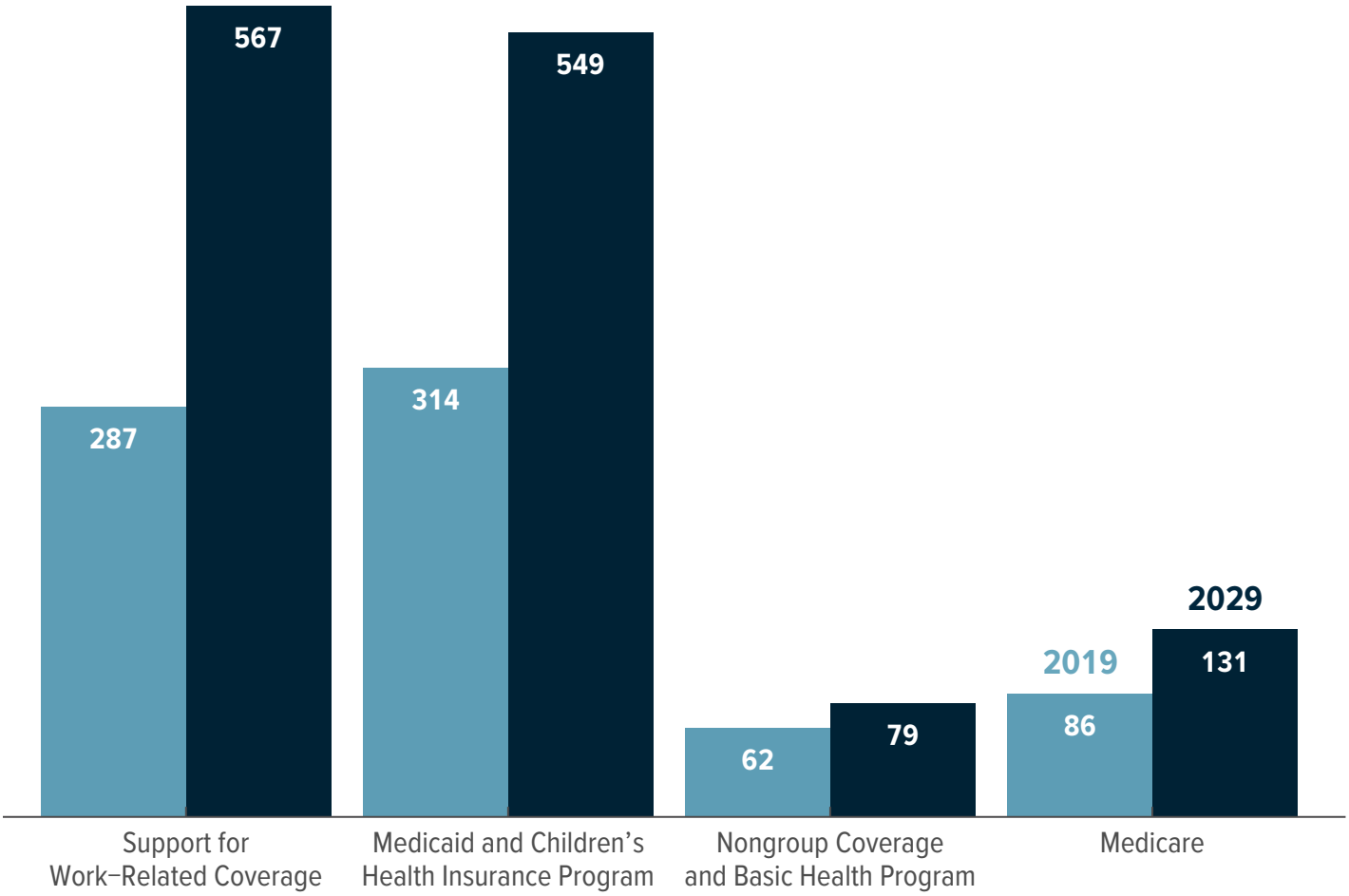
CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

CBO

Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029

Federal Health Insurance Subsidies
Billions of Dollars



MAY 2019

At a Glance

The federal government subsidizes health insurance for most Americans through a variety of programs and tax provisions. This report, which describes the Congressional Budget Office's updated baseline projections, provides estimates for the 2019–2029 period of the number of noninstitutionalized civilians under age 65 with health insurance and the federal costs associated with each kind of subsidy.

- In an average month for each year during that period, between 240 million and 242 million such people are projected to have health insurance, mostly from employment-based plans. But the number of people without health insurance is projected to rise from 30 million in 2019 to 35 million in 2029.

- Net federal subsidies for insured people will total $737 billion in 2019, according to estimates by CBO and the staff of the Joint Committee on Taxation (JCT). That annual sum is projected to reach $1.3 trillion in 2029.

- In each year during the period, Medicaid and the Children's Health Insurance Program account for between 40 percent and 45 percent of the federal subsidies, as do subsidies in the form of tax benefits for work-related insurance. Medicare accounts for about 10 percent, and subsidies for coverage obtained through the marketplaces established by the Affordable Care Act or through the Basic Health Program account for less than 10 percent.

- Since CBO's most recent report comparable to this one was published in May 2018, the projection of the number of people with employment-based coverage has risen by 3 million, on average, for the 2019–2028 period spanned by both reports. The projection of the average number of uninsured people has fallen by 1 million over that period. Projected net federal subsidies for health insurance from 2019 to 2028 have risen by 2 percent.

- Compared with actual amounts of spending in 2018, CBO's projections for that year made in September 2017 were generally close—with the largest error being an overestimate of $15 billion (or 5 percent) for Medicaid spending.

In preparing the current projections, CBO and JCT used a new version of CBO's health insurance simulation model, HISIM2. It incorporates new sources of survey and administrative data, better accounts for employers' and consumers' selection among different types of insurance plans, and can more easily simulate the effects of new insurance products. CBO and JCT use HISIM2 to estimate the major sources of health insurance coverage and associated premiums. On the basis of those estimates, the agencies use other models (for related taxes, Medicaid, and Medicare, for example) to estimate the associated budgetary costs.

Contents

Notes

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

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

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

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

In most states, the federal poverty level is $12,490 for a single person in 2019. For each additional person in a household, $4,420 is added. Income levels reflect modified adjusted gross income (MAGI) for the calendar year. MAGI equals gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and the income of dependent filers.

The sum of the estimates of the number of people enrolled in health insurance plans and the number of people who are uninsured exceeds the estimate of the total population under age 65 by between 11 million and 12 million every year of the projection period, because some people will have multiple sources of coverage. To arrive at the estimates given in this report, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) did not assign a primary source of coverage to people who reported multiple sources; the resulting amounts align better with estimates of spending as well as with information about health insurance coverage from household surveys. (By contrast, when CBO and JCT have estimated changes in the sources of insurance coverage stemming from proposed legislation, the agencies have used only people's primary source of coverage to count them, an approach that has generally proved more useful for that purpose.)

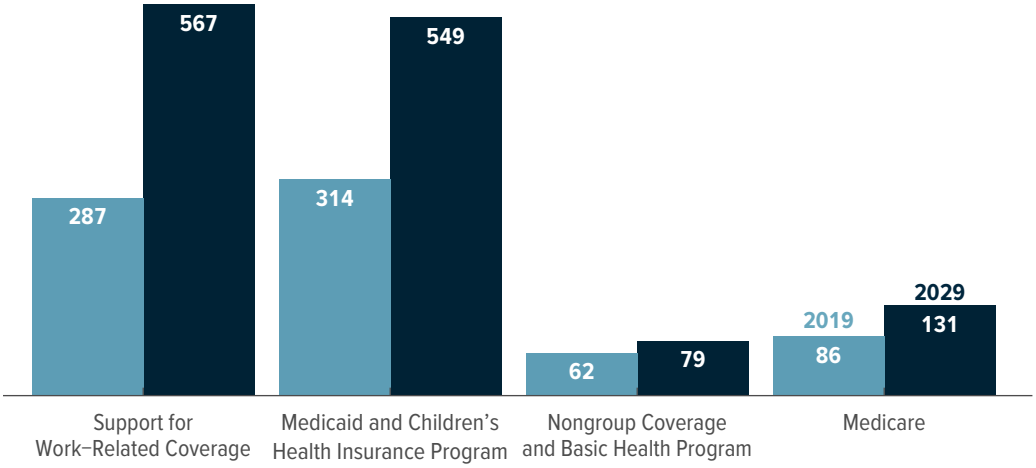
The projections in this report do not incorporate the effects of the following judicial decision and administrative action, which occurred too recently to fully analyze: a decision issued by the District Court for the District of Columbia in the case of *New York v. United States Department of Labor*, No. CV 18-1747, 2019 WL 1410370 (D.D.C. Mar. 28, 2019), that voided major provisions of the Department of Labor's June 2018 regulation entitled "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans," 83 Fed. Reg. 28912 (June 21, 2018), and a proposed rule by the Centers for Medicare & Medicaid Services entitled "Basic Health Program, Federal Funding Methodology for Program Years 2019 and 2020," 84 Fed. Reg. 12552 (April 2, 2019). A preliminary analysis suggests that the effects in subsequent projections would be noticeable but small.

Visual Summary

In a report issued each year, the Congressional Budget Office and the staff of the Joint Committee on Taxation provide projections of health insurance coverage for noninstitutionalized civilians under age 65 and the federal costs of that coverage for that year and the following decade. Net federal subsidies for health insurance coverage for people under age 65 are projected to total $737 billion in 2019 and $9.9 trillion over the 2020–2029 period.

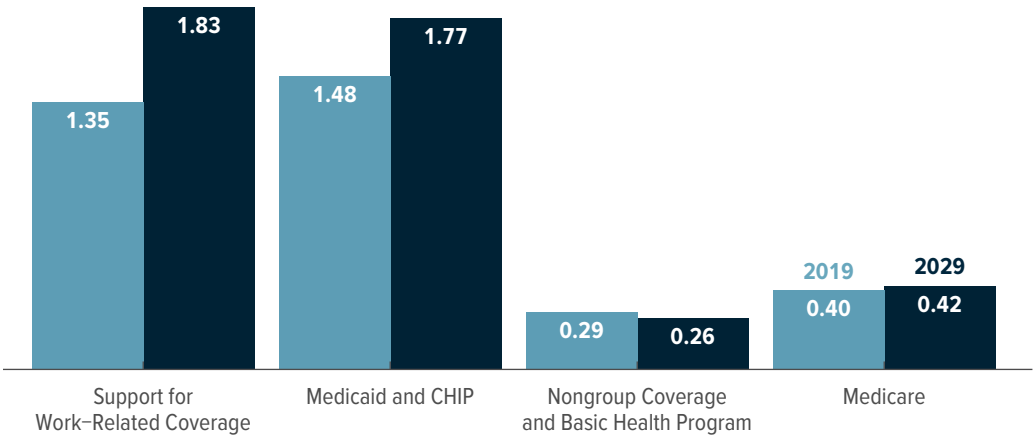
Federal Health Insurance Subsidies

Billions of Dollars



In 2019, the federal government is projected to spend $314 billion for Medicaid and the Children's Health Insurance Program (CHIP) and $287 billion on support for work-related coverage for people under age 65.

Percentage of Gross Domestic Product

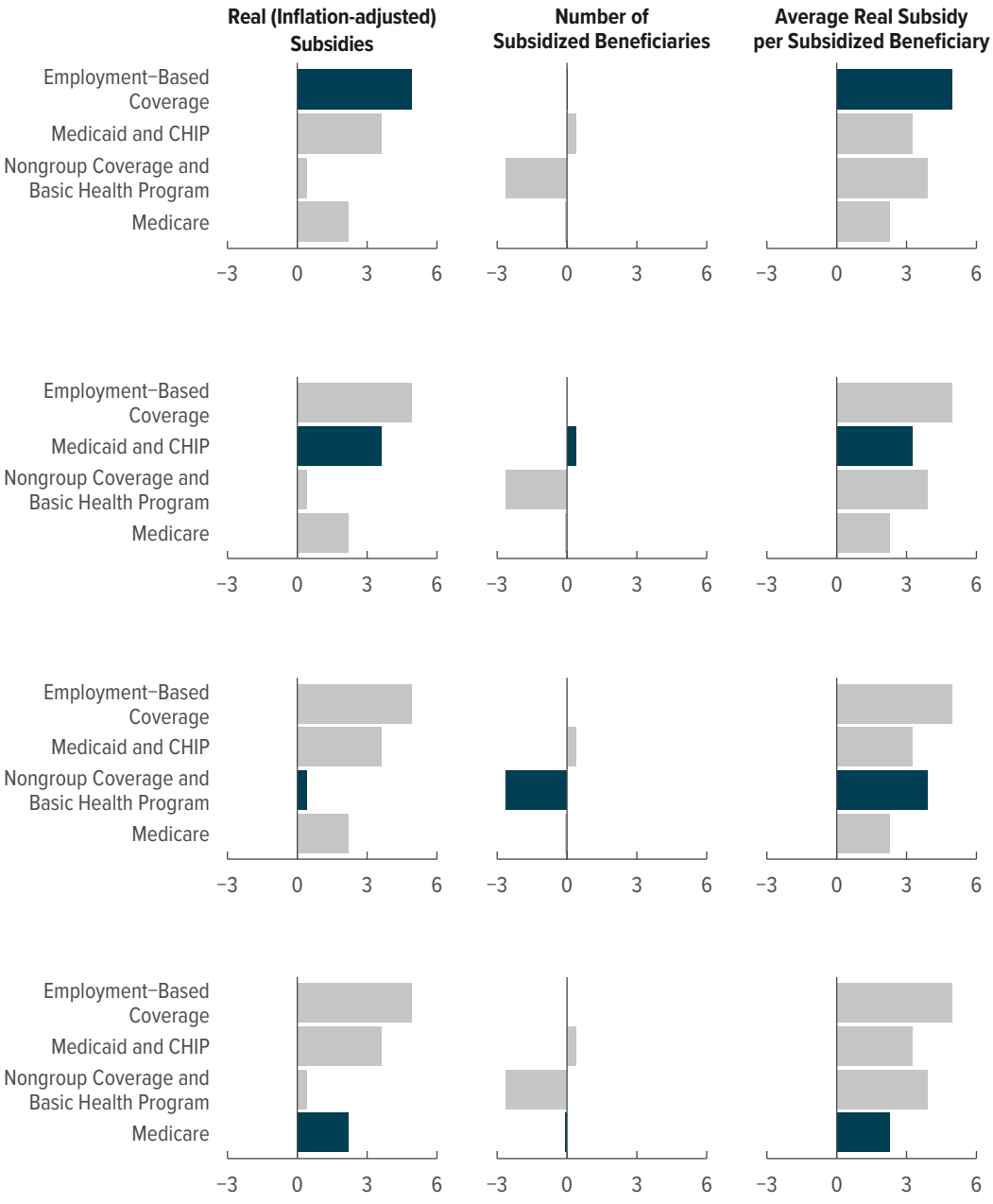


As a share of gross domestic product, total federal subsidies are projected to grow over the coming decade; subsidies for work-related coverage are projected to grow the fastest.

See Figure 2-1 on page 18

Average Annual Percentage Change in Health Insurance Coverage and Federal Subsidies, 2020 to 2029

Percent



Enrollment in employment-based coverage is projected to be stable over the next decade, while the average real subsidy per recipient is projected to grow by an average of 5 percent per year.

For Medicaid and CHIP, growth in the average real subsidy per beneficiary is projected to be slower than it is for private health insurance.

