



## Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act

In preparing the March 2012 baseline budget projections, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have updated estimates of the budgetary effects of the health insurance coverage provisions of the Affordable Care Act (ACA).<sup>1</sup> That legislation comprises the Patient Protection and Affordable Care Act (Public Law 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

The insurance coverage provisions of the ACA establish a mandate for most legal residents of the United States to obtain health insurance; create insurance “exchanges” through which certain individuals and families may receive federal subsidies to substantially reduce the cost of purchasing health insurance; significantly expand eligibility for Medicaid; impose an excise tax on certain health insurance plans with relatively high premiums; establish penalties on certain employers who do not provide minimum health benefits to their employees; and make other changes to prior law.<sup>2</sup>

CBO and JCT now estimate that the insurance coverage provisions of the ACA will have a net cost of just under \$1.1 trillion over the 2012–2021 period—about \$50 billion less than the agencies’ March 2011 estimate for that 10-year period (see Table 1, following the text).<sup>3</sup> The net costs reflect:

- Gross additional costs of \$1.5 trillion for Medicaid, the Children’s Health

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<sup>1</sup> See Congressional Budget Office, *Updated Budget Projections: Fiscal Years 2012 to 2022* (March 2012).

<sup>2</sup> For more information on the insurance coverage provisions of the ACA, see Congressional Budget Office, *cost estimate for H.R. 4872, the Reconciliation Act of 2010* (March 20, 2010).

<sup>3</sup> The budgetary effects of the ACA discussed in this report are its effects on federal revenues and mandatory spending; they do not include federal administrative costs, which will be subject to future appropriation action. CBO has previously estimated that the Internal Revenue Service will need to spend between \$5 billion and \$10 billion over 10 years to implement the law, and that the Department of Health and Human Services and other federal agencies will have to spend at least \$5 billion to \$10 billion over that period. In addition, the ACA included explicit authorizations for spending by a variety of grant and other programs; that funding is also subject to future appropriation action.

Insurance Program (CHIP), tax credits and other subsidies for the purchase of health insurance through the newly established exchanges and related costs, and tax credits for small employers,

- Offset in part by about \$0.4 trillion in receipts from penalty payments, the new excise tax on high-premium insurance plans, and other budgetary effects (mostly increases in tax revenues).

Those amounts do not encompass all of the budgetary impacts of the ACA because that legislation has many other provisions, including some that will cause significant reductions in Medicare spending and others that will generate added tax revenues, relative to what would have occurred under prior law. CBO and JCT have previously estimated that the ACA will, on net, reduce budget deficits over the 2012–2021 period; that estimate of the overall budgetary impact of the ACA has not been updated.<sup>4</sup>

The current estimate of the *gross* costs of the coverage provisions (\$1,496 billion through 2021) is about \$50 billion higher than last year's projection; however, the other budgetary effects of those provisions, which partially offset those gross costs, also have increased in CBO and JCT's estimates (to \$413 billion), leading to the small decrease in the *net* 10-year tally. Over the 10-year period from 2012 through 2021, enactment of the coverage provisions of the ACA was projected last March to increase federal deficits by \$1,131 billion, whereas the March 2012 estimate indicates that those provisions will increase deficits by \$1,083 billion. The net cost was boosted by an additional \$168 billion in estimated costs for Medicaid and CHIP and \$8 billion less in estimated revenues from the excise tax on high-premium health insurance plans. But those increases were more than offset by a reduction of \$97 billion in the projected costs for the tax credits and other subsidies for health insurance provided through the exchanges and related spending, a reduction of \$20 billion in the projected costs for tax credits for small employers, and a reduction of \$107 billion in deficits from the projected revenue effects of changes in taxable compensation and penalty payments and from other small changes in estimated spending.

