT also present estimates that focus only on those changes in coverage and federal deficits that stem from the ACA's major provisions related to health insurance coverage.

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

By CBO and JCT's estimates, an average of about 244 million noninstitutionalized residents of the United States under age 65 will have health insurance in any given month in 2016. Almost two-thirds of them will obtain 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 that they purchase either through or outside one of the health insurance marketplaces (previously referred to as exchanges in CBO's publications) established under the ACA or coverage that is provided by Medicare or through various other sources. On average, about 27 million people under age 65—10 percent of that population—will be uninsured in 2016, CBO and JCT estimate (see [Figure 1](#)).

From 2017 through 2026, the number of people with coverage is expected to grow from 246 million to 253 million; the number of people obtaining coverage through some sources will increase slightly, and for other sources that number will decrease slightly. The number of uninsured people is also expected to rise, from 26 million to 28 million, but the portion of the under-65 population without insurance is projected to remain at about 10 percent.

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

CBO and JCT currently estimate that in 2016 the federal subsidies, taxes, and penalties associated with health insurance coverage will result in a net subsidy from the federal government of \$660 billion, or 3.6 percent of gross domestic product (GDP). That amount is projected to rise at an average annual rate of 5.4 percent, reaching \$1.1 trillion (or 4.1 percent of GDP) in 2026. For the entire 2017–2026 period, the projected net subsidy is \$8.9 trillion. Two types of costs account for most of that amount:

- Federal spending for Medicaid and CHIP benefits provided to people under age 65 (excluding those who reside in a nursing home or other institution) is projected to

amount to \$3.8 trillion—or 43 percent of the total net subsidy. That amount includes \$1.0 trillion in subsidies for people whom the ACA made eligible for Medicaid.

- Federal subsidies associated with employment-based coverage for people under age 65, which stem almost entirely from the exclusion of most premiums for such coverage from income and payroll taxes, are projected to be \$3.6 trillion—or 41 percent of the total net subsidy.

Other subsidy costs are much smaller:

- Medicare benefits (net of premium payments and other offsetting receipts) for noninstitutionalized beneficiaries under age 65 are projected to amount to \$1.0 trillion—or 11 percent of the total net subsidy. Such spending is primarily for people who are disabled.
- Subsidies for coverage obtained in the nongroup market, including the health insurance marketplaces, and through the Basic Health Program are estimated to total \$0.9 trillion—or 10 percent of the total net subsidy.

The costs of those subsidies are offset to a small extent—\$0.4 trillion (or 5 percent)—by taxes and penalties collected from health insurance providers, uninsured people, and employers.

How Much Do the ACA's Insurance Coverage Provisions Cost?

The effects of the health insurance coverage provisions of the ACA are incorporated into the estimates of overall health insurance coverage and are a subset of the estimates of the net federal subsidies associated with such coverage that are discussed above. To separate the effects of the ACA's coverage provisions from those broader estimates, CBO and JCT compared their current projections with estimates of what would have occurred if the ACA had never been enacted. In 2016, those provisions are estimated to reduce the number of uninsured people by 22 million and to result in a net cost to the federal government of \$110 billion. For the 2017–2026 period, the projected net cost of those provisions is \$1.4 trillion. Those estimates address only the insurance coverage provisions of the ACA, which do not generate all of the law's budgetary effects. Many other provisions—such as various tax provisions that increase revenues and reductions in Medicare payments to hospitals, to other providers of care, and to private insurance plans delivering Medicare's benefits—are, on net, expected to reduce budget deficits.

How Have Estimates of the Cost of the ACA's Insurance Coverage Provisions Changed?

For the 2016–2025 period, CBO and JCT's projection of the net cost of the ACA's insurance coverage provisions is now \$136 billion higher than their March 2015

estimate (from the last detailed projections that the agencies published).¹ The largest difference from the March 2015 projection stems from an increase in projected spending for Medicaid because more people whom the ACA made eligible for Medicaid are expected to enroll than were anticipated when that projection was made. Compared with the projection made by CBO and JCT in March 2010, just before the ACA was enacted, the current estimate of the net cost of the insurance coverage provisions over the 2016–2019 period (the final years of the 10-year budget window used in the original report) is lower by \$157 billion, or 25 percent.²

How Will Future Reports Present Baseline Projections Related to Insurance Coverage?

Although CBO and JCT have included in this report estimates that separately identify the effects of the ACA's insurance coverage provisions on the federal budget, generating such estimates is becoming more difficult and less meaningful. As a result, CBO and JCT will no longer make separate projections of all of the incremental effects of the ACA's insurance coverage provisions; instead, they will present their projections of overall insurance coverage levels and related subsidies, taxes, and penalties under current law. In future years, the agencies will update and publish those broader estimates annually. Consistent with their statutory responsibilities, CBO and JCT will continue to estimate the effects of proposed legislation related to the ACA, including proposals to modify certain provisions of the law or to repeal it entirely.

Health Insurance Coverage for People Under Age 65

CBO and JCT project that, on average, 90 percent of the noninstitutionalized civilian population under 65 will have health insurance coverage during 2016. The primary sources of such coverage are employment-based plans, Medicaid, nongroup policies, and Medicare.

Employment-Based Coverage

The most common source of health insurance coverage for the noninstitutionalized civilian population under age 65 is coverage obtained through an individual or family member's employer. CBO and JCT estimate that in 2016 an average of about 155 million people (or about 57 percent of the population under age 65) will have such employment-based coverage in any given month (see [Table 1](#)). This number is projected to decline to 152 million in 2019 and to stay at that level through 2026, when about 54 percent of the population under age 65 is expected to be enrolled in employment-based coverage.

1. See Congressional Budget Office, *Updated Budget Projections: 2015 to 2025* (March 2015), Appendix, www.cbo.gov/publication/49973.

2. See Congressional Budget Office, cost estimate for H.R. 4872, the Reconciliation Act of 2010 [final health care legislation] (March 20, 2010), www.cbo.gov/publication/21351.

Most of the projected reduction in employment-based coverage is attributable to the ACA: CBO and JCT expect that as a result of the ACA, some employers will decline to offer coverage and that some employees will elect to forgo offers of coverage that are made in favor of another source of coverage, such as Medicaid (see “Effects on Employment-Based Coverage” on [page 20](#)). Another factor contributing to the reduction is the continuation of 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.³ That historical decline can be seen in the decreasing share of the population under age 65 with employment-based coverage over the past three decades.⁴ Finally, projected changes in the size and composition of the labor force, due in part to the ACA and in part to the aging of the population, also factor into the projected decline in employment-based coverage.

Medicaid and CHIP

The next largest source of coverage among people under age 65 is Medicaid. CBO estimates that an average of 62 million noninstitutionalized people who receive full benefits will be covered by Medicaid in any given month in 2016.⁵ In 2026, that number is projected to grow to 69 million people (15 million made eligible through the ACA’s optional state expansion of Medicaid coverage and 54 million otherwise eligible).

CBO estimates that 6 million people, mostly children, will be enrolled in CHIP, on average, in 2016. That number falls to about 2 million in 2026, as funding projected in the baseline declines sharply.⁶ Taken together, Medicaid and CHIP are projected to provide insurance coverage for about one-quarter of the population under age 65 in 2026.

Medicaid enrollment has been boosted by implementation of the ACA. Under that law, states are permitted but not required to expand eligibility for Medicaid to adults under

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3. Michael Chernew, David M. Cutler, and Patricia Seliger Keenan, “Increasing Health Insurance Costs and the Decline in Insurance Coverage,” *Health Services Research*, vol. 40, no. 4 (August 2005), pp.1021–1039, <http://dx.doi.org/10.1111/j.1475-6773.2005.00409.x>.
 4. Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2014: With Special Feature on Adults Aged 55–64*, DHHS Publication 2015-1232 (May 2015), Table 112, [www.cdc.gov/nchs/data/14.pdf](http://www.cdc.gov/nchs/data/hus/14.pdf) (15 MB).
 5. Some enrollees receive only partial benefits from Medicaid. They include Medicare enrollees who receive only assistance with Medicare cost sharing and premiums, individuals who receive only family planning services, and unauthorized immigrants who receive only emergency services.
 6. Annual spending for CHIP reaches \$13 billion in 2017 in CBO’s current projections, but federal funding for the program expires at the end of fiscal year 2017. Under the rules governing baseline projections for expiring programs, CBO projects funding for CHIP after 2017 at an annualized amount of about \$6 billion; the estimates of enrollment shown 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 programs would terminate at some point during fiscal year 2018.

age 65 whose income is equal to or less 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 individuals than it pays for those who would have been eligible otherwise.

By the end of 2015, 30 states and the District of Columbia had expanded their programs under the ACA; about half of the people who meet the new eligibility criteria reside in those states. CBO anticipates that more states will expand coverage during the next decade and that by 2026, about 80 percent of the people who meet the new eligibility criteria will live in states that have expanded Medicaid coverage. According to CBO's estimates, on average, about 7 million people made eligible for Medicaid by the ACA were enrolled in the program in 2014. That number rose to about 10 million in 2015. The agency's estimates of enrollment over the next decade reflect the expectations that additional states will expand their Medicaid coverage and that more people will enroll in the program in those states that have already done so; the number of people made eligible for Medicaid by the ACA who are enrolled in the program is projected to reach 11 million in 2016 and 15 million in 2026 (for additional details, see "Effects on Medicaid and CHIP" on [page 19](#)).

Nongroup Coverage and the Basic Health Program

Insurance purchased individually (known as a nongroup policy) covers a much smaller share of the population under age 65 than does either employment-based group coverage or Medicaid. In 2016, about 22 million people under age 65, on average, 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 in the marketplaces—with or without government subsidies—or outside them.) An additional 1 million people are estimated to participate in the Basic Health Program, which offers subsidies to certain low-income people that are based on the subsidies available through the marketplaces.