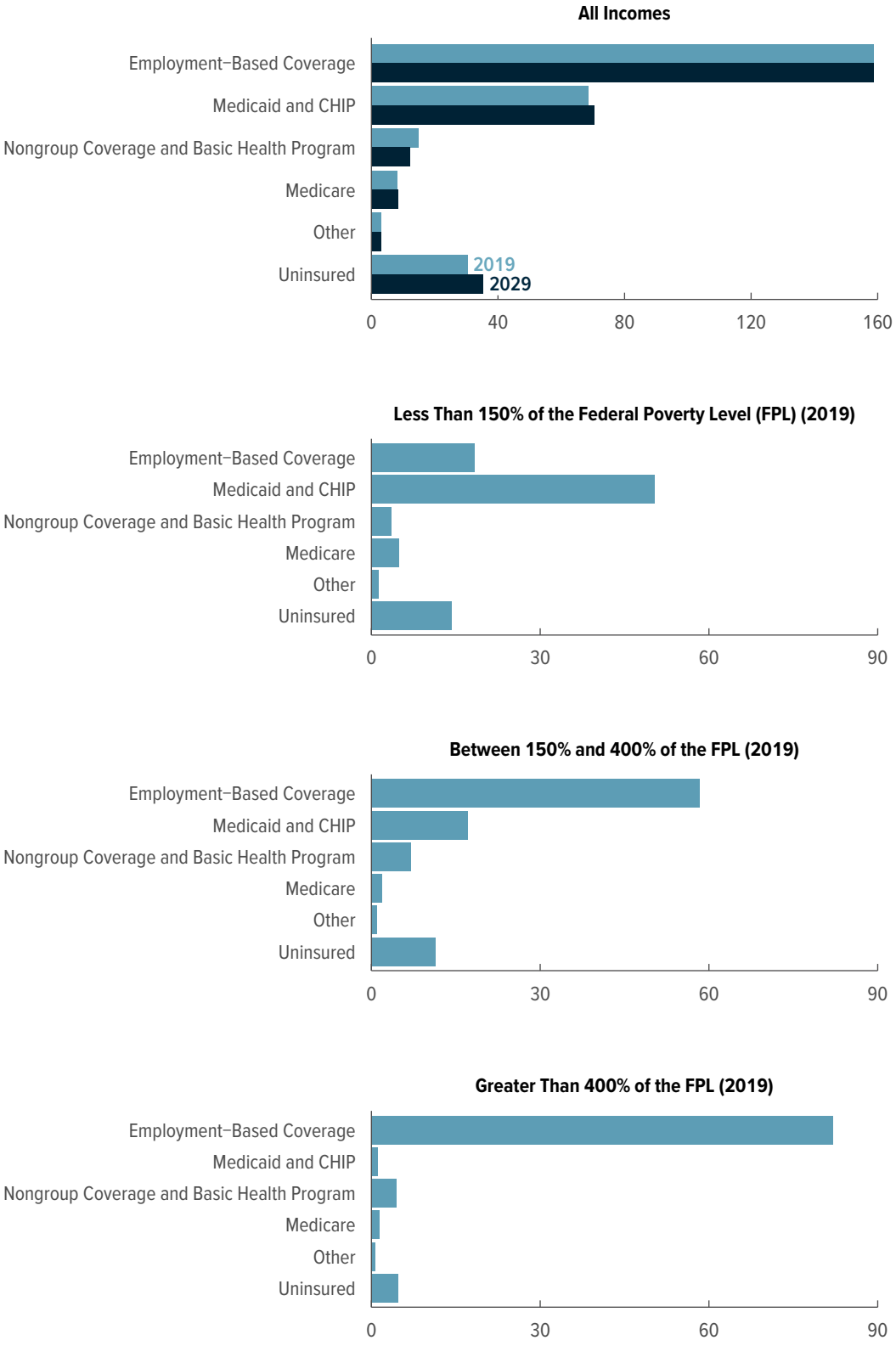
Subsidized nongroup coverage and coverage by the Basic Health Program are projected to decline by an average of 3 percent per year over the next decade, while the average real subsidy per subsidized beneficiary is projected to grow by 4 percent per year.

For Medicare, growth in the average real subsidy per beneficiary is projected to be slower than it is for private health insurance and for Medicaid and CHIP.

See Figure 1-2 on page 8

Health Insurance Coverage by Type and Income

Millions of People



Of the 273 million people under age 65 in 2019, 159 million are projected to have coverage through an employer, and 30 million are projected to be uninsured.

Of the 87 million people under age 65 with income below 150 percent of the FPL in 2019, 58 percent are estimated to be enrolled in Medicaid or CHIP.

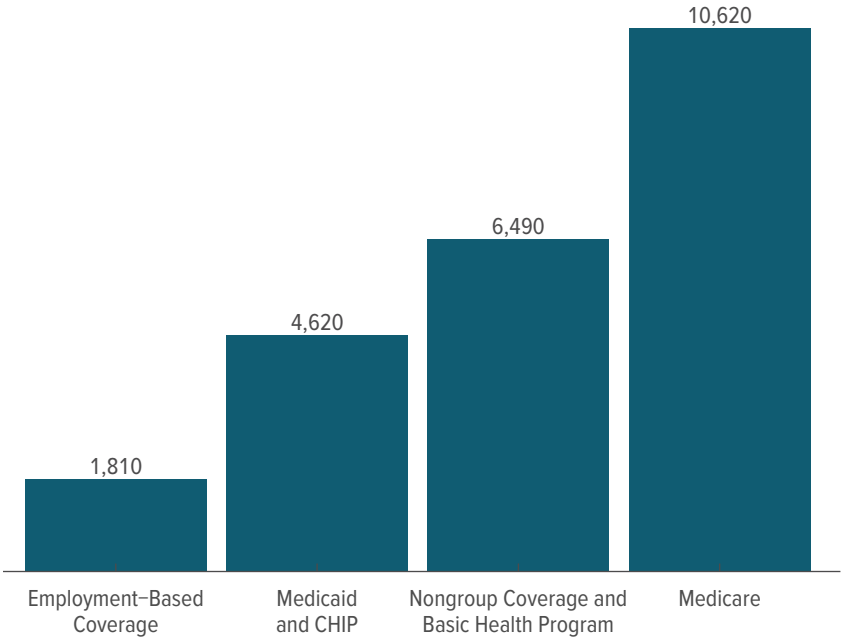
Of the 93 million people under age 65 with income between 150 percent and 400 percent of the FPL, 63 percent are estimated to be enrolled in employment-based insurance.

Of the 93 million people under age 65 with income above 400 percent of the FPL, the vast majority are estimated to be enrolled in employment-based insurance.

See Figure 1-1 on page 7

Average Federal Subsidies for Recipients by Type of Health Insurance, Calendar Year 2019

Dollars



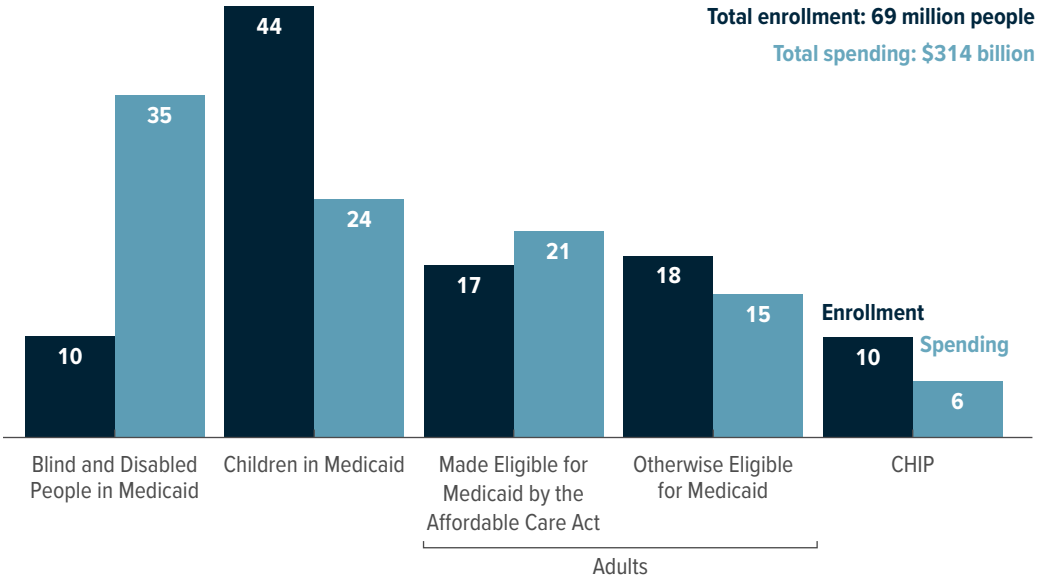
The average federal subsidy for health insurance costs per recipient varies substantially by type of health insurance. The variation occurs because the people who are eligible for each type of insurance differ by age, health status, income, and disability status; because the federal government subsidizes the coverage to different extents; and because the prices paid to providers differ for different types of coverage.

The amounts shown cannot be used to estimate the costs of shifting a group of people from one type of coverage to another because the average cost for each type of coverage depends on the characteristics of the people who are eligible for and enroll in it.

See Figure 2-2 on page 19

Share of Enrollment in and Spending for Medicaid and CHIP by Eligibility Category, 2019

Percentage of Total



Different eligibility categories for Medicaid and CHIP account for very different shares of enrollment and spending. For example, children in Medicaid are projected to constitute 44 percent of enrollment but only 24 percent of spending in 2019, whereas people with disabilities account for 10 percent of enrollment and 35 percent of spending.

See Figure 2-3 on page 20

CHAPTER

1

Projected Health Insurance Coverage

The federal government subsidizes health insurance for most Americans through a variety of programs and tax provisions. In order to estimate the net effects that those subsidies have on the federal budget, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) project the number of people with different types of health insurance coverage.[1]

By the agencies' estimates, 89 percent of the noninstitutionalized civilian population under age 65 will have health insurance in 2019, on average, mostly from employment-based plans and Medicaid (see Table 1-1). Other major sources of coverage include the Children's Health Insurance Program (CHIP), nongroup policies, and Medicare. Over the 2019–2029 period, on average, 88 percent of that population is projected to be insured, under an assumption that current laws affecting health care generally remain unchanged.

The types of coverage that people enroll in vary substantially depending on their income (see Figure 1-1). Of the total population under age 65, 58 percent of people are estimated to obtain employment-based insurance in 2019. That number is 21 percent for people with income below 150 percent of the federal poverty guidelines (known as the federal poverty level, or FPL), 63 percent for people with income between 150 percent and 400 percent of the FPL, and 88 percent for people with income above 400 percent of the FPL. Enrollment in Medicaid and CHIP also varies substantially by income: 58 percent of people with income below 150 percent of the FPL are estimated to enroll in such coverage in 2019. That share declines to an estimated 18 percent for people with income between 150 percent and 400 percent of the FPL (many of whom had higher income over the course of a year than they did when they enrolled in Medicaid).

Over the 2020–2029 period, the number of enrollees in each of the types of coverage used by the most people is projected to be generally stable (see Figure 1-2 on page 8). Enrollment in employment-based coverage, CHIP, and Medicare by noninstitutionalized people under age 65 is estimated to be roughly the same, enrollment in nongroup coverage is estimated to decline slightly, and enrollment in Medicaid to increase slightly.

Projecting insurance coverage is an inherently uncertain endeavor, so CBO and JCT's estimates presented here could be either too high or too low when compared with actual outcomes in the future. But the estimates reflect the best data available and aim to represent the average of possible outcomes under current law.

CBO and JCT's Methods for Developing Baseline Projections of Insurance Coverage and Federal Subsidies

To make projections of enrollment in health insurance coverage and federal subsidies for that coverage, CBO and JCT complete five main steps. Analysts at the agencies use a variety of different models, including CBO's health insurance simulation model.

First, CBO analysts update that model to incorporate new information, including the most recent administrative and survey data on enrollment and premiums; recently enacted legislation, judicial decisions, or changes in regulations; and CBO's most recent macroeconomic forecast. Second, analysts use the model to project coverage distributions for the next 10 years and carefully review the output from the model. Third, because some aspects of current law are simplified in the simulation model, analysts use separate models, such as models of Medicaid enrollment, to adjust output from the simulation model. For use beginning with this year's projections, CBO has developed a new and improved version

1. Adopting a widely held definition, CBO and JCT consider private health insurance coverage to be a policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals. Such coverage is often referred to as comprehensive major medical coverage. See Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094.

Table 1-1.

Health Insurance Coverage, 2019 to 2029

Millions of People, by Calendar Year

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Total Population Under Age 65	273	273	273	274	274	275	275	276	276	276	277
Employment-Based Coverage	159	159	159	159	158	158	158	158	158	159	159
Medicaid and CHIP[a]											
Blind and disabled	7	7	7	7	7	7	7	7	7	7	7
Children	30	30	30	30	30	30	30	30	30	30	30
Adults made eligible for Medicaid by the ACA	12	12	12	13	13	13	14	14	14	14	14
Adults otherwise eligible for Medicaid	13	12	12	12	13	13	13	13	13	13	13
CHIP	7	7	7	7	7	7	7	7	7	7	7
Subtotal	69	68	68	69	70	70	70	71	71	71	71
Nongroup Coverage and the Basic Health Program											
Nongroup coverage purchased through marketplaces[b]											
Subsidized	8	8	7	7	7	7	7	6	6	6	6
Unsubsidized	1	1	1	1	1	1	1	1	1	1	1
Subtotal	9	9	8	8	8	8	8	7	7	7	7
Nongroup coverage purchased outside marketplaces	5	5	4	4	4	4	4	4	4	4	4
Total, nongroup coverage	14	13	13	12	12	12	12	12	12	11	11
Coverage through the Basic Health Program[c]	1	1	1	1	1	1	1	1	1	1	1
Medicare[d]	8	8	8	8	8	8	8	8	8	8	8
Other Coverage[e]	3	3	3	3	3	3	3	3	3	3	3
Uninsured[f]	30	32	33	33	34	34	34	34	35	35	35
Memorandum:											
Number of Insured People	242	241	240	240	241	241	241	241	241	241	242
Insured as a Percentage of the Population											
Including all U.S. residents	89	88	88	88	88	88	88	88	87	87	87
Excluding noncitizens not lawfully present	91	90	90	90	90	89	89	89	89	89	89

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

The table shows coverage for the noninstitutionalized civilian population under age 65. The components do not sum to the total population because some people report multiple sources of coverage. CBO and JCT estimate that in every year of the projection period, between 11 million and 12 million people (or about 5 percent of insured people) have multiple sources of coverage, such as employment-based coverage and Medicaid.

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

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

a. Includes only noninstitutionalized enrollees with full Medicaid benefits. Estimates are adjusted to account for people enrolled in more than one state.

b. Many people can purchase subsidized health insurance coverage through marketplaces established under the ACA, which are operated by the federal government, state governments, or partnerships between the federal and state governments.

c. The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.

d. Includes noninstitutionalized Medicare enrollees under age 65. Most Medicare-eligible people under age 65 qualify for Medicare because they participate in the Social Security Disability Insurance program.

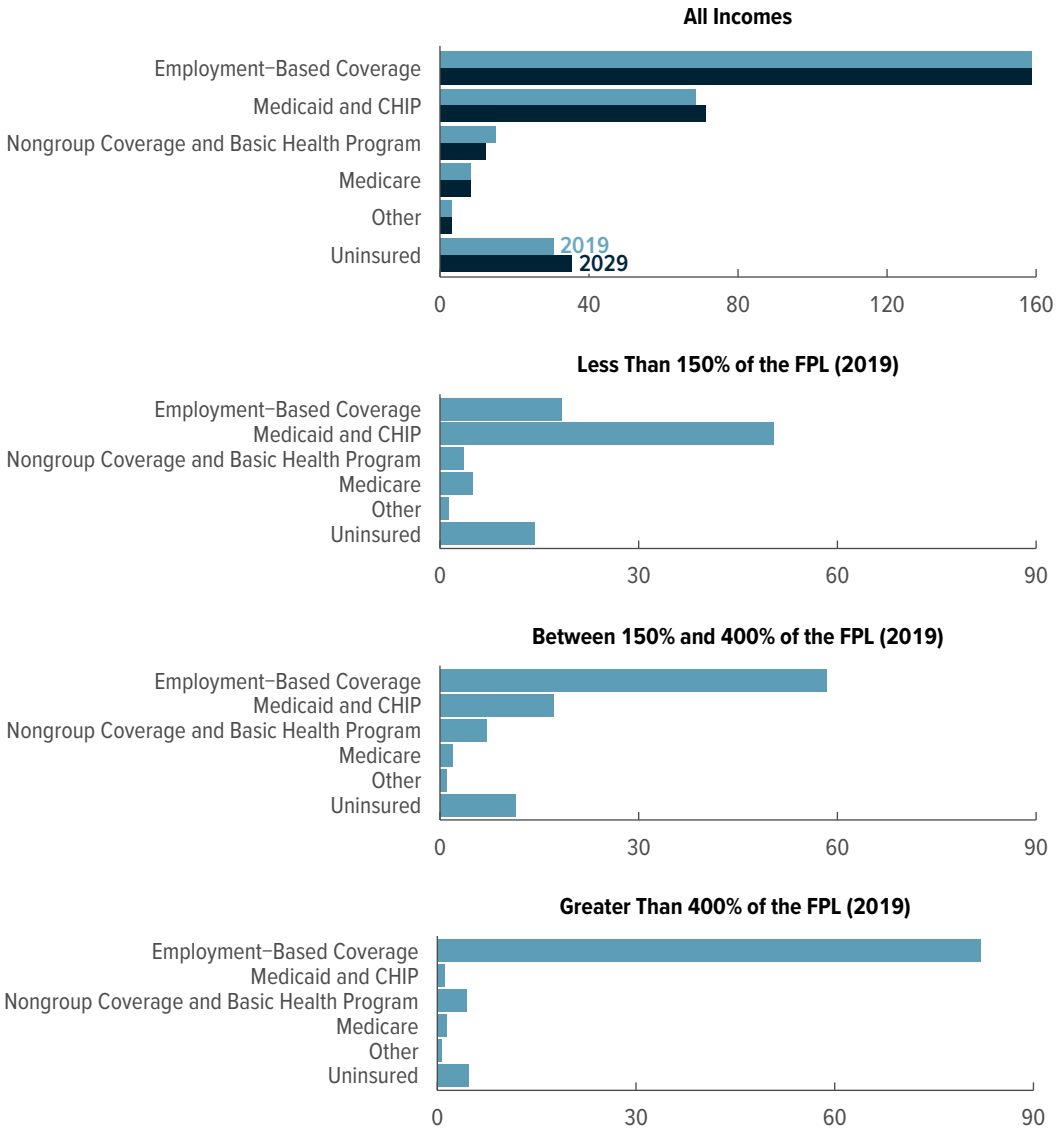
e. Includes people with other kinds of insurance, such as student health plans, coverage provided by the Indian Health Service, or coverage from foreign sources.

f. Includes noncitizens not lawfully present in this country, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid or CHIP who do not enroll; people who purchase nongroup insurance policies that do not meet the agencies' definition of comprehensive health insurance; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

Figure 1-1.

