Congressional Budget Office

AUGUST 2017

The Effects of Terminating Payments for Cost-Sharing Reductions

Summary

The Affordable Care Act (ACA) requires insurers to offer plans with reduced deductibles, copayments, and other means of cost sharing to some of the people who purchase plans through the marketplaces established by that legislation. The size of those reductions depends on those people's income. In turn, insurers receive federal payments arranged by the Secretary of Health and Human Services to cover the costs they incur because of that requirement.

At the request of the House Democratic Leader and the House Democratic Whip, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have estimated the effects of terminating those payments for cost-sharing reductions (CSRs). In particular, the agencies analyzed what would happen under this policy: By the end of this month, it is known that CSR payments will continue through December 2017 but not thereafter.

Effects on Market Stability and Premiums

CBO and JCT expect that insurers in some states would withdraw from or not enter the nongroup market because of substantial uncertainty about the effects of the policy on average health care costs for people purchasing plans. In the agencies' estimation, under the policy, about 5 percent of people live in areas that would have no insurers in the nongroup market in 2018. By 2020, though, insurers would have observed the operation of markets in many areas under the policy and CBO and JCT expect that more insurers would participate, so people in almost all areas would be able to buy nongroup insurance (as is projected to be the case throughout the next decade under CBO's baseline projection).[1]

Because they would still be required to bear the costs of CSRs even without payments from the government, participating insurers would raise premiums of "silver" plans to cover the costs. In order to qualify for CSRs, most enrollees must purchase a silver plan through the nongroup insurance marketplace in their area, generally have income between 100 percent and 250 percent of the federal poverty level (FPL), receive premium tax credits toward the silver plan, and not be eligible for other types of coverage, such as employment-based coverage or Medicaid. According to CBO and JCT's projections, for single policyholders, gross premiums (that is, before premium tax credits are accounted for) for silver plans offered through the marketplaces would, on average, rise by about 20 percent in 2018 relative to the amount in CBO's March 2016 baseline and rise slightly more in later years. Such premiums for other plans would rise a few percent during the next two years, on average, above the increases already projected in the baseline in response to uncertainty among states and insurers about how to respond under the policy. In later years, the agencies anticipate, premiums for other plans would not generally rise above baseline projections because CSRs are not available for those plans.

When premiums for silver plans increased under the policy, tax credit amounts per person for purchasing insurance in the nongroup market would increase because the credits are directly linked to those premiums. According to CBO and JCT's projections, many people eligible for the credits with income between 100 percent and 200 percent of the FPL—who, under the baseline, receive most of the cost-sharing reductions paid—would use their increased tax credits to purchase the same silver plans with low cost sharing that they would purchase

1. Under the policy analyzed, because of the timing, insurers would know about the termination of the CSR payments before having to finalize premiums for next year. But if the timing was different, if CSR payments were stopped after premiums were finalized or were already being charged, CBO and JCT expect that additional insurers would exit the marketplaces in 2018 to reduce their financial losses.

under the baseline, and they would pay net premiums (with the tax credits factored in) that were similar to what they would pay if the CSR payments were continued. Alternatively, they could buy insurance that covered less of their health care expenses, and in many of those cases, the tax credits would cover the premiums entirely. Because CBO and JCT anticipate that most insurance commissioners would eventually permit insurers to substantially increase the gross premiums for silver plans in the marketplaces and not to do so for other plans, almost all people at other income levels would then buy other plans. (Under the baseline, some of those people would buy silver plans, and some would buy other plans.)

Effects on the Federal Budget and Health Insurance Coverage

Implementing the policy would increase the federal deficit, on net, by $194 billion from 2017 through 2026, CBO and JCT estimate. Total federal subsidies for health insurance in the nongroup market—in particular, the sum of the premium tax credits and the CSR payments—would increase for two reasons: The average amount of subsidy per person would be greater, and more people would receive subsidies in most years.

Because the tax credits would increase when premiums for silver plans rose, the agencies estimate that the average subsidy per person receiving premium tax credits to purchase nongroup health insurance would increase. Increases in those tax credits for people with income between 100 percent and 200 percent of the FPL would roughly offset the reductions in CSR payments. However, increases in premium tax credits for those with income between 200 percent and 400 percent of the FPL would substantially exceed the small reductions in CSR payments for this group.