Health Insurance Marketplaces. Under the ACA, individuals and families can purchase health insurance through the marketplaces operated by the federal government, state governments, or partnerships between the federal and state governments; those meeting certain criteria may receive federal subsidies for that coverage.

About 13 million people selected plans through the marketplaces in 2016 by the close of the open-enrollment period; however, CBO and JCT estimate that, in any given month, an average of about 12 million people will be covered by insurance

purchased through the marketplaces.⁷ The agencies estimate that 10 million of those people will receive subsidies to purchase their coverage.

CBO and JCT expect average enrollment to continue to increase to 15 million people in 2017 and then to between 18 million and 19 million people each year from 2018 to 2026. Between 80 percent and 85 percent of those enrollees—or about 14 million to 16 million people—are expected to receive subsidies for purchasing that insurance each year after 2017.

Subsidized Coverage. The number of people enrolled in subsidized coverage through the marketplaces is projected to change over the course of the 2017–2026 period for several reasons. First, CBO and JCT expect enrollment to grow from 2016 to 2018 as more people gain experience with the marketplaces and subsidies and as the penalties for not having insurance coverage are phased up to their permanent levels. Additionally, enrollment through the marketplaces depends substantially on the availability of other insurance options. 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 employers change their insurance offerings, some of their employees are expected to enroll in coverage through the marketplaces.

Projected changes to eligibility for Medicaid and CHIP will also affect who is eligible to enroll in subsidized coverage through the marketplaces. If someone is eligible for Medicaid or CHIP, he or she is not eligible to receive subsidies for coverage through a marketplace. Under current law, funding for CHIP will expire at the end of 2017. In accordance with the rules governing baseline projections, CBO therefore projects funding for CHIP after 2017 at an annualized amount of about \$6 billion. With funding at that level, significantly fewer people would be able to enroll in CHIP, and those who could not do so would instead obtain coverage through the marketplaces, Medicaid, or an employer, or they would become uninsured. CBO and JCT anticipate that about 1 million additional people would enroll in coverage through the marketplaces after CHIP's funding dropped, increasing the agencies' estimate of subsidized enrollment through the marketplaces for years after 2017.

Countering those developments—that is, decreasing the estimate of subsidized enrollment through the marketplaces—is CBO's expectation that additional states will expand eligibility for Medicaid over the 2017–2026 period. Some of the people who

7. CBO and JCT estimate that average enrollment in any given month during the year will be lower than the number of people who selected a plan by the end of the open-enrollment period and lower than the total number of people who will have coverage at some point during the year. Some people are covered for only part of the year, and enrollment varies over the course of a year because people 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 and because some people stop paying the premiums or leave their marketplace-based coverage as they become eligible for insurance through other sources.

would become eligible for Medicaid through those expansions would have otherwise been eligible to enroll in subsidized coverage through the marketplaces. CBO and JCT therefore expect that as more people become eligible for Medicaid coverage, enrollment in coverage through the marketplaces will decline. That trend continues over the 2017–2026 period in CBO’s baseline. Hence, by 2026, about 14 million people are projected to obtain subsidized coverage through the marketplaces, down from a projected peak of 16 million in 2019.

Unsubsidized Coverage. Over the 2016–2019 period, the number of people enrolled in unsubsidized coverage through the marketplaces is projected to grow from 2 million to 4 million. In the next few years, as experience with the marketplaces continues to grow—and as additional people shift out of plans purchased directly from insurers that do not comply with the ACA’s requirements but that are temporarily still available—more people who currently purchase unsubsidized coverage are expected to purchase their insurance through the marketplaces. After 2019, CBO and JCT expect unsubsidized coverage obtained through the marketplaces to stay relatively stable at around 4 million people; the expansion of Medicaid in additional states, discussed above, would probably not affect the unsubsidized population.

Other Nongroup Coverage. Outside the marketplaces, 9 million people are expected to purchase nongroup coverage in 2016, and 7 million people are expected to purchase such coverage in 2026. CBO and JCT believe that a number of people who are not eligible for subsidies for coverage through the marketplaces will continue to purchase nongroup coverage outside the marketplaces, in some cases through a broker or online. That number is projected to decline as experience with and enrollment through the marketplaces increases. Whether people who purchase unsubsidized nongroup coverage do so through a marketplace or directly from an insurer does not affect the federal budget.⁸

Basic Health Program. Under the ACA, states also have the option to establish a Basic Health Program, which is primarily for people whose income is between 138 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 otherwise have been eligible through a marketplace. States can use those funds, in addition to funds from other sources, to offer health insurance to eligible people that covers a broader set of benefits or requires smaller out-of-pocket payments than is available through the marketplaces.⁹ So far, only Minnesota and New York have created a Basic Health Program. CBO and JCT anticipate that other states will

8. Nongroup plans are generally subject to the same requirements whether they are offered through the marketplaces or directly from insurers. Insurers are also required to consider all enrollees in nongroup plans that comply with the ACA’s requirements as members of a single risk pool.

9. For more information about the Basic Health Program, see Centers for Medicare & Medicaid Services, “Basic Health Program” (accessed March 23, 2016), <http://go.usa.gov/cAa7A>.

probably pursue this option in the future but that enrollment from those states will not be large. In total, about 1 million people are projected to be enrolled in such a plan in each year from 2016 through 2026.

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 are eligible for Medicare two years after they qualify for Disability Insurance.) An average of about 9 million people under age 65 are projected to be covered by Medicare in 2016, and that number is projected to remain stable over the 2017–2026 period.

Other miscellaneous sources of coverage account for 5 million to 6 million people each year from 2016 to 2026. Those sources include student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.

Uninsured

An average of 27 million people under age 65 are projected to be uninsured in 2016. 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 estimated to reach 28 million in 2026 (see [Table 1](#)).¹⁰ In that year, according to CBO and JCT's estimates, about 35 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 35 percent would not purchase insurance to which they had access through an employer, through the marketplaces, or directly from insurers.

10. The sum of the estimates of the number of people enrolled in health insurance plans through the different sources of coverage and the number of people who are uninsured exceed CBO and JCT's estimate of the total population under age 65 by 12 million to 14 million people, depending on the year, because some people will have multiple sources of coverage. People who report having both employment-based coverage and Medicaid constitute one of the most common examples of multiple sources of coverage. To arrive at the estimates shown here, CBO and JCT have not assigned a primary source of coverage to individuals who report multiple sources of coverage. Those amounts better align with estimates of spending as well as with information on the levels and sources of health insurance coverage from household surveys. (By contrast, CBO and JCT's estimates showing changes in sources of insurance coverage stemming from the ACA have counted individuals using only their primary source of coverage because that approach has generally proven more useful for reporting incremental effects of the ACA on coverage.)

Subsidies for Health Insurance Coverage for People Under Age 65

The federal government encourages people to obtain health insurance from one of several sources by making it less expensive than it would be otherwise. Under current law, the federal government subsidizes health insurance coverage for people under age 65 in four main ways:

- Excluding from federal income and payroll taxes nearly all premiums for employment-based coverage,
- Providing roughly two-thirds of all funding for Medicaid (the states participating in the program are required to provide the remainder),
- Offering tax credits and other subsidies to people who meet various criteria and 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.

If current laws remained in place, the federal government would also collect taxes and penalties related to health insurance coverage, including 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 who do not offer health insurance that meets certain standards.

Under current law, the federal subsidy for health insurance coverage for people under age 65—net of taxes and penalties—is estimated to be about \$660 billion in 2016 and to total \$8.9 trillion over the 2017–2026 period (see [Table 2](#)). That sum reflects projections by CBO and JCT about choices that people would make about obtaining health insurance if current laws remained in place.

Those subsidy estimates differ in concept from estimates of the effects of *changes in law* that would remove those subsidies. Such cost estimates would incorporate changes in individual decisions and other behavioral responses that would be expected to occur under a proposed change in law. For instance, if the Medicaid program was altered, not only would estimates of outlays for that program change, but estimates of other outlays and revenues would probably change as well to reflect people’s responses to changes in Medicaid. Such responses are not included in the subsidy estimates in this report but would be included in estimates of the budgetary effects of legislative proposals.

Employment-Based Coverage

One of the largest subsidies for health insurance coverage is for employment-based coverage. The federal tax system provides preferential treatment for health care coverage that people receive from their employer—the most common source of

coverage for people under age 65. Employers' payments for health 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.

Owners of noncorporate businesses generally are not considered employees and therefore are not eligible for the exclusion of health insurance benefits purchased by their businesses. They are, however, allowed to deduct that cost from their taxable income. The deduction for self-employed individuals who participate in their company's group health plan is included in this estimate of subsidies conveyed through the tax system for employment-based coverage. The deduction for self-employed individuals who purchase nongroup insurance is discussed below.

In all, JCT estimates that subsidies for employment-based coverage will total about \$266 billion in 2016. That amount is estimated to grow to roughly \$460 billion in 2026 and to total \$3.6 trillion over the 2017–2026 period. The amount of the tax subsidy for employment-based coverage is very large because the number of people with such coverage is large. It is important to note that the estimate of the subsidy is not equal to the tax revenues that would be collected if the tax exclusion was eliminated because people would adjust their behavior to reduce the tax liability created by such a change.

Other budgetary effects related to employment-based coverage result from tax credits for certain small employers that provide health insurance to their employees; they are eligible to receive a tax credit of up to 50 percent of the cost of that insurance. CBO and JCT project that, under current law, those tax credits would amount to about \$1 billion a year, totaling \$9 billion over the 2017–2026 period.

