

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

In preparing the January 2015 baseline budget projections, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have updated their estimates of the budgetary effects of the major provisions of the Affordable Care Act (ACA) that relate to health insurance coverage.<sup>1</sup> The new baseline estimates rely on analyses completed in the early part of December 2014 and incorporate information on enrollment made available by then and administrative actions issued through early November 2014. However, the estimates do not reflect CBO’s updated economic projections (which were completed after the agency’s analysis of insurance coverage was under way), the most recent data on enrollment through insurance exchanges, or any federal administrative actions or decisions by states about expanding Medicaid coverage that have occurred since that time. Hence, the updates are preliminary.

CBO and JCT currently estimate that the ACA’s coverage provisions will result in net costs to the federal government of \$76 billion in 2015 and \$1,350 billion over the 2016–2025 period. Compared with the projection from last April, which spanned the 2015–2024 period, the current projection represents a downward revision in the net costs of those provisions of \$101 billion over those 10 years, or a reduction of about 7 percent.<sup>2</sup> And compared with the projection made by CBO and JCT in March 2010, just before the ACA was enacted, the current estimate represents a downward revision in the net

costs of those provisions of \$139 billion—or 20 percent—for the five-year period ending in 2019, the last year of the 10-year budget window used in that original estimate.

Those estimates address only the insurance coverage provisions of the ACA and do not reflect all of the act’s budgetary effects. Because the provisions of the ACA that relate to health insurance coverage established entirely new programs or components of programs and because those provisions have mostly just begun to be implemented, CBO and JCT have produced separate estimates of the effects of the provisions as part of the baseline process. By contrast, because the provisions of the ACA that do not relate directly to health insurance coverage generally modified existing federal programs (such as Medicare) or made various changes to the tax code, determining what would have happened since the enactment of the ACA had the law not been in effect is becoming increasingly difficult. The incremental budgetary effects of those noncoverage provisions are embedded in CBO’s baseline projections for those programs and tax revenues, respectively, but they cannot all be separately identified using the agency’s normal procedures. As a result, CBO does not produce estimates of the budgetary effects of the ACA as a whole as part of the baseline process. Moreover,

1. 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. In addition to provisions dealing with health insurance coverage, that act included other provisions that made changes to the federal tax code, Medicare, Medicaid, and other programs.

2. For the most recent previous baseline, published in August 2014, CBO and JCT did not update their detailed estimates of the coverage provisions of the ACA for any years after 2014, except for a \$600 million decline in outlays relative to the April 2014 baseline for grants to states for operating exchanges over the 2015–2017 period. Therefore, this appendix compares the current baseline projections with the detailed projections from April 2014. See Congressional Budget Office, “Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014” (April 2014), [www.cbo.gov/publication/45231](http://www.cbo.gov/publication/45231), which was released together with Congressional Budget Office, *Updated Budget Projections: 2014 to 2024* (April 2014), [www.cbo.gov/publication/45229](http://www.cbo.gov/publication/45229).

as the implementation of the provisions related to insurance coverage proceeds and historical data increasingly include the effects of those provisions, CBO and JCT will also cease to make separate projections of the effects of all of those provisions.

CBO typically revises its baseline budget projections after the Administration releases its proposed budget for the coming year (in part because that release includes data on federal spending that has occurred during the previous year). The revised projections that CBO will prepare this spring will include further updates to CBO and JCT's estimates of the insurance coverage provisions of the ACA, incorporating new information about health insurance coverage and the insurance exchanges that has become available, as well as the economic projections published in this report.

## Insurance Coverage Provisions

Among the key elements of the ACA's insurance coverage provisions that are encompassed by the estimates discussed here are the following:

- Many individuals and families are able to purchase subsidized health insurance through exchanges (often called marketplaces) operated by the federal government, by a state government, or through a partnership between the federal and state governments.
- States are permitted but not required to expand eligibility for Medicaid, and the federal government pays a larger share of the costs for individuals who are newly eligible under the ACA than for those who were eligible previously.
- The Children's Health Insurance Program (CHIP), which was previously funded through the end of fiscal year 2013, received funding under the ACA for fiscal years 2014 and 2015.
- Most citizens of the United States and noncitizens who are lawfully present in the country must either obtain health insurance or pay a penalty for not doing so (under a provision known as the individual mandate).
- Certain employers that decline to offer their employees health insurance coverage that meets specified standards will be assessed penalties.
- A federal excise tax will be imposed on some health insurance plans with high premiums.
- Most insurers offering policies either for purchase through the exchanges or directly to consumers outside of the exchanges must meet several requirements. In particular, they must accept all applicants regardless of health status, and they may vary premiums only by age, smoking status, and geographic location (and premiums charged for adults age 21 or older may not vary according to age by a ratio of more than 3 to 1).
- Certain small employers that provide health insurance to their employees are eligible to receive a tax credit of up to 50 percent of the cost of that insurance.

The ACA also made other changes to rules governing health insurance coverage that are not listed here. Those other provisions address coverage in the nongroup, small-group, and large-group markets, in some cases including employment-based plans that are financed by employers, which are often called self-insured plans.

## Budgetary Effects of the Insurance Coverage Provisions

CBO and JCT currently estimate that the ACA's coverage provisions will result in net costs to the federal government of \$76 billion in 2015 and \$1,350 billion over the 2016–2025 period. The estimated net costs in 2015 stem almost entirely from spending for subsidies that are provided through insurance exchanges and from an increase in spending for Medicaid (see Table B-1). For the 2016–2025 period, the projected net costs consist of the following:

- Gross costs of \$1,993 billion for subsidies for insurance obtained through the exchanges and related spending and revenues, for Medicaid and CHIP, and for tax credits for small employers, and
- An offsetting amount of \$643 billion in net receipts from penalty payments, additional revenues resulting from the excise tax on certain high-premium insurance plans, and the effects on income and payroll tax revenues and associated outlays arising from projected changes in coverage offered through employers.

