CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 26, 2017

H.R. 1628
Better Care Reconciliation Act of 2017

An Amendment in the Nature of a Substitute [LYN17343]
as Posted on the Website of the Senate Committee on the Budget on June 26, 2017

The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have completed an estimate of the direct spending and revenue effects of the Better Care Reconciliation Act of 2017, a Senate amendment in the nature of a substitute to H.R. 1628. CBO and JCT estimate that enacting this legislation would reduce the cumulative federal deficit over the 2017-2026 period by $321 billion. That amount is $202 billion more than the estimated net savings for the version of H.R. 1628 that was passed by the House of Representatives.

The Senate bill would increase the number of people who are uninsured by 22 million in 2026 relative to the number under current law, slightly fewer than the increase in the number of uninsured estimated for the House-passed legislation. By 2026, an estimated 49 million people would be uninsured, compared with 28 million who would lack insurance that year under current law.

Following the overview, this document provides details about the major provisions of this legislation, the estimated costs to the federal government, the basis for the estimate, and other related information, including a comparison with CBO's estimate for the House-passed act.

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OVERVIEW

Effects on the Federal Budget

CBO and JCT estimate that, over the 2017-2026 period, enacting this legislation would reduce direct spending by $1,022 billion and reduce revenues by $701 billion, for a net reduction of $321 billion in the deficit over that period (see Table 1, at the end of this document):

- The largest savings would come from reductions in outlays for Medicaid—spending on the program would decline in 2026 by 26 percent in comparison with what CBO projects under current law—and from changes to the Affordable Care Act's (ACA's) subsidies for nongroup health insurance (see Figure 1). Those savings would be partially offset by the effects of other changes to the ACA's provisions dealing with insurance coverage: additional spending designed to reduce premiums and a reduction in revenues from repealing penalties on employers who do not offer insurance and on people who do not purchase insurance.

- The largest increases in deficits would come from repealing or modifying tax provisions in the ACA that are not directly related to health insurance coverage, including repealing a surtax on net investment income and repealing annual fees imposed on health insurers.

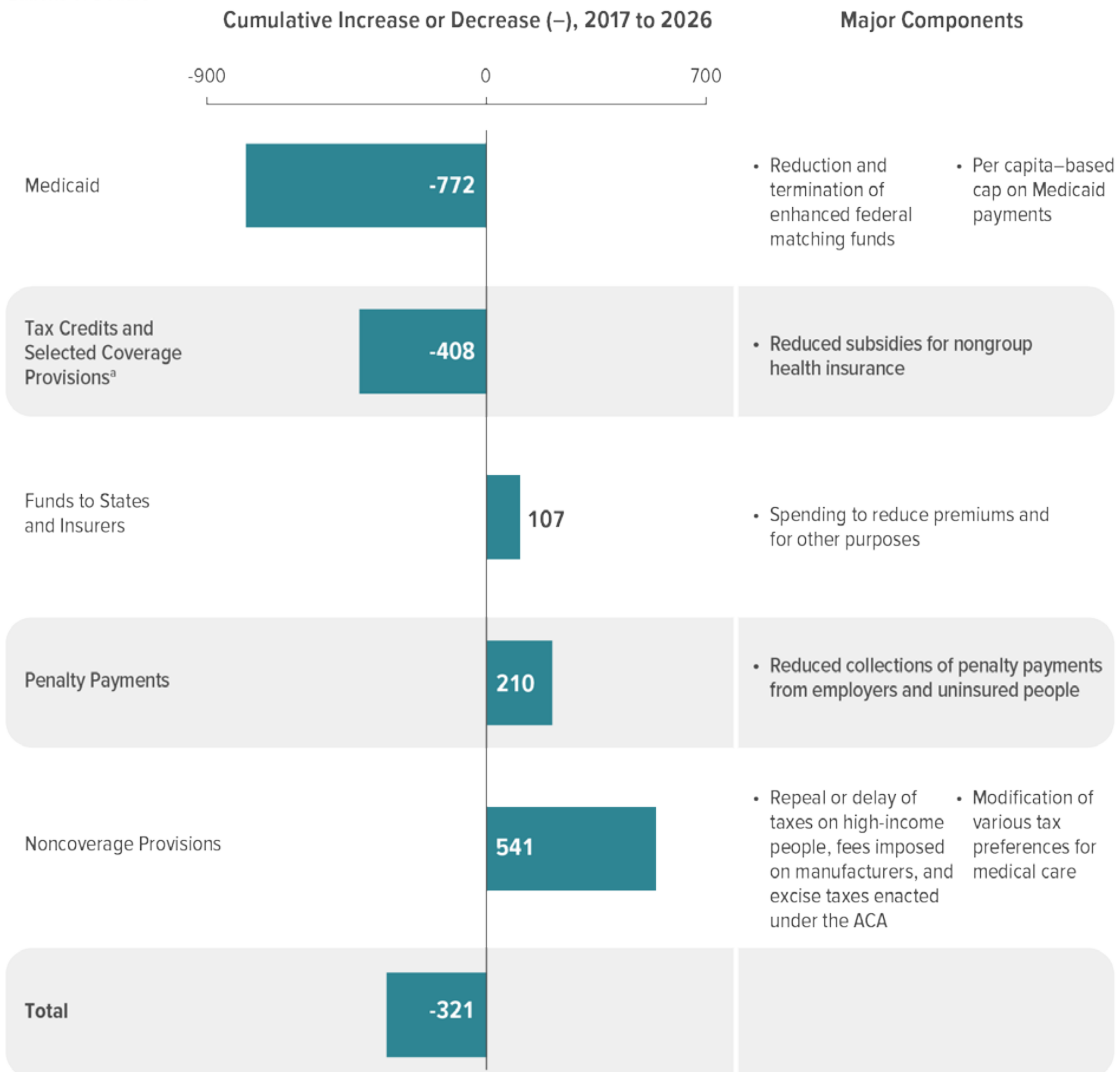
Pay-as-you-go procedures apply because enacting this legislation would affect direct spending and revenues. CBO and JCT estimate that enactment would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027. The agencies expect that savings, particularly from Medicaid, would continue to grow, while the costs would be smaller because a rescinded tax on employees' health insurance premiums and health plan benefits would be reinstated in 2026. CBO has not completed an estimate of the potential impact of this legislation on discretionary spending, which would be subject to future appropriation action.

Effects on Health Insurance Coverage

CBO and JCT estimate that, in 2018, 15 million more people would be uninsured under this legislation than under current law—primarily because the penalty for not having insurance would be eliminated. The increase in the number of uninsured people relative to the number projected under current law would reach 19 million in 2020 and 22 million in 2026. In later years, other changes in the legislation—lower spending on Medicaid and substantially smaller average subsidies for coverage in the nongroup market—would also lead to increases in the number of people without health insurance. By 2026, among people under age 65, enrollment in Medicaid would fall by about 16 percent and an estimated 49 million people would be uninsured, compared with 28 million who would lack insurance that year under current law.

Figure 1.

Net Effects of the Better Care Reconciliation Act on the Budget Deficit



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

These estimates are for the Better Care Reconciliation Act of 2017, a Senate amendment in the nature of a substitute to H.R. 1628.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation.

ACA = Affordable Care Act.

a. Includes subsidies for coverage through marketplaces and related spending and revenues, small-employer tax credits, Medicare, and other effects of coverage provisions on revenues and outlays.

Stability of the Health Insurance Market

Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on the proportion of people living in areas with participating insurers and on the likelihood of premiums' not rising in an unsustainable spiral. The market for insurance purchased individually with premiums not based on one's health status would be unstable if, for example, the people who wanted to buy coverage at any offered price would have average health care expenditures so high that offering the insurance would be unprofitable.

Under Current Law. Although premiums have been rising under current law, most subsidized enrollees purchasing health insurance coverage in the nongroup market are largely insulated from increases in premiums because their out-of-pocket payments for premiums are based on a percentage of their income; the government pays the difference between that percentage and the premiums for a reference plan (which is the second-lowest-cost plan in their area providing specified benefits). The subsidies to purchase coverage, combined with the effects of the individual mandate, which requires most individuals to obtain insurance or pay a penalty, are anticipated to cause sufficient demand for insurance by enough people, including people with low health care expenditures, for the market to be stable in most areas.

Nevertheless, a small number of people live in areas of the country that have limited participation by insurers in the nongroup market under current law. Several factors may lead insurers to withdraw from the market—including lack of profitability and substantial uncertainty about enforcement of the individual mandate and about future payments of the cost-sharing subsidies to reduce out-of-pocket payments for people who enroll in nongroup coverage through the marketplaces established by the ACA.

Under This Legislation. CBO and JCT anticipate that, under this legislation, nongroup insurance markets would continue to be stable in most parts of the country. Although substantial uncertainty about the effects of the new law could lead some insurers to withdraw from or not enter the nongroup market in some states, several factors would bring about market stability in most states before 2020. In the agencies' view, those key factors include the following: subsidies to purchase insurance, which would maintain sufficient demand for insurance by people with low health care expenditures; the appropriation of funds for cost-sharing subsidies, which would provide certainty about the availability of those funds; and additional federal funding provided to states and insurers, which would lower premiums by reducing the costs to insurers of people with high health care expenditures.

The agencies expect that the nongroup market in most areas of the country would continue to be stable in 2020 and later years as well, including in some states that obtain waivers that would not have otherwise done so. (Under current law and this legislation, states can apply for Section 1332 waivers to change the structure of subsidies for

nongroup coverage; the specifications for essential health benefits [EHBs], which set the minimum standards for the benefits that insurance in the nongroup and small-group markets must cover; and other related provisions of law.) Substantial federal funding to directly reduce premiums would be available through 2021. Premium tax credits would continue to provide insulation from changes in premiums through 2021 and in later years. Those factors would help attract enough relatively healthy people for the market in most areas of the country to be stable, CBO and JCT anticipate. That stability in most areas would occur even though the premium tax credits would be smaller in most cases than under current law and subsidies to reduce cost sharing—the amount that consumers are required to pay out of pocket when they use health care services—would be eliminated starting in 2020.

In the agencies' assessment, a small fraction of the population resides in areas in which—because of this legislation, at least for some of the years after 2019—no insurers would participate in the nongroup market or insurance would be offered only with very high premiums. Some sparsely populated areas might have no nongroup insurance offered because the reductions in subsidies would lead fewer people to decide to purchase insurance—and markets with few purchasers are less profitable for insurers. Insurance covering certain services would become more expensive—in some cases, extremely expensive—in some areas because the scope of the EHBs would be narrowed through waivers affecting close to half the population, CBO and JCT expect. In addition, the agencies anticipate that all insurance in the nongroup market would become very expensive for at least a short period of time for a small fraction of the population residing in areas in which states' implementation of waivers with major changes caused market disruption.

Effects on Premiums and Out-of-Pocket Payments

The legislation would increase average premiums in the nongroup market prior to 2020 and lower average premiums thereafter, relative to projections under current law, CBO and JCT estimate. To arrive at those estimates, the agencies examined how the legislation would affect the premiums charged if people purchased a benchmark plan in the nongroup market.

In 2018 and 2019, under current law and under the legislation, the benchmark plan has an actuarial value of 70 percent—that is, the insurance pays about 70 percent of the total cost of covered benefits, on average. In the marketplaces, such coverage is known as a silver plan.

Under the Senate bill, average premiums for benchmark plans for single individuals would be about 20 percent higher in 2018 than under current law, mainly because the penalty for not having insurance would be eliminated, inducing fewer comparatively healthy people to sign up. Those premiums would be about 10 percent higher than under current law in 2019—less than in 2018 in part because funding provided by the bill to

reduce premiums would affect pricing and because changes in the limits on how premiums can vary by age would result in a larger number of younger people paying lower premiums to purchase policies.

In 2020, average premiums for benchmark plans for single individuals would be about 30 percent lower than under current law. A combination of factors would lead to that decrease—most important, the smaller share of benefits paid for by the benchmark plans and federal funds provided to directly reduce premiums.

That share of services covered by insurance would be smaller because the benchmark plan under this legislation would have an actuarial value of 58 percent beginning in 2020. That value is slightly below the actuarial value of 60 percent for "bronze" plans currently offered in the marketplaces. Because of the ACA's limits on out-of-pocket spending and prohibitions on annual and lifetime limits on payments for services within the EHBs, all plans must pay for most of the cost of high-cost services. To design a plan with an actuarial value of 60 percent or less and pay for those high-cost services, insurers must set high deductibles—that is, the amounts that people pay out of pocket for most types of health care services before insurance makes any contribution. Under current law for a single policyholder in 2017, the average deductible (for medical and drug expenses combined) is about $6,000 for a bronze plan and $3,600 for a silver plan. CBO and JCT expect that the benchmark plans under this legislation would have high deductibles similar to those for the bronze plans offered under current law. Premiums for a plan with an actuarial value of 58 percent are lower than they are for a plan with an actuarial value of 70 percent (the value for the reference plan under current law) largely because the insurance pays for a smaller average share of health care costs.

Although the average benchmark premium directly affects the amount of premium tax credits and is a key element in CBO's analysis of the budgetary effects of the bill, it does not represent the effect of this legislation on the average premiums for all plans purchased. The differences in the actuarial value of plans purchased under this legislation and under current law would be greater starting in 2020—when, for example, under this bill, some people would pay more than the benchmark premium to purchase a silver plan, whereas, under current law, others would pay less than the benchmark premium to purchase a bronze plan.