Health Insurance Coverage by Type and Income

Millions of People



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Of the 93 million people under age 65 with income above 400 percent of the FPL, the vast majority are estimated to be enrolled in employment-based insurance.

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

The figure shows coverage for the noninstitutionalized civilian population under age 65.

Estimates by income are calculated using the projected income distribution from CBO's health insurance model, HISIM2. Income in HISIM2 is based on income reported in the Current Population Survey—with various adjustments to better match tax data—that is then extended over the projection period to be consistent with CBO's macroeconomic forecast of economic growth and projections of employment.

In most states, the FPL is $12,490 for a single person in 2019. For each additional person in a household, $4,420 is added.

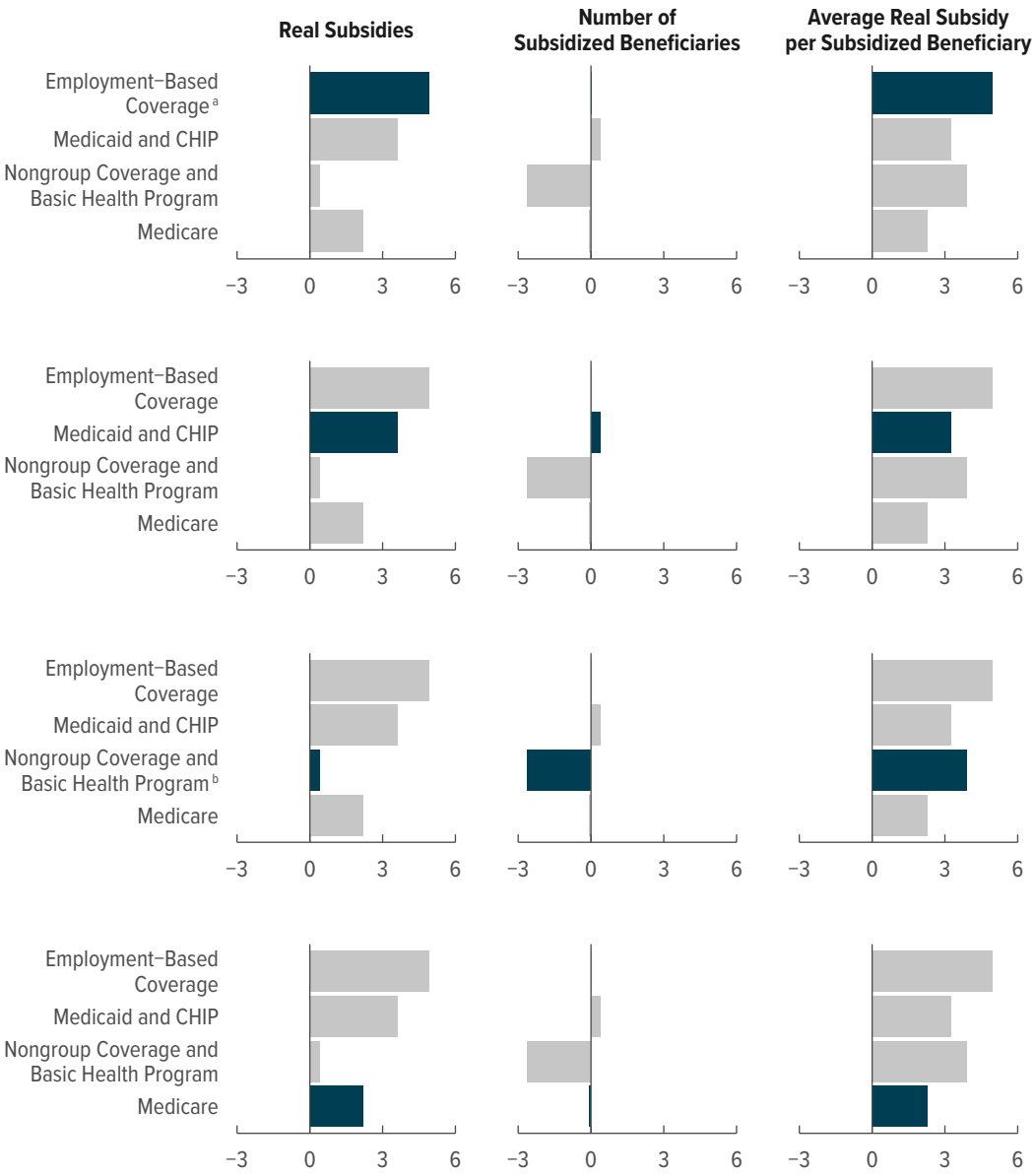
The income of some Medicaid and CHIP enrollees appears higher that the programs' upper income limits because they were probably enrolled for only part of the year and their income exceeded eligibility thresholds before or after being enrolled. CBO and JCT expect that those individuals' income met eligibility criteria when they applied for and enrolled in Medicaid or CHIP.

CHIP = Children's Health Insurance Program; FPL = federal poverty level; JCT = Joint Committee on Taxation.

Figure 1-2.

Average Annual Percentage Change in Health Insurance Coverage and Federal Subsidies, 2020 to 2029

Percent



Enrollment in employment-based coverage is projected to be stable over the next decade, while the average real subsidy per recipient is projected to grow by an average of 5 percent per year.

For Medicaid and CHIP, growth in the average real subsidy per beneficiary is projected to be slower than it is for private health insurance.

Subsidized nongroup coverage and coverage by the Basic Health Program are projected to decline by an average of 3 percent per year over the next decade, while the average real subsidy per subsidized beneficiary is projected to grow by 4 percent per year.

For Medicare, growth in the average real subsidy per beneficiary is projected to be slower than it is for private health insurance and for Medicaid and CHIP.

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

The figure shows subsidies for the noninstitutionalized civilian population under age 65. Real subsidies are adjusted to remove the effects of inflation and are measured in 2019 dollars.

CHIP = Children's Health Insurance Program.

a. Real subsidies include the tax exclusion for employment-based coverage, tax credits for small employers, and the income tax deduction for self-employment health insurance. The average real subsidy per subsidized beneficiary is calculated using only the tax exclusion for employment-based coverage.

b. Real subsidies include premium tax credits for coverage obtained through the marketplaces, outlays for the Basic Health Program, and collections and payments for risk adjustment and reinsurance. The average real subsidy per subsidized beneficiary excludes collections and payments for risk adjustment and reinsurance.

of its health insurance simulation model, HISIM2 (see Box 1-1).

Fourth, after the coverage projections are completed, CBO analysts estimate total spending for Medicaid, CHIP, and the Basic Health Program using program-specific models. Fifth, JCT uses its tax models to estimate the net costs of federal subsidies for work-related coverage and coverage through the nongroup market, as well as taxes and penalties related to coverage.[2]

Employment-Based Coverage

The most common source of health insurance for the noninstitutionalized civilian population under age 65 is a current or former employer—either one's own or a family member's. In CBO and JCT's estimates, a monthly average of about 159 million people (or about 58 percent of the population under age 65) have employment-based coverage in 2019—a decrease from 2018, when an estimated 160 million people had employment-based coverage. The agencies estimate that the decline largely stems from the elimination of the penalty associated with the individual mandate.[3] (For a discussion of the various ways in which repealing the individual mandate penalty affects health insurance coverage, see Box 1-2.)

According to CBO's estimates, access to an offer of employment-based insurance varies notably by income: About 36 percent of people with income below 150 percent of the FPL are estimated to have access to such coverage in 2019, while about 90 percent of people with income above 400 percent of the FPL do (see Figure 1-3 on page 12). People's decision to take up an offer of employment-based coverage also varies notably with income. In CBO's projections, about 21 percent of people with income below 150 percent of the FPL enroll in employment-based coverage, while about 88 percent of people with income above 400 percent of the FPL do.

CBO and JCT estimate that the number of people enrolled in employment-based coverage over the next decade will not change significantly. By the agencies' projections, continued growth in employment and wages tends to boost the number of people with employment-based coverage in part because more workers have access to such coverage. Also, higher wages mean workers are less likely to be eligible for subsidies in the marketplaces established under the Affordable Care Act (ACA) and thus have a greater preference for employment-based coverage. But those factors that would increase enrollment are expected to be generally offset over the decade, because health insurance premiums are projected to grow faster than wages, which tends to decrease the number of employers that offer health insurance and the number of people who enroll in it.

Medicaid and CHIP

The next-largest source of coverage among people under age 65 is Medicaid. In CBO and JCT's estimates, a monthly average of 62 million noninstitutionalized people receive full Medicaid benefits in 2019.[4] That number is unchanged from the number in 2018.

By 2029, the number of people under age 65 receiving full Medicaid benefits is projected to grow to a monthly average of 64 million people, comprising:

- 7 million people with disabilities,
- 30 million children,
- 14 million adults made eligible for Medicaid through the ACA's expansion of Medicaid coverage at states' option, and
- 13 million adults otherwise eligible for Medicaid.

2. For more information on how CBO prepares its baseline, see Congressional Budget Office, *How CBO Prepares Baseline Budget Projections* (February 2018), www.cbo.gov/publication/53532. For more information on how CBO and JCT analyze major health care proposals, see Congressional Budget Office, *How CBO and JCT Analyze Major Proposals That Would Affect Health Insurance Coverage* (February 2018), www.cbo.gov/publication/53571. For more information about CBO's new model, see Congressional Budget Office, "CBO Releases Four Products Explaining How Its New Health Insurance Simulation Model Works," *CBO Blog* (April 18, 2019), www.cbo.gov/publication/55116.

3. The individual mandate penalty was eliminated by Public Law 115-97, originally called the Tax Cuts and Jobs Act.

4. Some enrollees receive only partial benefits from Medicaid. They include Medicare enrollees who receive assistance from Medicaid only for out-of-pocket payments and premiums for Medicare, people who receive only family planning services, and noncitizens who are not lawfully present who receive only emergency services. Spending for enrollees who receive partial benefits is excluded from the estimates in this report. That spending is accounted for in CBO's baseline projections of total spending for the Medicaid program.

Box 1-1.

The Model Underlying CBO's Baseline Estimates of Health Insurance Coverage

The Congressional Budget Office uses its health insurance simulation model to help create baseline projections of health insurance coverage and premiums for people under age 65. In collaboration with the staff of the Joint Committee on Taxation (JCT), the agency also uses the model to estimate the effects of proposed legislation on health insurance coverage and premiums.

The model calculates employers' and individuals' probable responses to changes in health insurance rules and subsidies. It also incorporates CBO's best estimates of insurers' likely responses to those same rules and subsidies. It is used in conjunction with other models to develop baseline budget projections (which incorporate the assumption that current laws generally remain the same).

CBO updates its health insurance simulation model at least once a year to incorporate information from the most recent administrative and survey data, CBO's most recent macroeconomic forecast, and relevant judicial decisions, enacted legislation, and administrative actions.

For use beginning in its 2019 baseline, CBO developed a new version of its health insurance simulation model, HISIM2.[1] It includes changes to the base data, incorporating new sources of survey and administrative data.[2] HISIM2 also incorporates reassessments of consumers' and employers' behavior, including the ways that businesses take workers' preferences into account when deciding whether to offer employment-based coverage and how individuals and families choose among coverage options. In addition, the new version of the model incorporates CBO and JCT's estimate of a link between people's income and their preference for employment-based coverage that is stronger this year than last year. (That link, combined with a forecast of continued growth in employment and wages, contributes to a projection of greater enrollment in employment-based coverage than estimated last year.) The revisions allow CBO and JCT to better account for employers' and consumers' selections among different types of insurance plans and to more easily simulate the effects of new insurance products.

Because HISIM2 includes changes to the underlying data and in the relationships among individuals, families, employment, income, and insurance coverage, it yields somewhat different coverage decisions and budgetary costs than the previous version of the model would have. The changes in the baseline stemming from HISIM2 are not large, however, and are similar in magnitude to the changes seen in previous baselines because of the use of more recent data and technical improvements.

CBO expects the new features of HISIM2 to be more apparent when it is used to analyze policy proposals.[3] For that task, results from the new version of the model may differ more substantially from results from the old version because of the changes to data and reassessments of the ways businesses and families make choices. As HISIM2 is used in the coming year, CBO will analyze and evaluate the results and endeavor to explain the major sources of such differences.

1. For details, see Congressional Budget Office, *HISIM2—The Health Insurance Simulation Model Used in Preparing CBO's Spring 2019 Baseline Budget Projections* (April 2019), www.cbo.gov/publication/55097. Material supplementing that document includes segments of computer code underlying the model's simulations of certain decisions about insurance choices.

2. For example, using administrative tax data, CBO and JCT analyzed differences in various businesses' workforces to improve the modeling of employers' offers of health insurance coverage. For details on changes to the base data used for HISIM2, see Jessica Banthin and others, *Sources and Preparation of Data Used in HISIM2—CBO's Health Insurance Simulation Model*, Working Paper 2019-04 (Congressional Budget Office, April 2019), www.cbo.gov/publication/55087.

3. For more information on how CBO and JCT analyze policy proposals related to health insurance coverage, see Congressional Budget Office, *How CBO and JCT Analyze Major Proposals That Would Affect Health Insurance Coverage* (February 2018), www.cbo.gov/publication/53571.

CBO and JCT's estimates of Medicaid enrollment over the next decade reflect the agencies' expectation that, if current federal laws remained in place, additional states would expand eligibility for the program. Under the ACA, states are permitted to expand eligibility for Medicaid to adults under age 65 whose income is no more than 138 percent of the FPL. The federal government pays a larger share of the costs for those people than it pays for those who are eligible otherwise. In the agencies' projections, most of the increase in enrollment during the 2019–2029 period stems from additional states' expanding eligibility for the program, rather than from additional enrollment in states that have already expanded eligibility. Currently, about

Box 1-2.

How Repealing the Individual Mandate Penalty Affects Health Insurance Coverage

In projections by the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT), the repeal of the penalty for not having health insurance starting in 2019 results in less insurance coverage. In total, the effects of that repeal that are described here are similar to those that CBO and JCT incorporated in the baseline a year ago.[1]

By 2021, in the current baseline, 7 million more people are uninsured than would have been if the individual mandate penalty had not been repealed; subsequently, that number remains roughly constant to the end of the projection period in 2029.

The effect of the repeal is partially offset by increases in coverage for other reasons. Most important, in the agencies' projections, additional states expand eligibility for Medicaid under the Affordable Care Act, and more people enroll in certain types of health insurance—specifically, those that are exempt from regulations governing the nongroup market but that nonetheless provide major medical coverage.