By CBO and JCT's estimates, the number of people receiving subsidies for nongroup health insurance would increase under the policy in most years. In particular, because tax credits would increase and gross premiums for plans other than silver plans in the marketplaces would not change substantially, many people with income between 200 percent and 400 percent of the FPL would, compared with outcomes under the baseline, be able to pay lower net premiums for insurance that pays for the same share (or an even greater share) of covered benefits. As a result, more people would purchase plans in the marketplaces than would have otherwise and fewer people would purchase employment-based health insurance—reducing the number of uninsured people, on net, in most years. (Under the policy, demand for employment-based insurance among some employees would be weaker because insurance in the marketplaces would be more attractive, and the agencies expect fewer employers would offer health insurance to their workers in most years.)

During the next two years, the increase in subsidies stemming from those two reasons would be partially offset by lower spending in areas where no insurers participated in the marketplaces in response to the policy, CBO and JCT estimate. In those years, the number of uninsured people would be slightly higher or about the same as under the baseline.

Overall Effects

As a result of the increase in total subsidies under the policy, CBO and JCT project these outcomes, compared with what would occur if the CSR payments were continued:

- The fraction of people living in areas with no insurers offering nongroup plans would be greater during the next two years and about the same starting in 2020;
- Gross premiums for silver plans offered through the marketplaces would be 20 percent higher in 2018 and 25 percent higher by 2020—boosting the amount of premium tax credits according to the statutory formula;
- Most people would pay net premiums (after accounting for premium tax credits) for nongroup insurance throughout the next decade that were similar to or less than what they would pay otherwise—although the share of people facing slight increases would be higher during the next two years;
- Federal deficits would increase by $6 billion in 2018, $21 billion in 2020, and $26 billion in 2026; and
- The number of people uninsured would be slightly higher in 2018 but slightly lower starting in 2020.

Those effects are uncertain and would depend on how the policy was implemented.

For this analysis, the agencies have measured the budgetary effects relative to CBO's March 2016 baseline to

produce estimates most comparable to those published earlier this year for legislation related to the budget reconciliation process for 2017. In an analysis using a preliminary version of updated projections of spending to subsidize health insurance purchased through the marketplaces that will be published soon, CBO and JCT find most of the results to be similar to those discussed here.[2] The main exception is this: Premiums under the policy would rise by a smaller amount in 2018—as the updated projections incorporate some increase in premiums next year as a result of current uncertainty about future CSR payments. Specifically, the agencies now expect that some insurers will assume that CSR payments will not be made in full during 2018 (as some insurers have indicated in preliminary filings), will incorporate the associated costs into their premiums for that year, and will, if CSR payments continue to be made, make adjustments in 2019 to account for them. Those expectations will be reflected in the updated projections but were not included in the March 2016 baseline.

How Key Elements of the Current System Work

In most marketplaces, people can choose among plans—such as bronze, silver, and gold—for which the average percentage of the total cost of covered medical expenses paid by the insurer (that is, the actuarial value of the plan) differs. The share of medical expenses that is not paid by the insurer is paid by enrollees in the form of deductibles and other cost sharing.

Silver plans differ from other plans because they must provide CSRs to eligible enrollees: The actuarial value depends on the policyholder's income as a percentage of the FPL.[3] Insurers are required to offer such plans to participate in the marketplaces. For people at most income levels, the actuarial value for a silver plan is 70 percent; the average deductible for a single policyholder, for medical and drug expenses combined, is about $3,600 in 2017. People with income between 100 percent and 250 percent of the FPL, however, are generally eligible for silver plans with higher actuarial values (and with lower deductibles), as follows:

- For people with income between 100 percent and 150 percent of the FPL, 94 percent (with an average deductible of about $300);
- For people with income between 150 percent and 200 percent of the FPL, 87 percent (with an average deductible of about $800); and
- For people with income between 200 percent and 250 percent of the FPL, 73 percent (with an average deductible of about $2,900).

Insurance companies can cover those higher shares of health care costs at current premium rates because they receive CSR payments from the federal government based on the number of enrollees they have in each eligibility category. To pay such shares of the cost of benefits in the absence of CSR payments, insurers would raise premiums.