**Table B-1.****Direct Spending and Revenue Effects of the Insurance Coverage Provisions of the Affordable Care Act**

Billions of Dollars, by Fiscal Year

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total, 2016- 2025
Exchange Subsidies and Related Spending and Revenues <sup>a</sup>	32	66	87	99	103	106	111	117	120	123	127	1,058
Medicaid and CHIP Outlays <sup>b</sup>	47	64	70	76	84	91	97	102	107	112	117	920
Small-Employer Tax Credits <sup>c</sup>	2	1	1	1	1	1	2	2	2	2	2	15
Gross Cost of Coverage Provisions	81	131	159	176	188	198	209	220	229	237	245	1,993
Penalty Payments by Uninsured People	-2	-4	-4	-4	-4	-4	-5	-5	-5	-5	-6	-47
Penalty Payments by Employers <sup>c</sup>	0	-7	-11	-13	-15	-15	-17	-19	-20	-22	-23	-164
Excise Tax on High-Premium Insurance Plans <sup>c</sup>	0	0	0	-5	-10	-13	-16	-19	-24	-29	-34	-149
Other Effects on Revenues and Outlays <sup>d</sup>	-3	-11	-19	-24	-27	-29	-31	-33	-35	-36	-38	-284
<b>Net Cost of Coverage Provisions</b>	<b>76</b>	<b>109</b>	<b>124</b>	<b>130</b>	<b>132</b>	<b>137</b>	<b>141</b>	<b>144</b>	<b>144</b>	<b>145</b>	<b>145</b>	<b>1,350</b>
<b>Memorandum:</b>												
Changes in Mandatory Spending	92	135	163	177	190	202	213	224	233	241	249	2,026
Changes in Revenues <sup>e</sup>	16	26	39	47	58	64	73	80	88	97	104	677

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

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

Except as noted, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

CHIP = Children's Health Insurance Program.

- Includes spending for exchange grants to states and net spending and revenues for risk adjustment and reinsurance. The risk corridors program is now recorded in the budget as a discretionary program; CBO estimates that payments and collections will offset each other in each year, resulting in no net budgetary effect.
- 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 over the 2016–2025 period will be about \$63 billion higher because of the coverage provisions of the Affordable Care Act than it would be otherwise.
- These effects on the deficit include the associated effects of changes in taxable compensation on revenues.
- Consists mainly of the effects of changes in taxable compensation on revenues. CBO estimates that outlays for Social Security benefits will increase by about \$8 billion over the 2016–2025 period and that the coverage provisions will have negligible effects on outlays for other federal programs.
- Positive numbers indicate an increase in revenues.

CBO and JCT estimate that the net costs of the coverage provisions of the ACA will rise sharply as the effects of the act phase in from 2015 through 2017, continue to rise steadily through 2022, and then change little from 2022 through 2025. The annual net costs are estimated to level off at about \$145 billion in the last years of the projection period.

The projected costs stop growing toward the end of the period in large part because of the nature of the rules for the indexing of exchange subsidies and the high-premium excise tax, which over time will slow the growth of gross costs and increase the growth of receipts. The ACA

specifies that if total exchange subsidies exceed a certain threshold in any year after 2017—a condition that CBO and JCT expect may be satisfied in some years—people will be required to pay a larger share of premiums in the following year than would otherwise be the case, thus restraining the amount that the federal government pays in subsidies. In addition, CBO and JCT expect that premiums for health insurance will tend to increase more rapidly than the threshold for determining liability for the high-premium excise tax, so the tax will affect an increasing share of coverage offered through employers and thus generate rising revenues. In response, many employers are expected to avoid the tax by holding

premiums below the threshold, but the resulting shift in compensation from nontaxable insurance benefits to taxable wages and salaries would subject an increasing share of employees' compensation to taxes. Those trends in exchange subsidies and in revenues related to the high-premium excise tax will continue beyond 2025, CBO and JCT anticipate, causing the net costs of the ACA's coverage provisions to decline in subsequent years.

## Effects of the Insurance Coverage Provisions on the Number of People With and Without Insurance

By CBO and JCT's estimates, about 42 million nonelderly residents of the United States were uninsured in 2014, about 12 million fewer than would have been uninsured in the absence of the ACA.<sup>3</sup> In 2015, the agencies estimate, 36 million nonelderly people will be uninsured—about 19 million fewer than would have been uninsured in the absence of the ACA. From 2016 through 2025, the annual number of uninsured is expected to decrease to between 29 million and 31 million—that is, between 24 million and 27 million fewer than would have been uninsured in the law's absence (see Table B-2).

The 31 million people projected to be uninsured in 2025 represent roughly one out of every nine residents under age 65 (see Figure B-1). In that year, about 30 percent of those uninsured people are expected to be unauthorized immigrants and thus ineligible for exchange subsidies or for most Medicaid benefits; about 10 percent will be ineligible for Medicaid because they live in a state that will not have chosen to expand coverage; about 15 percent to 20 percent will be eligible for Medicaid but will choose not to enroll; and the remaining 40 percent to 45 percent will not purchase insurance to which they have access through an employer, through an exchange, or directly from an insurer.

3. CBO and JCT's estimate of the outcome relative to what would have happened in the absence of the ACA is different from the result of subtracting the number of people who were uninsured in 2013 from the number who were uninsured in 2014. The agencies' estimate accounts for effects of the coverage provisions since the law's enactment, whereas tallies in any given year after the enactment would incorporate the incremental change in that year from both the effects of the ACA and any underlying trends that would have occurred in the absence of the law.

The projected gains in insurance coverage relative to what would have occurred in the absence of the ACA are the net result of several changes in the extent and types of coverage. In 2018 and later years, between 24 million and 25 million people are projected to have coverage through the exchanges, and 14 million to 16 million more, on net, are projected to have coverage through Medicaid and CHIP than would have had it in the absence of the ACA. Partly offsetting those increases, however, are projected net decreases of 9 million to 10 million in the number of people with employment-based coverage and 4 million to 5 million in the number of people with coverage in the nongroup market outside the exchanges.

## Enrollment in and Subsidies for Coverage Through Exchanges

Subsidies for insurance obtained through exchanges and related spending and revenues account for a little more than half of the gross costs of the coverage provisions of the ACA. Those amounts depend on the number of people who purchase insurance through the exchanges, the premiums charged for such insurance, and other factors.

### Enrollment in Exchange Coverage

CBO and JCT's estimate of total exchange subsidies for each year is based on the agencies' projection of the average number of people who will enroll in that year. That average number for each year will be less than the total number of people who will have coverage at some point during the year because some people will be covered for only part of the year. Coverage through the exchanges varies over the course of a year because people who experience qualifying life events (such as a change in income or family size, the loss of employment-based insurance, the birth of a child, and several other situations) are allowed to purchase coverage later in the year and because some people leave their exchange-based coverage as they become eligible for insurance through other sources or stop paying the premiums. In 2014, for example, despite a peak in April of about 8 million people who had selected a plan through an insurance exchange, only about 6 million, on average, were covered through the exchanges over the course of the calendar year, according to CBO and JCT's estimates. That average is less than the total number of people covered through the exchanges during some part of 2014 particularly because of lower enrollment during the open-enrollment period early in the year and net attrition of enrollees later in the year.