In the projections, the decline in coverage by 2021 breaks out this way:

- Nongroup coverage declines by about 4 million primarily for two reasons. Some people choose not to be enrolled once they do not face a penalty. Others decide not to enroll when facing higher premiums brought about by lower enrollment by relatively healthy people.
- Coverage through Medicaid and the Children's Health Insurance Program declines by about 2 million, again mainly for two reasons. Some people who would have enrolled to avoid the penalty no longer do so. Others who, induced by the penalty, would have applied for coverage through a marketplace and learned that they were eligible for Medicaid, no longer enroll in the program.
- Employment-based coverage declines by about 1 million, mostly because some employees who would have enrolled to avoid the penalty no longer do so.

CBO and JCT have concluded that some of that effect of eliminating the penalty occurred in 2018 (earlier than they previously expected). By the agencies' estimates, 1 million people were uninsured in that year principally because they thought that the penalty had been repealed for 2018 or that it would not be enforced.[2]

1. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (May 2018), pp. 20–21, www.cbo.gov/publication/53826. The current estimate of the effects of repealing the individual mandate penalty draws upon additional information beyond what was cited in the May 2018 report, including Bradley Heim, Ithai Z. Lurie, and Daniel W. Sacks, *Does the Individual Mandate Affect Insurance Coverage? Evidence From the Population of Tax Returns* (paper presented at the 2019 National Bureau of Economic Research Public Economics Conference, Cambridge, Mass., April 4–5, 2019), papers.nber.org/conf_papers/f120008.pdf (1.3 MB); Paul D. Jacobs, "Mandating Health Insurance Coverage for High-Income Individuals," *National Tax Journal*, vol. 71, no. 4 (December 2018), pp. 807–828, https://tinyurl.com/yyohsd3r; and Matthew Fiedler, *How Did the ACA's Individual Mandate Affect Insurance Coverage? Evidence From Coverage Decisions by Higher Income People* (USC–Brookings Schaeffer Initiative for Health Policy, May 31, 2018), https://tinyurl.com/y26s5nsl.

2. For information about people's understanding of the mandate in 2018, see Ashley Kirzinger and others, *Kaiser Health Tracking Poll—March 2018: Non-Group Enrollees* (April 3, 2018), https://tinyurl.com/y9osz5pm.

65 percent of people who meet the eligibility criteria established under the ACA live in states that expanded Medicaid. CBO and JCT anticipate that, under current law, the share would increase annually at a rate based on the historical pace of expansion since 2014. By 2029, about three-quarters of the people who would meet the new eligibility criteria are projected to be in states with expanded Medicaid coverage.

CBO and JCT project enrollment in CHIP to be relatively unchanged in the 2019–2029 period, with 7 million people, mostly children but also some pregnant women, enrolled in the program in each year. Together, Medicaid and CHIP are projected to provide insurance coverage for one-quarter of the population under age 65 in 2029.

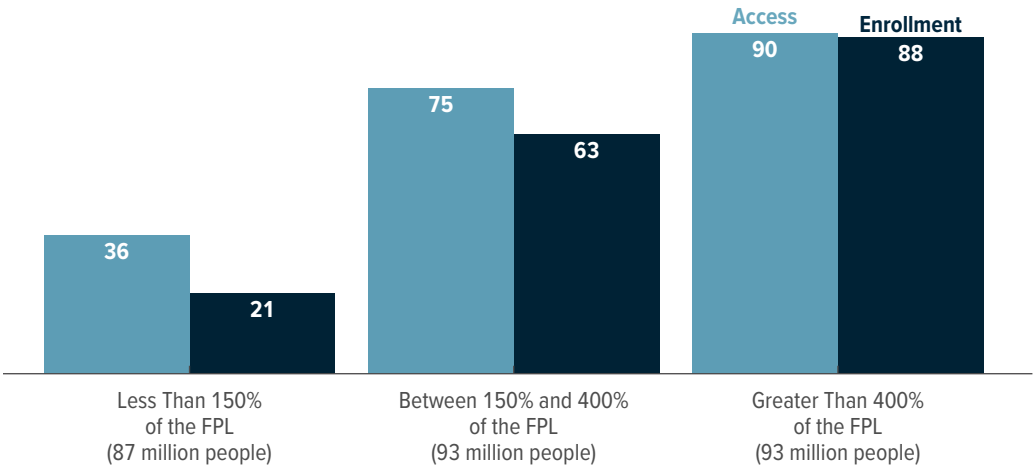
Nongroup Coverage and the Basic Health Program

A small share of the population purchases private health insurance individually through the nongroup market. Whereas employment-based policies and Medicaid currently cover 58 percent and 23 percent of the population under age 65, respectively, nongroup coverage applies to just 5 percent.

Figure 1-3.

Access to and Enrollment in Employment-Based Insurance by Income, 2019

Percent



Access to employment-based insurance tends to grow with income, as higher-income people are more likely to be employed, and their employers are more likely to offer insurance.

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

The figure shows access and enrollment for the noninstitutionalized civilian population under age 65.

FPL = federal poverty level.

Another source of coverage, much smaller still, is the Basic Health Program, which allows states to offer subsidized health coverage to certain low-income people outside the marketplaces established under the ACA.

Nongroup Coverage

In 2019, a monthly average of about 14 million people under age 65 are expected to have nongroup coverage—a decline from 2018, when an estimated monthly average of 15 million people enrolled in such coverage.[5] According to CBO and JCT's analysis, the decline is largely attributable to the repeal of the individual mandate penalty, partially offset by increases in enrollment in nongroup coverage that is exempt from some of the regulations governing the nongroup market but nonetheless provides comprehensive major medical coverage.

Of the 14 million people under age 65 whom CBO and JCT expect to enroll in nongroup coverage in 2019, an estimated 9 million will have purchased it through the marketplaces established under the ACA.[6] (Nongroup policies can be purchased either through the marketplaces—with or without government subsidies—or elsewhere.) The agencies estimate that 8 million of those people will receive subsidies. (The appendix provides information on premiums and stability in the marketplaces.)

5. CBO and JCT's estimates of enrollment in nongroup coverage include people with insurance that covers high-cost medical events and various services, including those provided by physicians and hospitals. Such coverage includes plans that must comply with all of the regulations governing the nongroup market as well as plans that are exempt from some regulations but continue to provide comprehensive major medical coverage. Examples of nongroup plans that are exempt from some regulations but still meet the agencies' definition of health insurance include ones that were in effect before 2014 (sometimes called grandfathered, grandmothered, or transitional plans), policies purchased by individuals through an association, and some types of short-term, limited-duration plans.

6. A total of 11 million people selected plans through the marketplaces by the close of the open-enrollment period. However, CBO and JCT estimate that the average monthly enrollment during the year will be lower than the total number of people who will have coverage at some point during the year because some people are covered for only part of the year—mostly because they stop paying the premiums or leave their marketplace-based coverage as they become eligible for insurance through other sources. That decline in coverage is partly offset because people who experience a qualifying life event (such as a change in income, the addition of a dependent, or the loss of employment-based insurance) may be allowed to purchase coverage later in the year.

By 2029, enrollment through the nongroup market is projected to fall to 11 million people, 6 million of them subsidized. That decline is largely the result of two factors:

- Some additional people will forgo health insurance in response to the elimination of the individual mandate penalty, and
- More states are expected to expand eligibility for Medicaid, reducing the number of people projected to obtain coverage through the marketplaces, because people who are eligible for Medicaid are not permitted to receive subsidies for marketplace coverage.

Basic Health Program

Under the ACA, states have the option to establish a Basic Health Program, which is primarily for people whose income is between 138 percent and 200 percent of the FPL. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would have been eligible through a marketplace. States can use those funds, in addition to funds from other sources, to offer health insurance that covers a broader set of benefits or requires smaller out-of-pocket payments than coverage in the marketplaces does.[7] Minnesota and New York have created a Basic Health Program. In CBO and JCT's projections, enrollment in the Basic Health Program is estimated to be about 1 million people in both 2018 and 2019. That number stays about the same each year throughout the 2019–2029 period.

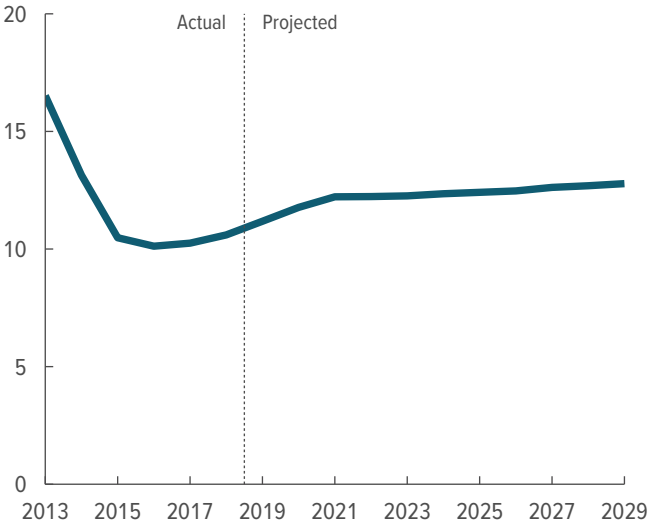
Medicare and Other Coverage

Although Medicare is best known for providing coverage for people age 65 or older, it also covers some people who are under age 65. Those younger enrollees receive Medicare coverage because they have qualified for benefits from the Social Security Disability Insurance (SSDI) program or have a qualifying diagnosis of end-stage renal disease (ESRD). In general, people become eligible for Medicare two years after they qualify for disability insurance. CBO and JCT estimate enrollment of people under 65 in Medicare to remain unchanged from 2018 to 2019, at 8 million people. The agencies project that number to stay the same in each year throughout the 2020–2029 period. Of those under age 65 and enrolled in Medicare, an estimated 99 percent receive Medicare benefits from the SSDI program and 1 percent because of an ESRD diagnosis.

Other miscellaneous sources of coverage account for about 3 million people each year from 2019 to 2029. Those sources include student health plans, the Indian Health Service, and foreign sources.

Figure 1-4.

Percentage of the Population Who Are Uninsured



Source: Congressional Budget Office, using data from the National Health Interview Survey.

The figure applies to the noninstitutionalized civilian population under age 65.

Actual values are calculated using the number of uninsured people reported by the National Health Interview Survey, adjusted downward to exclude people with coverage provided by the Indian Health Service, which CBO considers to be health insurance coverage. Beginning in 2015, values include an additional slight adjustment as part of a set of integrated estimates of coverage derived from different data sources.

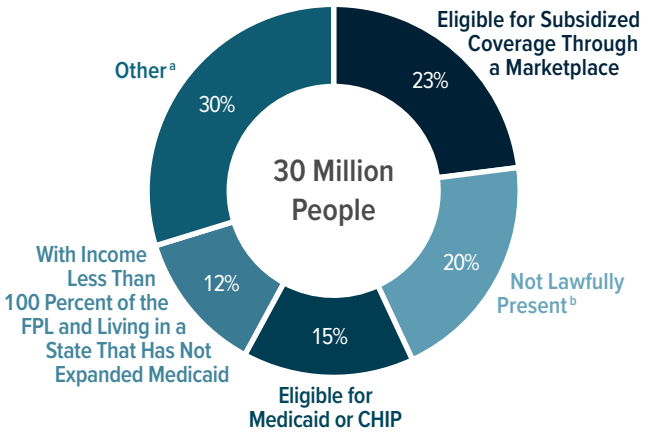
Uninsured

In 2019, 30 million people under age 65, or 11 percent of that population, are projected to be uninsured, an increase from 29 million in 2018 and 28 million in 2017 (see Figure 1-4). Increases in health insurance premiums and the elimination of the individual mandate penalty have contributed to that rise. An additional factor in the increase is people's becoming aware of and enrolling in

7. For more information about the Basic Health Program, see Centers for Medicare & Medicaid Services, "Basic Health Program" (accessed April 22, 2019), www.medicaid.gov/basic-health-program/index.html.

Figure 1-5.

Composition of the Uninsured Population, 2019*



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

The figure shows information on the noninstitutionalized civilian population under age 65 that is estimated to be uninsured.

CHIP = Children's Health Insurance Program; FPL = federal poverty level.

a. People who have access to health insurance through an employer or directly from insurers but choose not to purchase it.

b. Noncitizens who are not lawfully present in this country are ineligible for marketplace subsidies and for most Medicaid benefits.

coverage (such as short-term, limited-duration plans that do not provide comprehensive major medical coverage) from sources that do not meet CBO and JCT's definition of health insurance.

CBO and JCT consider people uninsured if they are not covered by an insurance plan or are not enrolled in a government program that provides financial protection from major medical risks. Among the uninsured under age 65 in 2019, 23 percent are estimated to be eligible for subsidized coverage through a marketplace but forgo it; 20 percent, to be noncitizens who are not lawfully present in this country; 15 percent, to be eligible for Medicaid or CHIP but to not enroll; 12 percent, to have income below 100 percent of the FPL and to live in states that did not expand Medicaid; and 30 percent, to have access to health insurance through an employer or directly from insurers but to choose to not purchase it (see Figure 1-5).*

By 2029, the number of uninsured people is projected to grow to 35 million, or 13 percent of people under age 65. That estimated growth stems largely from an increase in the number of people expected to forgo health insurance in response to the elimination of the individual mandate penalty. Again, an additional factor is people's increasing enrollment in coverage from sources that do not meet CBO and JCT's definition of health insurance.

Uncertainty Surrounding the Estimates of Coverage

The distribution of health insurance coverage in future years could differ from the projections presented here for a variety of reasons. If national economic trends diverge from CBO's economic forecast, for example, that would alter the number of people offered insurance by their employers, as well as the number of people eligible for Medicaid or coverage through the marketplaces. Additionally, changes in health care laws or regulations would affect health insurance markets. For example, the Administration has recently proposed or finalized several regulations that could substantially affect private health insurance, but their potential effects on insurance coverage and premiums are uncertain. Moreover, such economic, legal, and regulatory factors may interact with one another in a variety of ways to bring about outcomes that differ from the projections presented here. In addition, uncertainty surrounds states' decisions about whether to expand eligibility for Medicaid and how to regulate private health insurance.

[*Values corrected on May 14, 2019]

CHAPTER

2

Projected Subsidies for Health Insurance Coverage

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

- Giving tax benefits for work-related coverage,
- Providing roughly three-fifths of all funding for Medicaid (and requiring states to provide the remainder),
- Offering tax credits to eligible people who purchase coverage through the health insurance marketplaces, and
- Providing coverage through the Medicare program to people under age 65 who receive benefits from the Social Security Disability Insurance program or who have been diagnosed with end-stage renal disease.

The costs of those subsidies are partly offset by related taxes and penalties. Those collections include excise taxes on providers of health insurance and penalty payments from large employers that do not offer health insurance that meets certain standards.

The net federal subsidy for health insurance coverage for people under age 65—that is, the cost of all the subsidies minus the taxes and penalties—will be $737 billion in 2019, the Congressional Budget Office and the staff of the Joint Committee on Taxation estimate (see Table 2-1). If current laws did not change, that subsidy would total $9.9 trillion over the 2020–2029 period. Those projections are subject to considerable uncertainty; they rely on, among other things, expectations about the choices that people might make about obtaining health insurance.

The total costs of subsidizing health insurance for noninstitutionalized people under age 65 depend on the number of enrollees in each type of coverage and on the average per-person costs of that coverage. Those costs vary substantially depending on the type of coverage—namely, on the expected health care costs of the people who are eligible for or tend to enroll in a particular type of coverage and the extent to which the federal government subsidizes that type of coverage (see Figure 2-1 on page 18). The average cost of federal subsidies for someone under age 65 who is covered by Medicare, for example, is $10,620 in 2019, CBO estimates (see Figure 2-2 on page 19). That number is particularly high because Medicare enrollees under the age of 65 either qualify for SSDI or have ESRD and are therefore costly to treat. By contrast, the average cost of federal subsidies for someone under age 65 with employment-based coverage in 2019 is $1,810, CBO and JCT estimate.[1] That number is much lower because the people who enroll in employment-based insurance tend to be healthier and because the government does not pay directly for that care—but, rather, subsidizes a portion of the costs through the exclusion from income and payroll taxes.[2]

Work-Related Subsidies

Health insurance that people receive from employers is the most common source of subsidized coverage for people under age 65. Employers' payments for workers' health insurance coverage are a form of compensation, but unlike cash compensation, those payments are excluded from income and payroll taxes. In most cases, the amounts paid by workers themselves for their share of the cost of employment-based coverage are also excluded from income and payroll taxes. The projected growth rates for the total amount of such subsidies and

1. The average cost of federal subsidies for employment-based coverage is calculated using the tax exclusion for that coverage.
2. The amounts shown cannot be used to estimate the costs of shifting people from one type of coverage to another because the average per-person costs for each type of coverage depend on the type of people who are eligible for and enroll in that type of coverage. Therefore, values in cost estimates for legislation that would shift some people from one type of coverage to another would differ from the estimates shown here.