Medicaid and CHIP

Outlays for all noninstitutionalized Medicaid and CHIP enrollees under age 65 who receive full benefits are estimated to amount to \$279 billion in 2016.¹¹ Over the 2017–2026 period, estimated outlays total \$3.8 trillion—\$1.0 trillion (26 percent) for people whom the ACA made eligible for Medicaid and \$2.8 trillion (74 percent) for people who would have been eligible for Medicaid or CHIP otherwise. Medicaid spending for the noninstitutionalized population under age 65 accounts for roughly 75 percent of total projected Medicaid spending over the 2017–2026 period.

Nongroup Coverage and the Basic Health Program

In 2016, premium tax credits, cost-sharing subsidies, Basic Health Program payments, net spending and revenues for risk adjustment and reinsurance, and grants to states will total \$43 billion, CBO and JCT estimate (see [Table 2](#)). Over the 2017–2026 period,

11. Spending for enrollees who receive partial assistance is excluded from those totals.

subsidies for coverage through the marketplaces and related spending and revenues are projected to total \$866 billion, as follows:

- Outlays of \$568 billion and a reduction in revenues of \$104 billion for premium tax credits (to cover a portion of eligible individuals' and families' health insurance premiums), which together total \$672 billion;
- Outlays of \$130 billion for cost-sharing subsidies (which reduce out-of-pocket payments for low-income enrollees);
- Outlays of \$63 billion for the Basic Health Program;
- Outlays of \$92 billion and revenues of \$91 billion related to payments and collections for risk adjustment and reinsurance (the projected outlays and revenues are exactly offsetting over the life of the programs, meaning they will ultimately have no net budgetary effect); and
- Outlays of less than \$1 billion for grants to states for establishing health insurance marketplaces.

Combined, the subsidies for coverage through the marketplaces and the Basic Health Program are projected to average \$4,240 per subsidized enrollee in calendar year 2016 and to rise to about \$7,100 in 2026.

Subsidies for insurance obtained through the health insurance marketplaces depend on the number of people who purchase such coverage, the reference premiums for the policies, and certain characteristics of enrollees, such as family size and income. (See [Box 1](#) for more on reference premiums.) Those subsidies fall into two categories: subsidies to cover a portion of participants' health insurance premiums and subsidies to reduce their cost-sharing amounts (out-of-pocket payments required under insurance policies). The first category of subsidies 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 available to those who are eligible for premium subsidies, 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 health insurers would bear especially high costs for having a disproportionate share of less healthy enrollees.¹² The programs, which were implemented in 2014, make payments to insurers that reflect differences in the health

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

status of each insurer's enrollees and in the resulting costs to insurers; those payments are financed by corresponding collections 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. Payments under the risk adjustment and reinsurance programs are recorded in the budget as mandatory outlays, and collections are recorded as revenues. In CBO's projections for the 2017–2026 period, risk-adjustment payments and collections each total about \$86 billion, and reinsurance payments and collections each total \$5 billion.¹³ Collections and payments ultimately offset exactly, but because of differences in the timing of collections and payments, slight discrepancies between the two will occur in any given period.

Nongroup coverage is also subsidized in part by the income tax deduction for self-employed health insurance. JCT estimates the cost of the tax preference for self-employed people who purchase nongroup insurance to be \$53 billion over the 2017–2026 period.

Medicare

Net outlays associated with Medicare coverage for noninstitutionalized people under age 65 are projected to be \$80 billion in 2016 and to total \$979 billion over the 2017–2026 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 \$15 billion in 2016. Under current law, those taxes and penalties would total \$441 billion over the 2017–2026 period, CBO and JCT estimate.

Excise Tax on High-Premium Insurance Plans. The ACA established an excise tax on certain high-cost employment-based coverage, which 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, federal collections of those excise taxes on high-cost group health plans total \$18 billion over the 2017–2026 period (see [Table 2](#)).

The excise tax is expected to cause employers and workers to shift to health plans with lower premiums to avoid paying the tax entirely or to reduce their tax liability. Those shifts will generally result in higher taxable income for affected workers, CBO and JCT

13. The ACA also established a risk corridors program designed in part to protect insurers from particularly large losses. Risk corridors are treated differently from risk adjustment and reinsurance: The payments to insurers are recorded as discretionary spending, and the government's collections from insurers are recorded as offsets to discretionary spending. Collections and spending for that program in 2016, related to plans purchased in 2014, each total \$362 million.

estimate, because those workers will receive less of their income in nontaxable health benefits and more in taxable wages.¹⁴

The net increase in revenues from the excise tax collections and from related shifts in taxable compensation combined is projected to be \$79 billion over the 2017–2026 period (see [Table 3](#)).

Penalty Payments by Uninsured People. Under a provision of the ACA known as the individual mandate, most U.S. citizens and noncitizens who lawfully reside in the country must either obtain health insurance or pay a penalty for not doing so. People who do not comply with the individual mandate (and do not obtain an exemption) must pay a penalty. The penalty equals the greater of two amounts: either a fixed dollar amount assessed for each uninsured person in a household or a share of the difference between the household’s adjusted gross income and its income threshold for tax filing. The fixed dollar amount per uninsured adult rises from \$325 in 2015 to \$695 in 2016 and at the rate of general inflation thereafter; the penalty per child is half as large. The income-based penalty rises from 2 percent in 2015 to 2.5 percent in 2016 and later. Both penalties are subject to a cap, and people who are uninsured for only part of the year face a reduced 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 8.13 percent in 2016 and is indexed for inflation thereafter. Other exemptions include those for having income below the tax-filing threshold, experiencing certain hardships, and being a member of certain religious groups. CBO and JCT expect that a substantial majority of the roughly 27 million people estimated to be uninsured in 2016 will receive an exemption. All told, the agencies expect that, on average, about 3 million people will pay the penalty for being uninsured in any given month in 2016 (including dependents who have the penalty paid on their behalf). Because some people will be insured in some months and uninsured in others, the total number of people who pay a penalty during that year will be greater than the monthly average.

According to the Internal Revenue Service, as of October 2015, roughly \$2 billion in penalty payments had been collected from people who were uninsured during 2014.¹⁵ In CBO and JCT’s projections, penalty payments by uninsured people amount to \$3 billion in 2016 and total \$38 billion over the 2017–2026 period.

14. Under the opposite assumption—that workers’ total compensation would be reduced by the amount of the premium reduction—their employers would have smaller deductions for compensation costs, and hence more taxable income. The resulting revenues would be similar to the amounts projected in the baseline.

15. John Koskinen, Internal Revenue Service, letter to Members of Congress (January 8, 2016), <http://go.usa.gov/cGh5j> (PDF, 196 KB).

Tax on Health Insurance Providers. Health insurers are subject to an excise tax established by the ACA. 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 prior year. Several categories of health insurers—such as self-insured plans and certain state government entities and tax-exempt providers—are fully or partially exempt from the tax. Fiscal year revenues from the tax, which began to be collected in 2014, are projected to total \$11 billion in 2016 but to fall to about \$1 billion in 2017 as a result of recent legislation that placed a moratorium on that tax for calendar year 2017. Receipts from the tax, under current law, would reach about \$13 billion in 2018 and rise steadily thereafter to about \$21 billion by 2026, for a total of \$156 billion over the decade, CBO and JCT estimate.

Employer Penalties. Some large employers who 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. The standards specify income-related thresholds regarding the costs of that coverage and the share of the cost of covered health benefits paid by the employer's insurance plan.¹⁶ 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 \$228 billion over the 2017–2026 period. However, the increased costs for employers who pay the penalties are projected to reduce other revenues by about \$50 billion because employers will generally shift the costs of the penalties to workers by lowering taxable wages, yielding a net reduction in the deficit of \$178 billion (see [Table 3](#)). The associated effects of changes in taxable compensation on tax revenues are included in JCT's estimate of the effects of the tax exclusion for employment-based coverage (in [Table 2](#)).

Effects of the Insurance Coverage Provisions of the ACA

The estimates of health insurance coverage and of the net federal subsidies associated with such coverage presented and discussed in the previous two sections of this report incorporate the effects of the insurance coverage provisions of the ACA. CBO and JCT also isolated the effects of those provisions for this report by comparing, as they have done in previous reports, their current projections with estimates of what would have occurred if the ACA had never been enacted. In 2026, 24 million more people are projected to have coverage than would have had it if the ACA had never been enacted. Two of the ACA's provisions in particular—those governing the health insurance marketplaces and allowing states to expand Medicaid coverage—are responsible for most of that increase. The number of people with employment-based coverage

16. To meet the standards, the cost to employees for self-only coverage must not exceed a specified share of their income (which is 9.66 percent in 2016 and is indexed for inflation over time), and the plan must pay at least 60 percent of the cost of covered benefits.

and the number of people with nongroup or other coverage outside the marketplaces are projected to decrease because of the ACA, but to a lesser degree.

The health insurance coverage provisions of the ACA will result in net costs to the federal government of \$110 billion in 2016, according to CBO and JCT's estimates (see [Table 3](#)). Those costs are expected to grow each year over the next decade, but such growth would slow after 2026. For the 2017–2026 period, the projected net cost of those provisions is \$1.4 trillion, consisting of the following amounts:

- Gross costs of \$1.9 trillion for subsidies for coverage obtained through the health insurance marketplaces or provided through the Basic Health Program, Medicaid and CHIP, and tax credits for small employers; and
- An offsetting amount of \$0.5 trillion in net receipts from penalty payments, revenues resulting from the excise tax on certain high-premium insurance plans, and the effects on income and payroll tax revenues and associated outlays arising from projected changes in employment-based coverage.