Under this legislation, starting in 2020, the premium for a silver plan would typically be a relatively high percentage of income for low-income people. The deductible for a plan with an actuarial value of 58 percent would be a significantly higher percentage of income—also making such a plan unattractive, but for a different reason. As a result, despite being eligible for premium tax credits, few low-income people would purchase any plan, CBO and JCT estimate.

By 2026, average premiums for benchmark plans for single individuals in most of the country under this legislation would be about 20 percent lower than under current law, CBO and JCT estimate—a smaller decrease than in 2020 largely because federal funding to reduce premiums would have lessened. The estimates for both of those years encompass effects in different areas of the country that would be substantially higher and substantially lower than the average effect nationally, in part because of the effects of state waivers. Some small fraction of the population is not included in those estimates. CBO and JCT expect that those people would be in states using waivers in such a way that no benchmark plan would be defined. Hence, a comparison of benchmark premiums is not possible in such areas.

Some people enrolled in nongroup insurance would experience substantial increases in what they would spend on health care even though benchmark premiums would decline, on average, in 2020 and later years. Because nongroup insurance would pay for a smaller average share of benefits under this legislation, most people purchasing it would have higher out-of-pocket spending on health care than under current law. Out-of-pocket spending would also be affected for the people—close to half the population, CBO and JCT expect—living in states modifying the EHBs using waivers. People who used services or benefits no longer included in the EHBs would experience substantial increases in supplemental premiums or out-of-pocket spending on health care, or would choose to forgo the services. Moreover, the ACA's ban on annual and lifetime limits on covered benefits would no longer apply to health benefits not defined as essential in a state. As a result, for some benefits that might be removed from a state's definition of EHBs but that might not be excluded from insurance coverage altogether, some enrollees could see large increases in out-of-pocket spending because annual or lifetime limits would be allowed.

Uncertainty Surrounding the Estimates

CBO and JCT have endeavored to develop budgetary estimates that are in the middle of the distribution of potential outcomes. Such estimates are inherently inexact because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by this legislation are all difficult to predict. In particular, predicting the overall effects of the myriad ways that states could implement waivers is especially difficult.

CBO and JCT's projections under current law itself are also uncertain. For example, enrollment in the marketplaces under current law will probably be lower than was projected under the March 2016 baseline used in this analysis, which would tend to decrease the budgetary savings from this legislation. However, the average subsidy per enrollee under current law will probably be higher than was projected in March 2016, which would tend to increase the budgetary savings from this legislation. (For a related discussion, see the section on "Use of the March 2016 Baseline" on page 15.)

Despite the uncertainty, the direction of certain effects of this legislation is clear. For example, the amount of federal revenues collected and the amount of spending on Medicaid would almost surely both be lower than under current law. And the number of uninsured people under this legislation would almost surely be greater than under current law.

Intergovernmental and Private-Sector Mandates

CBO has reviewed the nontax provisions of the legislation and determined that they would impose intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA) by preempting state laws. Although the preemptions would limit the application of state laws, they would impose no duty on states that would result in additional spending or a loss of revenues. JCT has determined that the tax provisions of the legislation contain no intergovernmental mandates.

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

MAJOR PROVISIONS OF THIS LEGISLATION

Under this legislation, budgetary effects related to health insurance coverage would stem from provisions that became effective in different years.

Upon enactment, the legislation would eliminate penalties associated with the requirements that most people obtain health insurance coverage and that large employers offer their employees coverage that meets specified standards. States would be allowed to meet fewer criteria to waive the ACA's requirement establishing essential health benefits and many other requirements related to subsidies and the marketplaces as long as the changes would not increase federal deficits; states would be provided funding to develop applications for waivers.

In 2018, the legislation would provide funding to health insurers to stabilize premiums and promote participation in the marketplaces.

In 2019, four major coverage provisions would take effect:

- Appropriating funding for grants to states through the Long-Term State Stability and Innovation Program.

- Requiring insurers to impose a six-month waiting period before coverage starts for people who enroll in insurance in the nongroup market if they have been uninsured for more than 63 days within the past year.

- Setting a limit whereby insurers would charge older people premiums that are up to five times higher than those charged younger people in the nongroup and small-group markets, unless a state sets a different limit.

- Removing the federal cap on the share of premiums that may go to insurers' administrative costs and profits (also known as the minimum medical loss ratio requirement) and effectively allowing each state to set its own cap.

In 2020, the following additional major coverage provisions would take effect:

- Changing the tax credit for health insurance coverage purchased through the nongroup market and repealing current-law subsidies to reduce cost-sharing payments. People with income below 100 percent of the federal poverty level (FPL) who are not eligible for Medicaid would become eligible for the tax credit, and people with income between 350 percent and 400 percent of the FPL would no longer be eligible. The maximum percentage of income specified by the bill that people would pay at different ages toward the purchase of a benchmark plan would be lower for some younger people and higher for some older people. The benchmark plan used to determine the amount of the tax credit would have a lower actuarial value.

- Capping the growth in per-enrollee payments for nondisabled children and nondisabled adults enrolled in Medicaid at no more than the medical care component of the consumer price index (CPI-M) and for most enrollees who are disabled adults or age 65 or older at no more than the CPI-M plus 1 percentage point, starting in 2020 and going through 2024. Starting in 2025, the rate of growth in per-enrollee payments for all groups would be pegged to the consumer price index for all urban consumers (CPI-U).

Starting in 2021, the bill would reduce the federal matching rate for funding for adults made eligible for Medicaid by the ACA; that rate would decline 5 percentage points per year through 2023 and then fall to equal the rate for other enrollees in a state in later years.

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

- Repealing the surtax on certain high-income taxpayers' net investment income, effective for tax years beginning after December 2016.

- Repealing the annual fee on health insurance providers, beginning in calendar year 2017.

- Delaying when the excise tax imposed on some health insurance plans with high premiums would go into effect. It is currently scheduled to take effect for tax years beginning after December 2019; the legislation would delay the effective date for six years.

- Repealing the increase in the Hospital Insurance payroll tax rate for certain high-income taxpayers, effective for earned income received beginning in 2023.

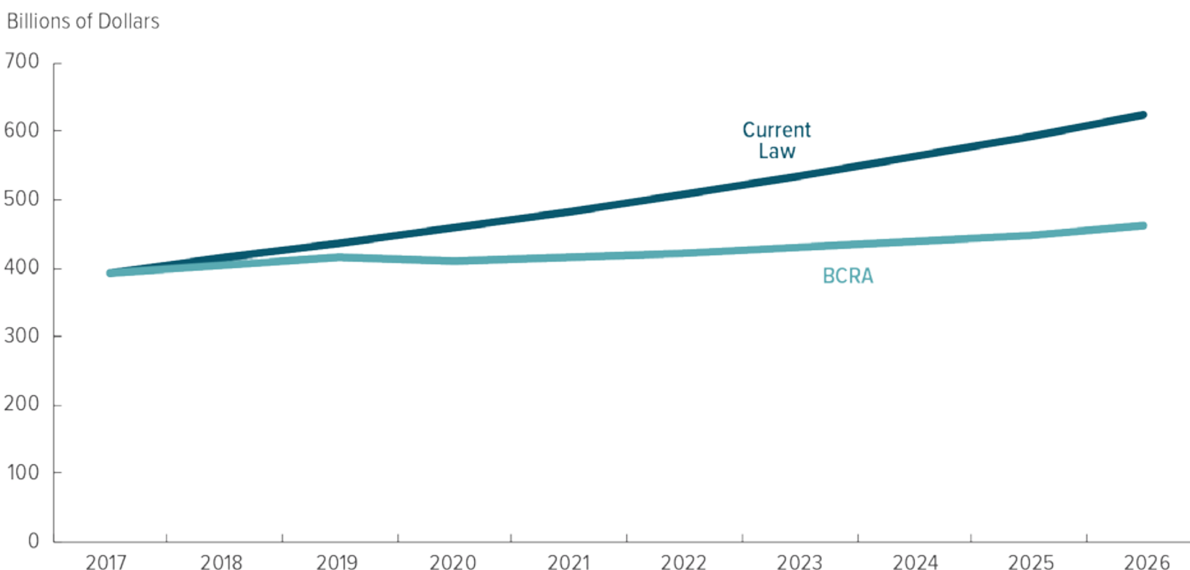
In addition, this legislation would make several changes to other health-related programs that would have smaller budgetary effects.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

CBO and JCT estimate that, on net, enacting this legislation would decrease federal deficits by $321 billion over the 2017-2026 period. The largest budgetary effects would stem from provisions affecting insurance coverage. Those provisions, taken together, would reduce projected deficits by $862 billion over the 2017-2026 period. Other provisions would increase deficits by $541 billion, mostly by reducing tax revenues. (See Table 2, at the end of this document, for the estimated budgetary effects of each major provision.) The largest effects on spending under this bill would be for Medicaid. Overall, including all provisions affecting Medicaid, CBO estimates that spending for the program would be reduced by $160 billion in 2026 compared with projections under current law (see Figure 2).

Figure 2.

Medicaid Spending Under Current Law and Under the Better Care Reconciliation Act



Source: Congressional Budget Office.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. Spending includes payments for medical services, payments to states for administration of the program, payments to hospitals that serve a disproportionate share of low-income patients, and payments made under the Vaccines for Children program.

BCRA = the Better Care Reconciliation Act of 2017 (a Senate amendment in the nature of a substitute to H.R. 1628).

Budgetary Effects of Health Insurance Coverage Provisions

The total deficit reduction that would result from the insurance coverage provisions includes the following amounts (shown in Table 3, at the end of this document):

- A reduction of $772 billion in federal outlays for Medicaid;

- Savings of $424 billion stemming mainly from modifying, in 2020, the ACA's tax credits for premium assistance to purchase nongroup health insurance and, in the same year, eliminating subsidies to reduce cost-sharing payments;

- Savings of $21 billion, mostly associated with shifts in the mix of taxable and nontaxable compensation—resulting in more taxable income—from net decreases in most years in the number of people estimated to enroll in employment-based health insurance coverage; and

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

Those decreases in the deficit would be partially offset by:

- A reduction in revenues of $210 billion from eliminating the penalties paid by uninsured people ($38 billion) and employers ($171 billion);

- An increase in spending of $107 billion for short-term assistance to insurers to address disrupted coverage and access and to provide support for states through the Long-Term State Stability and Innovation Program; and

- A net increase in spending of $42 billion for the Medicare program stemming from changes in payments to hospitals that serve a disproportionate share of low-income patients.

Revenue Effects of Other Provisions

JCT estimates that this legislation would reduce revenues by $563 billion over the 2017-2026 period by repealing many of the revenue-related provisions of the ACA (apart from those directly related to health insurance coverage, which are discussed above).

Direct Spending Effects of Other Provisions

This legislation would also make changes to spending apart from those directly related to health insurance coverage (which are discussed above), such as eliminating funds for grants provided through the Prevention and Public Health Fund. CBO and JCT estimate that those provisions would reduce direct spending, on net, by about $22 billion over the 2017-2026 period.

Changes in Spending Subject to Appropriation

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

BASIS OF ESTIMATE

For this cost estimate, CBO and JCT assume that the legislation will be enacted by July 31, 2017, and use CBO's March 2016 baseline. The agencies have provided an overall estimate of the budgetary effects of the coverage provisions in this legislation, and not separate estimates for each provision, for three related reasons. First, the agencies' modeling is done in an integrated way. Second, there are important interactions among the provisions, so the sum of the parts (when considered separately) does not equal the whole. Third, the order in which the provisions are considered would matter. For the noncoverage spending provisions, the agencies have done separate estimates. Various publications by JCT have provided considerable information about the basis of earlier

estimates for noncoverage revenue provisions that remains applicable, and those provisions are not discussed further in this document.[1]

Use of the March 2016 Baseline

On the basis of consultation with the budget committees, CBO and JCT measured the costs and savings in this estimate relative to CBO's March 2016 baseline projections, with adjustments for legislation that was enacted after that baseline was produced. That approach is not unusual: The budgetary effects of reconciliation legislation are typically estimated relative to the baseline that underlies the budget resolution that specified the reconciliation instructions and that was the basis for the deficit reduction goals stated in the resolution. The March 2016 baseline has been used by CBO and JCT for cost estimates for all pieces of legislation related to the budget reconciliation process for 2017, including this one.

CBO's most recent baseline projections were completed in late January 2017, after the budget resolution was adopted. The agencies have not had time to undertake a follow-on analysis of the effects of this legislation under that baseline.

In the projections published in January 2017, the direct spending and revenue effects of the ACA's insurance coverage provisions and the total number of people projected to be uninsured were similar to those in the March 2016 baseline, but the number of people projected to purchase subsidized coverage in the marketplaces was smaller, and the average subsidy per person was larger. If this legislation was evaluated relative to the January 2017 baseline rather than the March 2016 baseline, it is unclear how different categories of insurance would be affected and whether the budgetary effects would differ noticeably.

Health Insurance Coverage Provisions

After providing information about overall effects to supplement the discussion in the overview, this section describes the methodology used to estimate the effects of the coverage provisions. Then, it provides additional details about each of the major coverage provisions identified above, in the order in which they would become effective, and discusses their specific effects.