Table 2-1.

Net Federal Subsidies Associated With Health Insurance Coverage, 2019 to 2029

Billions of Dollars, by Fiscal Year

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	Total, 2020–2029
Work-Related Coverage												
Tax exclusion for employment-based coverage[a,b]	283	301	320	341	363	387	410	466	502	530	562	4,182
Income tax deduction for self-employment health insurance[c]	4	4	3	3	3	4	4	4	5	5	5	39
Small-employer tax credits[b]	*	*	*	*	*	*	*	*	*	*	*	*
Subtotal	287	304	324	344	367	390	414	470	507	534	567	4,222
Medicaid and CHIP[d]												
Blind and disabled	109	115	121	127	135	143	152	161	172	182	194	1,502
Children	76	80	85	91	96	102	108	114	120	126	133	1,055
Adults made eligible for Medicaid by the ACA	66	66	70	76	83	89	95	102	108	115	121	925
Adults otherwise eligible for Medicaid	46	48	51	54	58	61	65	68	72	76	81	635
CHIP	18	16	14	14	15	16	16	17	18	18	19	164
Subtotal	314	325	341	363	387	411	436	462	490	518	549	4,282
Marketplace-Related Coverage and the Basic Health Program												
Premium tax credit outlays	43	44	43	45	47	49	52	54	55	56	57	503
Premium tax credit revenue reductions	9	10	9	10	10	11	11	12	12	12	12	109
Subtotal	53	53	53	55	58	60	64	66	67	68	70	612
Outlays for the Basic Health Program	6	6	6	7	7	7	8	8	9	9	10	77
Collections for risk adjustment and reinsurance	-6	-5	-6	-6	-6	-6	-7	-7	-7	-8	-8	-66
Payments for risk adjustment and reinsurance	9	5	6	6	6	6	7	7	7	8	8	65
Subtotal	62	59	59	61	65	68	72	74	75	77	79	689
Medicare[e]	86	88	92	96	100	104	109	114	120	127	131	1,082
Taxes and Penalties Related to Coverage												
Gross collections of excise tax on high-premium insurance plans[f]	0	0	0	-2	-7	-9	-10	-12	-16	-19	-22	-96
Penalty payments by uninsured people	-3	0	0	0	0	0	0	0	0	0	0	0
Net receipts from tax on health insurance providers[g]	0	-13	-14	-15	-15	-16	-17	-17	-18	-19	-20	-164
Gross collections of employer penalties[f]	-8	-9	-9	-6	-6	-7	-7	-7	-8	-8	-7	-74
Subtotal	-11	-22	-22	-23	-29	-32	-34	-36	-42	-45	-49	-334
Net Subsidies	**737**	**755**	**794**	**842**	**889**	**941**	**997**	**1,085**	**1,149**	**1,211**	**1,277**	**9,940**

Continued

for the amount per recipient are about the same—as is the projected growth rate for private health insurance premiums—because the number of recipients is projected to be stable over the coming decade.

Another work-related subsidy is the income tax deduction for health insurance premiums that can be used by self-employed people, including sole proprietors and workers in partnerships. (Many of those people purchase insurance individually instead of as part of a group; their coverage is categorized as nongroup rather than employment-based even though their subsidies are work-related.) In addition, some small employers that provide health insurance to their employees are eligible

Table 2-1. Continued

Net Federal Subsidies Associated With Health Insurance Coverage, 2019 to 2029

Billions of Dollars, by Fiscal Year

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	Total, 2020–2029
Memorandum:												
Collections of Excise Tax on High-Premium Insurance Plans, Including the Associated Effects on Revenues of Changes in Taxable Compensation	0	0	0	-6	-14	-18	-22	-25	-31	-35	-42	-193

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

The table shows subsidies for the noninstitutionalized civilian population under age 65.

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

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

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

a. Includes the effect on tax revenues of the exclusion of premiums for people under age 65 with employment-based insurance from federal income and payroll taxes and includes the effects on taxable wages of the excise tax on high-cost plans and penalty payments by employers. The estimates shown, which JCT produced, differ from the agency's estimates of the tax expenditure for the exclusion of employer-paid health insurance because effects stemming from the exclusion for people over age 65 are not included here and because the Federal Insurance Contributions Act tax exclusion for employer-paid health insurance is included here.

b. Includes increases in outlays and reductions in revenues.

c. The estimates shown, which JCT produced, do not include effects stemming from the deduction for people over age 65.

d. For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits.

e. For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

f. Excludes the associated effects on revenues of changes in taxable compensation, which are included in the estimate of the tax exclusion for employment-based insurance. If those effects were included, net revenues stemming from the excise tax would total $193 billion over the 2020–2029 period, and revenues from penalty payments by employers would total $58 billion over that 10-year period.

g. Net receipts include effects on individual and corporate tax receipts. The tax is suspended in 2019.

to receive a tax credit of up to 50 percent of the cost of that insurance.

JCT estimates that subsidies for work-related coverage for people under age 65 will total about $287 billion in 2019 (or about 1.4 percent of gross domestic product, or GDP).[3] That amount is projected to grow to $567 billion in 2029 and to total $4.2 trillion over the 2020–2029 period. Those sums are large because the number of people with such coverage is large.[4]

Medicaid and CHIP

Medicaid is jointly financed by state governments and the federal government, with the federal government paying for roughly 60 percent of the cost of services, on average. Federal outlays for all noninstitutionalized Medicaid enrollees under age 65 who receive full benefits are estimated to amount to $296 billion in 2019 (see Figure 2-3). For the 2020–2029 period, projected

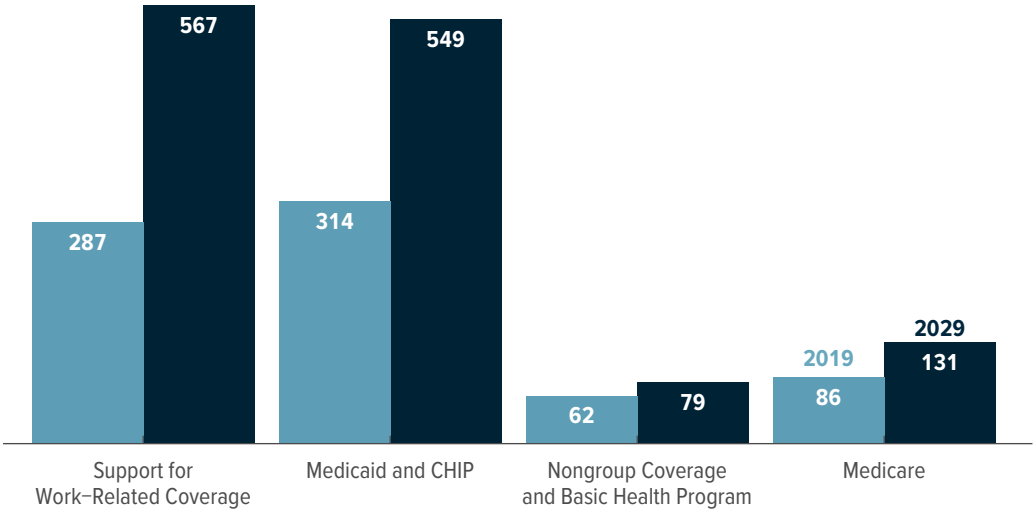
3. That estimate excludes federal spending on medical benefits provided by the Department of Veterans Affairs and on the Defense Department's TRICARE program. For more information about those programs, see Congressional Budget Office, "Military and Veterans' Health Care," www.cbo.gov/topics/health-care/military-and-veterans-health-care.

4. The estimated subsidies are not equal to the tax revenues that would be collected if those subsidies were eliminated, because in that event, many people would adjust their behavior to reduce the tax liability created by the change.

Figure 2-1.

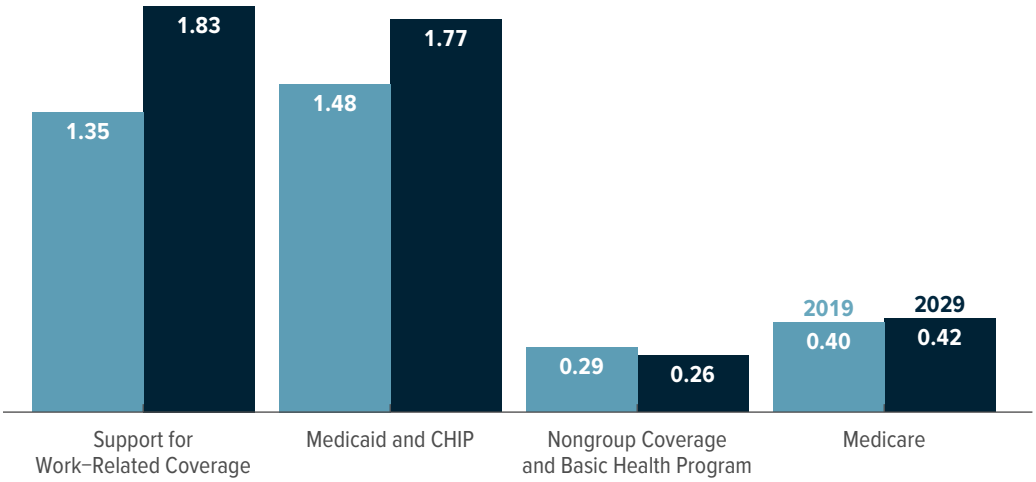
Federal Health Insurance Subsidies

Billions of Dollars



In 2019, the federal government is projected to spend $314 billion for Medicaid and CHIP and $287 billion on support for work-related coverage for people under age 65.

Percentage of Gross Domestic Product



As a share of gross domestic product, total federal subsidies are projected to grow over the coming decade; subsidies for work-related coverage are projected to grow the fastest.

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

The figure shows subsidies for the noninstitutionalized civilian population under age 65.

CHIP = Children's Health Insurance Program.

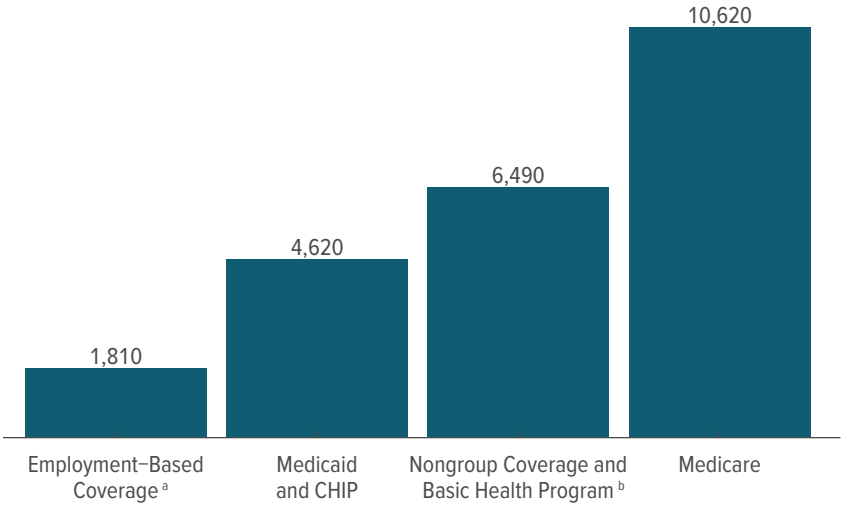
outlays total $4.1 trillion, comprising the following main components:

- $1.5 trillion (or 36 percent of the total) for people with disabilities;
- $1.1 trillion (or 26 percent of the total) for children;
- $925 billion (or 22 percent of the total) for adults made eligible for Medicaid by the Affordable Care Act; and

Figure 2-2.

Average Federal Subsidies for Recipients by Type of Health Insurance, Calendar Year 2019

Dollars



The average federal subsidy for health insurance costs per recipient varies substantially by type of health insurance. The variation occurs because the people who are eligible for each type of insurance differ by age, health status, income, and disability status; because the federal government subsidizes the coverage to different extents; and because the prices paid to providers differ for different types of coverage.

The amounts shown cannot be used to estimate the costs of shifting a group of people from one type of coverage to another because the average cost for each type of coverage depends on the characteristics of the people who are eligible for and enroll in it.

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

The figure shows average federal subsidies for the noninstitutionalized civilian population under age 65.

CHIP = Children's Health Insurance Program.

a. Includes the tax exclusion for employment-based coverage.

b. Includes premium tax credits for coverage through the marketplaces and outlays for the Basic Health Program.

- $635 billion (or 15 percent of the total) for adults otherwise eligible for Medicaid.

Medicaid spending for the noninstitutionalized population under age 65 who receive full Medicaid benefits accounts for roughly 80 percent of total projected Medicaid spending for medical services over the 2020–2029 period.

Like Medicaid, the Children's Health Insurance Program is also jointly financed by state governments and the federal government. In 2019, the federal government will pay about 90 percent of the cost of services. In 2020, that share is projected to be roughly 80 percent, and from 2021 to 2029, about 70 percent, as higher matching rates established by the ACA and the HEALTHY KIDS Act (division C of Public Law 115-120) end. Federal outlays for CHIP are estimated to amount to $18 billion in 2019 and $164 billion over the 2020–2029 period.

Marketplace-Related Coverage and the Basic Health Program

In 2019, net subsidies for nongroup coverage obtained through the marketplaces and payments for the Basic Health Program will total $62 billion, CBO and JCT estimate. Over the 2020–2029 period, such costs are projected to total $689 billion and to consist of the following main components:

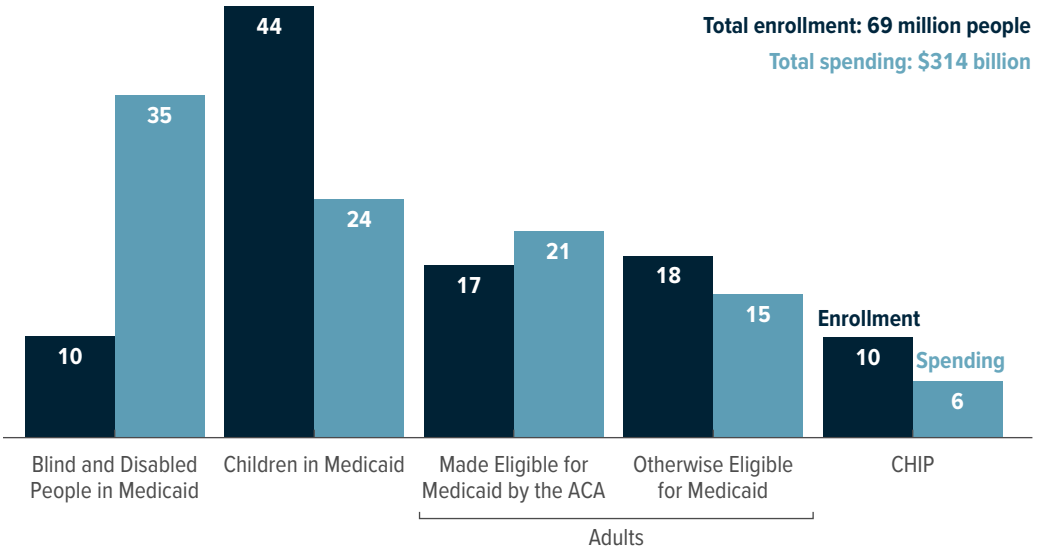
- Outlays of $503 billion and a reduction in revenues of $109 billion for premium tax credits, totaling $612 billion (those tax credits cover a portion of eligible people's health insurance premiums and, because they are refundable, can exceed individuals' tax liability, resulting in outlays in addition to the reduction in revenues);

- Outlays of $77 billion for the Basic Health Program; and

Figure 2-3.

Share of Enrollment in and Spending for Medicaid and CHIP by Eligibility Category, 2019

Percentage of Total



Different eligibility categories for Medicaid and CHIP account for very different shares of enrollment and spending. For example, children in Medicaid are projected to constitute 44 percent of enrollment but only 24 percent of spending in 2019, whereas people with disabilities account for 10 percent of enrollment and 35 percent of spending.

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

The figure shows enrollment and spending for the noninstitutionalized civilian population under age 65.