This report also presents estimates through fiscal year 2022, because the baseline projection period now extends through that additional year. The ACA's provisions related to insurance coverage are now projected to have a net cost of \$1,252 billion over the 2012–2022 period (see Table 2, following the text); that amount represents a gross cost to the federal government of \$1,762 billion, offset in part by \$510 billion in receipts and other budgetary effects (primarily revenues from penalties and other sources). The addition of 2022 to the projection period has the effect of increasing the costs of the coverage provisions of the ACA

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<sup>4</sup> See the statement of Douglas W. Elmendorf, Director, Congressional Budget Office, before the Subcommittee on Health, House Committee on Energy and Commerce, *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010* (March 30, 2011). For the provisions of the ACA unrelated to insurance coverage, most of which involve ongoing programs or revenue streams, separating the portion of the updated projections for those programs or revenue streams that is attributable to the ACA from the portion that would have existed under prior law is very difficult.

relative to those projected in March 2011 for the 2012–2021 period because that change adds a year in which the expansion of eligibility for Medicaid and subsidies for health insurance purchased through the exchanges will be in effect. CBO and JCT have not estimated the budgetary effects in 2022 of the other provisions of the ACA; over the 2012–2021 period, those other provisions were previously estimated to reduce budget deficits.

CBO and JCT's projections of health insurance coverage have also changed since last March. Fewer people are now expected to obtain health insurance coverage from their employer or in insurance exchanges; more are now expected to obtain coverage from Medicaid or CHIP or from nongroup or other sources. More are expected to be uninsured. The extent of the changes varies from year to year, but in 2016, for example, the ACA is now estimated to reduce the number of people receiving health insurance coverage through an employer by an additional 4 million enrollees relative to the March 2011 projections. In that year, CBO and JCT now estimate that there will be 2 million fewer enrollees in insurance exchanges. In the other direction, CBO and JCT now estimate that, in 2016, the ACA will increase enrollment in Medicaid and CHIP slightly more than previously estimated (but considerably more in 2014 and 2015), and it will reduce the number of people with nongroup or other coverage by 3 million less and the number of uninsured people by 2 million less than previously estimated.

Compared with prior law, the ACA is now estimated by CBO and JCT to reduce the number of nonelderly people without health insurance coverage by 30 million to 33 million in 2016 and subsequent years, leaving 26 million to 27 million nonelderly residents uninsured in those years (see Table 3, at the end of this report). The share of legal nonelderly residents with insurance is projected to rise from 82 percent in 2012 to 93 percent by 2022. According to the current estimates, from 2016 on, between 20 million and 23 million people will receive coverage through the new insurance exchanges, and 16 million to 17 million people will be enrolled in Medicaid and CHIP. Also, 3 million to 5 million fewer people will have coverage through an employer compared with the number under prior law.<sup>5</sup>

## Reasons for Changes in Estimates Since March 2011

The major sources for the differences between the March 2011 and March 2012 projections are the following:

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<sup>5</sup> Some observers have expressed surprise that CBO and JCT's previous estimates did not show a much larger reduction in the number of people receiving employment-based health insurance. CBO and JCT's estimates take account of the expanded eligibility for Medicaid and the subsidies to be provided through the insurance exchanges, but they also recognize that the legislation leaves in place substantial financial incentives for firms to offer health insurance coverage and also creates new financial incentives for firms to offer such coverage and for many people to obtain it through their employers. Shortly, CBO will release an extensive analysis conducted with JCT of the incentives for firms to offer or not offer health insurance under the ACA, as well as a range of estimates of sources of coverage and federal budgetary outcomes that would result from the ACA under alternative assumptions about employers' behavior.

- **New Legislation.** Several laws were enacted during the past year that changed the estimated budgetary effects of the insurance coverage provisions of the ACA.
- **Changes in the Economic Outlook.** The March 2012 baseline incorporates CBO's macroeconomic forecast published in January 2012, which reflects a slower recovery when compared with the forecast published in January 2011 (which was used in producing the March 2011 baseline).<sup>6</sup>
- **Technical Changes.** The March 2012 baseline incorporates updated projections of the growth in private health insurance premiums, reflecting slower growth than the previous projections. In addition, CBO and JCT made a number of other technical changes in their estimating procedures.