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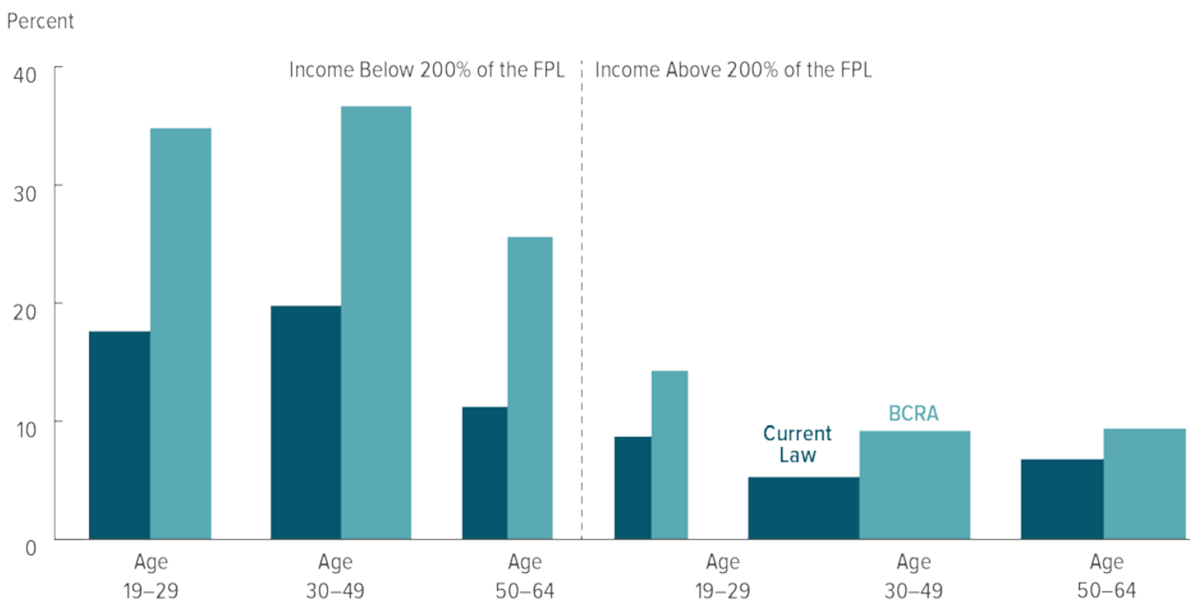
1. See Joint Committee on Taxation, "JCT Publications 2017," www.jct.gov/publications.html?func=select&id=76. On March 7, 2017, JCT published 10 documents relating to an earlier version of this legislation—JCX-7-17 through JCX-16-17—which are posted there. In addition, see Joint Committee on Taxation, *Estimated Revenue Effects of the Tax Provisions Contained in Title II of H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives*, JCX-27-17 (May 24, 2017).

Additional Information About Overall Effects. CBO and JCT expect that this legislation would increase the number of uninsured people substantially. The increase would be disproportionately larger among older people with lower income—particularly people between 50 and 64 years old with income of less than 200 percent of the federal poverty level (see Figure 3). This section provides additional information about two major sources of coverage as well as about stability of the health insurance market.

Figure 3.

Share of Nonelderly Adults Without Health Insurance Coverage Under Current Law and the Better Care Reconciliation Act, by Age and Income Category, 2026



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

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation.

Estimates reflect the average number of people under age 65 without insurance coverage over the course of the year in the noninstitutionalized civilian population of the 50 states and the District of Columbia.

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

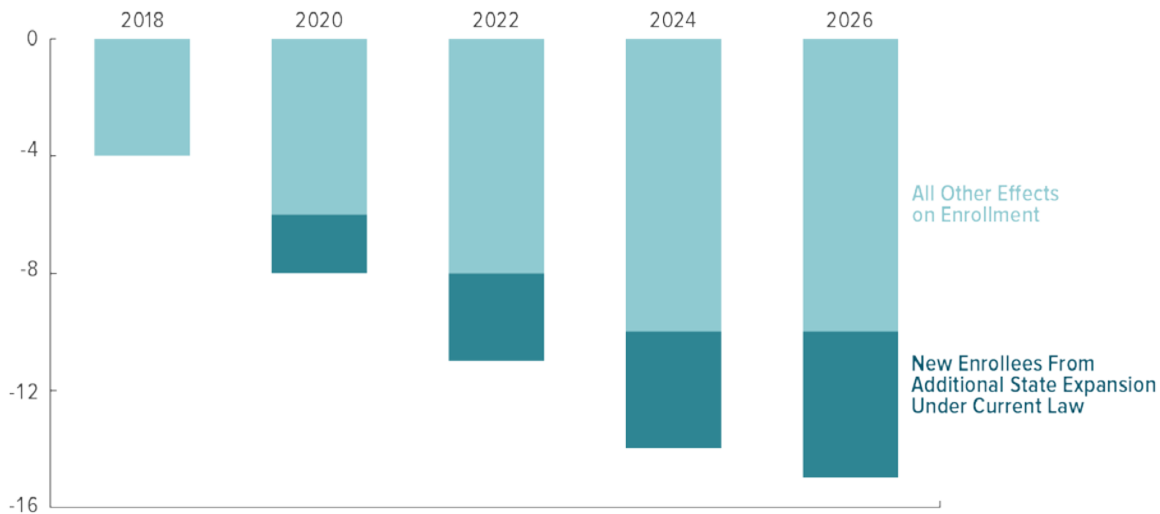
BCRA = the Better Care Reconciliation Act of 2017 (a Senate amendment in the nature of a substitute to H.R. 1628); FPL = federal poverty level.

Medicaid. Enrollment in Medicaid would be lower throughout the coming decade, with 15 million fewer Medicaid enrollees by 2026 than projected under current law in CBO's March 2016 baseline (see Figure 4). Some of that decline would be among people who are currently eligible for Medicaid benefits, and some would be among people who CBO projects would, under current law, become eligible in the future as additional states adopted the ACA's option to expand eligibility.

Figure 4.

Changes in Medicaid Enrollment Under the Better Care Reconciliation Act, Selected Years

Millions of People



Source: Congressional Budget Office.

These estimates are for the Better Care Reconciliation Act of 2017 (BCRA), a Senate amendment in the nature of a substitute to H.R. 1628.

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

Nongroup coverage. On net, CBO and JCT estimate that roughly 7 million fewer people would obtain coverage in 2018 through the nongroup market under this legislation than under current law; that figure would be about 9 million in 2020 and about 7 million in 2026 (see Table 4, at the end of this document). Fewer people would enroll in the nongroup market mainly because the penalty for not having insurance would be eliminated and, starting in 2020, because the average subsidy for coverage in that market would be substantially lower for most people currently eligible for subsidies—and for some people that subsidy would be eliminated.

Market Stability. In CBO and JCT's assessment, a small fraction of the population resides in areas in which—because of this legislation, for at least for some of the years after 2019—no insurers would participate in the nongroup market or insurance would be offered only with very high premiums. In the first case, the elimination of cost-sharing subsidies for low-income people and the greater share of income that older people pay toward premiums would shrink the demand for insurance compared with that under current law, and it would probably not be profitable for insurers to bear the fixed costs of operating in some markets. In the second case, because the total subsidy per person under the legislation would be substantially smaller than under current law, the fraction of purchasers who are subsidized would fall. Among the unsubsidized population, less healthy people are more likely to purchase insurance—and the higher costs for them

would put upward pressure on premiums. As unsubsidized people became a greater fraction of the purchasers, that pressure would be greater and could result in very high premiums in some markets—mainly during the second half of the coming decade, when much less federal funding would be provided to reduce premiums. In both cases, instability in a given market would probably be resolved within a few years by states' actions: States could obtain a waiver that would allow changes to certain market regulations for the purpose of reducing premiums; they could reduce premiums directly using funding obtained through the waiver process; they could obtain a greater share of the funding from the State Stability and Innovation Program to directly reduce premiums; and they could spend their own funds to directly lower premiums.

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

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

Mandate Penalties. This legislation would, upon enactment, eliminate penalties associated with requirements that most people obtain health insurance coverage (also called the individual mandate) and that large employers offer their employees health insurance coverage that meets specified standards (also called the employer mandate). As

2. For additional information, see Congressional Budget Office, "Methods for Analyzing Health Insurance Coverage" (accessed June 25, 2017), www.cbo.gov/topics/health-care/methods-analyzing-health-insurance-coverage.

a result, fewer people would enroll in health insurance obtained through the nongroup market, in employment-based health insurance coverage, and in Medicaid. The estimated savings from the reduced subsidies stemming from such lower enrollment would exceed the estimated loss of revenues from eliminating the mandate penalties.

Nongroup Coverage. In the nongroup market, some people would choose not to have insurance because they choose to be covered by insurance under current law to avoid paying the penalties. And, under this legislation, without the mandate penalties, some people would forgo insurance in response to the higher premiums that CBO and JCT project would be charged. Insurers would still be required to provide coverage to any applicant, and they would not be able to vary premiums to reflect enrollees' health status or to limit coverage of preexisting medical conditions. Those features are most attractive to applicants with relatively high expected costs for health care, so CBO and JCT expect that repealing the individual mandate penalty would tend to reduce insurance coverage less among older and less healthy people than among younger and healthier people. Thus, the agencies estimate that repealing that penalty, taken by itself, would increase premiums in the nongroup market.

Employment-Based Coverage. Under current law, the prospect of paying the employer mandate penalty tips the scale for some businesses and causes them to decide to offer health insurance to their employees. Thus, eliminating that penalty would cause some employers to not offer health insurance. Similarly, the demand for insurance among employees is greater under current law because some employees want employment-based coverage so that they can avoid paying the individual mandate penalty. Eliminating that penalty would reduce such demand and would cause some employers to not offer coverage or some employees to not enroll in coverage they were offered, CBO and JCT estimate.

Medicaid. Under current law, the penalty associated with the individual mandate applies to some Medicaid-eligible adults and children. (For example, it applies to single individuals with income above about 90 percent of the FPL.) In addition, some people apply for coverage in the marketplaces because of the penalty and turn out to be eligible for Medicaid. And some who are not subject to the penalty think they would be if they did not enroll in Medicaid.

The agencies do not expect that, with the penalty eliminated under this legislation, people enrolled in Medicaid would disenroll. However, among people who would become eligible for Medicaid under the legislation or who would need to recertify their eligibility, the proportion of people who enroll in the program would, by CBO and JCT's expectations, be lower—closer to the proportions observed for those groups prior to the institution of the penalty.

Waivers. This legislation would alter the way that states may waive certain provisions of the ACA by making the approval process quicker, more flexible, and less stringent—

which would result in a broader set of changes, CBO and JCT expect. Under current law and this legislation, states can apply for Section 1332 waivers to change the premium tax credits, the definition of essential health benefits, and certain other provisions of law affecting health insurance.

According to this legislation, a waiver shall be granted if the Secretary of Health and Human Services (HHS) and, if the waiver affects premium tax credits, the Secretary of the Treasury, determine that it would not increase the federal deficit. Three requirements for waivers to be approved under current law would be eliminated: that waiver programs provide health insurance coverage to a comparable number of state residents, that they meet requirements for out-of-pocket spending, and that coverage is at least as comprehensive as the federal EHBs. As under current law, however, states could not use waivers to change federal regulations relating to preexisting conditions, requiring insurers to offer coverage to any applicant, or requiring that premiums in the nongroup market not be based on an individual's health (allowing them to vary only on the basis of age, smoking status, and geographic location). In addition, under the legislation, states could not use waivers to change regulations related to continuous coverage.

Under this legislation (as under current law), states could apply to receive funds that would have been provided to their residents in the absence of a waiver that has been granted. For example, Hawaii is projected to receive about $3 million of such "pass-through" funds over the next five years under the only waiver approved so far. Those funds will be used to reduce premiums for employees of small businesses in lieu of having the state's small businesses be eligible for federal tax credits.

CBO and JCT expect that, over the 2017-2026 period, under current law, some states will receive waivers, and under this legislation, more would. The agencies expect that states would pursue additional waivers for various reasons—to obtain more funding than their residents would otherwise receive, to lower premiums, and to reduce cost sharing, for example. Some of those waivers would also be used to counteract instability arising under the bill. However, CBO and JCT anticipate that, to avoid administering the premium tax credits themselves, few states would make significant changes to the credits. (The agencies expect that the Internal Revenue Service would administer federal tax credits, but would not administer different state credits.) For the same reason, the agencies expect that few states would change market regulations in such a way that no benchmark plan was available to use in calculating the credit amounts—which would occur if the EHBs were not well defined.

As a result of the additional waivers stemming from this bill, the agencies expect that about half the population would be in states receiving substantial additional pass-through funding. Compared with what would occur under this bill without additional waivers, federal deficits would increase and the number of people with health insurance coverage would be about the same, according to CBO and JCT's estimates. Additional waivers would probably cause market instability in some areas, in addition to being used to

counteract instability in others. Average premiums for benchmark plans would be lower in most states that obtain waivers.

Effects on the Budget. Any savings projected by the Administration to result from waivers would be provided to states as pass-through funding to be used for approved purposes. Hence, waivers would have no effect on the federal deficit if the Administration's projections of savings were accurate.

To estimate the effects of additional waivers on the federal budget, CBO and JCT first projected this bill's effects without additional waivers. Then, the agencies adjusted those projections to reflect the likelihood that the additional waivers would not be deficit neutral in practice.

According to CBO and JCT's estimates, in total, by 2026, about one-fifth of the subsidies for nongroup coverage that would have been provided without the additional waivers would instead be provided as pass-through funds to states. A small portion of the population would be in states that decided to fully administer their own system and receive the entire amount of their projected subsidies as pass-through funding. In other cases, states would rely on the federal government to administer premium tax credits and would receive pass-through funding related to incremental reductions in federal costs projected under the waivers. As an illustration, if the Administration projected that a state using a waiver to narrow the scope of its EHBs would reduce the premium tax credits of its residents by 10 percent, then the state would receive that amount in pass-through funding.