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

- Outlays of $65 billion and revenues of $66 billion related to payments and collections for risk adjustment.

The third component of those subsidies is projected to have no net costs over time. The risk adjustment and reinsurance programs were established under the ACA to stabilize premiums in the nongroup and small-group insurance markets by reducing the likelihood that particular insurers with a disproportionate share of less healthy enrollees would bear especially high costs.[5] The programs make payments to insurers with less healthy enrollees; the payments are financed by collecting funds from insurers with healthier enrollees in the case of risk adjustment and by an assessment on a broad range of insurers in the case of reinsurance. The payments are recorded in the budget as mandatory outlays, and the collections are recorded as revenues.

Per enrollee, subsidies for insurance obtained through the marketplaces and outlays for the Basic Health Program depend on the premiums for benchmark plans used for determining subsidies and on certain characteristics of enrollees, such as age, family size, and income. Combined, subsidies for coverage through the marketplaces and the Basic Health Program are projected to average $6,490 per subsidized enrollee in calendar year 2019. That amount rises to about $11,670 in 2029, as subsidies grow with premiums and also cover a greater proportion of premiums over time. (That proportion increases mainly because the amounts enrollees pay are limited to certain percentages of their income.) Growth in the total net subsidy amount is smaller than growth in the amounts per subsidized enrollee because the number of enrollees is projected to fall over the next decade.

Medicare

Net outlays for Medicare coverage for noninstitutionalized people under age 65 are projected to be $86 billion in 2019 and to total $1.1 trillion over the 2020–2029 period. That total is about one-eighth of total projected net spending for the Medicare program. By CBO's estimates, in 2019 the average cost for a

5. The risk adjustment and reinsurance programs began in 2014. The reinsurance program was temporary, ending after plan year 2016, and CBO estimates that outlays for it will end in 2020; beginning in 2021, estimated revenues and outlays are only for risk adjustment.

Medicare enrollee under 65 will be $10,620. That cost is projected to rise to $16,320 in 2029. That rate of growth is expected to be slower than the increase in the government's average cost for private health insurance and for Medicaid and CHIP but similar to the growth for the economy overall.

Taxes and Penalties

Taxes and penalties related to health insurance coverage are expected to partially offset the federal subsidies for it. By CBO and JCT's estimates, those taxes and penalties will amount to $11 billion in 2019. Under current law, they would total $334 billion over the 2020–2029 period—mostly from an excise tax on high-premium insurance plans, a tax on health insurance providers, and penalties imposed on some employers for not offering their employees health insurance that meets specified standards.

Excise Tax on High-Premium Insurance Plans

An excise tax on certain high-cost employment-based coverage is scheduled to be collected beginning in 2022. Originally, the tax was scheduled to take effect in 2018, but lawmakers delayed its implementation. In CBO and JCT's projections, collections of that tax total $96 billion over the 2020–2029 period.

The excise tax is expected to cause some employers and workers to shift to health plans with lower premiums in order to avoid paying it or to reduce their tax liability. Those shifts would generally increase income tax revenues, CBO and JCT estimate, because affected workers would receive less of their income in nontaxable health benefits and more in taxable wages. Including those increases in income tax revenues, JCT estimates receipts stemming from the imposition of the excise tax to total $193 billion over the coming decade.[6]

Tax on Health Insurance Providers

Health insurers are subject to an excise tax (although legislation eliminated it for calendar year 2019). The ACA specifies the total amount of tax to be assessed, and that total is divided among insurers according to their share of total applicable premiums charged in the previous year. Some health insurers, such as firms operating self-insured plans and certain state government entities and tax-exempt providers, are fully or partly exempt from the tax. Net revenues from the tax are projected to be $13 billion in 2020 and under current law would increase to about $20 billion by 2029, for a total of $164 billion over the decade, CBO and JCT estimate.

Penalties on Employers

Some large employers that do not offer health insurance coverage that meets certain standards under the ACA will owe a penalty if they have any full-time employees who receive a subsidy through a health insurance marketplace.[7] The requirement generally applies to employers with at least 50 full-time-equivalent employees. In CBO and JCT's projections, payments of those penalties total $74 billion over the 2020–2029 period. However, the increased costs for employers that pay the penalties are projected to reduce other revenues by $17 billion, because employers would generally be expected to shift the costs of the penalties to workers by lowering taxable wages. Once that shift is taken into account, the net reduction in the deficit is $58 billion.

Uncertainty Surrounding the Estimates of Subsidies

The ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other parties will behave in the future are all difficult to predict, so the estimates of federal subsidies for health insurance are uncertain. CBO and JCT have endeavored to develop budgetary estimates that are in the middle of the distribution of potential outcomes.

One reason that the estimates of subsidies are uncertain is that the projections of how many people will enroll in different types of coverage are themselves uncertain. Then, the per-person cost of subsidizing each type of coverage could differ from projections for many reasons, including changes in the mix of people, in terms of their health status or income, who enroll in each type of coverage; changes in how employers and employees value health insurance; and changes in state policies on eligibility for Medicaid and CHIP.

6. If workers' wages were instead held constant, their total compensation would be reduced by the amount of the change in premiums. Their employers would have smaller deductions for compensation costs and hence more taxable income—and the resulting total revenues would be similar.

7. To meet the standards, the cost to employees for self-only coverage must not exceed a specified share of their income (which is 9.86 percent in 2019 and is scheduled to grow over time), and the plan must pay at least 60 percent of the cost of covered benefits.

Many other factors will also affect federal subsidies for health care. One important factor is the extent to which the emergence and adoption of health care technology will raise or lower costs. New and less expensive medical procedures or treatments could prove effective in helping patients, which could lower costs. But other new procedures and treatments might be more expensive and increase costs. Other factors that could affect health care costs include changes in the structure of payment systems, changes in the ownership structure of providers, and innovations in the delivery of health care—say, the expansion of telemedicine. Those changes could encourage providers to supply more cost-effective treatments and reduce costs per enrollee. Other changes could raise costs per enrollee, such as those reaching previously underserved populations.

CHAPTER

3

Comparisons With Previous Estimates and Actual Amounts

As part of the process of updating baseline projections, the Congressional Budget Office and the staff of the Joint Committee on Taxation carefully analyze how the current projections differ from the prior year's projections and how their previous projections compare with actual enrollment and spending outcomes. Such evaluations help guide the agencies' efforts to improve the quality of their projections and help ensure that the current projections accurately reflect any significant changes in economic trends, enrollment and spending patterns, and policy that occurred over the previous year.

Changes in the Estimates of Insurance Coverage and Subsidies Since May 2018

In CBO and JCT's current projections for the 2019–2028 period (the span covered by both last year's projections and the current ones), an average of 3 million more people obtain employment-based insurance and 1 million fewer people are uninsured, compared with the amounts estimated in May 2018. Since last year, the agencies have increased their estimate of the net federal subsidies associated with health insurance coverage for people under age 65 from $9.3 trillion to $9.4 trillion for that period (see Table 3-1). The changes are primarily driven by updated demographic, economic, enrollment, and spending data.

Changes in the Estimates of Insurance Coverage

Since last year, CBO and JCT's projections of enrollment in Medicaid, nongroup coverage, the Basic Health Program, and Medicare among people under age 65 are largely unchanged, on average, over the 2019–2028 period. The agencies have changed other projections of enrollment (or projections related to it) in the following ways:

- The noninstitutionalized civilian population under the age of 65 is projected to be slightly smaller;
- Enrollment in employment-based coverage is higher;
- Enrollment in the Children's Health Insurance Program is higher;
- Enrollment in other miscellaneous types of coverage is lower; and
- The number of uninsured people is lower.

Total Population. CBO has lowered its projections of the total noninstitutionalized civilian population under age 65 by 1 million in each year of the 2019–2028 period—a change first incorporated in CBO's January 2019 baseline. In the agency's current projections, 276 million noninstitutionalized civilian people under age 65 are expected to reside in the United States in 2028; in the May 2018 projections, that number was 278 million. The revision arises primarily because the agency has reduced its projections of fertility rates and net immigration to better reflect historical trends and has slightly increased its projection of mortality rates.

Employment-Based Coverage. Since last year, CBO and JCT have increased their projections of enrollment in employment-based insurance coverage by an average of 3 million people per year between 2019 and 2028. That increase reflects the agencies' updated assessment of people's preference for employment-based coverage made on the basis of new data and improved analytical methods. Recent data indicate that enrollment in employment-based coverage has increased substantially in the past few years.[1] That increase, a larger reversal of the downward trend that existed before 2014 than the agencies were expecting a year ago, is carried through into the current projections.

Medicaid and CHIP. Relative to the May 2018 estimates, current projections of enrollment in Medicaid

1. See Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094.

Table 3-1.

Comparison of Current and Previous Projections of Health Insurance Coverage and Net Federal Subsidies

	2019			2019–2028		
	May 2018 Projection	May 2019 Projection	Difference	May 2018 Projection	May 2019 Projection	Difference
	Insurance Coverage for the Year[a] (Millions of people)			Average Insurance Coverage Over the Period[a] (Millions of people)		
Total Population	273	273	-1	276	274	-1
Employment-Based Coverage	159	159	-1	156	159	3
Medicaid and CHIP[b]						
Adults made eligible for Medicaid by the ACA	12	12	*	13	13	*
People otherwise eligible for Medicaid	48	50	1	49	50	*
CHIP	6	7	1	6	7	1
Total	66	69	2	69	70	1
Nongroup Coverage and the Basic Health Program						
Subsidized nongroup	7	8	1	7	7	*
Unsubsidized nongroup	5	6	1	6	5	*
Total, nongroup coverage	12	14	2	12	12	*
Coverage through the Basic Health Program[c]	1	1	*	1	1	*
Medicare[d]	8	8	*	8	8	*
Other Coverage[e]	5	3	-2	5	3	-2
Uninsured[f]	32	30	-2	35	34	-1
	Effects on the Federal Deficit[g] (Billions of dollars)			Effects on the Cumulative Federal Deficit Over the Period[g] (Billions of dollars)		
Work-Related Coverage						
Tax exclusion for employment-based coverage[h]	276	283	7	3,653	3,903	250
Income tax deduction for self-employment health insurance[i]	5	4	-2	64	38	-26
Small-employer tax credits	1	**	-1	8	**	-7
Subtotal	282	287	4	3,725	3,942	217
Medicaid and CHIP[j]						
Adults made eligible for Medicaid by the ACA	62	66	4	842	870	28
People otherwise eligible for Medicaid	233	230	-3	3,049	3,015	-34
CHIP	16	18	2	143	163	21
Subtotal	310	314	3	4,034	4,047	14
Marketplace-Related Coverage and the Basic Health Program						
Premium tax credits	53	53	**	703	595	-108
Outlays for the Basic Health Program	4	6	2	57	73	16
Net collections and payments for risk adjustment and reinsurance	**	3	3	-1	3	4
Subtotal	57	62	5	760	672	-88
Medicare[k]	84	86	2	1,049	1,037	-13
Taxes and Penalties Related to Coverage						
Gross collections of excise tax on high-premium insurance plans[l]	0	0	0	-47	-75	-27
Penalty payments by uninsured people	-3	-3	**	-3	-3	**
Net receipts from tax on health insurance providers[m]	0	0	0	-161	-144	17
Gross collections of employer penalties[l]	-8	-8	**	-101	-75	26
Subtotal	-11	-11	**	-313	-297	16
Net Subsidies	**723**	**737**	**14**	**9,255**	**9,401**	**146**

Continued

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

Estimates of insurance coverage apply to calendar years, and estimates of the effect on the federal deficit apply to fiscal years.

The table applies to the noninstitutionalized civilian population under age 65.

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

a. The components do not sum to the total population because some people report multiple sources of coverage. CBO and JCT estimate that in every year of the projection period, between 11 million and 12 million people (or about 5 percent of insured people) have multiple sources of coverage, such as employment-based coverage and Medicaid. Estimates reflect average monthly enrollment over the course of a year and include spouses and dependents covered under family policies.

b. Includes only noninstitutionalized enrollees with full Medicaid benefits. Estimates are adjusted to account for people enrolled in more than one state.

c. The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.

d. Includes noninstitutionalized Medicare enrollees under age 65. Most Medicare-eligible people under age 65 qualify for Medicare because they participate in the Social Security Disability Insurance program.

e. Includes people with other kinds of insurance, such as student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.

f. Includes noncitizens not lawfully present in this country, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid or CHIP who do not enroll; people who purchase nongroup insurance policies that do not meet the agencies' definition of comprehensive health insurance; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

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

h. Includes the effect on tax revenues of the exclusion of premiums for people under age 65 with employment-based insurance from federal income and payroll taxes and includes the effects on taxable wages of the excise tax on high-cost plans and penalty payments by employers. The estimates shown, which JCT produced, differ from the agency's estimate of the tax expenditure for the exclusion of employer-paid health insurance because effects stemming from the exclusion for people over age 65 are not included here and because the Federal Insurance Contributions Act tax exclusion for employer-paid health insurance is included here.

i. The estimates shown, which JCT produced, do not include effects stemming from the deduction for people over age 65.

j. For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits.

k. For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized beneficiaries under age 65.

l. Excludes the associated effects on revenues of changes in taxable compensation, which are included in the estimate of the tax exclusion for employment-based insurance.

m. Net receipts include the effects on individual and corporate tax receipts. The tax is suspended in 2019.

and CHIP are 1 million higher, on average, over the 2019–2028 period. Estimates of enrollment in Medicaid are not significantly different from last spring's projections, but estimates of enrollment in CHIP are now higher because recent enrollment has exceeded previous estimates.

CBO and JCT have also increased their estimates of the fraction of people meeting the eligibility criteria established under the Affordable Care Act who live in states that expanded Medicaid. The increase results from improved data underlying CBO's models rather than modifications made to the agency's projections of the rate of states' expansions of Medicaid in the future. On net, however, CBO and JCT's projections of enrollment by people made eligible for Medicaid by the ACA are largely unchanged from the May 2018 estimates.

Nongroup Coverage and the Basic Health Program. Average monthly enrollment in the nongroup market is now projected to be 2 million higher in 2019, 1 million lower in 2028, and less than 500,000 different, on average, over the 2019–2028 period. Projections of enrollment in the Basic Health Program are not noticeably different.

The boost of 2 million in nongroup enrollment for 2019 relative to the May 2018 projection is roughly evenly split between an increase in subsidized coverage and an increase in unsubsidized coverage. Projections

of subsidized coverage in 2019 are higher because the number of people who signed up for it through the marketplaces during the most recent open-enrollment period was higher than the agencies previously expected. Projections of unsubsidized coverage in 2019 are higher largely because of lower-than-expected premiums this year.

On average over the 2019–2028 period, however, CBO and JCT's current projections of both subsidized and unsubsidized enrollment through the nongroup market are not noticeably different from last year's projections. Over that 10-year period, factors that have increased projections of nongroup enrollment are offset by other factors that have reduced projections of enrollment. In particular, lower estimates for premiums in each year of the span, which would tend to increase projected enrollment in nongroup coverage, are offset by higher estimates of the number of businesses that will offer employment-based coverage. That increase in employment-based coverage is associated with a reduction in the number of people who would otherwise enroll in coverage through the nongroup market.

Other Coverage. Compared with what they estimated last year, CBO and JCT currently project that, if current laws remained unchanged, 2 million fewer people would be enrolled in other miscellaneous types of health care coverage, on average, over the 2019–2028 period. Those sources of coverage include student health plans, the Indian Health Service, and foreign sources. The projections for those types of coverage are lower primarily because the agencies now use improved data to estimate the number of people with those kinds of insurance.

Uninsured. In CBO and JCT's current projections, an average of 1 million fewer people are uninsured between 2019 and 2028 than the agencies estimated last May. That difference stems mostly from net changes in projections for other health insurance categories. For example, CBO and JCT lowered their projection of the number of uninsured people in 2019 by 2 million primarily because their current estimates of enrollment in nongroup coverage, Medicaid, and CHIP for the year are higher than last year's.

Changes in the Estimates of Subsidies, Penalties, and Taxes

In CBO and JCT's current projections, the net cost to the federal government of subsidizing health insurance coverage is $14 billion higher for 2019 and $146 billion (or about 2 percent) higher for the 2019–2028 period than it was in the agencies' May 2018 projections. That increase is mainly the result of higher estimates of the net cost of the tax exclusion for employment-based coverage, partially offset by lower estimates of nongroup subsidies.