### **New Legislation**

Legislation enacted since March 2011 reduced the costs of the ACA's coverage provisions by about \$38 billion, according to CBO and JCT's estimates.

Lawmakers enacted three laws that modified the ACA's coverage provisions:

- The Three Percent Withholding Repeal and Job Creation Act (P.L. 112-56) adds nontaxable Social Security benefits to the definition of modified adjusted gross income for the purposes of determining eligibility for certain applicants for Medicaid and for subsidies for health insurance purchased through the exchanges. That change reduced the number of individuals who will qualify for Medicaid and increased the number who will qualify for subsidies through the exchanges. CBO and JCT estimated that the legislation will reduce the costs of the ACA's insurance coverage provisions by \$13 billion over the 2012–2021 period. That estimate includes a reduction of \$33 billion in spending for Medicaid and an increase of \$15 billion in costs for exchange subsidies over the 2012–2021 period, along with other effects that will increase deficits by an estimated \$5 billion. (The budgetary effects of this legislation were incorporated in CBO's January 2012 baseline.)<sup>7</sup>
- The Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (P.L. 112-9) includes a provision that was estimated to reduce the costs of the ACA's insurance coverage provisions by about \$25 billion over the 2012–2021 period, mostly through reductions in the net costs of providing subsidies for purchasing health insurance through the exchanges. (The budgetary effects of this legislation were incorporated in CBO's August 2011 baseline.)<sup>8</sup>
- The Department of Defense and Full-Year Continuing Appropriations Act of 2011 (P.L. 112-10) repealed the Free Choice Voucher program, which

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<sup>6</sup> See Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2012 to 2022* (January 2012).

<sup>7</sup> Ibid, p. 100.

<sup>8</sup> See Congressional Budget Office, *The Budget and Economic Outlook: An Update* (August 2011), p. 64.

provided a mechanism through which certain employees could use their employer's health insurance contribution to purchase coverage through the exchanges. CBO and JCT estimated that repealing this provision will increase revenues by \$0.4 billion over the 2012–2021 period. (The budgetary effects of this legislation were also incorporated in CBO's August 2011 baseline.)<sup>9</sup>

### **Changes in the Economic Outlook**

In its January 2012 economic forecast, CBO revised its projections of certain economic factors that will affect the number of people eligible for subsidized health insurance coverage under the ACA through Medicaid, CHIP, or the health insurance exchanges. In that forecast, the unemployment rate is higher throughout the projection period than it was in last year's forecast. CBO also now estimates that wages and salaries will be lower than it previously anticipated.

Those changes yield an increase in the projected number of people eligible for Medicaid and CHIP as a result of the ACA. They also yield a small reduction in the number projected to be eligible for subsidies for purchasing insurance through the exchanges. That reduction is the net effect of two changes resulting from the forecast of lower incomes: More people are now projected to be eligible for Medicaid or CHIP rather than for exchange subsidies, and at the same time, some people whose incomes were expected to be too high for them to be eligible for exchange subsidies are now projected to be eligible for them. The first effect on estimated participation in the exchanges is greater than the second.<sup>10</sup> (Those shifts in eligibility because of revised economic projections more than offset the shifts in eligibility in the other direction caused by the change in the definition of income used to determine eligibility enacted in P.L. 112-56.)

### **Technical Changes**

Growth in private health care spending has been slower in the past several years than it had been earlier. According to recent data on national health expenditures, private health insurance premiums per enrollee in the United States grew by 8.4 percent per year, on average, between 2000 and 2005 but by 5.3 percent per year, on average, between 2005 and 2010—and by only 3.7 percent in 2010.<sup>11</sup> Similar trends are observed in the growth of private health insurance premiums in survey data from the Medical Expenditure Panel Survey: Premiums per enrolled employee grew by between 8.5 percent and 9.6 percent annually between 2000 and 2005 but by between 4.4 percent and 5.3 percent annually between 2005 and 2010.<sup>12</sup> Consequently, CBO has reduced its projection of the growth in such

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<sup>9</sup> Ibid, p. 65.