This legislation, with its less stringent approval process, would facilitate the approval of some waiver applications that have already been submitted and would boost the number of new requests and approvals. CBO and JCT analyzed the budgetary effects of those two cases separately. In both cases, the agencies expect that the process used to determine the amount of pass-through funds would cause deficits to increase compared with what would have occurred without the additional waivers.

States with an already-submitted waiver request would, if it was approved under this legislation, receive pass-through funds based on the difference between projected federal costs under the waiver (which would be calculated using current-law subsidies available at the time the waiver application was submitted) and projected federal costs under current law. Because current-law subsidies are larger in most cases than the subsidies under this legislation, pass-through funding for an already-submitted waiver would generally be larger than the subsidies the residents of those states would receive under this bill.

A waiver application not already submitted would engender pass-through funding based on projections of federal costs under this bill with and without the waiver. States would have an incentive to be optimistic in their estimates of savings—with projections of

federal costs without the waiver that were high and state costs with the waiver that were low. Particularly during the next few years, the Administration would not have enough data about experience under this legislation to fully adjust for that incentive, CBO and JCT anticipate. After a few years, however, additional waivers would probably result in pass-through funding amounts only slightly above what would have been spent without them.

Effects on Health Insurance Coverage. CBO and JCT estimate that the additional waivers would have little effect on the number of people insured, on net, by 2026. In the agencies' assessment, the effect would be minimal in many cases, larger and positive in some cases, and substantially negative in a few cases. The range of potential changes under those waivers is broad, and the following discussion describes only a few possibilities.

The agencies expect that most of the population affected by additional waivers would be in states that narrow the scope of the EHBs. That change would directly lower premiums in the nongroup market, on average, and result in savings from reduced federal subsidies that states would receive as pass-through funds.

In some of those cases in which states changed the EHBs, the pass-through funds would be used to lower premiums further. As a result of the lower premiums, the number of unsubsidized people who would become insured in the nongroup market would increase. However, that increase would be roughly offset by decreases in employment-based coverage and subsidized coverage in the nongroup market. Some employers would respond over time to the presence of lower-premium plans in the nongroup market by not offering coverage. People eligible for subsidies in the nongroup market would receive little benefit from the lower premiums, and many would therefore decline to purchase a plan providing fewer benefits.

In other cases in which the EHBs were changed, those pass-through funds would be used to attract relatively healthy low-income people to purchase subsidized plans by covering certain services with low or no copayments. That approach would increase the number of people with insurance coverage and prevent or mitigate market instability, although the effect would be limited by the amount of funds available to reduce cost sharing.

A small fraction of the population affected by additional waivers, CBO and JCT anticipate, would be in states where waivers substantially reduce the number of people insured. That reduction would occur if a state changed the structure of the subsidies for health insurance so that they provided a greater share of assistance to people who would have bought health insurance without subsidies. Alternatively, such a reduction would occur if a state reduced subsidies, received pass-through funds, and used those funds for purposes other than health insurance coverage.

Effects on Market Stability. Because a large portion of the population affected by additional waivers would be in states that narrow the scope of the EHBs, CBO and JCT expect insurance covering certain services to become more expensive—in some cases, extremely expensive. For example, if the EHBs were modified to drop coverage of services that have high costs and are used by few people, coverage for maternity care, mental health care, rehabilitative and habilitative treatment, and certain very expensive drugs could be at risk. Such modifications would lower premiums for many people and increase the number of people with coverage for a narrower set of benefits. But, on the basis of historical experience, CBO and JCT anticipate that the funding available to help provide coverage for those high-cost services would be insufficient in some cases even if a special program was designed for that purpose. Therefore, the agencies expect that insurance coverage for high-cost services would become extremely expensive in those areas, as it was in some places before the enactment of the ACA in 2010. A state is required to have mechanisms to reduce the chance of such outcomes as part of its waiver program under current law, but would not be under this legislation.

Some states could use waivers to administer their own system and make broad changes to the rules governing the nongroup market, affecting some small fraction of the population. The effects of such changes would be hard to predict, and premiums in the nongroup market could be very expensive for at least a short period of time.

Effects on Premiums and Out-of-Pocket Costs. The narrowing of the scope of the EHBs that CBO and JCT expect would result from additional waivers would directly lower the premiums for benchmark plans, as discussed above. Those declines would occur because the plans would cover fewer services—reducing both expenditures by insurers and the cost of bearing the risk that expenditures could be higher than insurers anticipate. States would probably also reduce premiums by using some pass-through funding to make payments to insurers.

However, out-of-pocket costs would increase if the scope of the EHBs was narrowed, as discussed above. If pass-through funding for the additional waivers was used to reduce cost sharing, out-of-pocket costs would decrease for people receiving that assistance.

Short-Term Assistance to Address Disrupted Coverage and Access. This legislation would provide a total of $50 billion to fund arrangements between the federal government and health insurers to address instances where coverage and access have been disrupted and to respond to urgent health care needs. CBO and JCT expect virtually all of these funds—$15 billion per year in 2018 and 2019 and $10 billion per year in 2020 and 2021—to be used to reduce premiums for plans offered in the nongroup market, increasing enrollment in them, primarily by people not eligible for premium tax credits.

Long-Term State Stability and Innovation Program. This legislation would provide a total of $62 billion to fund grants to states for four purposes. The first, for which a minimum of $5 billion per year is allocated in 2019 through 2021, is to enter into

arrangements with health insurers to reduce premiums in the nongroup market. CBO and JCT anticipate that about three-quarters of the total funding would be used for that purpose, which would increase health insurance coverage—primarily for people not eligible for premium tax credits. The other three purposes are the following: to help people purchase nongroup coverage if they have or are projected to have high health care costs and do not have access to health insurance offered through an employer; to provide payments to health care providers; and to provide assistance to reduce out-of-pocket costs, such as copayments, coinsurance, and deductibles, in the nongroup market.

Continuous Coverage. This legislation would generally require insurers, starting in calendar year 2019, to impose a six-month waiting period before coverage can start for people who enroll in insurance in the nongroup market if they have been uninsured for more than 63 days within the past year. Imposing that waiting period would, CBO and JCT expect, slightly increase the number of people with insurance, on net, throughout the 2018-2026 period—but not in 2019, when the incentives to obtain coverage would be weak because premiums would be relatively high.

Most insurance coverage in the nongroup market, both under this legislation and under current law, would stem from decisions occurring during an open enrollment period at the end of the calendar year, and the following discussion focuses on those decisions. (Enrollment outside those periods would be available only to people who experience qualifying events such as getting married.) Several factors would tend to increase insurance coverage in the nongroup market:

- Some people, regardless of whether or not they had insurance coverage in a given year, would decide to purchase coverage at the beginning of the next year so that they would not be subject to a waiting period at the beginning of the year after that—whereas without this provision, they would skip a year of coverage, knowing that they could purchase coverage at the beginning of the upcoming year if they expected their use of health care to increase.

- Some people who were insured at the beginning of a given year would retain that coverage throughout the year if, with an interruption in coverage, they had to wait until July of the following year to regain it—whereas without the waiting period, they would drop the coverage at some point during the year.

- Some people who were uninsured in a given year could concentrate their use of health care in the second half of the next year and pay premiums for 6 months rather than 12, increasing the value per month of the coverage and inducing them to be become insured during that period—whereas without this provision, they would not be insured at all during that year.

Those factors, CBO and JCT estimate, would outweigh other factors that would tend to decrease coverage:

- Some people who were uninsured for more than 63 days and then decided to become insured at the end of a given year would have to wait six additional months to do so, whereas without this provision, they would become insured at the beginning of the next year.

- Some people who were uninsured for more than 63 days in a given year and expected to incur major health care costs during the first six months of the next year would, with the waiting period, remain uninsured during that time—whereas without the waiting period, they would have purchased insurance at the beginning of the next year to help cover those costs.

Age-Rating Rules. Beginning in calendar year 2019, this legislation would expand the limits on how much insurers in the nongroup and small-group markets can vary premiums on the basis of age. Under current law, a 64-year-old can generally be charged premiums that cost up to three times as much as those offered to a 21-year-old. Under this legislation, that allowable difference would shift to five times as much unless a state chose otherwise. CBO and JCT anticipate that most states would accept that change.

The change in age-rating rules would tend to reduce premiums for younger people and increase premiums for older people, resulting in a slight increase in insurance coverage, on net—mainly among people not eligible for subsidies. The structure of the premium tax credits would limit the effect of such a change. People eligible for subsidies in the nongroup market would be largely insulated from changes in premiums: A person receiving a premium tax credit would pay a certain maximum percentage of his or her income toward the reference premium, and the tax credit would cover the difference between the premium and that percentage of income. Consequently, despite the changes in premiums for younger and older people, the net premiums (after tax credits) for most people receiving subsidies would not be affected much by this provision. The net premiums for older people ineligible for subsidies, however, would be much higher under this legislation than otherwise.

Minimum Medical Loss Ratio. This legislation would, starting in calendar year 2019, repeal the federal requirement that health insurers maintain a minimum medical loss ratio, which is equivalent to capping the share of premiums that may go toward insurers' administrative costs and profits. CBO and JCT anticipate that about half the population resides in states that would choose to maintain the current requirement. Other states would allow a greater share of premiums to go toward administrative costs and profits. In those states, in areas with little competition among insurers, the provision would cause insurers to raise premiums and would increase federal costs for subsidies through the marketplaces, CBO and JCT expect. States would have little incentive to constrain premium increases for policies sold through the marketplaces if unsubsidized enrollees were able to buy a different and cheaper plan in the nongroup market sold outside the marketplaces. That is because premiums paid by subsidized enrollees in the marketplaces

would largely be determined by their income, and the increases would primarily be borne by the federal government in the form of larger premium tax credits. The agencies expect that this provision would have little effect on the number of people covered by health insurance.

Premium Tax Credits and Cost-Sharing Reductions. According to CBO and JCT's estimates, the average subsidy per subsidized enrollee under this legislation would be significantly lower than the average subsidy under current law, starting in calendar year 2020. Nevertheless, some people would be eligible for larger subsidies than those under current law, whereas others would be eligible for smaller ones.

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

Under current law, the size of the premium tax credits depends on household income and a reference premium in an enrollee's rating area. The enrollee pays a certain maximum percentage of his or her income toward the reference premium, and the size of the subsidy varies by geography and age for a given income level. The premium tax credits cover the amount by which the reference premium—that is, the premium for the second-lowest-cost silver plan that covers the eligible people in the household in the area in which they reside—exceeds that percentage of income. The enrollee is insulated from variations in premiums in different geographic locations and is also largely insulated from increases in the reference premium. If a person chooses a plan with premiums higher than those for the reference plan, then he or she pays the difference as an additional amount toward the premium, providing some incentive to choose lower-priced insurance. Similarly, if the person chooses a plan with premiums lower than the reference plan's, then he or she pays a lower cost.

Under this legislation, starting in 2020, the reference premium would be changed to become the premium for the median plan with an actuarial value of 58 percent. Cost-sharing subsidies would be eliminated. Eligibility for premium tax credits would be extended to people with income below 100 percent of the FPL who were not eligible for Medicaid and eliminated for people with income above 350 percent of the FPL. For those with income exceeding 150 percent of the FPL, this legislation would generally reduce the percentage of income that younger people had to pay toward their premiums and increase that percentage for older people. (For families, the age of the oldest taxpayer would be used to determine the age-adjusted percentage of income that must be paid toward the premiums.)

Effects by Income. For many lower-income people, the net premiums paid under this legislation would be similar to those under current law, but the plans they would purchase would have higher deductibles and other cost-sharing requirements. In a set of illustrative examples, CBO and JCT estimate that a 40-year-old with income at 175 percent of the FPL in 2026 could pay a net premium of $1,700 for a silver plan under current law and $1,600 for a plan with actuarial value of 58 percent under this legislation (see Table 5). However, because the reference premium would be changed and cost-sharing subsidies would be eliminated under this legislation, the average share of the cost of medical services paid by the insurance purchased by that person would fall—from 87 percent to 58 percent—and his or her payments in the form of deductibles and other cost sharing would rise.[3] Those changes, CBO and JCT estimate, would contribute significantly to a reduction in the number of lower-income people who would obtain coverage through the nongroup market under this legislation, compared with the number under current law.

People with income below 100 percent of the FPL who were not eligible for Medicaid could generally receive premium tax credits under this legislation and not under current law. However, even with the net premium of $300 shown in the illustrative examples for a person with income at 75 percent of the FPL ($11,400 in 2026), the deductible would be more than half their annual income. The net premium of a silver plan for a 40-year-old would be about 15 percent of their annual income, and the deductible would be more than one-third of their annual income. Many people in that situation would not purchase any plan, CBO and JCT estimate, although some people with assets to protect or who expect to have high use of health care would.

Many of the people who are projected be eligible for Medicaid under current law but not eligible under this bill would face a similar choice. Those people would instead be eligible for a premium tax credit under this legislation. But because of the expense for premiums and the high deductibles, most of them would not purchase insurance, CBO and JCT estimate. (The vast majority of people enrolled in Medicaid pay no premiums and have either no out-of-pocket costs or nominal amounts of such costs.)