Work-Related Coverage. CBO and JCT have increased their estimate of federal subsidies for work-related coverage. The largest component of those subsidies, by far, is the tax exclusion for employment-based coverage. The agencies have increased their estimates of the net cost of the exclusion by $7 billion (or 2 percent) for 2019 and by $250 billion (or 7 percent) for the 2019–2028 period. The cost of the exclusion depends on the number of people with employment-based coverage, the marginal tax rates of people enrolled in that coverage, and premiums for that coverage. The increase results in part from higher projected enrollment in employment-based insurance.

That increase is offset, in part, by slower growth of premiums. In 2018, CBO and JCT projected spending by private health insurers per beneficiary, which is the basis for premiums, to increase by an average of 5.8 percent per year over the 2019–2028 period.[2] The agencies now estimate that rate to be 5.4 percent. (CBO and JCT project spending by private health insurers on health care and administration on the basis of trends in premium growth and of projected growth in personal income, which affects people's ability to buy health insurance.) The change results mainly from new data from the Centers for Medicare & Medicaid Services indicating a lower rate of spending growth than previously reported.

Medicaid and CHIP. CBO has increased its projections of outlays for Medicaid and CHIP by $3 billion for 2019 and by $14 billion for the 2019–2028 period. Outlays for CHIP are projected to be $21 billion higher over that period because of recent higher-than-expected enrollment in the program. That increase is partially offset by a $7 billion reduction in projected Medicaid spending for the period.

2. CBO and JCT's projection of the underlying growth in spending by private health insurers per enrollee differs somewhat from their projection of growth in premiums for employment-based coverage because the latter also incorporates changes under current law that affect employers' willingness to offer insurance and employees' taking up an offer (for example, the imposition of the excise tax on high-premium health insurance plans beginning in 2022).

Marketplace-Related Coverage and the Basic Health Program. CBO and JCT reduced their projections of spending for subsidies for health insurance purchased through the marketplaces by $108 billion (or 15 percent), on net, over the 2019–2028 period. That reduction largely reflects the fact that insurers, overall, requested smaller increases in premiums for 2019 than the agencies expected last spring. In CBO and JCT's current projections, gross premiums for benchmark plans used to determine subsidies are 11 percent lower in 2019 and 16 percent lower in 2028 than in the agencies' May 2018 projections. The reduction over the period is partially offset by spending on the Basic Health Program that is now estimated to be $16 billion higher.

In total, CBO and JCT's estimates of the net cost of subsidies for nongroup coverage and the Basic Health Program are now $88 billion lower for the 2019–2028 period.

Taxes and Penalties Related to Coverage. CBO and JCT have reduced their estimate of collections of penalty payments from employers that do not offer coverage meeting the ACA's standards by $26 billion for the 2019–2028 period as a result of new data from the Department of the Treasury showing less reported penalty liability than previously projected.

CBO and JCT have increased their estimate of the gross revenues resulting from the excise tax on high-premium employment-based insurance by $27 billion for the 2019–2028 period. The tax, which is currently scheduled to take effect in 2022, will impose a 40 percent fee on the contributions that firms and employees make toward their employment-based insurance when those contributions exceed statutory thresholds. By the agencies' expectations, some firms will choose to pay the tax, and others will offer insurance plans with lower premiums in order to avoid it.

The increase in revenues stems from an increase in projected total enrollment in employment-based insurance and from technical improvements to modeling. On the basis of new data, CBO and JCT now estimate that a greater percentage of firms will choose to pay the excise tax rather than alter the types of insurance plans they offer to their employees. The increase in projected revenues is partially offset by the agencies' lower projections of private health insurance spending per enrollee.

Comparisons With Actual Amounts

In order to improve their baseline projections, CBO and JCT compare their projections of health insurance coverage and federal subsidies for people under age 65 with actual enrollment and costs reported by the Administration, state governments, and surveys whenever possible. This report compares projections for 2018 published in September 2017 and May 2018 with actual amounts for 2018 (see Table 3-2).[3]

Coverage

Differences in health insurance coverage between those two sets of projections and actual amounts were 1 million or less for most categories of coverage. In two cases, for CHIP and employment-based coverage, the actual amounts differed by 3 million from the 2017 projections. When the projection for CHIP was made, funding for the program was scheduled to expire at the end of fiscal year 2017, but in 2018, funding was extended. As for employment-based coverage, recent growth turned out to be stronger than CBO and JCT previously forecast, perhaps because of improving labor market conditions.

Subsidies

The largest errors in the subsidy estimates that could be examined (because sufficient preliminary data were available to estimate the actual 2018 amounts) occurred in projections of Medicaid spending and risk adjustment outlays (amounts paid to insurance plans that attract less healthy enrollees).

Medicaid. Among the various estimates for 2018, the largest error occurred in CBO's September 2017 projection of federal spending on Medicaid. The agency estimated that Medicaid spending for noninstitutionalized enrollees under age 65 who have full Medicaid benefits would total $302 billion in 2018—about $15 billion (or 5 percent) more than the actual amount currently estimated for that year. When CBO made its September 2017 estimate, available data showed that outlays had been growing strongly because of continued increases in the number of enrollees made eligible by the ACA.

3. For comparisons of CBO and JCT's projections with actual outcomes for 2017, see Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (May 2018), pp. 25–27, www.cbo.gov/publication/53826; for 2014 to 2016, see Congressional Budget Office, *CBO's Record of Projecting Subsidies for Health Insurance Under the Affordable Care Act: 2014 to 2016* (December 2017), www.cbo.gov/publication/53094.

Table 3-2.

Selected Estimates of Health Insurance Coverage and Net Federal Subsidies in CBO's September 2017 and May 2018 Projections Compared With Actual Coverage and Subsidies in 2018

	September 2017 Projection	May 2018 Projection	Actual Amounts	Difference, September 2017	Difference, May 2018
	Selected Categories of Health Insurance Coverage for People Under Age 65 (Millions of people, calendar year 2018)				
Employment-Based Coverage	157	158	160	-3	-1
Medicaid and CHIP					
Adults made eligible for Medicaid by the ACA	13	12	12	1	*
People otherwise eligible for Medicaid	51	49	50	1	-2
CHIP	5	6	7	-3	-1
Total	68	67	69	-1	-2
Nongroup Coverage and the Basic Health Program					
Nongroup coverage purchased through marketplaces					
Subsidized	9	8	8	1	-1
Unsubsidized	2	2	1	*	*
Subtotal	11	9	10	1	*
Nongroup coverage purchased outside marketplaces	5	5	5	*	1
Total, nongroup coverage	16	15	15	1	*
Coverage through the Basic Health Program	1	1	1	*	*
Medicare	8	8	8	*	*
Other Coverage	5	5	3	2	2
Uninsured	30	29	29	1	*

Continued

However, that growth unexpectedly slowed in the second half of 2017 and the first half of 2018, as did the growth in spending for people otherwise eligible for Medicaid.

For its May 2018 projections, CBO lowered its estimate of Medicaid spending for the year on the basis of newer data through March 2018, which showed relatively slow growth in outlays for the program to that point in the year. Later in 2018, spending for Medicaid grew more quickly than it had in 2017 and early 2018. As a result, CBO's May 2018 estimate of Medicaid spending for the year was $7 billion (or 2 percent) lower than actual spending turned out to be.

Risk Adjustment. The second-largest error occurred in CBO's May 2018 projection of risk adjustment outlays. The agency estimated that those payments would total $7 billion in 2018—about double the actual amount reported by the Administration for 2018. The overestimate was the result of a temporary halt in payments to insurers in July 2018 in response to a federal court decision. Later in the summer of 2018, the Department of Health and Human Services reissued regulations that allowed the risk adjustment payments and collections to resume. Typically, risk adjustment outlays occur in September—and under that schedule, they would have been made in fiscal year 2018. Instead, most of those delayed payments were made in the first quarter of fiscal year 2019. CBO expects that payments and collections for 2019 and later years will occur on the same schedule as they did in prior years, unlike the pattern in 2018.

Table 3-2. Continued

Selected Estimates of Health Insurance Coverage and Net Federal Subsidies in CBO's September 2017 and May 2018 Projections Compared With Actual Coverage and Subsidies in 2018

	September 2017 Projection	May 2018 Projection	Actual Amounts	Difference, September 2017	Difference, May 2018
	Selected Categories of Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65 (Billions of dollars, fiscal year 2018)				
Medicaid and CHIP[a]					
Medicaid[b]	302	280	287	15	-7
CHIP	13	16	17	-4	-2
Total	315	296	304	10	-8
Nongroup Coverage and the Basic Health Program					
Premium tax credits[c]	47	49	49	-2	**
Payments for cost-sharing reductions[d]	9	0	0	9	0
Outlays for the Basic Health Program[c]	5	4	5	1	-1
Collections for risk adjustment and reinsurance[e]	-5	-5	-5	**	**
Payments for risk adjustment and reinsurance[e]	5	7	3	2	4
Total	62	55	52	10	3
Medicare[a,f]	81	82	83	-2	-1
Penalty Payments by Uninsured People[g]	-4	-4	-3	-1	**

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation; and additional sources listed below.

Comparisons are shown only for categories of net federal subsidies associated with health insurance coverage for people under age 65 for which sufficient preliminary data were available to estimate the actual 2018 amounts. Estimates of actual enrollment reflect data from different sources that CBO then adjusts slightly to develop integrated estimates that are consistent with one another and that sum accurately to depict the total population. For more information on the individual data sources and how CBO develops its integrated estimates, see Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094.

CHIP = Children's Health Insurance Program; * = between −500,000 and 500,000; ** = between −$500 million and $500 million.

a. See Department of the Treasury, "Final Monthly Treasury Statement of Receipts and Outlays of the United States Government for Fiscal Year 2018 Through September 30, 2018, and Other Periods" (October 2018), https://go.usa.gov/xmKQk (PDF, 1.8 MB).

b. Actual value reported by the Department of the Treasury adjusted to reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits.

c. Office of Management and Budget, *Budget of the U.S. Government: Appendix*, "Detailed Budget Estimates by Agency: Department of the Treasury" (March 2019), pp. 958–959, https://go.usa.gov/xmKQf (PDF, 13.9 MB).

d. On October 12, 2017, the Administration announced that, without an appropriation, it would no longer make payments to insurers for cost-sharing reductions.

e. Office of Management and Budget, *Budget of the U.S. Government: Appendix*, "Detailed Budget Estimates by Agency: Department of Health and Human Services" (March 2019), pp. 451–452, https://go.usa.gov/xmKQf (PDF, 13.9 MB).

f. Actual value reported by the Department of the Treasury, adjusted to reflect benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

g. Actual value based on preliminary data from the Internal Revenue Service. See Internal Revenue Service, "SOI Tax Stats–Individual Income Tax Returns" (accessed April 11, 2019), https://go.usa.gov/xm5ju.

Appendix: Premiums and Stability in the Marketplaces

In 2019, a monthly average of about 9 million people are projected to buy nongroup policies through the health insurance marketplaces established under the Affordable Care Act (ACA). That coverage can be purchased with or without government subsidies, depending on an enrollee's income relative to the federal poverty guidelines (known as the federal poverty level, or FPL). Gross premiums—that is, the amounts without subsidies—for nongroup coverage that is subject to all rules governing that market may vary only on the basis of age, tobacco use, geographic location, and family size.

People in families with income generally between 100 percent and 400 percent of the FPL are eligible for tax credits to help cover a portion of their premiums. The size of those tax credits varies with income and premiums. Net premiums that enrollees pay after accounting for the tax credits are often substantially lower than the gross premiums. Among most people receiving such credits, net premiums for a given plan vary only by income and family size.

In 2019, the average gross premium for subsidized enrollees in all states that use the federally facilitated marketplace platform healthcare.gov is about $7,510 per year. The average net premium paid after subsidies is about $1,040. People not receiving subsidies pay the gross amount.[1]

In most marketplaces, people can choose among plans—such as bronze, silver, and gold—for which the portion of covered medical expenses paid by the insurer differs. The second-lowest-cost silver plan available in the marketplaces in any given area is known as the benchmark plan and is the basis for determining the size of the subsidy that enrollees are eligible for.

1. CBO's calculations are based on data on plans selected during the open-enrollment period for 2019. See Centers for Medicare & Medicaid Services, "2019 Marketplace Open Enrollment Period Public Use Files," https://go.usa.gov/xmTZD.

The average percentage of covered expenses paid by the insurer is called the actuarial value of the plan. Silver plans differ from other plans because they must provide cost-sharing reductions (CSRs) to eligible enrollees. For people at most income levels, the actuarial value of a silver plan is about 70 percent. People who qualify for CSRs are eligible for silver plans with higher actuarial values: 73 percent for people with income between 200 percent and 250 percent of the FPL; 87 percent for people with income between 150 percent and 200 percent of the FPL; and 94 percent for people with income between 100 percent and 150 percent of the FPL. The actuarial values of bronze and gold plans are about 60 percent and 80 percent, respectively.

The nongroup health insurance market is driven in large part by individual decisions to purchase insurance, which are affected by the stability of the market. If premiums are priced too low or too high, the mix of healthy and unhealthy people who want to purchase health insurance may change, potentially causing some insurers to be unprofitable. In recent years, the nongroup insurance market has stabilized, as insurers are generally profitable, and in 2019, more insurers have entered the market than left. Although the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimate declines in enrollment in nongroup policies in the marketplaces over the next decade, the agencies expect that market to remain stable because of the amount of the tax credits for premiums, the structure of the credits in insulating subsidized enrollees from large increases in gross premiums, and enrollment that is sufficient to sustain profits for insurers.

Premiums for Benchmark Plans in the Marketplaces

Between 2015 and 2018, gross premiums for the benchmark silver plans in the marketplaces for a person of a given age increased substantially; they grew by 7 percent to 8 percent in 2015 and 2016 and by 22 percent in 2017. Then, in 2018, gross benchmark premiums rose by

32 percent; a significant contributor to that increase was the incorporation of the cost of CSRs in those premiums (discussed more shortly, under the heading "Premiums by Metal Tier").

This year, those premiums have remained about the same as they were last year (see Figure A-1). That steadiness is the net result of several factors. Factors that put downward pressure on gross premiums in 2019 include these:

- **Increased competition.** One way insurers compete for enrollees is through lower premiums. The increase in the number of insurers in the marketplaces and a decrease in the share of the population living in a county with only one insurer in the marketplace between 2018 and 2019 reduced the number of people living in areas with a low level of competition among insurers (see Figure A-2). That increased competition among insurers tended to drive down premiums.

- **Insurers' profitability.** Data through the first half of 2018 suggest that, on average, for the second consecutive year, insurers in the marketplaces were profitable in 2018.[2] That profitability indicates that they have set premiums high enough to cover the expected costs for the people purchasing health insurance in the nongroup market.

Factors that put upward pressure on gross premiums include these:

- **Elimination of the individual mandate penalty.** The elimination of the individual mandate penalty, which took effect in 2019, is projected to result in a less healthy mix of people enrolling in coverage through the nongroup market, as some healthier enrollees choose to go without coverage. However, insurers appear to have accounted for at least part of that effect when setting premiums for 2018, given the general uncertainty about whether the individual mandate would be enforced.

- **Expanded availability of products exempt from rules governing the nongroup market.** Rules issued by the Administration that were designed to increase enrollment in certain types of products that are exempt from rules governing the nongroup market took effect beginning in 2019.[3] People newly enrolling in those types of coverage are expected to be healthier than those enrolled in nongroup coverage that is subject to all regulations governing the nongroup market (which includes coverage offered through the marketplaces). Their departure exerts upward pressure on premiums for the benchmark plans. However, in CBO and JCT's estimation, the increase is small in 2019.

Between 2018 and 2029, insurers are projected to increase gross premiums for the benchmark plans for a person of a given age by an average of roughly 5.3 percent per year. That premium growth is mostly attributable to projected growth in health care spending per person. As that spending increases, insurers will be required to cover the same proportion of costs as they do currently—and they are expected to pass a portion of those costs along to enrollees by increasing premiums.[4] A small portion of the premium growth stems from a shift in the health status of enrollees. Some healthier people are expected to depart the market, and some sicker people are expected to newly enroll in coverage—as more people respond over time to the elimination of the individual mandate penalty and as more products exempt from some of the regulations governing the nongroup market become available.