<sup>10</sup> Another factor that reduced the projected number of people whose income will make them eligible for exchange subsidies is an adjustment to the projected distribution of income that increased the number of people with very low income and also increased the number of people with income above the range of eligibility for exchange subsidies.

<sup>11</sup> See Centers for Medicare and Medicaid Services, National Health Expenditure Data: Historical, Table 16, "Per Enrollee Expenditures and Average Annual Percent Change in Medicare Spending and in Private Health Insurance Premiums, Calendar Years 1969–2010," <http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>.

<sup>12</sup> Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, 2000, 2005, and 2010 Medical Expenditure Panel Survey, Insurance Component Tables I.C.1 and

premiums, particularly in the early years of the coming decade. CBO now projects that private health insurance premiums per enrollee will increase by 5.7 percent per year, on average, between 2012 and 2022. By 2021, premiums are now estimated to be about 8 percent lower than CBO estimated in March 2011. That change reduces the estimated costs of the coverage provisions of the ACA.

CBO and JCT also made a number of technical changes in their estimating procedures. Those changes incorporate new information from survey data and other sources; improvements in the methods used to estimate changes in insurance coverage, including refinements in how households decide which types of health insurance policies to take up; and additional information about how the Administration is likely to implement certain aspects of the coverage provisions of the ACA, derived from proposed regulations and other administrative guidance and announcements that have been issued over the past year.<sup>13</sup>

## Changes in the Major Components of the Insurance Coverage Estimates

Because many of the changes discussed above were incorporated in the current estimates simultaneously, precisely quantifying the effects of each change is not possible. The combined effects of those changes over the 2012–2021 period are these:

- An increase of \$168 billion in projected outlays for Medicaid and CHIP;
- A decrease of \$97 billion in projected costs for exchange subsidies and related spending;
- A decrease of \$20 billion in the cost of tax credits for small employers; and
- An additional \$99 billion in net deficit reductions from penalty payments, the excise tax on high-premium insurance plans, and other effects on tax revenues and outlays—with most of those effects reflecting changes in revenues.

### Medicaid and CHIP Outlays

According to CBO and JCT's projections for the 2012–2021 period, spending for Medicaid resulting from the coverage provisions of the ACA will be \$160 billion more than estimated last year, and such spending for CHIP will be \$8 billion more. Those upward revisions are attributable in part to higher projected enrollment in those programs, especially for 2014 and 2015. The upward

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I.D.1, [http://meps.ahrq.gov/mepsweb/data\\_stats/quick\\_tables\\_search.jsp?component=2&subcomponent=1](http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1).

<sup>13</sup> On March 12, 2012, the Department of Health and Human Services issued a final rule related to the implementation of insurance exchanges (see [http://www.ofr.gov/OFRUpload/OFRData/2012-06125\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2012-06125_PI.pdf)). CBO's March 2012 estimates of the effects of the insurance coverage provisions of the ACA were finalized prior to the issuance of that rule and therefore do not incorporate any new information that the rule may contain.

revisions also reflect an increase in the projected federal share of costs for people enrolled in the programs under the ACA.<sup>14</sup>

The higher unemployment and lower wages and salaries in CBO's latest economic forecast, as compared with those in CBO's forecast last year, will increase the number of people who will qualify for Medicaid and CHIP as a result of the ACA. The increase in the projected number of enrollees in Medicaid because of those economic revisions accounts for almost all of the estimated increase in the additional participation in the program stemming from the ACA. In addition, the changes to the economic outlook mean that more children are now estimated to be eligible for and to enroll in CHIP compared with the March 2011 estimates; those changes add about 1 million CHIP enrollees in 2014 and 2015 and account for about half of the total increase in projected enrollment in the program relative to previous projections.