Although offering a different benefit package would make plans more attractive to people with low income, it is difficult for insurers to design plans that have an actuarial value of 58 percent and that pay for much care before the deductible is met—such as providing prescription drugs with low copayments. Those designs are constrained by the

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3. In 2017, the average deductible for a single policyholder (for medical and drug expenses combined) is about $6,000 for a bronze plan (with an actuarial value of 60 percent) and about $3,600 for a silver plan (with an actuarial value of 70 percent). People with income of less the 250 percent of the FPL are eligible for plans with lower deductibles: about $2,900 for people with income between 200 percent and 250 percent of the FPL and a plan having actuarial value of 73 percent, about $800 for people with income between 150 percent and 200 percent of the FPL and a plan having actuarial value of 87 percent, and about $300 for people with income between 100 percent and 150 percent of the FPL and a plan having actuarial value of 94 percent.

requirements for EHBs, limits on out-of-pocket spending, and prohibitions on annual or lifetime limits on payments for covered services. (Waivers affecting the EHBs could change those constraints at least somewhat.)

People with income between 350 percent and 400 percent of the FPL would be eligible for premium tax credits under current law, but not under this bill. People with income above 400 percent of the FPL would not receive premium tax credits in either case. However, for a 40-year-old with income at either 375 percent of the FPL or 450 percent of the FPL, net premiums for a single policyholder would be fairly similar under current law and the legislation for a plan with similar actuarial value. (Many people purchasing a family policy, however, would receive several thousand dollars in premium tax credits under current law that they would not receive under this bill.)

Effects by Age. Enacting this legislation would also result in significant changes in net premiums paid in the nongroup market according to people's age. In the illustrative examples, CBO and JCT estimate that, under current law, a 21-year-old, 40-year-old, and 64-year-old with income at 175 percent of the FPL in 2026 would all pay the same net premium of $1,700 for a plan with an actuarial value of 87 percent. Under this legislation, the net premium for a plan with an actuarial value of 58 percent would be smaller for younger people and larger for older people, but the net premium for a plan with an actuarial value of 70 percent would be larger for people of any age.

For people not eligible for premium tax credits, premiums for older people could be five times larger than those for younger people in many states, rather than only three times larger under current law. Because of such differences, CBO and JCT estimate that, under this legislation, a larger share of enrollees in the nongroup market would be younger people and a smaller share would be older people than would be the case under current law.

Caps on Federal Medicaid Spending. Under current law, the federal government and state governments share in the financing and administration of Medicaid. In general, states pay health care providers for services to enrollees, and the federal government reimburses states for a percentage of their expenditures. All federal reimbursement for medical services is open-ended, meaning that if a state spends more because enrollment increases or costs per enrollee rise, additional federal payments are automatically generated. This bill would establish a per capita cap on most Medicaid spending for medical services and offer states an option for a block grant to provide medical services for certain adults. In addition to affecting total spending, the caps would have a variety of other effects on states and enrollees, including an interaction with the effects of work requirements, in the near term and the longer term.

Per Capita Cap for Medicaid. Under this legislation, beginning in fiscal year 2020, the federal government would limit the amount of reimbursement it provides to states. That limit would be set for a state by calculating the average per-enrollee cost of medical

services for most enrollees who received full Medicaid benefits over eight consecutive quarters of the state's choosing between the first quarter of federal fiscal year 2014 and the third quarter of 2017. Those enrollees would be in five specified categories: the elderly, disabled adults, nondisabled children, adults made eligible for Medicaid by the ACA, and all other adults. The Secretary of HHS would then inflate the average per-enrollee costs for each state for most nondisabled children and nondisabled adults enrolled in Medicaid using the CPI-M and for most enrollees who are disabled adults or age 65 or older using the CPI-M plus 1 percentage point. Disabled children would be excluded from the per capita caps and covered as under current law. Beginning in 2025, the inflation factor for all groups would be the consumer price index for all urban consumers (CPI-U). The final limit on federal reimbursement for each state starting in 2020 would be the average cost per enrollee for the five specified groups of enrollees, reflecting growth from the base period in the relevant inflation factors multiplied by the number of enrollees in each category.

If a state spent more than the amount eligible for federal reimbursement, the federal government would provide no reimbursement for spending over the limit. By CBO's projections for the 2017-2024 period, the limit on federal reimbursement would reduce outlays because Medicaid spending, on a per-enrollee basis, for nondisabled children and nondisabled adults under current law (after the changes to the Medicaid expansion population have been accounted for) would grow faster, at 4.9 percent, than the CPI-M, at 3.7 percent. However, for most enrollees who are disabled adults or age 65 or older, that rate is 3.3 percent, lower than the CPI-M plus 1 percentage point. The per capita cap would have a small effect on spending for those groups, even though the cap would not generally be binding for them, because some shifting of costs among groups would probably occur, and spending for a particular group in a particular year could be affected. In 2025 and beyond, the differences between spending growth for Medicaid under current law and the growth rate of the per capita caps for all groups would be substantial, as CBO projects the growth rate of the CPI-U in those years to be 2.4 percent.

Block Grant Option for States. Starting in 2020, under this legislation, states would have the option to receive federal aid for providing medical assistance to nondisabled adults (excluding adults made eligible for Medicaid by the ACA) in the form of a block grant rather than under a per-enrollee cap. A state's initial block grant would be determined by multiplying the amount of the per capita cap, as estimated by the Secretary of HHS, for the state's nondisabled adult population by the state's total number of nondisabled adult enrollees in the year before the preceding fiscal year, adjusted for population growth plus 3 percentage points. In subsequent years, the block grant amount would grow at the rate of the CPI-U.

A state would be required to contribute, at a minimum, an amount calculated using its matching rate for enrollees under the Children's Health Insurance Program (CHIP), not including the 23 percentage-point decrease for such rates established under the ACA. (The state matching rate for CHIP ranges from 18 percent to 35 percent, depending on the

state, and averages 30 percent.) Because this option would be attractive mainly to a few states that expect to decline in population (and not in most states experiencing population growth, as it would further constrain federal reimbursement), CBO expects this option would have little effect on enrollment in Medicaid.

Effects on States and Enrollees. With less federal reimbursement for Medicaid, states would need to decide whether to commit more of their own resources to finance the program at current-law levels or to reduce spending by cutting payments to health care providers and health plans, eliminating optional services, restricting eligibility for enrollment through work requirements and other changes, or (to the extent feasible) arriving at more efficient methods for delivering services. CBO anticipates that states would adopt a mix of those approaches, which would result in additional savings to the federal government.

States would not have substantial additional flexibility under the per capita caps. Under the block grant option, states would have additional flexibility to make changes to their Medicaid program—such as altering cost sharing and, to a limited degree, benefits.

Other ways in which Medicaid spending caps affected enrollees would depend greatly on how states responded to the caps, which would be affected by the particular structure of their program. If states chose to leave their Medicaid program unchanged and instead found other ways to offset the loss of federal funds, enrollees would notice little or no change in their Medicaid coverage. To the extent that states delivered services more efficiently, the health of enrollees would not be affected.

If states reduced payment rates, fewer providers might be willing to accept Medicaid patients, especially given that, in many cases, Medicaid's rates are already significantly below those of Medicare or private insurance for some of the same services. If states reduced payments to Medicaid's managed care plans, some plans might shrink their provider networks, curtail quality assurance, or drop out of the managed care program altogether. If states reduced covered services, some enrollees might decide either to pay out of pocket or to forgo those services entirely. And if states narrowed their categories of eligibility or used administrative procedures that made it more difficult to enroll, some enrollees would lose access to Medicaid coverage, although some would become eligible for subsidies for nongroup coverage through the marketplaces or could choose to enroll in employment-based insurance, if it was available.

Interaction of Work Requirements With Caps on Federal Spending. Because caps on federal Medicaid spending would shift a greater share of the cost of Medicaid to states over time, some states would, CBO anticipates, use work requirements—allowed under a separate provision that would take effect in fiscal year 2018—to reduce enrollment and the associated costs. (CBO also anticipates that some states would adopt work requirements before spending caps took effect in 2020.) Under current law, states may not condition the receipt of Medicaid on any criteria related to a person's employment

status. This legislation would permit states to impose a work requirement for an adult as long as the individual is not disabled, elderly, or pregnant (or exempted for another specified reason). The definition of work would be the same as the Temporary Assistance for Needy Families program's, which includes activities such as unsubsidized employment, subsidized employment, vocational training, and educational activities. The legislation would provide states with broad discretion to define how many hours of work each week were required; how long enrolled people would have before needing to meet the requirements; and, if they failed to meet the requirements, when benefits would cease.

Longer-Term Effects. Over the next decade, CBO projects, a large gap would grow between Medicaid spending under current law and under this bill (see Figure 2 on page 13). In later years, that gap would continue to widen because of the compounding effect of the differences in spending growth rates: CBO projects that the growth rate of Medicaid under current law would exceed the growth rate of the per capita caps for all groups covered by the caps starting in 2025.

Under this legislation, after the next decade, states would continue to need to arrive at more efficient methods for delivering services (to the extent feasible) and to decide whether to commit more of their own resources, cut payments to health care providers and health plans, eliminate optional services, restrict eligibility for enrollment, or adopt some combination of those approaches. Over the long term, there would be increasing pressure on more states to use all of those tools to a greater extent. CBO and JCT do not have an insurance coverage baseline beyond the coming decade and therefore are not able to quantify the effect on insurance coverage in the long term. However, the agencies expect that after 2026, enrollment in Medicaid would continue to fall relative to what would happen under current law.

Federal Matching Rate for Medicaid Costs. Under current law, states are permitted, but not required, to expand eligibility for Medicaid to adults under 65 whose income is equal to or less than 138 percent of the FPL (who are referred to here as newly eligible). The federal government pays a larger share of the medical costs for those people than it pays for those who were previously eligible. Beginning in fiscal year 2021, this legislation would reduce the federal matching rate for all newly eligible adults from 90 percent of the medical costs for them to 85 percent in 2021, 80 percent in 2022, and 75 percent in 2023. Thereafter, that rate would fall to the matching rate for other enrollees. The federal matching rate for other enrollees ranges from 50 percent to 75 percent, depending on the state, and averages about 57 percent.

The 31 states and the District of Columbia that have already expanded Medicaid to the newly eligible cover roughly half of that population nationwide. In its March 2016 baseline, CBO projected that under current law, additional states will expand their Medicaid programs and that, by 2026, roughly 80 percent of newly eligible people will reside in states that have done so. Under this legislation, largely because states would pay for a greater share of costs for enrollees, CBO expects that no additional states would

expand eligibility, thereby reducing both enrollment in and spending for Medicaid, compared with the amounts anticipated under current law.

CBO also anticipates that some states that have already expanded their Medicaid programs would no longer offer that coverage, gradually reducing the share of the newly eligible population residing in a state with expanded eligibility as the matching rate for that population declined—with that share reaching about 30 percent in 2026. That estimate reflects different possible outcomes without any explicit prediction about which states would make which choices. In considering the possible outcomes, CBO took into account several factors: the extent of optional coverage provided to the newly eligible population and other groups before the ACA's enactment (as a measure of a state's willingness to provide coverage above statutory minimums), states' ability to bear costs under this legislation, and potential methods to mitigate those costs (such as changes to benefit packages and payment rates). Another factor is the possibility that some states, to avoid abrupt changes to eligibility and other aspects of the program, might begin to act before 2021 in anticipation of future changes that would result from this legislation. How individual states would ultimately respond is highly uncertain.

Noncoverage Spending Provisions

This legislation would also make changes to spending for other federal health care programs. CBO and JCT estimate that those provisions would decrease direct spending by about $22 billion over the 2017-2026 period. This section provides additional details about the changes in direct spending resulting from provisions other than the coverage provisions (except for a provision eliminating a limitation on recapturing excess advance payments of premium tax credits, which is discussed in JCT's publications mentioned earlier). (To most clearly link the analysis to the corresponding sections of the legislation, the headings in this section, as well as in Table 2, adopt its phrasing.)

Better Care Reconciliation Implementation Fund. This bill would appropriate $500 million for administrative expenses related to the cost of implementing the act. CBO estimates that this provision would increase direct spending by $500 million over the 2017-2026 period.

Federal Payments to States. For a one-year period following enactment, this legislation would prevent federal funds from being made available to an entity (including its affiliates, subsidiaries, successors, and clinics) if it is:

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

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

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

- An entity that had expenditures under the Medicaid program that (when combined with the expenditures of its affiliates, subsidiaries, successors, and clinics) exceeded $350 million in fiscal year 2014.

CBO expects that the prohibition, as phrased, would apply only if at least one entity, affiliate, subsidiary, successor, or clinic satisfied the first three criteria. CBO identified only one organization that would be affected: Planned Parenthood Federation of America and its affiliates and clinics.[4]

Most federal funds received by such entities come from payments for services provided to enrollees in states' Medicaid programs. CBO estimates that the prohibition would reduce direct spending by $225 million over the 2017-2026 period. Those savings would be partially offset by increased spending for other Medicaid services, as discussed below.

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

Because the Medicaid program pays the costs of about 45 percent of all births, CBO estimates that the additional births stemming from the reduced access under this legislation would add to federal spending for the program. In addition, some of those children would themselves qualify for Medicaid and possibly for other federal programs. By CBO's estimates, during the one-year period in which the funding prohibition would apply, the number of births in the Medicaid program would increase by several thousand, increasing direct spending for the program by $79 million over the 2017-2026 period. Overall, with those costs netted against the savings estimated above, implementing the provision would reduce direct spending by $146 million over the 2017-2026 period, CBO estimates.