Between 2018 and 2029, gross premiums for a benchmark silver plan for people with income between 150 percent and 400 percent of the FPL (with changes in the age mix of that population accounted for) are projected to grow by an average of 5.5 percent per year in nominal terms and 3.4 percent per year in real terms (that is, after the effects of inflation are removed). Growth in net premiums for those people—which is projected to average 2.8 percent per year in real terms over the same time period—is largely independent of the growth in gross premiums for a benchmark plan. Because subsidized enrollees' net premiums are primarily based

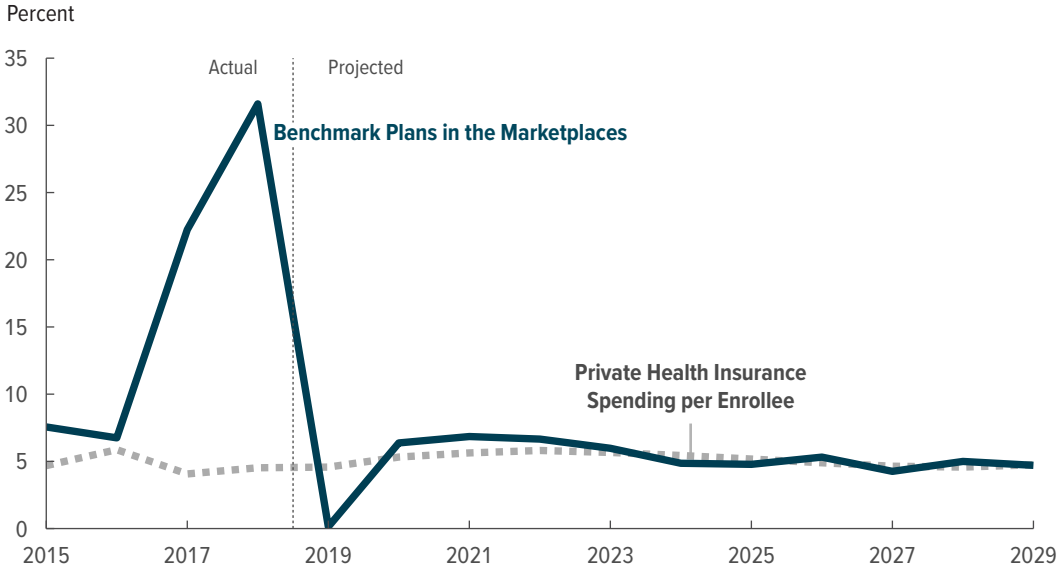
2. See Rachel Fehr, Cynthia Cox, and Larry Levitt, *Individual Insurance Market Performance in Mid-2018* (Kaiser Family Foundation, October 5, 2018), https://tinyurl.com/yyhjvgch.

3. See Congressional Budget Office, *How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans* (January 2019), www.cbo.gov/publication/54915.

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

Figure A-1.

Annual Percentage Change in Gross Premiums for Benchmark Plans in the Marketplaces



In 2017 and 2018, premiums for benchmark silver plans purchased through the marketplaces established under the ACA grew much more quickly than did those for private health insurance overall. In 2019, they were about the same as they were the year before. Over the 2020–2029 period, they are projected to grow at a rate similar to that for private health insurance premiums overall.

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

A benchmark plan is the second-lowest-cost silver plan available in the marketplace in any given area.

CBO and JCT project future spending by private insurers on health care and administration on the basis of trends in the growth of premiums and of projected growth in personal income, which affects people's ability to buy health insurance. Calculations of the growth of premiums include adjustments to remove the effects of changes in the composition of the population in terms of age and sex.

ACA = Affordable Care Act; JCT = Joint Committee on Taxation.

on a percentage of their income, growth in such premiums over time is determined by changes in their income relative to the FPL and by the percentage of income that they pay. That percentage of income increases over time depending on the extent to which growth in private health insurance premiums—including those for employment-based plans and, beginning in 2020, nongroup plans—exceeds income growth.

Premiums by Age and Income

For any given income relative to the FPL, people of different ages pay different gross premiums but the same net premiums; the size of their subsidy varies (see Figure A-3 on page 35). In 2019, the average benchmark premium for a 21-year-old, for example, is estimated to be $4,560 for coverage for the year. If that was the gross premium in one's local area, a person of that age with income at 150 percent of the FPL would pay about $760 for that plan; with income at 225 percent of the FPL, about $2,030; with income at 325 percent of the FPL, about $3,450; and with income at 425 percent of the FPL, the full gross premium of $4,560.

Gross premiums in almost all states are rated by age, and for coverage in the nongroup market, most states require insurers to charge 64-year-olds premiums that are three times those for a 21-year-old. If that was the case in the area used for the example just given, the average benchmark premium for a 64-year-old would be $13,690 for the year. Even so, at the different levels of income eligible for subsidies, the 64-year-old's net premiums would be the same as those for a 21-year-old because the subsidies, based primarily on income, are much larger. But if the 64-year-old had income at 425 percent of the FPL, he or she would pay the full gross premium. That amount is about four times greater than it would be if that person's income was at 325 percent of the FPL, for instance.

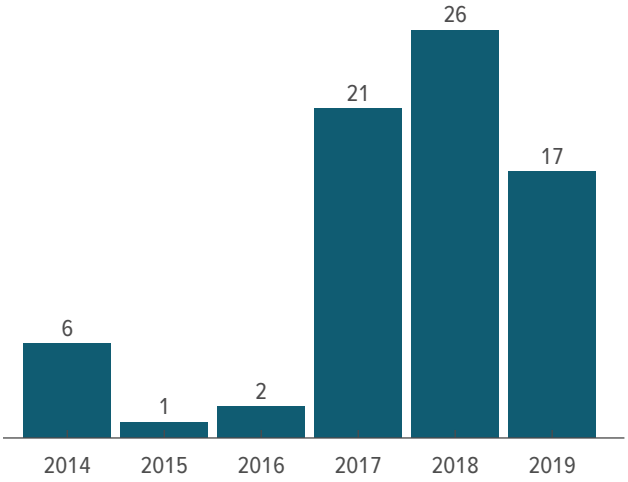
Premiums by Metal Tier

Before 2018, gross premiums corresponded with the actuarial value of the plans—with bronze plans being the least expensive, followed by silver plans, and then gold plans. Premiums during that period were set with the expectation that the federal government would reimburse insurers for the cost of CSRs through direct payments.

Figure A-2.

Share of Enrollees Living in a County With Only One Insurer in the Marketplace

Percent



Source: Kaiser Family Foundation.

On October 12, 2017, the Administration announced that, without an appropriation from the Congress for that purpose, it would no longer make such payments to insurers. Because insurers are still required to offer CSRs for enrollees with certain incomes who enroll in silver plans and to bear the costs even without a direct payment from the government, almost all insurers covered those costs by explicitly increasing premiums for silver plans offered through the marketplaces between 2017 and 2018.

As a result of the structure of the subsidies for coverage purchased through the marketplaces, higher gross premiums for silver plans increase the amount of tax credits paid by the federal government, thereby covering insurers' costs for CSRs. CBO and JCT's projections reflect the agencies' expectations that, in the absence of the direct payments, CSRs will continue to be funded through premium tax credits in future years.[5]

For plans besides silver ones, insurers in most states did not increase gross premiums between 2017 and 2018 much, if at all, to cover the costs of CSRs. Because tax credits are primarily based on the income of enrollees and can be used to enroll in any plan sold through the marketplaces, enrollees can use those credits to cover a greater share of premiums for plans other than silver ones in those states. For example, more people were able to use their higher premium tax credits to obtain bronze plans, which cover a smaller share of benefits than silver plans, for free or for very low out-of-pocket payments for premiums in 2018 than in 2017. Also, some people purchased gold plans in 2018 and paid net premiums that were similar to or lower than those they would have paid if they had purchased silver plans covering a smaller share of costs.

Higher gross premiums for silver plans affect premiums for people who are not eligible for premium tax credits (most of whom have income above 400 percent of the FPL). However, many of those enrollees have the option of purchasing other plans to avoid paying the premium increases resulting from the October 2017 policy change regarding the government's payments for CSRs. Just as insurers in most states have not appreciably increased premiums for plans other than silver ones to cover the costs of CSRs, insurers in many states have not increased the premiums of silver plans sold outside the marketplaces to cover the costs of CSRs either. Therefore, many people who are not eligible for subsidies have been able to select a plan besides a silver one or a silver plan sold outside the marketplaces and avoid paying the premium increases stemming from the lack of a direct appropriation for CSRs.

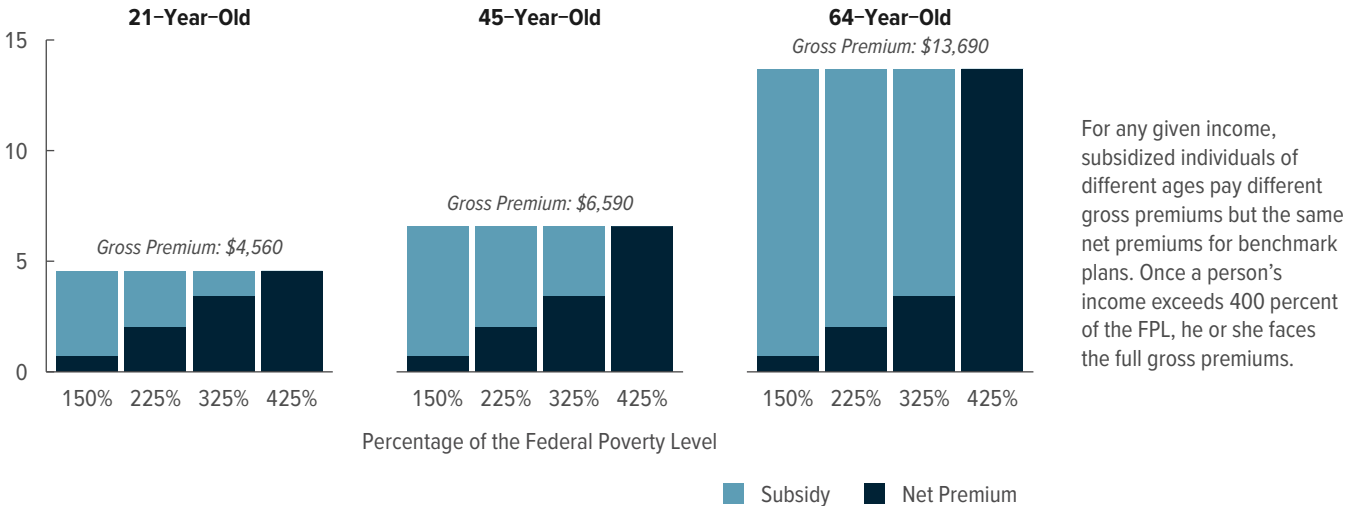
CBO and JCT estimate that, in 2017, when the government reimbursed insurers for the cost of CSRs through direct payments, the average premium for the

5. CBO has determined that the requirement that the federal government compensate insurers for CSRs should continue to be viewed as a form of entitlement authority and, as a result, that the agency's baseline should project funding that is adequate to make all required payments, as specified by the Balanced Budget and Emergency Deficit Control Act. For additional background, see Congressional Budget Office, "Cost-Sharing Reductions in CBO's Spring 2018 Baseline," *CBO Blog* (May 3, 2018), www.cbo.gov/publication/53799.

CBO has observed how the government's operations and insurance markets adapted to the termination of direct payments and how CSRs have been funded through premium tax credits. The agency has aligned its current baseline projections to actual premiums in the marketplaces and does not project direct payments for CSRs. That approach reflects what is actually happening—namely, that almost all insurers have covered the costs of CSRs by increasing premiums for silver plans offered through the marketplaces. In 2019, insurance regulators in all states have allowed insurers to explicitly increase premiums for silver plans in the marketplaces to account for CSRs. Although regulators in the District of Columbia have not allowed that increase, premiums in that area are, by CBO's estimates, sufficient to cover the cost of CSRs.

Figure A-3.

Illustrative Examples, for Single Individuals, of Net Premiums and Subsidies for Health Insurance Purchased Through the Marketplaces, 2019



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

Net premiums equal gross premiums minus the projected premium tax credits for which a person is eligible. Premium tax credits are calculated as the difference between the benchmark premium and a specified percentage of income for a person with income at a given percentage of the FPL. That specified percentage generally grows over time. For the purpose of determining the premium tax credits, eligibility is based on the most recently published FPL as of the first day of the annual open-enrollment period for coverage for the year. The benchmark premium is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which a person resides.

The examples incorporate the federal default age-rating methodology, which most states use. Specifically, compared with premiums for a 21-year-old, premiums for a 64-year-old are three times higher and for a 45-year-old, 1.444 times higher.

For coverage in 2019, the modified adjusted gross income for a single person in most states at 150 percent of the FPL is $18,210; at 225 percent of the FPL, $27,315; at 325 percent of the FPL, $39,455; and at 425 percent of the FPL, $51,595.

FPL = federal poverty level.

second-lowest-cost silver plan (the benchmark plan) was about 24 percent more expensive than that for the lowest-cost bronze plan and about 19 percent cheaper than that for the lowest-cost gold plan. By CBO and JCT's estimates, in 2018, after the government stopped those direct payments to insurers, the average premium for the benchmark silver plan was 39 percent more expensive than it was for the lowest-cost bronze plan and 9 percent cheaper than it was for the lowest-cost gold plan. Those figures reflect the faster premium growth for silver plans relative to that for plans in other tiers in 2018.

Stability in the Marketplaces

Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on the proportion of people who live in areas with participating insurers and on the likelihood that premiums will not rise in an unsustainable spiral. In the marketplaces, where premiums cannot be based on individual enrollees' health status, the market for insurance would be unstable if, for example, the people who wanted to buy coverage at any offered price had average health care expenditures so high that offering the insurance would be unprofitable for insurers.

CBO and JCT project an overall decline in nongroup coverage over the 2020–2029 period. In 2019, those enrolled in nongroup coverage are estimated to represent 8 percent of the private health insurance market for people under age 65, and in 2029, 7 percent. Despite the decline in nongroup coverage, the marketplaces are

projected to be stable in most areas in large part because most enrollees purchasing subsidized health insurance are insulated from large increases in premiums. The subsidies—combined with the rules requiring insurers to offer coverage for preexisting medical conditions, the relative ease of comparison shopping in the marketplaces, and the effects of other rules governing the nongroup insurance market—are anticipated to produce sufficient demand for nongroup insurance, including among people with low health care expenditures, to attract at least one insurer almost everywhere.

Data about the number of insurers selling insurance in the marketplaces and the profitability of insurers in the past two years suggest that the risk that markets will become unstable in the next few years has lessened. In 2019, for the first time since 2015, more insurers entered the nongroup market than left. On net, insurers participating in the marketplaces entered into 608 counties and exited from 5.[6] The portion of enrollees living in a county with only one insurer decreased to 17 percent in 2019 from 26 percent the year before.

Data on insurers' profitability in the first half of 2018—as measured by the share of premiums that goes toward their administrative costs and profits rather than payments of claims—show that insurers were profitable, on average, for the second consecutive year and that profitability increased from 2017 to 2018. Therefore, the premium increases from 2017 to 2018 were probably sufficient to account for changes in the underlying health risk of the population and the additional costs to insurers of providing CSRs in most areas.

6. See Rachel Fehr, Cynthia Cox, and Larry Levitt, *Insurer Participation on ACA Marketplaces, 2014–2019* (Kaiser Family Foundation, November 14, 2018), https://tinyurl.com/yycm26dp.

List of Tables and Figures

Tables

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About This Document

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

Kate Fritzsche, Kevin McNellis, and Emily Vreeland prepared the report. Susan Yeh Beyer, Alice Burns, Zhuang Hao, Philippa Haven, Keren Hendel, Lori Housman, Ben Hopkins, Geena Kim, Sean Lyons, Eamon Molloy, Romain Parsad, Allison Percy, Ezra Porter, Lisa Ramirez-Branum, Robert Stewart, Colin Yee (formerly of CBO), Rebecca Yip, Chris Zogby, and the staff of the Joint Committee on Taxation contributed to the analysis. Jessica Banthin, Chad Chirico, Theresa Gullo, Leo Lex, Sarah Masi, Alexandra Minicozzi, and David Weaver provided guidance and helpful comments.

Mark Hadley, Jeffrey Kling, and Robert Sunshine reviewed the document; John Skeen edited it; and Casey Labrack prepared it for publication. An electronic version is available on CBO's website (www.cbo.gov/publication/55085).

CBO continually seeks feedback to make its work as useful as possible. Please send any comments to communications@cbo.gov.

Keith Hall
Director
May 2019