The agencies have separately identified those effects on coverage and net costs in this report but will not do so in the future because estimating what would have occurred if the ACA had never been enacted is becoming more difficult. (See [Box 2](#) for more information.) The estimates address only the insurance coverage provisions of the ACA, which do not generate all of the law's budgetary effects.¹⁷ Many other provisions—such as various tax provisions that increase revenues and reductions in Medicare payments to hospitals, to other providers of care, and to private insurance plans delivering Medicare's benefits—are, on net, expected to reduce budget deficits.

The estimates of the effects of the insurance coverage provisions of the ACA incorporate CBO's updated economic projections, data on enrollment through the marketplaces through the end of January 2016, administrative data on Medicaid enrollment, new data on premiums for both employment-based coverage and plans purchased through the marketplaces, and recent decisions by states about expanding Medicaid coverage. The updated estimates also incorporate several technical improvements to modeling, including a decrease in the share of future wage growth projected to go to lower-income people.

Insurance Coverage Provisions

Among the many insurance coverage provisions of the ACA are the following key elements:

17. For more information, see Congressional Budget Office, "Estimating the Budgetary Effects of the Affordable Care Act," *CBO Blog* (June 17, 2014), www.cbo.gov/publication/45447.

- Many individuals and families are eligible for subsidized health insurance through the health insurance marketplaces or through the Basic Health Program that states have the option of establishing.
- States are permitted but not required to expand eligibility for Medicaid to 138 percent of the FPL, and the federal government pays a larger share of the costs for individuals whom the ACA made eligible than for those who would have been eligible otherwise.
- Beginning in 2016, the federal government pays a larger share of the costs for CHIP.¹⁸
- Under the individual mandate, most citizens of the United States and noncitizens who are lawfully present in the country must either obtain health insurance or pay a penalty for not doing so.
- Certain employers that decline to offer their employees health insurance coverage that meets specified standards are assessed penalties.
- Beginning in 2020, a federal excise tax will be imposed on some health insurance plans with high premiums. Although that tax was originally scheduled to take effect in 2018, the Consolidated Appropriations Act, 2016, delayed the start by two years.
- Plans sold through the marketplaces along with most sold directly to consumers must accept all applicants regardless of their health status, and premiums for those plans may vary only by age (for adults age 21 or older, such variation is limited to a ratio of 3 to 1), smoking status, and geographic location.
- Children are generally permitted to stay on a parent's insurance plan until age 26.
- 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.

The ACA also made changes to other rules governing health insurance coverage that are not listed above. Most of those rules address coverage in the nongroup, small-group, and large-group markets, including in some cases self-insured plans

18. CHIP, which was funded through the end of 2013 before the enactment of the ACA, received funding under the ACA for 2014 and 2015. Funding was subsequently provided through 2017 by the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10). As a result, CBO no longer counts its funding for additional years as an effect of the ACA.

(employment-based plans for which the risk is borne not by insurers but by employers).¹⁹

Several of the ACA's insurance coverage provisions have been modified by subsequent legislation, judicial decisions, or administrative actions. CBO and JCT's estimates are for the provisions as they currently exist and are being implemented; as a result, those estimates differ from what would have happened under the law as originally enacted.

Effects on the Uninsured

By CBO and JCT's estimates, an average of about 35 million residents of the United States under age 65 were uninsured during any given month in 2015; that is about 17 million less than the number of people under 65 that the agencies estimate would have been uninsured if the ACA had never been enacted.²⁰

Those estimates of the effects of the ACA on insurance coverage are the net result of several changes in the extent and types of coverage. In 2026, 18 million people are projected to have coverage through the health insurance marketplaces, 1 million people are projected to have coverage through the Basic Health Program, and 19 million more people, on net, are projected to have coverage through Medicaid and CHIP than would have had it if the ACA had not been enacted. Partly offsetting those increases, however, are projected net decreases of 9 million in the number of people with employment-based coverage and 4 million in the number of people with coverage in the nongroup market outside the marketplaces or with coverage through other sources.

19. For more information on regulations governing health insurance, see Congressional Budget Office, *Private Health Insurance Premiums and Federal Policy* (February 2016), www.cbo.gov/publication/51130.

20. CBO and JCT's estimate of the number of people who would have been uninsured if the ACA had never been enacted is different from the result of subtracting the number of people who were uninsured in 2013 or 2014 from the number who were uninsured in 2015. The agencies' estimate accounts only for the effects of the coverage provisions since the law's enactment, whereas tallies in any given year after the enactment would also incorporate the incremental changes in that year from any underlying trends that would have occurred if the law had never been enacted. This estimate cannot be directly compared with estimates of the reduction in the number of uninsured people made by the Department of Health and Human Services, although it is broadly consistent with those estimates. CBO and JCT's estimate differs from the Administration's partly because of a difference in timing; the Administration's most recent estimate goes through the first quarter of 2016, whereas CBO and JCT's estimate covers only calendar year 2015. Additionally, the two estimates use a different population; CBO and JCT include children in their estimates, whereas the Administration does not. See Namrata Uberoi, Kenneth Finegold, and Emily Gee, *Health Insurance Coverage and the Affordable Care Act, 2010–2016*, ASPE Issue Brief (Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, March 2016), <http://go.usa.gov/cGzjw> (PDF, 732 KB); and Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Coverage and the Affordable Care Act," ASPE Data Point (September 2015), <http://go.usa.gov/cGzjk> (PDF, 536 KB).

Some people will pay penalties for being uninsured. CBO and JCT estimate those penalties to amount to \$3 billion in 2016 and \$5 billion in 2026. For the 2017–2026 period as a whole, those amounts are projected to total \$38 billion.

Effects on Medicaid and CHIP

According to CBO's estimates, the total increase in Medicaid enrollment stemming from the ACA will average 13 million in any given month in 2016; that number is projected to continue to grow over the coming years as more states expand their Medicaid programs to people whose income is at or below 138 percent of the FPL. By 2026, the number of people enrolled in Medicaid as a result of the ACA is estimated to average 19 million (see [Table 4](#)).

In its estimates, CBO can identify people whom the ACA made eligible for Medicaid because the federal government pays a higher share of costs for those enrollees (and as a result, they are tracked separately). The agency estimates that those enrollees constitute the majority of people enrolling in Medicaid as a result of the ACA. (In addition, CBO expects that some people who would have been eligible for Medicaid but who would not have enrolled if the ACA had never been enacted will now enroll in the program.) The number of people enrolled in Medicaid who were made eligible by the ACA was about 10 million in 2015. The agency's estimates of enrollment over the next decade reflect the expectation that additional states will expand Medicaid coverage and that more people will enroll in the program in states that have already expanded Medicaid; the number of people enrolled in Medicaid who were made eligible by the ACA is projected to reach 11 million in 2016 and 15 million in 2026.

In addition, CBO and JCT expect that the ACA's individual mandate, increased outreach efforts under that law, and new opportunities for eligible people to apply for coverage through the health insurance marketplaces will increase enrollment of people who would have been eligible for Medicaid if the ACA had not been enacted. CBO estimates that in 2015, Medicaid enrollment increased by about 2 million people who would have been eligible without the ACA but who chose to enroll as a result of the ACA's enactment. (That estimate cannot be verified because there is no way to know whether new enrollees who would have been eligible without the ACA would have signed up if the ACA had never been enacted.)

As with projections of enrollment through the health insurance marketplaces, the numbers that CBO projects for Medicaid enrollment represent averages over the course of a year and differ from counts of enrollment at any particular point during a year. Unlike the rules governing plans offered through the marketplaces, which limit enrollment opportunities to an annual open-enrollment period and to other specified circumstances, the rules governing Medicaid allow people who are eligible to enroll at any time during a year. People move into and out of Medicaid for many reasons, including changes in their need for health care and changes in their financial circumstances.

Although several provisions of the ACA probably affect enrollment in CHIP, CBO estimates that, on net, CHIP enrollment will be largely unchanged by the ACA. The agency estimates that the ACA nevertheless affects federal spending for CHIP. In particular, it increased the share of CHIP's costs covered by the federal government, and that cost is included in the estimated budgetary effects of the ACA presented in this report.

In CBO and JCT's projections, the additional cost to the federal government for Medicaid and CHIP resulting from the ACA is \$74 billion in 2016 and grows to \$144 billion in 2026. For the 2017–2026 period as a whole, that cost is projected to total \$1,063 billion (see [Table 3](#)). Federal spending for people whom the ACA made eligible for Medicaid is projected to be \$64 billion in 2016 and to total \$969 billion over the 2017–2026 period.

Effects on the Marketplaces and the Basic Health Program

Because the ACA established subsidies for health insurance purchased through the marketplaces and the Basic Health Program, the incremental effects of the ACA associated with those sources of insurance are the same as the overall effects discussed earlier in this report.

About 13 million people selected health insurance plans for 2016 through the marketplaces by the close of the open-enrollment period; however, CBO and JCT estimate that the average number of people who are covered by insurance purchased through the marketplaces during the year will be 12 million. The agencies estimate that 10 million of those people, on average, will receive subsidies to purchase their coverage.

CBO and JCT project average enrollment to continue to increase to 15 million people in 2017 and then to be between 18 million and 19 million people each year from 2018 to 2026. Between 80 percent and 85 percent of those enrollees—or about 14 million to 16 million people—are expected to receive subsidies for purchasing that insurance each year after 2017.

In 2016, premium tax credits, cost-sharing subsidies, Basic Health Program payments, net spending and revenues for risk adjustment and reinsurance, and grants to states will total \$43 billion, CBO and JCT estimate (see [Table 3](#)). That amount is projected to rise to \$106 billion in 2026 and to total \$866 billion over the 2017–2026 period.

Effects on Employment-Based Coverage

Changes in employment-based coverage under the ACA affect federal tax revenues and outlays. In particular, if fewer people have employment-based health insurance, CBO and JCT expect that more of their income will take the form of taxable wages and thus increase revenues. As a result of the ACA, between 4 million and 9 million fewer people are projected to have employment-based coverage each year from 2017

through 2026 than would have had such coverage if the ACA had never been enacted. That net difference is the result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by active workers, retirees under age 65, and their families.