Medicaid Provisions. Under current law, states can elect the Community First Choice option, allowing them to receive a 6 percentage-point increase in their federal matching rate for some services provided by home and community-based attendants to certain Medicaid recipients. The legislation would terminate the increase in the federal matching funds beginning in calendar year 2020. That change would decrease direct spending by about $19 billion over the next 10 years, CBO estimates.

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4. If the provision was implemented in a way that affiliates, subsidiaries, successors, and clinics could satisfy the criteria separately, then the provision could apply to more entities, perhaps many more.

Restoring Fairness in DSH Allotments. Under current law, Medicaid allotments to states for payments to hospitals that treat a disproportionate share of uninsured and Medicaid patients—known as allotments for "disproportionate share hospitals," or DSH allotments—are to be cut significantly in each year from 2018 to 2025. The cuts are currently scheduled to be $2 billion in 2018 and to increase each year until they reach $8 billion in 2024 and 2025.

This legislation would eliminate those cuts, starting in 2018, for states that did not expand Medicaid under the ACA. In addition, the Secretary of HHS would calculate each state's ratio of its allotments for disproportionate share payments per Medicaid enrollee and increase the allotments for states that did not expand Medicaid by an amount sufficient to bring their allotments for 2020 to 2023 up to the national average per enrollee. Those changes would increase outlays by $19 billion over the next 10 years, CBO estimates.

Reducing State Medicaid Costs. This bill would decrease the period for which Medicaid benefits may be covered retroactively from up to three months before a recipient's application to the first of the month in which a recipient makes an application. By CBO's estimates, that change would decrease direct spending by about $5 billion over the 2017-2026 period.

Providing Safety Net Funding for Nonexpansion States. This legislation would provide $2 billion in funding in each year from 2018 to 2022 to states that did not expand Medicaid eligibility under the ACA. Those states could use the funding, within limits, to supplement payments to providers that treat Medicaid enrollees. Such payments to providers would not be subject to the per capita caps. Any states that chose to expand Medicaid coverage as of July 1 of each year from 2017 through 2020 would lose access to the funding available under this provision in the following year and thereafter. CBO estimates that this provision would increase direct spending by $10 billion over the 2017-2026 period.

Provider Taxes. Under current law, states that tax health care providers are required to collect those taxes at uniform rates from all providers of the same type. The federal government limits the amount of such taxes that states can collect without incurring reductions in federal Medicaid payments. Currently, that limit is set at 6 percent of a provider's net revenues from services for patients. The legislation would lower that limit to 5.8 percent in 2021 and further lower it by 0.2 percentage points annually until the threshold reached 5.0 percent. With those lower limits, states would collect less in provider taxes, and some states would probably reduce their Medicaid spending to compensate for at least part of the lost revenues. CBO estimates that such reductions would amount to about half of the lost revenues, reducing direct spending by $5 billion over the 2017-2026 period.

Medicaid and CHIP Quality Performance Bonus Payments. This bill would provide $8 billion in funding from 2023 through 2026 to states that spend some amount less (specified by the Secretary of HHS) than the cap on their per capita payments and that meet peer-reviewed performance standards for health care quality in Medicaid and CHIP. Because CBO anticipates that only some states would meet the two criteria, and because some of the funds provided under the legislation would be spent after 2026, this provision is estimated to increase direct spending by $3 billion over the 2017-2026 period.

Prevention and Public Health Fund. This legislation would, beginning in fiscal year 2018, repeal the provision that established the Prevention and Public Health Fund. The federal government awards grants through the fund to public and private entities to carry out prevention, wellness, and public health activities. Funding under current law is projected to be $900 million in 2018 and to rise to $2 billion in 2025 and each year thereafter. CBO estimates that eliminating that funding would reduce direct spending by $9 billion over the 2017-2026 period.

Support for State Response to Opioid Crisis. This bill would provide $2 billion in 2018 for grants to states to support treatment and recovery services for people with substance use disorders or mental health problems. CBO estimates that this provision would increase direct spending by $2 billion over the 2017-2026 period.

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

Changes in Spending Subject to Appropriation

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

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting this legislation would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027. The agencies expect that gross savings, particularly from Medicaid, would continue to grow, while the gross costs would be smaller because the tax on employees' health insurance premiums and health plan benefits would be reinstated in 2026.

MANDATES ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

CBO has reviewed the nontax provisions of the legislation and determined that they would impose intergovernmental mandates as defined in UMRA. If a nondomicile insurer applied for a license in a state to cover a small business health plan, and the state did not approve or deny the application within 90 days, the legislation would temporarily preempt the state's laws and allow the insurer to operate in the state until action was taken on the application. In addition, the legislation would preempt state laws precluding health insurance issuers from offering coverage for small business health plans. Although the preemptions would limit the application of state laws, they would impose no duty on states resulting in additional spending or a loss of revenues.

JCT has determined that the tax provisions of the legislation contain no intergovernmental mandates.

MANDATES ON THE PRIVATE SECTOR

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

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

In addition, the nontax provisions of the legislation would impose a private-sector mandate on insurers that offer health insurance coverage in the nongroup market. The legislation would require those insurers to withhold coverage for six months from individuals who have not maintained continuous coverage. The cost of the mandate would include the administrative costs of verifying continuous coverage for individuals who apply for insurance and enforcing waiting periods. Additionally, the cost to insurers would include any net loss of income resulting from the delay in the collection of premiums from policyholders during the mandatory waiting period or from people's decisions not to purchase insurance because of the waiting period. But insurers also would gain premium collections beginning in 2018 from people induced to enroll by the continuous coverage provision. In 2019, the first year that the mandate would be in effect, relatively few people would be induced to enroll by the continuous coverage provision, because premiums would be relatively high and the net cost of the mandate would total about $100 million, CBO estimates. In subsequent years, more people would be induced to enroll by the continuous coverage provision in response to lower

premiums. In those years, premium collections from people induced to enroll by that provision would more than offset the loss of premium collections from individuals who had not maintained continuous coverage.

PREVIOUS CBO ESTIMATES

This legislation would reduce federal deficits over the 2017-2026 period by $202 billion more than the House-passed version of H.R. 1628 (see Figure 5).[5] Direct spending would be $89 billion greater, mainly because of higher Medicaid spending through 2024. Revenues would be $291 billion greater, primarily because a smaller share of the premium tax credits, which are refundable, would take the form of a reduction in tax liability and because the income threshold for determining the medical care deduction would be higher.[6]

The number of people with health insurance coverage would be slightly lower under this legislation during the next two years and slightly higher in later years—but the differences relative to the estimates for the House-passed legislation would be no more than 1 million in any year. The structure of subsidies for coverage in the nongroup market differs in the two versions of the legislation and would have substantially different effects by income and by age. The overall spending on such subsidies under this legislation would be $134 billion lower than under the House-passed legislation.

Under both versions of the legislation, about half the population would be in states substantially affected by waivers to provisions of the ACA. Under this legislation, because many people in the nongroup market would be paying premiums based on their income, CBO and JCT expect that there would be less pressure to try to lower premiums by using waivers to narrow the scope of the EHBs than under the House-passed legislation. However, there would be offsetting pressure under this bill for states to obtain federal funding to pursue their policy goals. Waivers to requirements that people maintain continuous insurance coverage would not be allowed under this legislation, although they would be under the House-passed version. However, waivers related to a broad array of other provisions, such as the structure of subsidies, would be allowed under this legislation.

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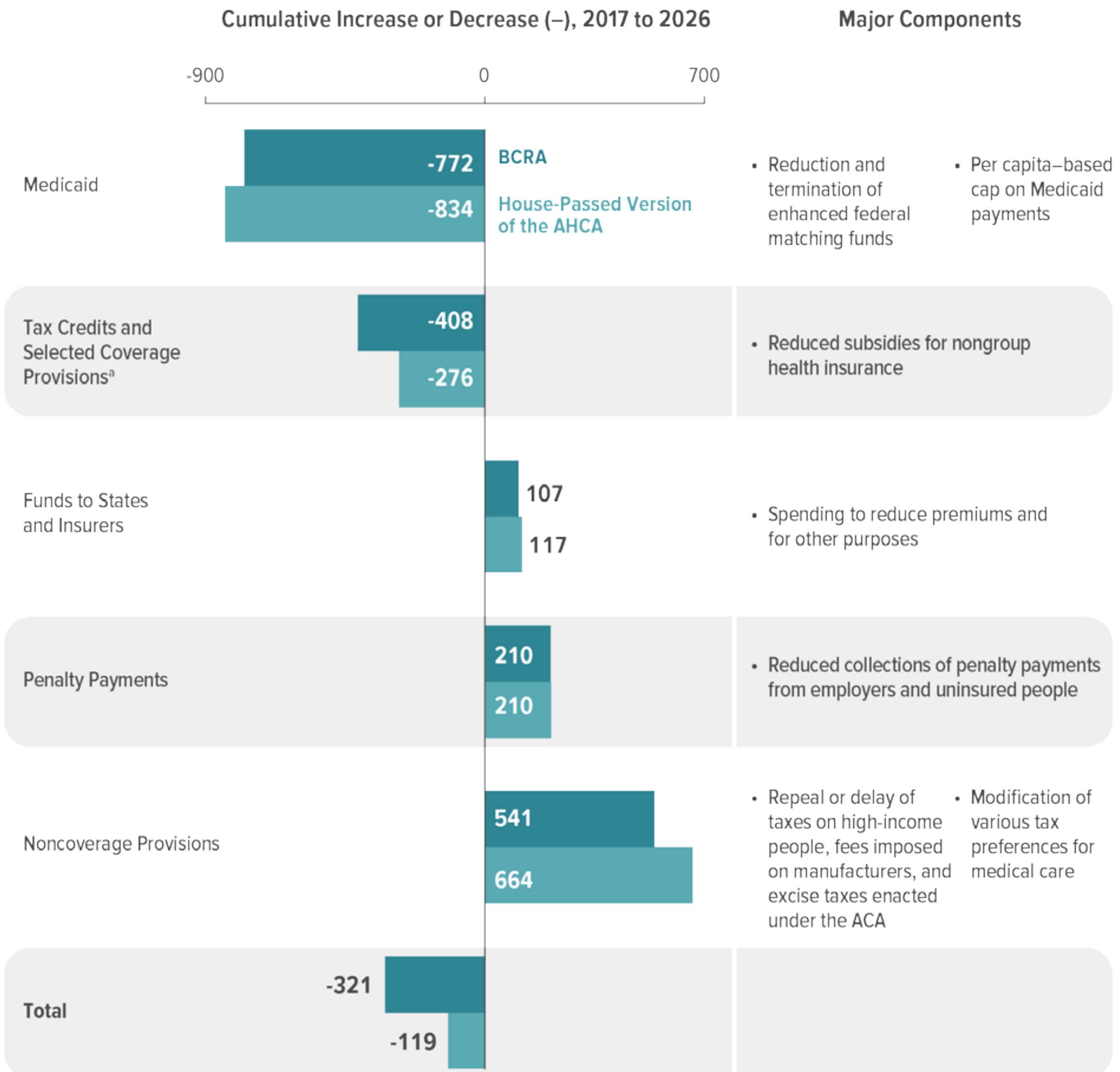
5. See Congressional Budget Office, cost estimate for H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives (May 24, 2017), www.cbo.gov/publication/52752. For discussion of previous versions of the legislation, see Congressional Budget Office, cost estimate for H.R. 1628, the American Health Care Act, incorporating manager's amendments 4, 5, 24, and 25 (March 23, 2017), www.cbo.gov/publication/52516, and cost estimate for the American Health Care Act (March 13, 2017), www.cbo.gov/publication/52486.

6. Refundable tax credits reduce a filer's income tax liability overall; if the credit exceeds the rest of the filer's income tax liability, the government pays all or some portion of that excess to the taxpayer. See Congressional Budget Office, *Refundable Tax Credits* (January 2013), www.cbo.gov/publication/43767.

Figure 5.

Net Effects of the Better Care Reconciliation Act and of the House-Passed Version of the American Health Care Act on the Budget Deficit

Billions of Dollars



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

These estimates are for two versions of H.R. 1628: the Better Care Reconciliation Act of 2017 (BCRA), a Senate amendment in the nature of a substitute; and the American Health Care Act of 2017 (AHCA), as passed by the House of Representatives.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation.

ACA = Affordable Care Act.

a. Includes subsidies for coverage through marketplaces and related spending and revenues, small-employer tax credits, tax credits for nongroup insurance, Medicare, and other effects of coverage provisions on revenues and outlays.

On average, premiums in 2018 under this legislation and the House-passed version would be about the same. Average premiums in 2019 would be slightly higher under this legislation, mostly because, in that year, subsidies would be larger for older people, who have higher average costs. For later years, the comparisons are difficult to make, mainly because of the complex effects of waivers in both versions of the legislation. For example, for the House-passed version of the legislation, CBO and JCT did not have an estimate of the average effect on premiums for the one-sixth of the population residing in states that would make substantial changes to market regulations, because the agencies judged that such an estimate would be too imprecise.[7]

ESTIMATE PREPARED BY:

Federal Spending

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Federal Revenues

Staff of the Joint Committee on Taxation

Impact on State, Local, and Tribal Governments

Leo Lex, Zachary Byrum, and the staff of the Joint Committee on Taxation

Impact on the Private Sector

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7. The agencies developed estimates of premiums for individuals as part of the microsimulation used in the analysis. Among the one-sixth of the population residing in states that would make substantial changes to market regulations, many people would pay low premiums but some people would pay very high premiums. CBO and JCT were uncertain how high those premiums could go, because insurers there might decide to not offer policies with high premiums and their decisions are hard to predict. That uncertainty about insurers' behavior had little effect on the agencies' estimates of the number of people with insurance coverage or on the number of people using tax credits, because the number of people who would pay high premiums was not large. However, the high premiums for those people would have had a substantial effect on the agencies' estimate of average premiums. Thus, that uncertainty made the estimate of the average too imprecise.