The premium tax credits also reduce the amount that certain low-income people pay for health care in the nongroup market. The eligibility for such tax credits and the method for calculating the credit amounts in the nongroup market would be unchanged under the policy. The size of the premium tax credits depends on household income and on the premiums for a benchmark plan—the second-lowest-cost silver plan—in an enrollee's geographic area. An enrollee eligible for the tax credits pays a certain maximum percentage of his or her income toward the premiums for that benchmark plan, and the credits cover the amount by which the premiums for the benchmark plan exceed that percentage of income.

When the premiums for the benchmark plan go up, the amount of the tax credits goes up, and the amount of the premiums paid by an enrollee who is eligible for the credits is generally unchanged. Hence, an enrollee eligible for the premium tax credits is insulated from variations in premiums in different geographic locations and is also largely insulated from increases in the premiums for the benchmark plan. If a person chooses a plan with premiums higher than those for the benchmark plan, then he or she pays the difference as an additional amount toward the premiums, providing some incentive to choose lower-priced insurance. Similarly, if the person

2. Those updated estimates will be used to adjust the current set of baseline projections of such spending, which were published in June 2017. See Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2017 to 2027* (June 2017), www.cbo.gov/publication/52801.

3. In addition, certain Native Americans are eligible for plans with no deductibles or other cost sharing; the eligibility rules for those plans differ.

chooses a plan with premiums lower than the benchmark plan's, then he or she pays a lower cost.

In addition, the federal requirement that health insurers maintain a minimum medical loss ratio, which is equivalent to capping the share of premiums that may go toward insurers' administrative costs and profits, would be unchanged under the policy analyzed here. That requirement, combined with the competitive pressure to attract enrollees to lower-priced insurance in markets with more than one insurer, would eventually constrain increases in premiums for silver plans—even though the sums paid by subsidized enrollees in the marketplaces would largely be determined by their income, and the increases would primarily be borne by the federal government in the form of larger premium tax credits.

Effects on Market Stability

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

Although premiums have been rising, subsidized enrollees purchasing health insurance coverage in the nongroup market are insulated from increases in premiums when they purchase a plan with premiums at or below those for the benchmark plan because the net premiums they pay are based on a percentage of their income. The subsidies to purchase coverage, combined with the requirement that most people obtain health insurance coverage (also known as the individual mandate), are anticipated to cause sufficient demand for insurance by enough people, including people with low health care expenditures, for the market to be stable in most areas as the ACA is currently being implemented. Under the baseline, fewer than one-half of one percent of people live in areas of the country that are projected to have no participation by insurers in the nongroup market. Several factors may affect insurers' decisions to not participate—including lack of profitability and substantial uncertainty about enforcement of the individual mandate and about future payments for CSRs.

CBO and JCT anticipate that, under this policy, the nongroup insurance market would also continue to be stable in most areas of the country. Subsidies to purchase insurance combined with the individual mandate would maintain sufficient demand for insurance by people with low health care expenditures. Substantial uncertainty about how consumers might respond to the significant increases in premiums following the termination of CSR payments would lead some insurers to withdraw from or not enter the nongroup market in some states, but the agencies anticipate that the situation would be temporary. Under the policy, CBO and JCT estimate, about 5 percent of people live in areas of the country in which insurers would not participate in the nongroup market in 2018, but insurers would participate in nearly all areas by 2020. (If the timing of the policy was different, its effects in 2018 would be different.)

Effects on Gross Premiums Charged by Insurers

Under this policy, average premiums for the second-lowest-cost silver plan offered through the marketplaces for single policyholders would be about 20 percent higher in 2018 than the premiums projected in CBO's March 2016 baseline, mainly because gross premiums alone, rather than premiums in combination with CSR payments, would have to cover the insurer's share of enrollees' health care costs. In 2020 and subsequent years, by CBO and JCT's estimates, the premiums for such benchmark plans would be about 25 percent higher than under the baseline.

Those increases would occur, CBO and JCT expect, because most state insurance commissioners would eventually allow insurers to compensate for the termination of CSR payments by raising premiums substantially for silver plans offered through the marketplaces. The agencies anticipate that insurers would propose to raise premiums for those plans because they are the plans required to bear—through cost-sharing reductions—the costs of having actuarial values of 87 percent or 94 percent for people with income between 100 percent and 200 percent of the FPL who enroll. Many insurance commissioners would favor that increase, CBO and JCT expect, because it would result in larger increases in premium tax credits for people in their states and, thus, lower net premiums paid by enrollees than alternatives that insurers might propose. Very few people at other income levels (facing the same gross premiums but for coverage with an actuarial value of 73 percent or lower)

would then enroll in silver plans in the marketplaces under the policy. Instead, they would purchase other plans, the agencies project.