Other changes in the estimates for Medicaid and CHIP stem from a proposed rule issued by the Administration that clarified how certain provisions may be implemented:<sup>15</sup>

- The proposed rule outlines the Administration's intent to provide states with a choice of three methods to shift their existing systems for determining eligibility for Medicaid to new systems under the ACA. The proposed rule appears to offer states a greater opportunity to define new thresholds so as to increase the number of enrollees who will qualify for higher matching payments from the federal government.<sup>16</sup>
- The proposed rule also specifies that, beginning in 2014, children in households with income under 138 percent of the federal poverty level will continue to be covered by CHIP in states where CHIP eligibility extends below that income threshold. CBO had previously assumed that those children would, in 2014, be switched to Medicaid, for which the federal government would be paying a lower share of their costs. This change accounts for about

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<sup>14</sup> CBO estimates that increases in state spending for Medicaid and CHIP related to the coverage provisions of the ACA for the 2012–2021 period will be about \$60 billion—essentially unchanged from the March 2011 estimates of state spending for the same period. The effect on state spending is expected to be about the same in the current estimates, despite the higher enrollment and larger federal costs, because more enrollees are expected to qualify for a higher federal share of their costs than estimated in March 2011. For the 2012–2022 period, state spending for Medicaid and CHIP is expected to increase by \$73 billion as a result of the coverage provisions of the ACA.

<sup>15</sup> Centers for Medicare and Medicaid Services, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," *Federal Register*, vol. 76, no. 159 (August 17, 2011), pp. 51148–51199, <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20756.pdf>.

<sup>16</sup> Costs for Medicaid and CHIP are shared by the federal government and the states. For most people qualifying for Medicaid under pre-ACA law, the federal government would pay about 57 percent of their costs, on average, with the rate varying between 50 percent and 75 percent among states. For people who were not eligible for Medicaid before but will be eligible under the ACA, the federal government will pay all of their costs through 2017 and between 90 percent and 95 percent of their costs thereafter. For people qualifying for CHIP, the federal government will pay, on average, about 93 percent of their costs between 2016 and 2019 and about 70 percent of their costs for other years (again, with variation among states).

half of the increase in projected enrollment in CHIP compared with projected enrollment in the March 2011 baseline.

### **Exchange Subsidies and Related Spending**

In CBO and JCT's updated estimates, subsidies to be provided through the new insurance exchanges over the 2012–2021 period are lower than in the previous estimates by \$97 billion—reflecting \$87 billion less in projected tax credits for health insurance premiums and \$10 billion less in projected cost-sharing subsidies and related spending. The major change affecting the cost of exchange subsidies is the reduction in projected premiums described above. That effect is slightly offset by an increase in the estimated cost of providing the essential health benefits (EHB) required by the ACA.

In particular, the Department of Health and Human Services (HHS) issued a bulletin in December 2011 that provided new information on its approach to establishing the EHB package.<sup>17</sup> Despite that bulletin, the specific approach that HHS will take in defining and implementing the package is still uncertain, and the decisions that states will make in response to federal regulations are difficult to predict. Nevertheless, because of the bulletin, CBO and JCT now expect that the scope of benefits that will qualify as allowable health insurance expenses for the purpose of exchange subsidies will be slightly broader than previously estimated.

Other changes also had an effect on projected exchange subsidies: Between 1 million and 2 million fewer people per year are expected to receive exchange subsidies, as compared with the March 2011 estimates. That change is, in part, a reflection of the revised economic forecast, which (as described above) caused CBO to project an increase in the number of people with income making them eligible for Medicaid and CHIP and a decrease in the number with income making them eligible for exchange subsidies.