**Table B-2.****Effects of the Affordable Care Act on Health Insurance Coverage**

Millions of Nonelderly People, by Calendar Year

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
<b>Insurance Coverage Without the ACA<sup>a</sup></b>											
Medicaid and CHIP	35	34	33	33	34	34	34	35	35	35	35
Employment-based coverage	158	160	163	164	165	165	165	166	166	166	166
Nongroup and other coverage <sup>b</sup>	24	25	25	26	26	26	26	27	27	27	27
Uninsured <sup>c</sup>	55	55	55	55	56	56	56	57	57	57	57
Total	272	274	277	278	280	281	282	283	284	285	286
<b>Change in Insurance Coverage Under the ACA</b>											
Insurance exchanges	12	21	25	25	25	24	25	24	24	24	24
Medicaid and CHIP	11	13	13	14	15	16	16	16	16	16	16
Employment-based coverage <sup>d</sup>	-2	-7	-8	-9	-9	-9	-10	-9	-9	-9	-9
Nongroup and other coverage <sup>b</sup>	-3	-4	-4	-4	-4	-4	-4	-4	-5	-4	-4
Uninsured <sup>c</sup>	-19	-24	-26	-26	-26	-27	-27	-27	-27	-27	-27
<b>Uninsured Under Current Law</b>											
Number of uninsured nonelderly people <sup>c</sup>	36	31	30	30	29	29	29	30	30	30	31
Insured as a percentage of the nonelderly population											
Including all U.S. residents	87	89	89	89	90	90	90	89	89	89	89
Excluding unauthorized immigrants	89	91	92	92	92	92	92	92	92	92	92
<b>Memorandum:</b>											
<b>Exchange Enrollees and Subsidies</b>											
Number with access to unaffordable employment-based insurance <sup>e</sup>	*	*	1	1	1	1	1	1	1	1	1
Number of unsubsidized exchange enrollees <sup>f</sup>	3	5	6	6	6	6	7	6	7	7	7
Average exchange subsidy per subsidized enrollee (Dollars)	4,330	4,700	4,940	5,350	5,620	5,930	6,260	6,650	6,990	7,340	7,710

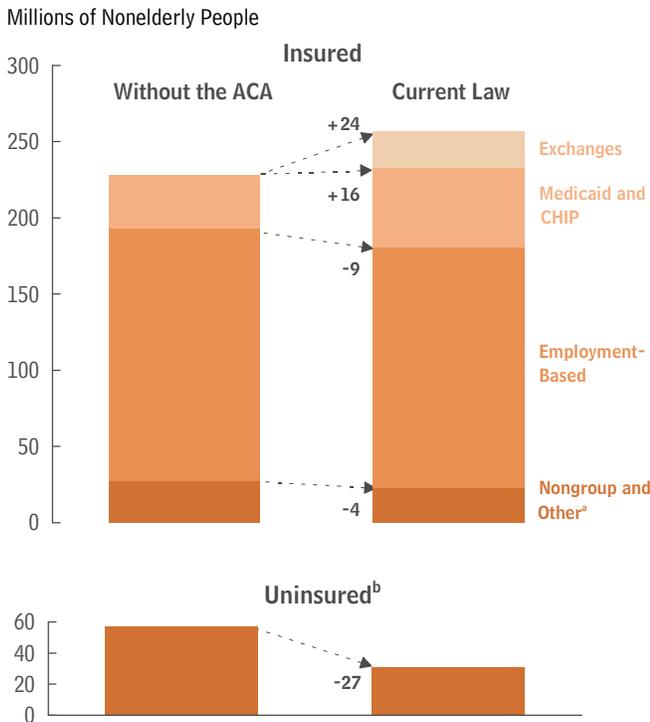
Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: Figures for the nonelderly population include residents of the 50 states and the District of Columbia who are younger than 65.

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

- Figures reflect average enrollment over the course of a year and include spouses and dependents covered under family policies; people reporting multiple sources of coverage are assigned a primary source.
- "Other" includes Medicare; the changes under the ACA are almost entirely for nongroup coverage.
- The uninsured population includes people who will be unauthorized immigrants and thus ineligible either for exchange subsidies or for most Medicaid benefits; people who will be ineligible for Medicaid because they live in a state that has chosen not to expand coverage; people who will be eligible for Medicaid but will choose not to enroll; and people who will not purchase insurance to which they have access through an employer, through an exchange, or directly from an insurer.
- The change in employment-based coverage is the net result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by workers and their families.
- Under the ACA, health insurance coverage is considered affordable for a worker and related individuals if the worker would be required to pay no more than a specified share of his or her income (9.56 percent in 2015) for self-only coverage. If coverage is considered unaffordable, the worker and related individuals may receive subsidies through an exchange if other eligibility requirements are met.
- Excludes coverage purchased directly from insurers outside of an exchange.

**Figure B-1.**  
**Effects of the Affordable Care Act on Health Insurance Coverage, 2025**



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

Notes: The nonelderly population consists of residents of the 50 states and the District of Columbia who are younger than 65.

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

- a. “Other” includes Medicare; the changes under the ACA are almost entirely for nongroup coverage.
- b. The uninsured population includes people who will be unauthorized immigrants and thus ineligible for exchange subsidies or for most Medicaid benefits; people who will be ineligible for Medicaid because they live in a state that will not have chosen to expand coverage; people who will be eligible for Medicaid but will choose not to enroll; and people who will not purchase insurance to which they have access through an employer, through an exchange, or directly from an insurer.

Over the course of calendar year 2015, an average of 12 million people are expected to be covered by insurance through the exchanges, but the actual number will not be known precisely until after the year has ended. (The total number enrolled at any particular time during the year might be higher.) Average annual enrollments are projected to increase to 21 million people in 2016 and then

to 24 million to 25 million people each year between 2017 and 2025. Roughly three-quarters of those enrollees are expected to receive subsidies for purchasing that insurance.

**Premiums for Exchange Coverage**

CBO and JCT currently estimate that the average cost of individual policies for the second-lowest-cost “silver” plan in the exchanges—that is, a plan that pays about 70 percent of the costs of covered benefits and represents the benchmark for determining exchange subsidies—is about \$4,000 in calendar year 2015.<sup>4</sup> That estimate represents a national average, reflecting the agencies’ projections of the age, sex, health status, and geographic distribution of those who will obtain coverage through the exchanges this year.

However, CBO and JCT expect to revise their estimates of premiums in the baseline projections to be published this spring. Those revisions will incorporate the economic projections that are included in this report, additional analysis of the available information about health care costs and insurance premiums, and revised estimates of the demographics of people receiving coverage through the exchanges. On the basis of the early stages of that analysis, CBO and JCT anticipate lowering their projections of premiums and thus the federal cost of exchange subsidies during the 2016–2025 period—though changes in other aspects of the coverage estimates and further analysis might lead to different conclusions.