The gross premiums for bronze plans with actuarial values around 60 percent and gold plans with actuarial values around 80 percent would change much less as a result of the policy, CBO and JCT anticipate, although some increases would occur during the next two years because of insurers' uncertainty about the policy's effects. The agencies expect that most state insurance commissioners would not allow insurers to significantly raise premiums for bronze and gold plans under the policy, especially after a year or two of experience, as those plans are not accompanied with cost-sharing reductions. Allowing premium increases for bronze and gold plans because of increases in costs for silver plans would distort prices in the market, because the increases would not correspond to changes in costs for those plans and would result in lower premium tax credits than if the increases were concentrated among silver plans.

However, for some bronze plans in the marketplaces, CBO and JCT project that gross premiums would modestly increase: those with an actuarial value that insurers would increase (within the allowable range) in an attempt to attract people who would have bought silver plans under the baseline but would not under the policy because of the large premium increases for them.

For gold plans in the marketplaces, the agencies project that gross premiums would be modestly lower under the policy because those plans would attract a larger share of healthier people who, under the baseline, would have bought silver plans. Under the baseline, gold plans tend to attract less healthy people who expect to have high health care expenditures, whereas silver plans attract healthier people as well.[4]

Effects on Net Premiums Paid by Enrollees

CBO and JCT anticipate that many people with income between 100 percent and 200 percent of the FPL purchasing insurance through the marketplaces would enroll in a silver plan with net premiums, after accounting for premium tax credits, that were similar under this policy and under the baseline. Some people in that income range would purchase bronze or gold plans for which the tax credits would cover the premiums entirely; however, in doing so, they would not be eligible for CSRs.

In general, CBO and JCT expect that most purchasers in the nongroup market with income between 200 percent and 400 percent of the FPL could pay net premiums equal to or less than those under the baseline for insurance with an actuarial value the same as (or even greater than) under the baseline. The main reason that purchasers could pay less or obtain a higher actuarial value is that the higher premiums for silver plans would boost the premium tax credit amounts.[5]

For purchasers in the nongroup market with income above 400 percent of the FPL, net and gross premiums would be the same because they are not eligible for premium tax credits. Under the policy, they could pay about the same premiums for bronze or silver plans (by purchasing outside the marketplaces) as under the baseline and lower premiums for gold plans (because of the health of enrollees in the plans), CBO and JCT project.

Effects for People With Income Between 100 Percent and 200 Percent of the FPL

To assess the potential effects of the policy change, CBO and JCT constructed a set of examples to illustrate average amounts for gross premiums, premium tax credits, and net premiums (after accounting for the tax credits) in 2026. The agencies project, for instance, that people with income at 125 percent of the FPL, regardless of age, would pay a net premium of $500 in 2026 to purchase a silver plan—the plan with the highest actuarial value for them—under the policy and $450 under the baseline (see Table 1, at the end of this document).[6] People

4. Federal risk-adjustment payments—which are made under the baseline and would be under the policy as well—aim to compensate insurers whose plans cover less healthy people, but the payments can address the risk only imperfectly. As a result, CBO and JCT anticipate that the greater share of healthy enrollees in gold plans under the policy would contribute to the modest reduction in premiums for those plans even though risk-adjustment payments would be made.

5. For related projections in California's market, see Wesley Yin and Richard Domurat, *Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding* (commissioned by Covered California, January 26, 2017), http://tinyurl.com/yb86m89v.

6. Those estimates of net premiums are determined by CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026, which differs under the policy and under the baseline. That projection takes into account the difference in the probability, as estimated under the policy and

with income at 175 percent of the FPL, the agencies estimate, would pay a net premium of $1,850 under the policy and $1,700 under the baseline for a silver plan. Although gross premiums would be higher because of the termination of CSR payments under the policy, net premiums would be determined as a percentage of people's income, and larger premium tax credits would make up most of the difference.