### **Tax Credits for Small Employers**

In the current estimates, CBO and JCT reduced the projected cost of small business tax credits to reflect preliminary tax data showing that small businesses have been slower to take advantage of the credits than originally estimated.

### **Other Revenues**

In the updated estimates, the amount of deficit reduction from penalty payments and other effects on tax revenues under the ACA is larger than the amount in the previous estimates. Primarily, that change reflects a larger estimated reduction in the number of people receiving health insurance coverage through their employer.

In particular, technical improvements in CBO's model of health insurance coverage and new information from the Administration have, on balance, increased the number of people projected not to receive employment-based coverage because of the ACA. For example, the new estimates incorporate an

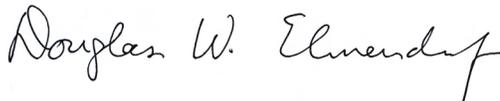
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<sup>17</sup> Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin* (December 16, 2011), [http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf).

announcement by the Administration that implementation of a provision requiring large employers to automatically enroll their employees in health insurance beginning in 2014 will be delayed; the estimates now reflect an assumption that the requirement will begin to take effect in 2015.<sup>18</sup>

Revising down the number of workers projected to receive insurance coverage through an employer relative to the previous estimates, by between 3 million and 4 million in most years, leads to an increase in estimated revenues because a larger share of total compensation will take the form of taxable wages and salaries and a smaller share will be in the form of nontaxable health benefits. In addition, that revision increases the estimated number of employers who will be required to pay penalties. Finally, penalties collected from individuals who do not have health insurance are projected to increase because the number of individuals who will remain uninsured is now estimated to be higher than was estimated in March 2011.

Holly Harvey, Jean Hearne, and Sarah Anders of CBO's Budget Analysis Division prepared this report under the supervision of Peter Fontaine. The estimates described here were the work of many analysts at CBO and on the staff of the Joint Committee on Taxation; the CBO analysts who played especially important roles were Jessica Banthin, Stuart Hagen, Paul Jacobs, Michael Levine, Alexandra Minicozzi, Julia Mitchell, Kirstin Nelson, Romain Parsad, Allison Percy, Robert Stewart, and Christopher Zogby. In keeping with CBO's mandate to provide objective, impartial analysis, this report makes no recommendations. It and other CBO publications are available on the agency's Web site ([www.cbo.gov](http://www.cbo.gov)).



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<sup>18</sup> Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, "Frequently Asked Questions from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods" (February 9, 2012), p. 3, [http://cciio.cms.gov/resources/files/Files2/02102012/employer\\_faq\\_bulletin\\_2\\_9\\_12\\_final.pdf](http://cciio.cms.gov/resources/files/Files2/02102012/employer_faq_bulletin_2_9_12_final.pdf).

**TABLE 1.**  
**Comparison of Estimates of the Effects of the Insurance Coverage Provisions Contained in**  
**the Affordable Care Act**

	March 2011 Estimate	March 2012 Estimate	Difference Between March 2012 and March 2011 Estimates
<b>CHANGES IN COVERAGE IN 2016</b>			
(Millions of nonelderly people, by calendar year)			
Medicaid and CHIP	16	17	*
Employer <sup>a</sup>	-1	-4	-4
Nongroup and Other <sup>b</sup>	-5	-2	3
Exchanges	22	20	-2
Uninsured <sup>c</sup>	-32	-30	2
<b>10-YEAR EFFECTS ON THE FEDERAL DEFICIT, 2012-2021<sup>d,e</sup></b>			
(Billions of dollars, by fiscal year)			
Medicaid and CHIP Outlays	627	795	168
Exchange Subsidies and Related Spending <sup>f</sup>	777	681	-97
Small Employer Tax Credits <sup>g</sup>	41	21	-20
Gross Cost of Coverage Provisions	1,445	1,496	51
Penalty Payments by Uninsured Individuals	-34	-45	-11
Penalty Payments by Employers <sup>g</sup>	-81	-96	-15
Excise Tax on High-Premium Insurance Plans <sup>g</sup>	-87	-79	8
Other Effects on Tax Revenues and Outlays <sup>h</sup>	-113	-193	-81
<b>Net Cost of Coverage Provisions</b>	<b>1,131</b>	<b>1,083</b>	<b>-48</b>

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

Notes: The Affordable Care Act is comprised of the Patient Protection and Affordable Care Act (P.L. 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

Numbers may not add up to totals because of rounding.