**Subsidies for Exchange Coverage**

Exchange subsidies depend both on benchmark premiums for policies sold through the exchanges and on certain characteristics of enrollees, such as age, family size, and income. CBO and JCT estimate that, under current law, exchange subsidies and related spending and revenues will amount to a net cost of \$32 billion in fiscal year 2015. That estimate is uncertain in part because the average number of people who will have such coverage during the fiscal year is not yet known and in part because detailed information on the demographics and income of the people who had such coverage last year is not yet available.

4. The size of the subsidy that someone will receive will be based in part on the premium of the second-lowest-cost silver plan offered through the exchange in which that person participates.

Over the 2016–2025 period, exchange subsidies and related spending and revenues are projected to result in a net cost of \$1.1 trillion, distributed as follows:

- Outlays of \$775 billion and a reduction in revenues of \$134 billion for premium assistance tax credits (to cover a portion of eligible individuals' and families' health insurance premiums), which sum to \$909 billion (see Table B-3);<sup>5</sup>
- Outlays of \$147 billion for cost-sharing subsidies (which reduce out-of-pocket payments for low-income enrollees);
- Outlays of \$1 billion in 2016 and 2017 for grants to states for operating exchanges; and
- Outlays of \$181 billion and revenues of \$180 billion related to payments and collections for risk adjustment and reinsurance (the projected outlays and revenues for those programs are exactly offsetting, with no net budgetary effect, when the amounts for 2015 are included).<sup>6</sup>

Subsidies in the exchanges are projected to average about \$5,000 per subsidized enrollee from 2016 through 2018 and to reach almost \$8,000 in 2025.<sup>7</sup>

The programs involving risk adjustment and reinsurance, along with another involving risk corridors, were established under the ACA to reduce the likelihood that particular health insurers will bear especially high costs to cover the expenses of a disproportionate share of less healthy enrollees. The programs, which took effect in 2014, generate payments by the federal government to insurers and collections by the federal government from insurers that reflect differences in the health status of each insurer's enrollees and the resulting costs to the insurers.

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5. The subsidies for health insurance premiums are structured as refundable tax credits; CBO and JCT treat the portions of such credits that exceed taxpayers' other income tax liabilities as outlays and the portions that reduce tax payments as reductions in revenues.
  6. Because outlays are subject to sequestration in 2015, some of the revenues collected in 2015 will be spent in 2016.
  7. The average exchange subsidy per subsidized enrollee includes both premium subsidies and cost-sharing subsidies and can therefore exceed the average benchmark premium in the exchanges.

Payments and collections under the risk adjustment and reinsurance programs are recorded in the budget as mandatory outlays and revenues. Risk corridors are treated differently: The payments to insurers are recorded as discretionary spending, and the government's collections are recorded as offsets to discretionary spending. By CBO's projections, over the 2016–2025 period:

- Risk-adjustment payments and collections will both total \$170 billion;
- Reinsurance payments will total \$11 billion, and collections will total \$10 billion (although the projected payments and collections are exactly offsetting when the amounts for 2015 are included); and
- Risk corridor payments and collections will both total \$5 billion.<sup>8</sup>

### **Enrollment in Medicaid and CHIP and the Federal Cost of Such Coverage**

In calendar year 2014, according to CBO and JCT's estimates, Medicaid enrollment increased by 6 million people who became newly eligible under the ACA, and Medicaid and CHIP enrollment increased by an additional 2 million people who were previously eligible and chose to enroll as a result of the ACA—for a total increase of 8 million people, on average, enrolled in Medicaid or CHIP compared with what would have occurred in the absence of the law. Over the coming years, the increase in the number of people enrolled in

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8. Collections and payments for the risk adjustment, reinsurance, and risk corridor programs will occur after the close of a benefit year. Therefore, collections and payments for insurance provided in one year will occur in the next year. Under the reinsurance program, an additional \$5 billion will be collected from health insurance plans and deposited into the general fund of the U.S. Treasury. That amount is the same as the sum appropriated for another program also established by the ACA, the Early Retiree Reinsurance Program, which was in operation before 2014 and which is not included here as part of the budgetary effects of the ACA's insurance coverage provisions. The risk corridors program does not extend throughout the projection period; instead, it covers insurance issued for calendar years 2014 to 2016, and corresponding payments and collections will occur during fiscal years 2015 to 2017. CBO expects that the payments and collections for that program will both total \$1 billion in 2015, \$1.5 billion in 2016, and \$2.5 billion in 2017.

**Table B-3.****Enrollment in, and Budgetary Effects of, Health Insurance Exchanges**

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total, 2016- 2025
<b>Exchange Enrollment</b> (Millions of nonelderly people, by calendar year) <sup>a</sup>												
Individually Purchased Coverage												
Subsidized	9	16	19	19	18	18	18	18	17	17	17	n.a.
Unsubsidized <sup>b</sup>	3	5	6	6	6	6	7	6	7	7	7	n.a.
<b>Total</b>	<b>12</b>	<b>21</b>	<b>25</b>	<b>25</b>	<b>25</b>	<b>24</b>	<b>25</b>	<b>24</b>	<b>24</b>	<b>24</b>	<b>24</b>	<b>n.a.</b>
Employment-Based Coverage												
Purchased Through SHOP Exchanges <sup>b</sup>	1	3	4	4	4	4	4	4	4	4	4	n.a.
<b>Effects on Direct Spending and Revenues</b> (Billions of dollars, by fiscal year)												
Changes in Mandatory Spending												
Outlays for premium credits	22	45	63	72	75	77	81	86	89	92	95	775
Cost-sharing subsidies	6	10	12	14	14	14	15	16	17	17	18	147
Exchange grants to states	1	1	*	0	0	0	0	0	0	0	0	1
Payments for risk adjustment and reinsurance <sup>c</sup>	16	16	17	15	17	19	19	20	20	19	19	181
<b>Total, Exchange Subsidies and Related Spending</b>	<b>45</b>	<b>71</b>	<b>93</b>	<b>101</b>	<b>106</b>	<b>110</b>	<b>116</b>	<b>122</b>	<b>125</b>	<b>128</b>	<b>131</b>	<b>1,104</b>
Changes in Revenues												
Reductions in revenues from premium credits	-5	-9	-12	-13	-14	-14	-14	-14	-14	-14	-14	-134
Collections for risk adjustment and reinsurance <sup>c</sup>	17	15	17	15	17	19	19	20	20	19	19	180
<b>Total, Revenues</b>	<b>12</b>	<b>5</b>	<b>5</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>46</b>
Net Increase in the Deficit From Exchange Subsidies and Related Spending and Revenues	32	66	87	99	103	106	111	117	120	123	127	1,058
<b>Memorandum:</b>												
Total Exchange Subsidies (Billions of dollars) <sup>d</sup>												
By fiscal year	32	64	87	99	103	106	111	117	120	123	127	1,057
By calendar year	38	75	92	102	104	106	113	118	121	124	128	1,084
Average Exchange Subsidy per Subsidized Enrollee (Dollars, by calendar year)	4,330	4,700	4,940	5,350	5,620	5,930	6,260	6,650	6,990	7,340	7,710	n.a.