Under the policy, because of the larger premium tax credits (reflecting the higher costs of silver plans), some people in this income range would pay no net premiums for a plan with a higher actuarial value than one they could have purchased with no net premiums under the baseline. For example, under the policy, a 64-year-old with income at 125 percent of the FPL could purchase a gold plan and pay no net premiums but, under the baseline, could obtain only a bronze plan with no net premiums.

Effects for People With Income Between 200 Percent and 400 Percent of the FPL

Under the policy, CBO and JCT anticipate, people with income between 200 percent and 400 percent of the FPL would continue to have access to the same silver plans that they are projected to purchase under the baseline—with net premiums being similar in 2026. For those people, silver plans would have an actuarial value between bronze and gold plans. In the marketplaces, the gross premiums for silver plans would be higher than under the baseline, but premium tax credits for many people in that income range would be larger (see Table 2, at the end of this document). Outside the marketplaces, where such tax credits could not be used, CBO and JCT expect that silver plans would be offered with gross premiums about the same as those charged under the baseline because insurers would design slightly different products for sale there and could therefore price them differently than the plans sold in the marketplaces. Plans outside the marketplaces could be attractive to younger people whose premiums were not a large enough percentage of their income to qualify them for tax credits.

in CBO's March 2016 baseline, that the specified percentages of income would be increased. Such an increase would apply if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceeded 0.504 percent of gross domestic product in the preceding year. CBO projects that the probability of reaching that percentage would be greater under the policy than it is under the baseline.

However, CBO and JCT project that, under the policy, people with income between 200 percent and 400 percent of the FPL who are eligible for premium tax credits would mostly use those larger amounts to purchase bronze or gold plans rather than silver plans—eventually boosting enrollment in the marketplaces. Bronze plans would have a lower actuarial value and lower premiums than silver or gold plans, offering potential enrollees a trade-off. But gold plans would have a higher actuarial value than silver plans available to people in this income range and, for many of those people, lower net premiums—such that very few of them would choose a silver plan.

For instance, in the agencies' set of illustrative examples for 2026 under the policy, a 40-year-old with income at 225 percent of the FPL could pay a net premium of $1,150 for a bronze plan or $3,050 for a gold plan. (A silver plan would be available with a net premium of $3,350—more than the cost for a gold plan with a higher actuarial value.) Under the baseline, that person could pay $2,050 for a bronze plan, $3,050 for a silver plan, or $4,900 for a gold plan. Thus, under the policy, that person would have lower net premiums for a plan of equal or higher actuarial value.

Gold plans would attract a larger share of enrollees under the policy—mostly people with income between 200 percent and 400 percent of the FPL who would have purchased a silver plan under the baseline. In addition to the larger premium tax credits under the policy, lower gross premiums would eventually contribute to higher enrollment. Under the policy, gross premiums for gold plans would eventually be lower than those for silver plans because, the agencies expect, silver plans would almost exclusively insure people with income between 100 percent and 200 percent of the FPL and (with CSRs) provide actuarial values of 87 percent or 94 percent—significantly higher than the actuarial value of around 80 percent for gold plans. Gross premiums for gold plans under the policy would be modestly lower than under the baseline because, in CBO and JCT's estimation, enrollees would be healthier and therefore have lower health care expenditures.

Enrollees' ages would make a bigger difference in their net premiums for those at the higher end of this income range. A 21-year-old with income at 375 percent of the FPL, for instance, could pay the same net premium in 2026 for a bronze plan ($4,300) or a silver plan ($5,100)

under the policy (by purchasing outside the marketplace) as under the baseline, and $350 less for a gold plan.[7] A 64-year-old with that income would see more attractive options. Such a person could pay a net premium of $6,800 for a gold plan under the policy, compared with $6,750 for a silver plan under the baseline. For a bronze plan, that person could pay $2,300 under the policy, compared with $4,350 under the baseline. Older people's much larger premium tax credits under the policy explain the difference.

Effects for People With Income Above 400 Percent of the FPL

For people with income above 400 percent of the FPL, silver plans offered through the marketplaces would be less attractive than other plans. Because those people are not eligible for premium tax credits, however, the increase in their purchases of gold plans would be proportionately smaller than the increase for people with income between 200 percent and 400 percent of the FPL—and the increase in their purchases of plans outside the marketplaces, proportionately larger. In the agencies' set of illustrative examples, a 40-year-old with income at 450 percent of the FPL, for instance, could pay the same net premium in 2026 for a bronze plan or a silver plan under the policy (by purchasing outside the marketplace) as under the baseline, and $450 less for a gold plan.