CHIP = Children's Health Insurance Program; \* = less than 0.5 million.

a. The change in employment-based coverage is the net result of increases in and losses of offers of health insurance from employers and changes in enrollment by workers and their families.

b. Other includes Medicare; the effects of the Affordable Care Act are almost entirely on nongroup coverage.

c. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.

d. Does not include federal administrative costs that are subject to appropriation.

e. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

f. Includes spending for high-risk pools, premium review activities, loans to co-op plans, grants to states for the establishment of exchanges, and the net budgetary effects of proposed collections and payments for risk adjustment and transitional reinsurance.

g. The effects on the deficit of this provision include the associated effects on tax revenues of changes in taxable compensation.

h. The effects are almost entirely on tax revenues.

TABLE 2.

### March 2012 Estimate of the Budgetary Effects of the Insurance Coverage Provisions Contained in the Affordable Care Act

EFFECTS ON THE FEDERAL DEFICIT <sup>a,b</sup>	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	11-Year Total, 2012-2022
(Billions of dollars, by fiscal year)												
Medicaid and CHIP Outlays <sup>c</sup>	-1	1	48	81	98	103	107	113	118	127	136	931
Exchange Subsidies and Related Spending <sup>d,e</sup>	2	4	16	46	74	92	102	109	114	121	127	808
Small Employer Tax Credits <sup>f</sup>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>2</u>	<u>1</u>	<u>2</u>	<u>2</u>	<u>2</u>	<u>2</u>	<u>2</u>	<u>23</u>
Gross Cost of Coverage Provisions	3	6	66	130	175	197	210	224	234	250	265	1,762
Penalty Payments by Uninsured Individuals	0	0	0	-3	-6	-7	-7	-7	-8	-8	-9	-54
Penalty Payments by Employers <sup>f</sup>	0	0	-4	-9	-10	-12	-13	-15	-16	-16	-17	-113
Excise Tax on High-Premium Insurance Plans <sup>f</sup>	0	0	0	0	0	0	-11	-18	-22	-27	-32	-111
Other Effects on Tax Revenues and Outlays <sup>g</sup>	<u>0</u>	<u>-1</u>	<u>-4</u>	<u>-8</u>	<u>-16</u>	<u>-24</u>	<u>-30</u>	<u>-35</u>	<u>-38</u>	<u>-37</u>	<u>-38</u>	<u>-231</u>
<b>NET COST OF COVERAGE PROVISIONS</b>	<b>3</b>	<b>5</b>	<b>58</b>	<b>110</b>	<b>143</b>	<b>154</b>	<b>150</b>	<b>149</b>	<b>151</b>	<b>161</b>	<b>169</b>	<b>1,252</b>

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

Notes: The Affordable Care Act is comprised of the Patient Protection and Affordable Care Act (P.L. 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

Numbers may not add up to totals because of rounding.

CHIP = Children's Health Insurance Program

a. Does not include federal administrative costs that are subject to appropriation.

b. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

c. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2012-2022 period would increase by about \$73 billion as a result of the coverage provisions.

d. Includes spending for high-risk pools, premium review activities, loans to co-op plans, grants to states for the establishment of exchanges, and the net budgetary effects of proposed collections and payments for risk adjustment and transitional reinsurance.

e. Figures may not equal the amounts shown in the table entitled "Health Insurance Exchanges: CBO's March 2012 Baseline" (posted on CBO's Web site) because different related items are included in the two tables.

f. The effects on the deficit of this provision include the associated effects on tax revenues of changes in taxable compensation.

g. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about \$7 billion over the 2012-2022 period, and that the coverage provisions would have negligible effects on outlays for other federal programs.