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

Note: SHOP = Small Business Health Options Program; n.a. = not applicable; \* = between zero and \$500 million.

- Figures reflect average enrollment over the course of a year and include spouses and dependents covered under family policies. Figures for the nonelderly population include residents of the 50 states and the District of Columbia who are younger than 65.
- Excludes coverage purchased directly from insurers outside of an exchange.
- CBO's April 2014 baseline for direct spending and revenues also included the net collections and payments for risk corridors. The risk corridors program is included in CBO's January 2015 baseline as a discretionary program. CBO estimates that the payments and collections for the risk corridors program will each total \$1 billion in fiscal year 2015, \$1.5 billion in fiscal year 2016, and \$2.5 billion in fiscal year 2017.
- Total exchange subsidies include premium credit outlays, reductions in revenues from premium credits, and outlays for cost-sharing subsidies.

Medicaid or CHIP because of the ACA is expected to be even larger—about 11 million in 2015 and 13 million to 16 million in each year between 2016 and 2025 (see Table B-2 on page 119).

Several factors account for the increase over time in the number of additional people enrolled in Medicaid or CHIP because of the ACA. Some of those additional enrollees will be people who are eligible for Medicaid because of the ACA's expansion of coverage: CBO and JCT expect that, in future years, more states will expand eligibility for Medicaid, and more people in states that have already expanded eligibility will enroll in the program. Others of the additional enrollees will be people who would have been eligible for Medicaid or CHIP in the absence of the ACA but would not have enrolled: CBO and JCT expect that the ACA's individual mandate, increased outreach, and new opportunities for people deemed eligible for those programs to apply via the exchanges will increase enrollment among that group.<sup>9</sup>

As with enrollment through the exchanges, the numbers that CBO and JCT project for Medicaid and CHIP enrollment represent averages over the course of a year and differ from enrollment at any particular point during a year. Unlike exchange plans, for which enrollment opportunities are limited to an annual open-enrollment period and times at which people experience qualifying life events, people who are eligible for Medicaid or CHIP can enroll at any time during a year. People move into and out of those programs for many reasons, including changes in their need for health care, a change in their awareness of the availability of coverage, and changes in their financial circumstances.

The ACA's total effect on enrollment in Medicaid can never be precisely determined. In particular, the number

9. Under current law, CHIP is funded through 2015, and CBO's projection of annual spending for the program is expected to reach \$10 billion in 2015. If the Congress does not provide additional funding for subsequent years, most state programs will terminate at some point during fiscal year 2016. However, under the rules governing baseline projections for expiring programs, CBO projects funding for CHIP after 2015 at an annualized amount of about \$6 billion; the estimates of enrollment shown here are based on that projected amount of funding. Because such funding is substantially less than the funding provided through 2015, projected enrollment in CHIP in CBO's baseline declines after that year. (For details about the CHIP baseline, see Chapter 3.)

of people who were previously eligible and who sign up for the program after 2013 because of the ACA can be estimated but not observed directly. However, the number of people who sign up who are newly eligible can eventually be determined because states that expand coverage under the ACA will report the number of enrollees who became eligible as a result of that expansion in order to receive the additional federal funding that is provided for such enrollees.

CBO and JCT estimate that the added costs to the federal government for Medicaid and CHIP resulting from the ACA will be \$47 billion in 2015 and will grow to \$76 billion in 2018 and \$117 billion in 2025. For the 2016–2025 period as a whole, those costs are projected to total \$920 billion (see Table B-1 on page 117).<sup>10</sup>

## Tax Credits for Small Employers

Certain small employers are eligible to receive tax credits to defray the cost of providing health insurance to their employees. CBO and JCT project that those tax credits will total \$2 billion in 2015 and \$15 billion over the 2016–2025 period.

## Penalty Payments and Excise Taxes

Under the ACA, some large employers who do not offer health insurance that meets certain standards will need to pay a penalty if they have full-time employees who receive a subsidy through an exchange. The standards specify thresholds for affordability and the share of the cost of covered benefits paid by the employer's insurance plan.<sup>11</sup> The requirement generally applies to employers with at least 50 full-time-equivalent (FTE) employees, but this year, employers with at least 50 but fewer than 100 FTE employees will be exempt from the requirement if they certify that they have not diminished health insurance coverage in certain ways or reduced their number

10. 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 over the 2016–2025 period will be about \$63 billion higher because of the coverage provisions of the ACA than it would have been otherwise.

11. To meet the standards, the cost to the employee for self-only coverage must not exceed a specified share of income (which is 9.56 percent in 2015 and is indexed for inflation over time), and the plan must pay at least 60 percent of the cost of covered benefits.

of FTE employees to avoid the penalty. CBO and JCT estimate that payments of those penalties will total \$164 billion over the 2016–2025 period.

In addition, most citizens of the United States and lawfully present noncitizens are required to obtain health insurance or pay a penalty. People who do not obtain coverage owe the greater of two amounts: (1) a flat dollar penalty per uninsured adult in a family, rising from \$325 in 2015 to \$695 in 2016 and indexed to inflation thereafter (the penalty for an uninsured child is half the amount for an uninsured adult, and an overall cap applies to family payments), or (2) a percentage of a household's adjusted gross income in excess of the income threshold for mandatory tax-filing—a share that will rise from 2.0 percent in 2015 to 2.5 percent in 2016 and subsequent years (also subject to a cap). CBO and JCT estimate that such payments from individuals will total \$47 billion over the 2016–2025 period.

Among the roughly 36 million nonelderly residents that CBO and JCT estimate will be uninsured in 2015, the majority will be exempt from the penalty. Those who are exempt include unauthorized immigrants (who are prohibited from receiving exchange subsidies and almost all Medicaid benefits), people with income low enough that they do not file income tax returns, people who have income below 138 percent of federal poverty guidelines and are ineligible for Medicaid because their state did not expand the program, members of Indian tribes, people who are incarcerated, and people whose premiums exceed a specified share of their income (which is 8.05 percent in 2015 and is indexed for inflation over time).