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Table 1 - SUMMARY OF THE DIRECT SPENDING AND REVENUE EFFECTS OF H.R. 1628, THE BETTER CARE RECONCILIATION ACT OF 2017, AN AMENDMENT IN THE NATURE OF A SUBSTITUTE [LYN17343] AS POSTED ON THE WEBSITE OF THE SENATE COMMITTEE ON THE BUDGET ON JUNE 26, 2017

Billions of Dollars, by Fiscal Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
CHANGES IN DIRECT SPENDING[a]												
Coverage Provisions												
Estimated Budget Authority	-2.5	-6.4	-14.9	-66.5	-93.7	-127.3	-142.3	-162.0	-181.4	-197.9	-183.9	-994.8
Estimated Outlays	-4.4	-21.0	-25.1	-68.5	-93.5	-109.1	-139.0	-161.0	-181.2	-196.9	-212.5	-999.8
Noncoverage Provisions												
Estimated Budget Authority	0.9	1.2	-1.3	-0.4	-0.8	-2.0	3.7	-6.1	-7.2	-8.4	-0.3	-20.3
Estimated Outlays	0.0	0.0	0.5	0.7	-0.3	-1.4	-4.2	-4.6	-5.6	-7.1	0.9	-22.1
Total Changes in Direct Spending												
Estimated Budget Authority	-1.6	-5.2	-16.1	-66.9	-94.4	-129.3	-138.6	-168.1	-188.6	-206.3	-184.3	-1,015.1
Estimated Outlays	-4.5	-21.0	-24.6	-67.8	-93.8	-110.6	-143.3	-165.7	-186.8	-204.0	-211.6	-1,021.9
CHANGES IN REVENUES[b]												
Coverage Provisions	-4.0	-14.4	-16.0	-10.2	-11.2	-12.5	-14.6	-16.9	-18.7	-19.4	-55.8	-137.9
Noncoverage Provisions	-1.7	-40.3	-39.7	-45.7	-52.4	-57.1	-70.7	-81.6	-89.7	-84.3	-179.8	-563.1
Total Changes in Revenues	-5.7	-54.6	-55.7	-55.9	-63.5	-69.6	-85.3	-98.4	-108.4	-103.7	-235.6	-701.0
INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES												
Net Increase or Decrease (-) in the Deficit	1.2	33.6	31.1	-11.8	-30.2	-41.0	-58.0	-67.2	-78.4	-100.3	23.9	-320.9

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

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation.
The costs of this legislation fall within budget functions 550 (health), 570 (Medicare), 600 (Income Security), and 650 (Social Security).
Numbers may not add up to totals because of rounding.

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

Table 2 - ESTIMATE OF THE DIRECT SPENDING AND REVENUE EFFECTS OF H.R. 1628, THE BETTER CARE RECONCILIATION ACT OF 2017, AN AMENDMENT IN THE NATURE OF A SUBSTITUTE [LYN17343] AS POSTED ON THE WEBSITE OF THE SENATE COMMITTEE ON THE BUDGET ON JUNE 26, 2017

Billions of Dollars, by Fiscal Year	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
ESTIMATED CHANGES IN DIRECT SPENDING[a]												
Coverage Provisions												
Estimated Budget Authority	-2.5	-6.4	-14.9	-66.5	-93.7	-127.3	-142.3	-162.0	-181.4	-197.9	-183.9	-994.8
Estimated Outlays	-4.4	-21.0	-25.1	-68.5	-93.5	-109.1	-139.0	-161.0	-181.2	-196.9	-212.5	-999.8
On-Budget	*-4.4*	*-21.0*	*-25.1*	*-68.5*	*-93.5*	*-109.1*	*-139.0*	*-161.0*	*-181.2*	*-196.9*	*-212.5*	*-999.8*
Off-Budget	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Title I												
Sec. 101 - Recapture of Excess Advance Payments of Premium Tax Credits												
Estimated Budget Authority	0	-2.2	-2.9	-1.6	-1.3	-1.6	-1.8	-2.2	-2.4	-2.6	-8.0	-18.7
Estimated Outlays	0	-2.2	-2.9	-1.6	-1.3	-1.6	-1.8	-2.2	-2.4	-2.6	-8.0	-18.7
Sec. 102 - Restrictions for the Premium Tax Credit												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 104 - Individual Mandate												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 105 - Employer Mandate												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 106 - State Stability and Innovation Program												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 107 - Better Care Reconciliation Implementation Fund												
Estimated Budget Authority	0.5	0	0	0	0	0	0	0	0	0	0.5	0.5
Estimated Outlays	0	*	0.1	0.1	0.1	0.1	*	*	0	0	0.4	0.5
Sec. 124 - Federal Payments to States[b]												
Estimated Budget Authority	*	-0.1	*	*	*	*	*	*	*	*	-0.2	-0.1
Estimated Outlays	*	-0.1	*	*	*	*	*	*	*	*	-0.2	-0.1
Sec. 125 - Medicaid Provisions[b]												
Estimated Budget Authority	0	0	0	-1.1	-1.9	-2.5	-3.2	-3.3	-3.5	-3.7	-3.0	-19.3
Estimated Outlays	0	0	0	-1.1	-1.9	-2.5	-3.2	-3.3	-3.5	-3.7	-3.0	-19.3
Sec. 126 - Medicaid Expansion												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 127 - Restoring Fairness in DSH Allotments												
Estimated Budget Authority	0	0.7	1.0	1.9	2.3	2.6	3.0	2.8	2.8	2.0	5.8	19.0
Estimated Outlays	0	0.7	1.0	1.9	2.3	2.6	3.0	2.8	2.8	2.0	5.8	19.0
Sec. 128 - Reducing State Medicaid Costs[b]												
Estimated Budget Authority	0	-0.2	-0.5	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.7	-1.8	-5.0
Estimated Outlays	0	-0.2	-0.5	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.7	-1.8	-5.0
Sec. 129 - Providing Safety Net Funding for Non-Expansion States												
Estimated Budget Authority	0	2.0	2.0	2.0	2.0	2.0	0	0	0	0	8.0	10.0
Estimated Outlays	0	1.8	2.0	2.0	2.0	2.0	0.2	0	0	0	7.8	10.0
Sec. 130 - Eligibility Redeterminations												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											

Continued

Table 2 Continued. Billions of Dollars, by Fiscal Year	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
Sec. 131 - Optional Work Requirement for Nondisabled, Nonelderly, Nonpregnant Individuals												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 132 - Provider Taxes												
Estimated Budget Authority	0	0	0	0	-0.2	-0.4	-0.7	-1.0	-1.4	-1.5	-0.2	-5.2
Estimated Outlays	0	0	0	0	-0.2	-0.4	-0.7	-1.0	-1.4	-1.5	-0.2	-5.2
Sec. 133 - Per Capita Allotment for Medical Assistance												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 134 - Flexible Block Grant Option for States												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 135 - Medicaid and CHIP Quality Performance Bonus Payments												
Estimated Budget Authority	0	0	0	0	0	0	8.0	0	0	0	0	8.0
Estimated Outlays	0	0	0	0	0	0	0	1.0	1.0	1.0	0	3.0
Sec. 136 - Grandfathering Certain Medicaid Waivers; Prioritization of HCBS Waivers												
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	0	0	0	0	0	0	0	0	0	0	0
Sec. 137 - Coordination With States												
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	0	0	0	0	0	0	0	0	0	0	0
Sec. 138 - Optional Assistance for Certain Inpatient Psychiatric Services												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 139 - Small Business Health Plans												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Title II												
Sec. 201 - Prevention and Public Health Fund												
Estimated Budget Authority	0	-0.9	-0.9	-1.0	-1.0	-1.5	-1.0	-1.7	-2.0	-2.0	-3.8	-12.0
Estimated Outlays	0	-0.1	-0.4	-0.7	-0.9	-1.0	-1.1	-1.3	-1.4	-1.7	-2.2	-8.8
Sec. 202 - Support for State Response to Opioid Crisis												
Estimated Budget Authority	0	2.0	0	0	0	0	0	0.0	0.0	0.0	2.0	2.0
Estimated Outlays	0	0	0.9	0.7	0.3	*	*	0.0	0.0	0.0	1.9	2.0
Sec. 203 - Community Health Center Program												
Estimated Budget Authority	0.4	0	0	0	0	0	0	0	0	0	0.4	0.4
Estimated Outlays	0	0.2	0.2	*	0	0	0	0	0	0	0.4	0.4
Sec. 204 - Change in Permissible Age Variation in Health Insurance Premium Rates												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 205 - Medical Loss Ratio Determined by the State												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											

Continued

Table 2 Continued. Billions of Dollars, by Fiscal Year	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
Sec. 206 - Stabilizing the Individual Insurance Markets												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 207 - Waivers for State Innovation												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 208 - Funding for Cost-Sharing Payments												
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	0	0	0	0	0	0	0	0	0	0	0
Sec. 209 - Repeal of Cost-Sharing Subsidy Program												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Total Changes in Direct Spending												
Estimated Budget Authority	**-1.6**	**-5.2**	**-16.1**	**-66.9**	**-94.4**	**-129.3**	**-138.6**	**-168.1**	**-188.6**	**-206.3**	**-184.3**	**-1,015.1**
Estimated Outlays	**-4.5**	**-21.0**	**-24.6**	**-67.8**	**-93.8**	**-110.6**	**-143.3**	**-165.7**	**-186.8**	**-204.0**	**-211.6**	**-1,021.9**
On-Budget	*-4.5*	*-21.0*	*-24.6*	*-67.8*	*-93.8*	*-110.6*	*-143.3*	*-165.7*	*-186.8*	*-204.0*	*-211.6*	*-1,021.9*
Off-Budget	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*

ESTIMATED CHANGES IN REVENUES[c]

Billions of Dollars, by Fiscal Year	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
Coverage Provisions	-4.0	-14.4	-16.0	-10.2	-11.2	-12.5	-14.6	-16.9	-18.7	-19.4	-55.8	-137.9
On-Budget	*-4.3*	*-17.2*	*-19.0*	*-11.9*	*-12.9*	*-14.3*	*-16.1*	*-18.2*	*-20.0*	*-20.8*	*-65.3*	*-154.7*
Off-Budget	*0.3*	*2.9*	*3.0*	*1.6*	*1.7*	*1.8*	*1.5*	*1.3*	*1.3*	*1.4*	*9.5*	*16.8*
Title I												
Sec. 101 - Recapture of Excess Advance Payments of Premium Tax Credits	0	0.2	1.1	0.9	0.4	0.5	0.6	0.7	0.8	1.0	2.7	6.3
Sec. 102 - Restrictions for the Premium Tax Credit	*included in estimate of coverage provisions*											
Sec. 103 - Modifications to Small Business Tax Cre	*included in estimate of coverage provisions*											
Sec. 104 - Individual Mandate	*included in estimate of coverage provisions*											
Sec. 105 - Employer Mandate	*included in estimate of coverage provisions*											
Sec. 106 - State Stability and Innovation Program	*included in estimate of coverage provisions*											
Sec. 108 - Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits[d]	0	0	0	-3.4	-6.9	-8.7	-10.7	-13.4	-16.4	-6.6	-10.3	-66.0
Sec. 109 - Repeal of Tax on Over-the-Counter Medications	*	-0.5	-0.5	-0.6	-0.6	-0.6	-0.6	-0.7	-0.7	-0.7	-2.3	-5.6
Sec. 110 - Repeal of Tax on HSAs	*	*	*	*	*	*	*	*	*	*	*	-0.1
Sec. 111 - Repeal of Limitations on Contributions to Flexible Spending Accounts	0	-0.3	-1.2	-1.6	-1.7	-1.8	-2.2	-2.6	-3.3	-4.1	-4.7	-18.6
Sec. 112 - Repeal of Tax on Prescription Medications	0	-4.0	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-12.1	-25.7
Sec. 113 - Repeal of Medical Device Excise Tax	0	-1.4	-1.9	-2.0	-2.1	-2.2	-2.3	-2.4	-2.6	-2.7	-7.4	-19.6
Sec. 114 - Repeal of Health Insurance Tax	0	-12.8	-13.5	-14.3	-15.1	-15.9	-16.8	-17.8	-18.7	-19.7	-55.7	-144.7
Sec. 115 - Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy	*	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.7	-1.8
Sec. 116 - Repeal of Chronic Care Tax	*	-3.5	-3.1	-3.4	-3.6	-3.9	-4.2	-4.5	-4.8	-5.1	-13.6	-36.1
Sec. 117 - Repeal of Medicare Tax Increase	0	0	0	0	0	-0.5	-9.3	-14.7	-16.5	-17.6	0	-58.6
Sec. 118 - Repeal of Tanning Tax	0	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
Sec. 119 - Repeal of Net Investment Tax	-1.6	-16.7	-15.9	-16.7	-17.8	-18.7	-19.7	-20.7	-21.7	-22.7	-68.7	-172.2
Sec. 120 - Remuneration	*	-0.1	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.5
Sec. 121 - Maximum Contribution Limit to HSAs Increased to Amount of Deductible and Out-of-Pocket Limitation	0	-1.0	-1.6	-1.7	-1.9	-2.1	-2.3	-2.5	-2.7	-2.9	-6.2	-18.6
Sec. 122 - Allow Both Spouses to Make Catch-Up Contributions to the Same HSA	0	*	*	*	*	*	*	*	-0.1	-0.1	-0.1	-0.4
Sec. 123 - Special Rule for Certain Expenses Incurred Before Establishment of HSAs	0	*	*	*	*	*	*	*	*	*	-0.1	-0.2
Sec. 139 - Small Business Health Plans	*included in estimate of coverage provisions*											