Those projected changes in coverage can be illustrated for a particular year. In 2026, for example, CBO and JCT estimate that 9 million fewer people would have employment-based coverage under current law than would have had it if the ACA had not been enacted. About 11 million people who would have enrolled in employment-based coverage had the ACA never been enacted are projected, under current law, to no longer have an offer of such coverage. An additional 4 million people who would have enrolled in employment-based coverage in the absence of the ACA and who will still have such an offer under the ACA are projected to nevertheless choose not to enroll in that coverage. Some of those 15 million people are expected to obtain coverage from some other source, such as Medicaid, for which they were made eligible by the ACA.

Those decreases in employment-based coverage in 2026 are, however, projected to be partially offset. About 6 million people who would not have had employment-based coverage if the ACA had never been enacted are expected to obtain such coverage under current law; they will either receive and accept a new offer of coverage or take up an offer that they would have received anyway. Some of those enrollees would have been uninsured if the ACA had never been enacted.

Because of the net reduction in employment-based coverage, the share of workers' pay that takes the form of nontaxable benefits (such as payments toward health insurance premiums) will be smaller—and the share that takes the form of taxable wages will be larger—than would otherwise have been the case. That shift in compensation is projected to reduce deficits by \$5 billion in 2016 and by a total of \$248 billion over the 2017–2026 period, primarily by boosting federal tax receipts, but also by reducing outlays from certain refundable tax credits. Partially offsetting the additional receipts during that period is an estimated \$9 billion increase in Social Security benefits that will be paid because of the higher wages paid to workers. All told, CBO and JCT project, those changes would reduce federal budget deficits by \$239 billion over the 2017–2026 period.

Effects on Nongroup and Other Coverage

According to CBO and JCT's estimates, 2 million fewer people will be enrolled in nongroup insurance plans offered outside the marketplaces or in other types of coverage, such as student health plans, in 2016 than if the ACA had not been enacted. That number stems almost entirely from changes in enrollment in nongroup plans and is expected to continue to grow over the coming years as more people switch to nongroup coverage offered through the marketplaces. By 2026, an average of 4 million fewer people are projected to enroll in nongroup plans outside the marketplaces and other types of coverage as a result of the ACA. The budgetary

effects caused by people switching out of nongroup plans—to enroll in Medicaid or subsidized coverage through the marketplaces, for example—are embedded in the estimates discussed above.

Trends in Net Costs of the Insurance Coverage Provisions of the ACA Beyond 2026

The projected costs of the insurance coverage provisions of the ACA continue to grow toward the end of the 2017–2026 period; however, CBO and JCT expect that growth to slow after 2026—possibly to such an extent that those net costs eventually decline—for two main reasons. First, the agencies anticipate that growth in the gross costs of coverage will begin to slow after 2026. In particular, additional states are projected to expand Medicaid coverage to people below 138 percent of the FPL in each year between 2017 and 2026. Hence, projected growth over the next decade in spending for Medicaid and CHIP that is attributable to the ACA reflects both additional enrollment and underlying trends in health costs. However, CBO and JCT estimate that additional states are unlikely to expand Medicaid coverage after 2026; growth in spending for Medicaid and CHIP attributable to the ACA would therefore probably be slower after 2026 than it is projected to be towards the end of the 2017–2026 period.

Second, CBO and JCT project that the revenues resulting from the excise tax on high-premium insurance plans will offset more of the gross costs of the ACA's insurance coverage provisions over time. The tax is expected to affect an increasing share of coverage offered through employers because premiums for health insurance are projected to increase more rapidly than the threshold for determining liability for the tax, thus generating rising revenues.

Changes in the Estimates of the Effects of the Insurance Coverage Provisions of the ACA Since March 2015

In CBO and JCT's current projections, in 2025 an average of 24 million people who would otherwise have been uninsured have health insurance because of the ACA. That estimate is 1 million less than the agencies' estimate from the most recent detailed projections of the effects of the ACA's insurance coverage provisions, which were published in March 2015.²¹ For the 2016–2025 period covered by both last year's and the current projections, the agencies have increased their estimate of the net cost

21. CBO and JCT last published detailed projections of the effects of the ACA's insurance coverage provisions as part of CBO's March 2015 baseline update. This report compares the current baseline projections with those projections. See Congressional Budget Office, *Updated Budget Projections: 2015 to 2025* (March 2015), Appendix, www.cbo.gov/publication/49973. Some of the revisions described in this report, such as those stemming from changes in law and the higher-than-expected enrollment in Medicaid among people whom the ACA made eligible for the program, were previously incorporated into CBO's August 2015 or January 2016 baselines. See Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2015 to 2025* (August 2015), Appendix A, www.cbo.gov/publication/50724, and *The Budget and Economic Outlook: 2016 to 2026* (January 2016), Appendix A, www.cbo.gov/publication/51129.

of those provisions from \$1,207 billion to \$1,344 billion (see [Table 5](#)).²²

Key Factors Contributing to Changes in the Estimates

The increase in the net cost of the coverage provisions results primarily from incorporating new data about enrollment and employer behavior and updates to CBO's projections of income.

The number of people estimated to have been enrolled in Medicaid in 2015 who were made eligible for the program by the ACA was significantly higher than CBO had previously projected, leading the agency to boost its projections of enrollment in the program in the first few years of the projection period. Conversely, CBO and JCT have lowered their projections of subsidized and unsubsidized coverage purchased through the marketplaces on the basis of information available about such enrollment in 2016. In addition, on the basis of available information from surveys, it appears that more employers are continuing to offer coverage to their employees than CBO and JCT had previously anticipated.

Over the next decade, earnings from wages and salaries are now expected to increase more slowly for lower-income people and more quickly for higher-income people than they were in the March 2015 projections.²³ Furthermore, average household wages in the current forecast are projected to be 1 percent to 2 percent lower overall through most of the next decade than they were previously projected to be during those years. Those revisions result in an increased share of the population with income below 200 percent of the FPL in the current projections, particularly in the latter years of the projection period. That increase expanded CBO's estimate of the share of the population eligible for Medicaid and thus further boosted projected enrollment in that program. One other result of the projected changes in income is that CBO and JCT have increased their projections of the per-person cost of subsidized coverage through the marketplaces and the Basic Health Program.

Several pieces of legislation enacted since March 2015 also affected projected enrollment and costs for Medicaid, the marketplaces, and employment-based coverage as well as projected revenues stemming from the excise tax on certain high-premium insurance plans. The net budgetary effect of those new laws on the ACA's insurance coverage provisions was small, however.

22. For changes since January 2016 in estimates for individual budget accounts affected by the ACA, see *Updated Budget Projections: 2016 to 2026* (March 2016), www.cbo.gov/publication/51384.

23. That technical change was implemented in CBO's January 2016 revenue projections and was incorporated into the estimates of the ACA's insurance coverage provisions presented in this report.

Changes in the ACA's Projected Effects on Health Insurance Coverage

Primarily as a result of those factors discussed above, CBO and JCT raised their projections for Medicaid enrollment, lowered their projections for coverage through the marketplaces, and revised their estimates of employment-based coverage.

Medicaid and CHIP. For most years, CBO has increased last year's projection of new enrollment in Medicaid resulting from the ACA by 2 million to 4 million people because the average number of people estimated to have been enrolled in 2015 who were made eligible by the ACA exceeded CBO's prior estimates by 2 million. In addition, the agency's projections of income growth and wages result in a larger share of the population having income below 138 percent of the FPL than was previously projected. The higher projected enrollment in each year over the next decade is the result of increases in CBO's estimates of both the share of the population that is eligible for Medicaid and the share of the eligible population that enrolls in the program.

Partially 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 2020, 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. CBO now projects that share would be reached in 2026.

All told, in CBO's current projection, an average of 18 million people are enrolled in Medicaid or CHIP in any given month in 2025 as a result of the ACA; in its March 2015 projection, that number was about 14 million (see [Table 5](#)).

Health Insurance Marketplaces and the Basic Health Program. The agencies have decreased their estimate of enrollment in coverage through the health insurance marketplaces and the Basic Health Program in each year. In CBO and JCT's current projections, in 2025 an average of 19 million people are enrolled in coverage through marketplaces or the Basic Health Program in any given month, whereas in last year's projections that number was 22 million. As part of that change, CBO and JCT have lowered their estimate of the number of people who will receive subsidies for enrolling in health insurance plans through the marketplaces. In March 2015, the agencies estimated that an average of 15 million people would receive subsidized coverage through the marketplaces in any given month in 2016 and that between 16 million and 18 million people, on average, would receive such coverage in later years. In the current projection, those estimates have fallen to 10 million people with subsidized

coverage in 2016 and between 12 million and 16 million people with such coverage in later years.²⁴

The reduction in the number of people who are projected to receive subsidies for coverage through the marketplaces, particularly in the near term, partly stems from the lower estimate of the number of people projected to lose their offer of employment-based coverage as a result of the ACA (as discussed below), which in turn reduced the number of people who are eligible to receive a subsidy through the marketplaces. (CBO and JCT expect employers to respond to the availability of new insurance coverage options under the ACA—by not offering insurance coverage for their employees—more slowly than the agencies had anticipated.) In addition, part of the reduction reflects a technical reclassification of about 1 million people who are estimated to obtain subsidized coverage through the Basic Health Program.²⁵

CBO and JCT have also revised downward their projection of unsubsidized enrollment in nongroup coverage through health insurance marketplaces because such enrollment has been smaller than they anticipated in the first two years that the marketplaces have been in operation. In the March 2015 projection, the agencies estimated that in each of the next 10 years, an average of 6 million people would be enrolled in unsubsidized plans purchased through the marketplaces in any given month; they now estimate that number will be 2 million in 2016, and it is projected to grow to 4 million by 2019. Some of the unsubsidized people who are no longer expected to purchase insurance through a marketplace are expected to purchase insurance directly from an insurer instead, particularly over the next two years.