According to CBO and JCT's estimates, federal revenues stemming from the excise tax on high-premium insurance plans will be \$149 billion over the 2016–2025 period. Roughly one-quarter of that amount will stem from excise tax receipts, and three-quarters will come from the effects on revenues of changes in employees' taxable compensation. In particular, CBO and JCT anticipate that many employers and workers will shift to health plans with premiums that are below the specified thresholds to avoid paying the tax, resulting generally in higher taxable wages for affected workers.

### **Other Effects on Revenues and Outlays**

Changes in insurance coverage under the ACA also affect federal tax revenues and outlays because fewer people will

have employment-based health insurance and thus more of their income will take the form of taxable wages. CBO and JCT project that, as a result of the ACA, between 7 million and 10 million fewer people will have employment-based insurance coverage each year from 2016 through 2025 than would have been the case in the absence of the ACA. That difference is the net result of projected increases and decreases in offers of health insurance from employers and in decisions to enroll by active workers, early retirees (people under the age of 65 at retirement), and their families.

In 2019, for example, about 13 million people who would have enrolled in employment-based coverage in the absence of the ACA will not have an offer of such coverage under current law, CBO and JCT estimate; in addition, an estimated 3 million people who would have enrolled in employment-based coverage in the absence of the ACA will still have such an offer but will choose not to enroll in that coverage. Some of those 16 million people are expected to gain coverage through some other source; others will forgo health insurance. Those decreases in employment-based coverage will be partially offset, however. About 7 million people who would not have had employment-based coverage in the absence of the ACA are expected to receive such coverage under current law; they will either take up an offer of coverage they would have received anyway or take up a new offer. Some of those enrollees would have been uninsured in the absence of the ACA. On balance, an estimated 9 million fewer people will have employment-based insurance under current law than would have had it in the absence of the ACA.

Because of the net reduction in employment-based coverage, the share of workers' pay that takes the form of nontaxable benefits (such as payments toward health insurance premiums) will be smaller—and the share that takes the form of taxable wages will be larger—than would otherwise have been the case. That shift in compensation is projected to reduce deficits by a total of \$292 billion over the 2016–2025 period by boosting federal tax receipts (and reducing outlays from certain refundable tax credits). Partially offsetting those added receipts will be an estimated \$8 billion increase in Social Security benefits that will be paid because of the higher wages paid to workers. All told, CBO and JCT project, those changes will reduce federal budget deficits by \$284 billion over the 2016–2025 period.

## Changes in the Estimates Since April 2014

CBO and JCT currently project that the insurance coverage provisions of the ACA will have a smaller budgetary cost than they estimated in April 2014, when the agencies last published a detailed projection for those provisions. For the 2015–2024 period (the period covered by last April’s estimates), CBO and JCT have lowered their estimate of the net costs, from \$1,383 billion to \$1,281 billion (see Table B-4).<sup>12</sup> That reduction of \$101 billion (or 7 percent) largely comprises the following:

- A \$68 billion reduction in the net cost of exchange subsidies and related spending and revenues;
- A \$59 billion increase in federal spending for Medicaid and CHIP; and
- A \$97 billion net increase in revenues (and decrease in outlays from certain refundable tax credits) arising from projected changes in coverage offered through employers.

In addition to those three sets of changes, which are discussed below, the revision also reflects an increase in net costs of \$5 billion stemming from changes in estimated penalty payments and estimated collections from the excise tax on high-premium insurance plans.

Various factors, including new data and improvements in the agencies’ modeling, account for the differences. Relevant updates of information included these: Average enrollment in the exchanges over the course of 2014 was slightly lower than anticipated; enrollment in “bronze” plans (which pay about 60 percent of the costs of covered benefits) during 2014 was higher than anticipated; and the estimated proportion of Medicaid enrollees who were newly eligible under the ACA was larger than expected.

### Exchange Subsidies and Related Spending and Revenues

CBO and JCT now project that the government’s net costs for exchange subsidies and related spending and revenues over the 2015–2024 period will be \$964 billion, \$68 billion (or 7 percent) below the previous projection:

- Premium assistance tax credits are projected to be \$827 billion, about \$28 billion (or 3 percent) less than in the previous projection, and
- Cost-sharing subsidies are projected to be \$135 billion, about \$39 billion (or 23 percent) less than in the previous projection.<sup>13</sup>

**Premium Assistance Tax Credits.** Lower estimated enrollment in coverage obtained through the exchanges in every year accounts for the majority of the \$28 billion reduction in the estimated cost of premium assistance tax credits.

CBO and JCT have reduced their estimate of average enrollment over the course of 2015 by 1 million people, from 13 million to 12 million. That revision occurred for two reasons. First, attrition from exchange plans during calendar year 2014 was slightly greater than the agencies had previously anticipated. Second, enrollment between mid-November and mid-December for coverage in 2015 was slightly lower than the agencies had previously anticipated. (About 7 million people selected a plan during that period.)<sup>14</sup> CBO and JCT expect that many people will sign up near the end of the ongoing open-enrollment period, which lasts through mid-February, following a pattern similar to last year’s. Even so, the agencies now view 12 million (rather than 13 million) as being closer to

12. See Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014* (April 2014), [www.cbo.gov/publication/45231](http://www.cbo.gov/publication/45231).

13. In addition, the risk corridors program has been reclassified in the federal budget as discretionary rather than mandatory. As a result, collections and payments for that program are included in the discretionary portion of CBO’s baseline estimates and are no longer included here as part of “exchange subsidies and related spending and revenues.” Because CBO had previously estimated that collections and payments for the program would exactly offset each other, that reclassification has no effect on CBO and JCT’s estimates of the net costs of the insurance coverage provisions of the ACA. However, the change reduces both mandatory outlays and revenues relative to previous projections.

14. About 6.4 million people enrolled through federally facilitated exchanges through December 19 (see Department of Health and Human Services, “Open Enrollment Week 5: December 13–December 19, 2014,” *HHS Blog* [December 23, 2014], <http://go.usa.gov/znbA>), and another 0.6 million people enrolled through state-based exchanges through December 13 (see Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace 2015 Open Enrollment Period: December Enrollment Report*, ASPE Issue Brief [December 2014], <http://go.usa.gov/tVx4>).