Continued

Table 2 Continued. Billions of Dollars, by Fiscal Year	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
Title II												
Sec. 204 - Change in Permissible Age Variation in Health Insurance Premium Rates	*included in estimate of coverage provisions*											
Sec. 205 - Medical Loss Ratio Determined by the State	*included in estimate of coverage provisions*											
Sec. 206 - Stabilizing the Individual Insurance Markets	*included in estimate of coverage provisions*											
Sec. 207 - Waivers for State Innovation	*included in estimate of coverage provisions*											
Sec. 209 - Repeal of Cost-Sharing Subsidy Program	*included in estimate of coverage provisions*											
Total Changes in Revenues	**-5.7**	**-54.6**	**-55.7**	**-55.9**	**-63.5**	**-69.6**	**-85.3**	**-98.4**	**-108.4**	**-103.7**	**-235.6**	**-701.0**
On-Budget	*-5.9*	*-57.0*	*-57.8*	*-55.7*	*-62.6*	*-68.2*	*-83.0*	*-95.1*	*-103.9*	*-101.9*	*-239.1*	*-691.1*
Off-Budget	*0.3*	*2.4*	*2.0*	*-0.3*	*-0.9*	*-1.4*	*-2.3*	*-3.3*	*-4.5*	*-1.8*	*3.5*	*-9.9*
INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES												
Net Increase or Decrease (-) in the Deficit	**1.2**	**33.6**	**31.1**	**-11.8**	**-30.2**	**-41.0**	**-58.0**	**-67.2**	**-78.4**	**-100.3**	**23.9**	**-320.9**
On-Budget	*1.5*	*36.0*	*33.2*	*-12.1*	*-31.1*	*-42.3*	*-60.3*	*-70.6*	*-83.0*	*-102.1*	*27.5*	*-330.8*
Off-Budget	*-0.3*	*-2.4*	*-2.0*	*0.3*	*0.9*	*1.4*	*2.3*	*3.3*	*4.5*	*1.8*	*-3.5*	*9.9*

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

Numbers may not add up to totals because of rounding.
CHIP = Children's Health Insurance Program; DSH = Disproportionate Share Hospital; HSA = Health Savings Account;
HCBS = Home and Community Based Services.
* = between -$50 million and $50 million.

a. For outlays, a positive number indicates an increase (adding to the deficit) and a negative number indicates a decrease (reducing the deficit).
b. Estimate interacts with the provision related to the Per Capita Allotment for Medical Assistance.
c. For revenues, a positive number indicates an increase (reducing the deficit) and a negative number indicates a decrease (adding to the deficit).
d. This estimate does not include effects of interactions with other subsidies; those effects are included in estimates for other relevant provisions.

Table 3 - ESTIMATE OF THE NET BUDGETARY EFFECTS OF THE INSURANCE COVERAGE PROVISIONS OF H.R. 1628, THE BETTER CARE RECONCILIATION ACT OF 2017

Billions of Dollars, by Fiscal Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total, 2017-2026
Medicaid	*	-12	-23	-52	-70	-87	-103	-124	-143	-158	-772
Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	-5	-12	-22	-49	-58	-57	-56	-54	-55	-56	-424
Elimination of Small-Employer Tax Credits[b,c]	*	*	*	*	-1	-1	-1	-1	-1	-1	-6
Elimination of Penalty Payments by Employers[c]	2	16	20	15	16	18	19	20	22	23	171
Elimination of Penalty Payments by Uninsured People	3	3	3	3	4	4	4	4	4	5	38
Funds Provided to States and Insurers	0	0	12	22	24	24	9	6	5	5	107
Medicare[d]	0	2	4	5	5	5	5	5	5	5	42
State Waiver Implementation Funding	*	*	1	*	*	*	*	0	0	0	2
Other Effects on Revenues and Outlays[e]	-1	-4	-5	-3	-3	-3	-2	-1	*	*	-21
Total Effect on the Deficit	*****	**-7**	**-9**	**-58**	**-82**	**-97**	**-124**	**-144**	**-162**	**-178**	**-862**
Memorandum: Additional Detail on Marketplace Subsidies and Related Spending and Revenues											
Premium Tax Credit Outlay Effects	-3	-7	-13	-27	-35	-33	-31	-28	-28	-29	-235
Premium Tax Credit Revenue Effects	-1	-2	-3	-6	-7	-7	-8	-8	-8	-8	-57
Subtotal, Premium Tax Credits	-4	-8	-17	-33	-42	-41	-39	-36	-36	-37	-292
Cost-Sharing Outlays	-1	-3	-4	-13	-13	-13	-14	-14	-15	-16	-105
Outlays for the Basic Health Program	*	-2	-1	-3	-3	-3	-3	-4	-4	-4	-27
Total, Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	-5	-12	-22	-49	-58	-57	-56	-54	-55	-56	-424

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

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation.
Positive numbers indicate an increase in the deficit; negative numbers indicate a decrease in the deficit.

Numbers may not add up to totals because of rounding.
* = between -$500 million and $500 million.

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

b. Includes effects on both outlays and revenues.

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

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

e. Consists mainly of the effects on revenues of changes in taxable compensation.

Table 4 - EFFECTS OF H.R. 1628, THE BETTER CARE RECONCILIATION ACT OF 2017, ON HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER AGE 65

Millions of People, by Calendar Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Population Under Age 65	273	274	275	276	276	277	278	279	279	280
Uninsured Under Current Law	26	26	27	27	27	27	27	28	28	28
Change in Coverage Under the BCRA										
Medicaid[a]	*	-4	-5	-8	-10	-11	-12	-14	-14	-15
Nongroup coverage, including marketplaces	-1	-7	-8	-9	-8	-7	-7	-7	-7	-7
Employment-based coverage	*	-4	-2	-1	-1	-1	*	*	*	*
Other coverage[b]	*	*	*	*	*	*	*	*	*	*
Uninsured	1	15	15	19	19	20	20	21	22	22
Uninsured Under the BCRA	28	41	43	46	46	47	48	49	49	49
Percentage of the Population Under Age 65 With Insurance Under the BCRA										
Including all U.S. residents	90	85	84	83	83	83	83	82	82	82
Excluding unauthorized immigrants	92	87	87	86	86	85	85	85	85	85

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

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

For these estimates, CBO and JCT consider individuals to be uninsured if they would not be enrolled in a policy that provides financial protection from major medical risks.

BCRA = Better Care Reconciliation Act; * = between -500,000 and zero.

a. Includes noninstitutionalized enrollees with full Medicaid benefits.

b. Includes coverage under the Basic Health Program, which allows states to establish a coverage program primarily for people whose income is between 138 percent and 200 percent of the federal poverty level. To subsidize that coverage, the federal government provides states with funding that is equal to 95 percent of the subsidies for which those people would otherwise have been eligible.

Table 5 - ILLUSTRATIVE EXAMPLE OF SUBSIDIES FOR NONGROUP HEALTH INSURANCE IN 2026 UNDER CURRENT LAW AND THE BETTER CARE RECONCILIATION ACT OF 2017

Dollars

	Bronze Plan				Silver Plan			
	Premium[a]	Premium Tax Credit[b]	Net Premium Paid	Actuarial Value of Plan (Percent)[c]	Premium[a]	Premium Tax Credit[b]	Net Premium Paid	Actuarial Value of Plan After Cost-Sharing Subsidies (Percent)[c]
Single Individual With Annual Income of $11,400 (75 percent of FPL) and Not Eligible for Medicaid[d, e]								
Current Law in a State Not Expanding Medicaid								
21 years old	4,300	0	4,300		5,100	0	5,100	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70
64 years old	12,900	0	12,900		15,300	0	15,300	
BCRA in a State Not Expanding Medicaid								
21 years old	3,200	2,900	300		4,100	2,900	1,200	
40 years old	5,000	4,700	300	58	6,400	4,700	1,700	70
64 years old	16,000	15,700	300		20,500	15,700	4,800	
Single Individual With Annual Income of $26,500 (175 percent of FPL)[d]								
Current Law								
21 years old	4,300	3,400	900		5,100	3,400	1,700	
40 years old	5,500	4,800	700	60	6,500	4,800	1,700	87
64 years old	12,900	12,900	0		15,300	13,600	1,700	
BCRA								
21 years old	3,200	1,900	1,300		4,100	1,900	2,200	
40 years old	5,000	3,400	1,600	58	6,400	3,400	3,000	70
64 years old	16,000	14,000	2,000		20,500	14,000	6,500	
Single Individual With Annual Income of $56,800 (375 percent of FPL)[d]								
Current Law								
21 years old	4,300	0	4,300		5,100	0	5,100	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70
64 years old	12,900	8,500	4,400		15,300	8,500	6,800	
BCRA								
21 years old	3,200	0	3,200		4,100	0	4,100	
40 years old	5,000	0	5,000	58	6,400	0	6,400	70
64 years old	16,000	0	16,000		20,500	0	20,500	
Single Individual With Annual Income of $68,200 (450 percent of FPL)[d]								
Current Law								
21 years old	4,300	0	4,300		5,100	0	5,100	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70
64 years old	12,900	0	12,900		15,300	0	15,300	
BCRA								
21 years old	3,200	0	3,200		4,100	0	4,100	
40 years old	5,000	0	5,000	58	6,400	0	6,400	70
64 years old	16,000	0	16,000		20,500	0	20,500	

Continued

Table 5 continued.

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

All dollar figures have been rounded to the nearest $100.

BCRA = Better Care Reconciliation Act; FPL = federal poverty level.

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

b. Under current law, premium tax credits are calculated as the difference between the reference premium and a specified percentage of income for a person with income at a given percentage of the FPL. The reference premium under current law is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which the person resides. A silver plan covers about 70 percent of the costs of covered benefits. The reference premium under the BCRA in a state without a waiver is the premium for a benchmark plan that covers 58 percent of the cost of covered benefits. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 takes into account the probability, estimated in CBO's March 2016 baseline and under the BCRA, that additional indexing may apply. Such additional indexing applies if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceed a specified percentage of gross domestic product in the preceding year. Under current law, that percentage is 0.504; under the BCRA, that percentage is 0.4.

c. The actuarial value of a plan is the percentage of costs for covered services that the plan pays. Cost-sharing subsidies are payments made by the federal government to insurers that reduce the cost-sharing amounts (out-of-pocket payments required under insurance policies) for covered people whose income is generally between 100 percent and 250 percent of the FPL. The cost-sharing subsidy amounts in this example would range from $1,100 for a 21-year-old with income at 175 percent of the FPL to $3,350 for a 64-year-old at the same income level. Under current law, cost-sharing subsidies have the effect of increasing the actuarial value of the plan from 70 percent for a typical silver plan to 94 percent for people whose income is at least 100 percent of the FPL and not more than 150 percent; to 87 percent for people with income greater than 150 percent of the FPL and not more than 200 percent; and to 73 percent for people with income greater than 200 percent of the FPL and not more than 250 percent. People whose income is greater than 250 percent of the FPL would receive a standard 70 percent actuarial value when purchasing a silver plan. Under the BCRA, cost-sharing subsidies would be eliminated starting in 2020. Under current law and under the BCRA, insurers are required to offer at least one silver plan and one gold plan in each marketplace in which they offer coverage. Under the BCRA, CBO projects that plans will be available with actuarial values of 58 percent, 70 percent, and 80 percent. The premiums for plans at 70 percent and 80 percent reflect not only the difference in the percentage of costs paid but also the effect of "risk selection," as people with higher expected health care costs are more likely to buy plans with higher actuarial values, and such differences are not fully eliminated by risk adjustment payments.

d. Income levels reflect modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers. CBO projects that in 2026, a modified adjusted gross income of $11,400 will equal 75 percent of the FPL, an income of $26,500 will equal 175 percent of the FPL, an income of $56,800 will equal 375 percent of the FPL, and an income of $68,200 will equal 450 percent of the FPL.

e. The single individuals in this illustration are assumed to be ineligible for Medicaid in each case. Under the ACA, most nondisabled adults who are not pregnant with income less than 138 percent of the FPL are eligible for Medicaid if their state has expanded Medicaid. In most states that have not expanded Medicaid, such people with income less than 100 percent of the FPL are not eligible for either Medicaid or marketplace subsidies. A small number of legal permanent residents who have lived in the United States for less than five years with income less than 100 percent of the FPL are eligible for marketplace subsidies under current law; such circumstances are not reflected in this illustrative example. In CBO's projections, under current law, about 80 percent of the potential newly eligible population resides in a state that has expanded Medicaid eligibility by 2026; and under the BCRA, about 30 percent of the potential newly eligible population resides in a state that has expanded Medicaid eligibility by 2026.