Employer-Based Coverage. In CBO and JCT's current projections, the net reduction in employment-based coverage stemming from the ACA starts out 4 million smaller in 2016 (a reduction of 2 million in that year rather than the 6 million previously estimated), but grows to be about 2 million larger in 2025 (a reduction of 9 million in that year rather than the 7 million previously estimated). That net change reflects two offsetting factors. First, CBO and JCT still project that some employers will stop offering health insurance coverage to their workers, but they now estimate that those changes

24. In January, CBO and JCT projected that an average of 11 million people in any given month would receive subsidized coverage through health insurance marketplaces in 2016. On the basis of new information on enrollment through the close of the open-enrollment period for the year, the agencies now project that in any given month in 2016, the average subsidized enrollment will be around 10 million people. See Congressional Budget Office, *The Budget and Economic Outlook: 2016 to 2026* (January 2016), p. 17, www.cbo.gov/publication/51129.

25. In previous projections, CBO and JCT had not identified those enrollees separately and instead included them in their estimate of the number of people who purchased subsidized coverage through the marketplaces. Because those enrollees do not sign up for coverage through the marketplaces and therefore are not included in data on total enrollment through the marketplaces, the agencies now provide separate estimates of the number of people who receive a subsidy through the marketplaces and the number of people who receive a subsidy through the Basic Health Program.

will, for the most part, occur a few years later and to a lesser extent than previously anticipated because there is little evidence that a substantial number of employers have changed their decision to offer health insurance coverage.²⁶ Second, CBO and JCT now project that fewer people will choose to enroll in employment-based coverage that is available to them than previously estimated. That reduction stems from an increase in the number of people whom the ACA made eligible for Medicaid who are expected to enroll in that program instead of remaining enrolled in employment-based coverage, as well as from legislation enacted that repealed the automatic enrollment requirement for certain large employers.²⁷

Changes in the Budgetary Effects of the ACA's Insurance Coverage Provisions

In CBO and JCT's current projections, the net cost of the ACA's insurance coverage provisions is \$136 billion (or 11 percent) higher over the 2016–2025 period than it was in their March 2015 projections. That net increase results mainly from the following changes:

- A \$146 billion increase in projections of federal spending for Medicaid and CHIP, mostly attributable to higher estimated enrollment among people whom the ACA made eligible for Medicaid.
- A \$46 billion reduction in the estimated net cost of subsidies for coverage through the marketplaces and in related spending and revenues. That net reduction results from a downward revision of projected subsidized enrollment through the marketplaces, which was partially offset by an increase in the estimated per-person cost of subsidized coverage through the marketplaces and the Basic Health Program.
- A \$28 billion reduction in projections of federal revenues—and thus a \$28 billion increase in the net cost of the coverage provisions—related to the excise tax on certain high-premium insurance plans. That reduction stems mainly from legislation enacted in 2015 that delayed the implementation of that tax and made it deductible to employers; a small decrease in the projected growth of premiums for employment-based coverage also contributed to that reduction.

26. For example, the Employee Benefit Research Institute found no change in the percentage of people under the age of 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, 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 was statistically unchanged from 2014. See Gary Claxton and others, *Employer Health Benefits: 2015 Annual Survey* (Kaiser Family Foundation and Health Research and Educational Trust, 2015), <http://tinyurl.com/h5xnpno>.

27. Section 604 of the Bipartisan Budget Act of 2015 (P.L. 114-74) repealed the requirement under the ACA that certain large employers automatically enroll new employees in a health insurance plan and continue the enrollment of current employees.

Various other small revisions account for the remaining \$8 billion net increase in the projected net cost of the ACA's insurance coverage provisions over the 2016–2025 period.

Changes in the Estimates Since the Enactment of the ACA

Although CBO and JCT's current projection of the net cost of the ACA's insurance coverage provisions is higher than the March 2015 projection for the period spanned by both estimates, the current projection is lower than the agencies' original estimate, made when the law passed in March 2010, for the four years covered by the two estimates (see [Figure 2](#)). In 2010, CBO and JCT projected that the provisions of the ACA that were related to health insurance coverage would cost the federal government \$623 billion from 2016 through 2019. In the agencies' current projections, those provisions are estimated to cost \$466 billion over that same period, a reduction of 25 percent. For 2019, for example, CBO and JCT projected in March 2010 that the ACA's insurance coverage provisions would have a net federal cost of \$172 billion; the current projections show a cost of \$123 billion—a reduction of \$49 billion, or 28 percent.

Technical revisions and updates to CBO's economic projections account for part of the downward revision since March 2010 to CBO and JCT's estimates (when measured on a year-by-year basis). For example, in light of new data showing slower-than-expected growth in enrollment through the health insurance marketplaces, CBO and JCT have revised downward their estimates of subsidies for coverage through the marketplaces, particularly those for the 2016–2019 period. Another revision that reduced projected federal costs was the slowdown in the overall growth of health care costs covered by private insurance and by the Medicare and Medicaid programs. Although it is unclear how much of that slowdown is attributable to the recession and its aftermath and how much reflects other factors, the slower growth has been sufficiently broad and persistent to persuade the agencies to significantly lower their projections of federal costs for health care.

Judicial decisions, new legislation, and administrative actions also help explain the significant changes in the projected net costs of those provisions. For example, the Supreme Court decision that made the expansion of eligibility for Medicaid optional for states significantly reduced projected net costs. As a result of such developments, assessing the accuracy of CBO and JCT's March 2010 estimate has become more difficult over time.

About This Document

Each year, the Congressional Budget Office issues a series of reports about the federal budget. This study provides background information that helps to explain some of the projections included in the most recent report, *Updated Budget Projections: 2016 to 2026*. In keeping with CBO's mandate to provide objective, impartial analysis, the report makes no recommendations.

Kate Fritzsche and Sarah Masi prepared the report with contributions from Jessica Banthin and Philip Ellis. Susan Beyer, Daniel Hoople, Sean Lyons, Alexandra Minicozzi, Eamon Molloy, Romain Parsad, Allison Percy, Kyle Redfield, Robert Stewart, and the staff of the Joint Committee on Taxation contributed to the analysis. Linda Bilheimer, Chad Chirico, Theresa Gullo, and Holly Harvey provided guidance and helpful comments.

Jeffrey Kling and Robert Sunshine reviewed the report, Bo Peery edited it, and Maureen Costantino and Jeanine Rees prepared it for publication. The report is available on the agency's website (www.cbo.gov/publication/51385).

A handwritten signature in black ink, appearing to read "Keith Hall". The signature is fluid and cursive, with the first name "Keith" and last name "Hall" clearly distinguishable.

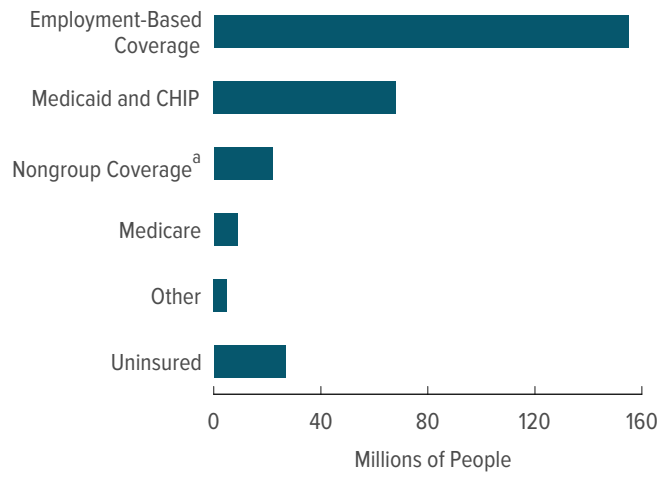
Keith Hall Director

March 2016

Figure 1.

[Return to Reference](#)

Health Insurance Coverage in 2016 for People Under Age 65



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

CHIP = Children’s Health Insurance Program.

a. Includes the Basic Health Program.

Table 1.

[Return to Reference 1, 2](#)

Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Population Under Age 65	272	273	274	275	276	276	277	278	279	279	280
Employment-Based Coverage	155	155	153	152	152	152	152	152	152	152	152
Medicaid and CHIP ^a											
Made eligible for Medicaid by the ACA	11	11	12	12	13	13	14	14	14	15	15
Otherwise eligible for Medicaid	51	51	51	53	52	53	53	53	53	53	54
CHIP	<u>6</u>	<u>6</u>	<u>4</u>	<u>3</u>	<u>3</u>	<u>3</u>	<u>3</u>	<u>3</u>	<u>3</u>	<u>3</u>	<u>2</u>
Subtotal	68	67	67	67	68	69	69	70	70	71	71
Nongroup Coverage and the Basic Health Program											
Purchased through marketplaces ^b											
Subsidized	10	12	15	16	15	15	15	15	15	14	14
Unsubsidized	<u>2</u>	<u>3</u>	<u>3</u>	<u>4</u>	<u>4</u>	<u>4</u>	<u>4</u>	<u>4</u>	<u>4</u>	<u>4</u>	<u>4</u>
Subtotal	12	15	18	19	19	19	19	18	18	18	18
Purchased outside marketplaces	<u>9</u>	<u>9</u>	<u>8</u>	<u>8</u>	<u>8</u>	<u>7</u>	<u>7</u>	<u>7</u>	<u>7</u>	<u>7</u>	<u>7</u>
Subtotal, nongroup coverage	22	24	26	27	27	26	26	26	26	25	25
Coverage through the Basic Health Program ^c	1	1	1	1	1	1	1	1	1	1	1
Medicare ^d	9	9	9	9	9	9	9	9	9	9	9
Other Coverage ^e	5	5	5	5	5	5	5	5	6	6	6
Uninsured ^f	27	26	26	27	27	27	27	27	28	28	28
Memorandum:											
Number of Insured People	244	246	247	247	248	249	250	251	251	252	253
Insured as a Percentage of the Population											
Including all U.S. residents	90	90	90	90	90	90	90	90	90	90	90
Excluding unauthorized immigrants	92	93	93	93	93	93	93	93	93	93	93

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

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 12 million to 14 million people (or 5 percent to 6 percent of insured people) have multiple sources of coverage, such as both employment-based coverage and Medicaid.