**Table B-4.****Comparison of CBO and JCT's Current and Previous Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act**

	April 2014 Baseline	January 2015 Baseline	Difference
<b>Change in Insurance Coverage Under the ACA in 2024</b> (Millions of nonelderly people, by calendar year) <sup>a</sup>			
Insurance Exchanges	25	24	-1
Medicaid and CHIP	13	16	3
Employment-Based Coverage <sup>b</sup>	-7	-9	-1
Nongroup and Other Coverage <sup>c</sup>	-5	-4	*
Uninsured <sup>d</sup>	-26	-27	-1
<b>Effects on the Cumulative Federal Deficit, 2015 to 2024<sup>e</sup></b> (Billions of dollars)			
Exchange Subsidies and Related Spending and Revenues <sup>f</sup>	1,032	964	-68
Medicaid and CHIP Outlays	792	851	59
Small-Employer Tax Credits <sup>g</sup>	15	14	**
Gross Cost of Coverage Provisions	1,839	1,829	-9
Penalty Payments by Uninsured People	-46	-43	3
Penalty Payments by Employers <sup>g</sup>	-139	-140	-1
Excise Tax on High-Premium Insurance Plans <sup>g</sup>	-120	-116	4
Other Effects on Revenues and Outlays <sup>h</sup>	-152	-249	-97
<b>Net Cost of Coverage Provisions</b>	<b>1,383</b>	<b>1,281</b>	<b>-101</b>

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

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

\*\* = between -\$500 million and zero.

- a. Figures for the nonelderly population include residents of the 50 states and the District of Columbia who are younger than 65.
- b. The change in employment-based coverage is the net result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by workers and their families.
- c. "Other" includes Medicare; the changes under the ACA are almost entirely for nongroup coverage.
- d. The uninsured population includes people who will be unauthorized immigrants and thus ineligible either for exchange subsidies or for most Medicaid benefits; people who will be ineligible for Medicaid because they live in a state that has chosen not to expand coverage; people who will be eligible for Medicaid but will choose not to enroll; and people who will not purchase insurance to which they have access through an employer, through an exchange, or directly from an insurer.
- e. Positive numbers indicate an increase in the deficit; negative numbers indicate a decrease in the deficit. These numbers exclude effects on the deficit of provisions of the ACA that are not related to insurance coverage and discretionary spending effects of the coverage provisions.
- f. Includes spending for exchange grants to states and net spending and revenues for risk adjustment and reinsurance. The risk corridors program is now recorded in the budget as a discretionary program; CBO estimates that payments and collections will offset each other in each year, resulting in no net budgetary effect.
- g. These effects on the deficit include the associated effects of changes in taxable compensation on revenues.
- h. Consists mainly of the effects of changes in taxable compensation on revenues.

the middle of the distribution of possible outcomes for average enrollment during 2015 as a whole.

For 2016, CBO and JCT have also revised downward their estimate of average enrollment through exchanges, from 24 million to 21 million. The agencies still expect enrollment to grow rapidly over the next two years in response to increased outreach by state health agencies and others and to increased awareness of the individual mandate; however, that growth is now anticipated to occur a little more gradually than it was previously.

In addition, for most years after 2016, CBO and JCT currently estimate that enrollment through exchanges will be 1 million lower than previously thought. That reduction primarily reflects an increase in the number of children who are expected to receive coverage through Medicaid, as discussed below.

CBO and JCT have incorporated several improvements to the modeling of benchmark premiums for exchange plans to better reflect the premium structure observed in 2014 and 2015. Those revisions resulted in higher projected premiums for some people and lower projected premiums for others, yielding largely offsetting effects on total exchange enrollment and a slight increase (on net) in premium assistance tax credits.

**Cost-Sharing Subsidies.** Outlays for cost-sharing subsidies over the 2015–2024 period are currently projected to be \$39 billion less than previously estimated, primarily because CBO and JCT now expect that more people will forgo those subsidies by choosing to enroll in a bronze plan instead of a silver plan. (Although eligible low-income individuals must enroll in a silver plan to receive cost-sharing subsidies, they are not required to enroll in a silver plan to receive premium assistance tax credits.)

The agencies had previously estimated that few people would forgo cost-sharing subsidies; however, data released since April 2014 show that 15 percent of people who chose a plan through an exchange during the open-enrollment period for 2014 and who qualified for a premium assistance tax credit chose a bronze plan.<sup>15</sup>

Those data suggest that a significant number of people are selecting plans that minimize their monthly premium payments, even if the amounts they ultimately pay for health care (including out-of-pocket payments) exceed what they would pay under silver plans. Over time, CBO and JCT expect, some enrollees will switch from bronze plans to silver plans because they incur large medical bills or become concerned (perhaps because of outreach efforts by insurers or others) about the possibility of incurring large out-of-pocket payments. Nonetheless, the agencies expect that some people purchasing coverage through exchanges solely to comply with the individual mandate will be focused on minimizing their premium payments and thus will continue to choose bronze plans. Therefore, CBO and JCT now estimate that, in years after 2015, 3 million people who would have been eligible for cost-sharing subsidies if enrolled in a silver plan will forgo those subsidies by signing up for a bronze plan.

### Medicaid and CHIP Outlays

CBO and JCT now project that the federal cost of the additional enrollment in Medicaid and CHIP under the ACA over the 2015–2024 period will be \$851 billion, \$59 billion (7 percent) more than the April 2014 projection. Roughly half of the upward revision reflects an increase in the estimated share of people enrolling in Medicaid under the ACA who will be newly eligible because of the law (and a decrease in the share who would have been eligible but would not have enrolled in the absence of the law). The remainder of the upward revision can be attributed mostly to an increase in the number of children who are projected to enroll in Medicaid after 2015, when CHIP is no longer funded under current law.

**The Composition of Enrollment in Medicaid.** CBO and JCT now estimate that enrollment in Medicaid in 2014 among those eligible for the program because of the ACA's coverage expansion was higher than originally thought and that enrollment among those previously eligible for the program was lower. As a result, the agencies now project that newly eligible Medicaid enrollees will represent a larger share of the projected increment to Medicaid enrollment under the ACA in future years as well. For 2015 and beyond, the agencies currently expect that roughly 70 percent of the people who will receive Medicaid coverage because of the ACA will be newly eligible for the program, compared with 55 percent to 65 percent in the previous projection.

15. See Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period*, ASPE Issue Brief (May 2014), p. 21, <http://go.usa.gov/MwFF>.

Federal costs per Medicaid enrollee are much higher for those who are newly eligible than for those who were previously eligible because the federal government pays a larger share of the costs for newly eligible enrollees (100 percent to 90 percent, depending on the year) than for other enrollees (an average of 57 percent). Therefore, the revision to the mix of enrollees resulted in a \$29 billion increase in projected federal spending for Medicaid over the 2015–2024 period.