**TABLE 3.**  
**March 2012 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage**

<b>EFFECTS ON INSURANCE COVERAGE<sup>a</sup></b>		2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
<i>(Millions of nonelderly people, by calendar year)</i>												
Prior-Law Coverage <sup>b</sup>	Medicaid and CHIP	34	34	35	34	32	32	31	32	32	32	32
	Employer	154	156	157	157	159	160	160	161	161	160	161
	Nongroup and Other <sup>c</sup>	25	25	25	27	28	28	31	30	30	31	31
	Uninsured <sup>d</sup>	<u>55</u>	<u>56</u>	<u>56</u>	<u>56</u>	<u>56</u>	<u>57</u>	<u>58</u>	<u>57</u>	<u>59</u>	<u>60</u>	<u>60</u>
	<b>TOTAL</b>	<b>269</b>	<b>271</b>	<b>272</b>	<b>274</b>	<b>275</b>	<b>277</b>	<b>280</b>	<b>280</b>	<b>282</b>	<b>283</b>	<b>284</b>
Change	Medicaid and CHIP	*	1	13	15	17	16	16	16	17	17	17
	Employer <sup>e</sup>	1	1	-2	-2	-4	-5	-5	-5	-4	-3	-3
	Nongroup and Other <sup>c</sup>	1	*	-1	-1	-2	-2	-3	-3	-3	-3	-3
	Exchanges	0	0	8	12	20	22	23	23	22	23	22
	Uninsured <sup>d</sup>	-2	-2	-18	-24	-30	-31	-31	-31	-32	-33	-33
<b>Uninsured Population Under the ACA</b>												
	Number of Uninsured Nonelderly People <sup>d</sup>	53	53	38	32	26	26	26	26	26	27	27
	Insured Share of the Nonelderly Population <sup>a</sup>											
	Including All Residents	80%	80%	86%	88%	91%	91%	91%	91%	91%	90%	90%
	Excluding Unauthorized Immigrants	82%	82%	88%	91%	93%	93%	93%	93%	93%	93%	93%
<b><i>Memo: Exchange Enrollees and Subsidies</i></b>												
	Number with Unaffordable Offer from Employer <sup>f</sup>			*	*	1	1	1	1	1	1	1
	Number of Unsubsidized Exchange Enrollees			1	2	4	4	4	5	5	5	5
	Average Exchange Subsidy per Subsidized Enrollee			\$4,780	\$5,040	\$5,210	\$5,300	\$5,780	\$6,170	\$6,490	\$6,940	\$7,270

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

Notes: The Affordable Care Act (ACA) is comprised of the Patient Protection and Affordable Care Act (P.L. 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

CHIP = Children's Health Insurance Program; \* = between 0.5 million and -0.5 million.

a. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.

b. Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source. To illustrate the effects of the ACA, which is now current law, changes in coverage are shown compared with coverage projections in the absence of that legislation, or "prior law."

c. Other includes Medicare; the effects of the ACA are almost entirely on nongroup coverage.

d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.

e. The change in employment-based coverage is the net result of changes in offers of health insurance from employers and enrollment by workers and their families. For example, in 2019, an estimated 11 million people who would have had an offer of employment-based coverage under prior law will lose their offer under current law, and another 3 million people will have an offer of employment-based coverage but will enroll in health insurance from another source instead. These flows out of employment-based coverage will be partially offset by an estimated 9 million people who will newly enroll in employment-based coverage under the ACA.

f. Workers who would have to pay more than a specified share of their income (9.5 percent in 2014) for employment-based coverage could receive subsidies via an exchange.