Estimates reflect average enrollment in any given month 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.

- a. Includes noninstitutionalized enrollees with full Medicaid benefits. Figures are adjusted to account for individuals enrolled in more than one state.
- b. 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 federal and state governments.
- 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 insurance from other categories, 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.

Table 2.

[Return to Reference 1, 2, 3, 4](#)**Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65**

Billions of Dollars, by Fiscal Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total, 2017- 2026
Subsidies												
Employment-based coverage												
Tax exclusion for employment-based coverage ^{a,b}	266	281	296	311	326	345	366	388	411	436	460	3,620
Small-employer tax credits ^b	1	1	1	1	1	1	1	1	1	1	1	9
Subtotal	268	282	297	312	327	346	367	389	412	437	461	3,629
Medicaid and CHIP ^c												
Made eligible for Medicaid by the ACA	64	67	71	77	83	91	99	107	116	125	134	969
Otherwise eligible for Medicaid	203	212	223	236	250	264	279	295	312	330	349	2,751
CHIP	13	13	12	6	6	6	6	6	6	6	6	70
Subtotal	279	292	306	319	338	361	384	408	434	460	489	3,790
Nongroup coverage and the Basic Health Program												
Premium tax credit outlays	27	35	45	51	54	57	60	62	65	68	70	568
Premium tax credit revenue reductions	5	8	8	9	10	11	11	11	12	12	13	104
Subtotal, premium tax credits	32	43	53	60	64	68	71	74	77	80	83	672
Cost-sharing outlays	7	9	11	12	13	13	13	14	14	15	16	130
Outlays for the Basic Health Program	3	4	5	5	6	6	7	7	7	8	8	63
Collections for risk adjustment and reinsurance	-10	-11	-7	-8	-9	-9	-10	-10	-10	-9	-9	-91
Payments for risk adjustment and reinsurance	12	10	8	8	9	9	10	10	10	9	9	92
Marketplace grants to states	1	*	*	0	0	0	0	0	0	0	0	*
Subtotal, subsidies through marketplaces and related spending and revenues	43	56	70	78	83	87	91	95	99	102	106	866
Income tax deduction for self-employed health insurance ^{b,d}	4	4	5	5	5	5	5	6	6	6	6	53
Subtotal	48	60	75	83	88	92	96	100	105	108	113	919
Medicare^e	80	81	83	86	91	95	99	104	109	112	118	979

Continued

Table 2.

Continued

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

Billions of Dollars, by Fiscal Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total, 2017- 2026
Taxes and Penalties Related to Coverage												
Gross collections of excise tax on high-premium insurance plans ^f	0	0	0	0	-1	-2	-2	-3	-3	-3	-4	-18
Penalty payments by uninsured people	-3	-3	-3	-3	-3	-4	-4	-4	-4	-4	-5	-38
Tax on health insurance providers	-11	-1	-13	-15	-15	-16	-17	-18	-19	-20	-21	-156
Gross collections of employer penalties ^f	0	-11	-21	-25	-20	-21	-23	-24	-26	-28	-29	-228
Subtotal	-15	-16	-36	-43	-39	-43	-46	-49	-53	-56	-59	-441
Net Subsidies	660	699	724	757	804	851	899	952	1,006	1,062	1,122	8,877

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

Positive numbers indicate an increase in outlays or a decrease in revenues, and negative numbers indicate a decrease in outlays or an increase in revenues.

Excludes outlays made by the federal government as an employer.

ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program; * = 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 people over age 65 with employment-based insurance are excluded here and 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. For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits. 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; thus, the government tracks those groups separately.
- d. JCT made this projection; it does not include effects stemming from people over age 65.
- e. For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.
- f. Excludes the associated effects of changes in taxable compensation on revenues, 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 \$79 billion over the 2017–2026 period and revenues from penalty payments by employers would total \$178 billion over that 10-year period.

Box 1.

[Return to Reference](#)

Premiums for Coverage Purchased Through the Health Insurance Marketplaces

The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) project future premiums for private insurance plans on the basis of past trends in premium growth and of projected growth in personal income, which affects people's ability to buy health insurance. The projections factor in both the slow growth in premiums of recent years and the faster growth of earlier years. The agencies also adjust those projections to account for the effects of the Affordable Care Act (ACA), which is anticipated to increase nongroup premiums over the next few years but to reduce employment-based premiums in the longer term.²⁸ Over the 2017–2026 period, private health insurers' spending per beneficiary, which is the basis for premiums, will increase by an average of 5.5 percent per year, CBO and JCT estimate.

A key determinant of the subsidy that an eligible person receives for purchasing insurance through one of the marketplaces established under the ACA is the so-called reference premium—that is, the premium of the second-lowest-cost “silver” plan offered through the marketplace in which that person participates.²⁹ CBO and JCT currently estimate that the average reference premium for a 21- to 24-year-old who purchases health insurance coverage through the marketplaces is about \$2,800 in calendar year 2016. (Analysts often focus on premiums for 21- to 24-year-olds because they are used as the basis for calculating premiums for other ages.) That estimate represents a national average, reflecting the agencies' projections of the geographic distribution of those who currently have coverage through the marketplaces.

Over the 2017–2026 period, the average reference premium for a 21- to 24-year-old is projected to grow by an average of 6.0 percent per year, about 0.5 percentage points faster than overall spending for private health insurance. That premium is expected to reach about \$5,100 in calendar year 2026.

The agencies expect premiums for plans in the marketplaces to rise more rapidly over the 2017–2021 period than insurers' spending per beneficiary for all types of private coverage—6.5 percent per year versus 5.4 percent per year—for several reasons. One factor, for example, is that the reinsurance payments that the government makes to insurers whose enrollees incur particularly high costs for medical care will be phased out over the next two years, pushing up premiums for plans in the marketplaces. Another such factor is that, in general, plans offered through the marketplaces appear to have lower payment rates for providers, narrower networks of providers, and tighter

28. For more detail on how the agencies project premiums, see Congressional Budget Office, *Private Health Insurance Premiums and Federal Policy* (February 2016), pp. 9–11, www.cbo.gov/publication/51130.

29. Silver plans are those that pay about 70 percent of the costs of covered health care services for a broadly representative group of enrollees; other levels of coverage, such as bronze and gold, pay different percentages.

management of their subscribers' use of health care than employment-based plans. CBO and JCT anticipate that some insurers offering plans in the marketplaces will decide to increase provider payment rates or broaden their networks over the next few years and to raise their premiums accordingly. From 2022 to 2026, the agencies expect premiums for marketplace plans and for other private insurance to grow by 5.5 percent per year, on average.

To assess changes in their projections over time, CBO and JCT compared their estimates of spending growth for the 2016–2025 period presented in this report with those published in March 2015. The agencies now estimate that health insurers' spending per beneficiary for all types of private coverage will increase by an average of 5.3 percent per year over that period; in the March 2015 projection, they had estimated that spending would increase by an average of 5.6 percent per year. That downward revision occurred in part because personal income is now estimated to grow more slowly than had previously been projected. CBO and JCT also revised their projections to incorporate recent data indicating that insurers' costs rose even more slowly in 2012 and 2013 than in preceding years. Those changes did not substantially affect the estimates of subsidies for health insurance coverage shown in this report.

Table 3.

[Return to Reference 1, 2, 3, 4, 5](#)**Direct Spending and Revenue Effects of the Insurance Coverage Provisions of the Affordable Care Act**

Billions of Dollars, by Fiscal Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total, 2017- 2026
Subsidies for Coverage Through Marketplaces and Related Spending and Revenues ^a	43	56	70	78	83	87	91	95	99	102	106	866
Medicaid and CHIP Outlays	74	78	81	85	91	100	108	116	125	134	144	1,063
Small-Employer Tax Credits ^b	1	1	1	1	1	1	1	1	1	1	1	9
Gross Cost of Coverage Provisions	119	134	152	164	174	187	199	212	225	238	252	1,938
Penalty Payments by Uninsured People	-3	-3	-3	-3	-3	-4	-4	-4	-4	-4	-5	-38
Penalty Payments by Employers ^b	0	-9	-16	-20	-15	-16	-18	-19	-20	-22	-23	-178
Excise Tax on High-Premium Insurance Plans ^d	0	0	0	0	-3	-7	-9	-11	-13	-16	-20	-79
Other Effects on Revenues and Outlays ^c	-5	-9	-13	-18	-22	-24	-27	-29	-31	-33	-34	-239
Net Cost of Coverage Provisions	110	113	119	123	130	136	142	150	157	163	170	1,403
Memorandum:												
Increases in Mandatory Spending	123	137	150	162	172	186	198	210	223	235	248	1,920
Increases in Revenues	13	24	31	39	42	50	55	60	66	72	78	517

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

Estimates exclude effects on the deficit of provisions of the Affordable Care Act that are not related to insurance coverage and effects on discretionary spending of the coverage provisions.

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

CHIP = Children's Health Insurance Program.