**Enrollment of Children in CHIP and Medicaid.** Under current law, states will receive no new budget authority for their CHIP programs in fiscal year 2016 and later. However, under the rules governing baseline projections for expiring programs, CBO projects funding for CHIP in each of those years of about \$6 billion. That assumed funding level compares to total state allotments in 2014 of \$9.7 billion. If CHIP is funded at the reduced \$6 billion level, CBO and JCT expect that some children will lose coverage through CHIP and will instead receive coverage through Medicaid, obtain private coverage (through the exchanges or their parents' employers), or become uninsured. On the basis of information provided by the Medicaid and CHIP Payment and Advisory Commission regarding requirements in current law to provide Medicaid coverage to certain children if CHIP funding is reduced, CBO and JCT now estimate that more of those children (about 3 million by 2024) will receive coverage through Medicaid rather than through the exchanges and employment-based coverage than the agencies previously estimated.<sup>16</sup> As a result, the agencies project greater spending for Medicaid (and reductions in enrollment through the exchanges and employment-based coverage, with corresponding budgetary effects).

### Other Effects on Revenues and Outlays

CBO and JCT now anticipate that the ACA's insurance coverage provisions will have other effects on revenues and outlays that will, on net, reduce the deficit by \$97 billion more for the 2015–2024 period than was anticipated previously. That revision stems from improvements in estimating methodology and from a downward revision to the number of people who are projected to have employment-based coverage in most years.

The lower estimate of the number of people who will have employment-based coverage (about 1 million fewer in most years of the projection period than thought previously) derives largely from an increase in the number of children who are expected to receive coverage through Medicaid after 2015. Less employment-based coverage means that nontaxable compensation in the form of health benefits provided by employers will be less and taxable compensation in the form of wages and salaries will be greater, as total compensation is expected to remain roughly the same. And to the extent that wages and salaries do not increase as much as payments for health benefits are reduced, corporate profits—which are also taxable—would increase. Therefore, the decrease in the estimate of employment-based coverage implies higher federal revenues than projected previously.

Other methodological improvements also increased CBO and JCT's estimate of tax revenues stemming from projected changes in coverage through employers. For example, as previously discussed, the new projections include modeling improvements to benchmark premiums for exchange plans. Although those changes resulted in largely offsetting effects on the number of people projected to have employment-based health insurance, the average income of those projected to no longer obtain employment-based insurance under the ACA is now higher than previously estimated. As a result, the reduction in employment-based insurance under the ACA yields a larger increase in federal revenues than previously estimated.

## Changes in the Estimates Since the Enactment of the ACA

CBO and JCT have updated their baseline estimates of the budgetary effects of the ACA's insurance coverage provisions many times since the law was enacted in March 2010. As time has passed, projected costs over the subsequent 10 years have risen because the period spanned by the estimates has changed: Each time the projection period changes, a less expensive early year is replaced by a more expensive later year. But when compared year by year, CBO and JCT's estimates of the net budgetary impact of the ACA's insurance coverage provisions have decreased, on balance, over the past five years (see Figure B-2).

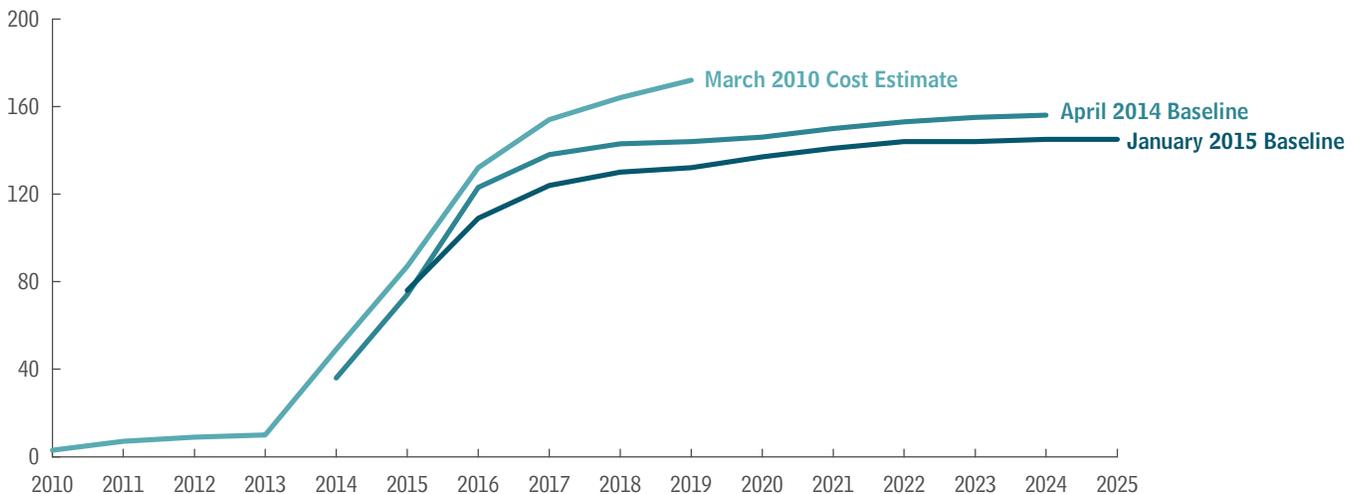
In March 2010, CBO and JCT projected that the provisions of the ACA related to health insurance coverage

16. Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP* (June 2014), pp. 6 and 8, [www.macpac.gov/reports](http://www.macpac.gov/reports).

**Figure B-2.**

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

Billions of Dollars, by Fiscal Year



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

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

would cost the federal government \$710 billion during fiscal years 2015 through 2019 (the last year of the 10-year projection period used in that estimate). The newest projections indicate that those provisions will cost \$571 billion over that same period, a reduction of 20 percent. For 2019, for example, CBO and JCT projected in March 2010 that the ACA's insurance coverage provisions would have a net federal cost of \$172 billion; the current projections show a cost of \$132 billion—a reduction of \$40 billion, or 23 percent.

The downward revision since March 2010 to CBO and JCT's estimate of the net federal costs of the ACA's insurance coverage provisions (when measured on a year-by-year basis) is attributable to many factors: Changes in law, revisions to CBO's economic projections, the Supreme Court decision that made the expansion of eligibility for

Medicaid optional for states, administrative actions, new data, and numerous improvements in CBO and JCT's modeling have all affected the projections. Another notable influence on the downward revision to projected federal costs is the slowdown in the growth of health care costs that has been experienced by private insurers, as well as by the Medicare and Medicaid programs. Although views differ on how much of the slowdown is attributable to the recession and its aftermath and how much to other factors, the slower growth has been sufficiently broad and persistent to persuade the agencies to significantly lower their projections of federal health care spending. In particular, since early 2010, CBO and JCT have reduced their 2016 projections of both insurance premiums for policies purchased through the exchanges and Medicaid spending per beneficiary by between 10 percent and 15 percent.