- Includes subsidies for coverage through the Basic Health Program, grants to states for establishing health insurance marketplaces, and net spending and revenues for risk adjustment and reinsurance. The risk corridors program is recorded in the budget as a discretionary program; CBO estimates that payments and collections will offset each other in each year, resulting in no net budgetary effect.
- These effects on the deficit include the associated effects of changes in taxable compensation on revenues.
- Consists mainly of the effects of changes in taxable compensation on revenues. CBO estimates that outlays for Social Security benefits will increase by about \$9 billion over the 2017–2026 period and that the coverage provisions will have negligible effects on outlays for other federal programs.

Box 2.

[Return to Reference](#)**Future Projections Related to the Insurance Coverage Provisions of the Affordable Care Act**

Although the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have included in this report estimates that separately identify the effects of the insurance coverage provisions of the Affordable Care Act (ACA) on the federal budget, generating such estimates is becoming more challenging and less meaningful. The question of what would have occurred if the ACA had never been enacted is difficult to answer for two reasons. First, the available data on coverage and spending increasingly reflect the effects of the ACA's coverage provisions—only some of which are tracked separately. Second, legislative changes, judicial decisions, and administrative actions continue to alter the nature of the law's provisions, making it increasingly difficult to define which aspects of current law constitute the ACA's insurance coverage provisions and to ascertain how those provisions affect health insurance coverage and federal programs.³⁰ Moreover, such a counterfactual scenario is becoming less and less relevant for understanding the effects of future changes to law.

As a result, CBO and JCT will no longer make separate projections of all of the incremental effects of the ACA's insurance coverage provisions; instead, they will present their projections of overall insurance coverage levels and related subsidies, taxes, and penalties under current law. Those projections will incorporate—but not separately identify—the changes stemming from enacting the ACA's coverage provisions. In some cases, as with outlays for the subsidies conveyed through the health insurance marketplaces, those changes will be readily identifiable. In other cases, as with subsidies associated with employment-based coverage, the effects of those provisions will be embedded in the agencies' baseline estimates of federal spending and revenues. In preparation for that transition, CBO and JCT have included in this report both the narrower estimates of the effects of only the coverage provisions of the ACA and broader estimates about coverage obtained through various sources for people under age 65 and the federal subsidies, taxes, and penalties associated with that coverage. In future years, the agencies will update and publish those broader estimates annually and will no longer publish estimates that focus only on the coverage and budgetary effects of the ACA.

30. CBO and JCT have previously noted those challenges, first in August 2010, shortly after the ACA was enacted, and in greater detail in June 2014. See Congressional Budget Office, *The Budget and Economic Outlook: An Update* (August 2010), Box 1-1, p. 6, www.cbo.gov/publication/21670, and "Estimating the Budgetary Effects of the Affordable Care Act," *CBO Blog* (June 17, 2014), www.cbo.gov/publication/45447.

Consistent with their statutory responsibilities, CBO and JCT will continue to estimate the effects of proposed legislation related to the ACA, including proposals to modify certain provisions of the law or to repeal it entirely.³¹ Because of the complexities involved in implementing a repeal of the ACA, the budgetary effects of repealing the act would not simply be the opposite of the estimates of the budgetary effects of enacting the ACA that are presented here.

31. For example, see Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act* (June 2015), www.cbo.gov/publication/50252.

Table 4.

[Return to Reference](#)

Effects of the Affordable Care Act on Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Change in Insurance Coverage Under the ACA											
Health insurance marketplaces	12	15	18	19	19	19	19	18	18	18	18
Basic Health Program ^a	1	1	1	1	1	1	1	1	1	1	1
Medicaid and CHIP ^b	13	14	14	14	16	17	17	18	18	18	19
Employment-based coverage ^c	-2	-4	-6	-8	-9	-9	-9	-9	-9	-9	-9
Nongroup and other coverage ^d	-2	-2	-3	-3	-3	-4	-4	-4	-4	-4	-4
Uninsured ^e	-22	-24	-23	-23	-23	-23	-24	-24	-24	-24	-24
Insurance Coverage Under Current Law											
Number of uninsured people ^e	27	26	26	27	27	27	27	27	28	28	28
Insured as a percentage of the population											
Including all U.S. residents	90	90	90	90	90	90	90	90	90	90	90
Excluding unauthorized immigrants	92	93	93	93	93	93	93	93	93	93	93
Memorandum:											
Number of Subsidized Enrollees Through Marketplaces	10	12	15	16	15	15	15	15	15	14	14
Number of Unsubsidized Enrollees Through Marketplaces ^f	2	3	3	4	4	4	4	4	4	4	4
Average Subsidy per Enrollee Receiving a Subsidy Through a Marketplace or the Basic Health Program	4,240	4,550	4,670	4,870	5,200	5,470	5,750	6,090	6,430	6,730	7,110

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.

Estimates reflect average enrollment in any given month over the course of a year and include spouses and dependents covered under family policies; people reporting multiple sources of coverage are assigned a primary source.

ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program.

- a. 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.
- b. The changes under the ACA are almost entirely for Medicaid.
- c. The change in employment-based coverage is the net result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by workers and their families.
- d. “Other coverage” includes Medicare; the changes under the ACA are almost entirely for nongroup coverage. Nongroup coverage here refers to coverage purchased directly from an insurer outside the health insurance marketplaces.
- e. 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.
- f. Excludes coverage purchased directly from insurers outside of a marketplace.

Table 5.

[Return to Reference 1, 2](#)

Comparison of CBO and JCT's Current and Previous Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act

	March 2015 Baseline	March 2016 Baseline	Difference
Change in Insurance Coverage Under the ACA in 2025 (Millions of people under age 65, by calendar year)^a			
Health Insurance Marketplaces and the Basic Health Program	22	19	-3
Medicaid and CHIP ^b	14	18	4
Employment-Based Coverage ^c	-7	-9	-2
Nongroup and Other Coverage ^d	-4	-4	*
Uninsured ^e	-25	-24	1
Effects on the Cumulative Federal Deficit, 2016 to 2025^f (Billions of dollars)			
Subsidies for Coverage Through Marketplaces and Related Spending and Revenues ^g	849	803	-46
Medicaid and CHIP Outlays	847	993	146
Small-Employer Tax Credits ^h	11	9	-2
Gross Cost of Coverage Provisions	1,707	1,805	98
Penalty Payments by Uninsured People	-43	-37	6
Penalty Payments by Employers ^h	-167	-155	12
Excise Tax on High-Premium Insurance Plans ^h	-87	-59	28
Other Effects on Revenues and Outlays ⁱ	-202	-210	-8
Net Cost of Coverage Provisions	1,207	1,344	136
Memorandum:			
Increases in Mandatory Spending	1,747	1,795	48
Increases in Revenues	540	452	-88

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

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; * = between zero and 500,000.

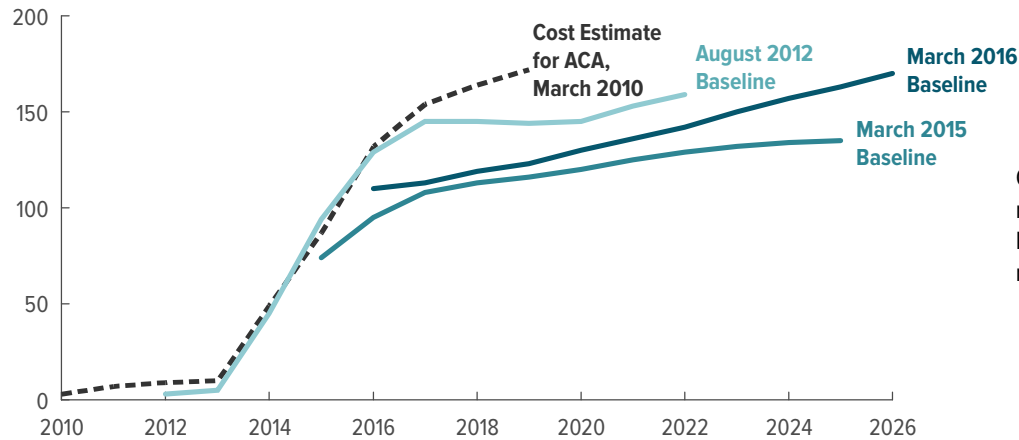
- a. Estimates include noninstitutionalized civilian residents of the 50 states and the District of Columbia who are younger than 65.
- b. The changes under the ACA are almost entirely for Medicaid.
- c. The change in employment-based coverage is the net result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by workers and their families.
- d. "Other Coverage" includes Medicare; the changes under the ACA are almost entirely for nongroup coverage. Nongroup coverage here refers to coverage purchased directly from an insurer outside the health insurance marketplaces.
- e. 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.
- f. Except in the memorandum lines, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit. Estimates exclude effects on the deficit of provisions of the ACA that are not related to insurance coverage and effects on discretionary spending of the coverage provisions.
- g. Includes subsidies for coverage through the Basic Health Program, grants to states for establishing health insurance marketplaces, and net spending and revenues for risk adjustment and reinsurance. The risk corridors program is recorded in the budget as a discretionary program; CBO estimates that payments and collections will offset each other in each year, resulting in no net budgetary effect.
- h. These effects on the deficit include the associated effects of changes in taxable compensation on revenues.
- i. Consists mainly of the effects of changes in taxable compensation on revenues.

Figure 2.

[Return to Reference](#)

CBO and JCT's Estimates of the Net Budgetary Effects of the Insurance Coverage Provisions of the Affordable Care Act

Billions of Dollars, by Fiscal Year



CBO and JCT's projections are now higher than those issued in March 2015 but lower than those made when the law was enacted.

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

Effects on the deficit of provisions of the Affordable Care Act (ACA) that are not related to insurance coverage and effects on discretionary spending of the coverage provisions are not shown.