Effects on the Federal Budget

CBO and JCT estimate that, on net, adopting this policy would increase the federal deficit by a total of $194 billion over the 2017–2026 period. That change would result from a $201 billion increase in outlays and a $7 billion increase in revenues (see Table 3, at the end of this document).

The total increase in the deficit that would result under the policy includes the following amounts:

- Costs of $247 billion from net increases in marketplace subsidies (an increase of $365 billion for premium tax credits offset by a reduction in CSR payments of $118 billion) stemming from increases in the average subsidy per person for people receiving the ACA's tax credits for premium assistance to purchase nongroup health insurance and in the number of people receiving those subsidies in most years and

- A net increase of $7 billion in federal outlays for Medicaid because of higher enrollment resulting from a reduction in the number of employers offering health insurance to their workers in most years.

Those increases in the deficit would be partially offset by:

- Savings of $47 billion, mostly associated with shifts in the mix of taxable and nontaxable compensation—resulting in more taxable income—from a net decrease in most years in the number of people estimated to enroll in employment-based health insurance coverage, and

- A net increase of $11 billion in revenues resulting from an increase in most years in the number of employers subject to penalties for not offering health insurance.

Effects on Health Insurance Coverage

According to CBO and JCT's estimates, the number of people uninsured under this policy would be about 1 million higher than under the baseline in 2018 but about 1 million lower in each year starting in 2020 (see Table 4, at the end of this document). In 2018, under the policy, the largest effect on coverage would derive from the drop in the number of insurers participating in the nongroup market.

By 2020, the effect on coverage would stem primarily from the increases in premium tax credits, which would make purchasing nongroup insurance more attractive for some people. As a result, a larger number of people would purchase insurance through the marketplaces, and a smaller number of people would purchase employment-based health insurance.

7. CBO and JCT expect that, under the policy, gross premiums for bronze and silver plans offered outside the marketplaces would be about the same as under the baseline and lower than those for plans offered through the marketplaces in most areas. For bronze plans, the agencies anticipate, some insurers would raise the actuarial value of plans offered through the marketplaces to 65 percent (the maximum currently allowed) to try to attract enrollees who might have purchased silver plans if the premiums were lower. Bronze plans offered outside the marketplaces with an actuarial value of 60 percent would have lower premiums. For silver plans, premiums would be lower for ones offered outside the marketplaces because plans offered through the marketplaces would have premiums covering the costs of people eligible for higher actuarial values (of 87 percent and 94 percent).

Uncertainty Surrounding the Estimates

CBO and JCT have endeavored to develop budgetary estimates that are in the middle of the distribution of potential outcomes. Such estimates are inherently imprecise because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by this policy are all difficult to predict.

Under this policy, the responses by states and insurers in the short term are particularly uncertain. For example, under the policy, total federal subsidies would be smaller and the number of uninsured people would be larger if more people lived in areas with no insurers in the marketplaces than the agencies project, and vice versa. Also, the increases in premium tax credits could be larger than CBO and JCT project if states allowed very large increases in premiums in 2018 to ensure that they had at least one insurer in an area. But the increases in tax credits could be smaller than projected if more people than the agencies expect lived in states requiring insurers to spread premium increases in 2018 across bronze, silver, and gold plans in the marketplaces as well as outside them, rather than focusing the increases on silver plans in the marketplaces.

Additional Issues Depending on How the Policy Was Implemented

CBO and JCT analyzed the effects of eliminating the Administration's authority to make CSR payments. For their analysis, the agencies assumed that hypothetical legislation with that end would be enacted by August 31, 2017, and that CSR payments would not be made after December 31, 2017. If the Administration, either of its own volition or in response to a court order, announced by August 31, 2017, that it would not make CSR payments after December 31, 2017, the agencies expect that the results would be similar to those discussed here. If the policy was implemented differently, various additional issues would arise.

Timing

If the announcement date and the effective date for the policy differed from what CBO and JCT used in this analysis, then the effects of the policy would differ. For example, if CSR payments were terminated after insurers had finalized or had begun charging premiums not incorporating such a change, insurers would suffer significant financial losses. To reduce those losses, some insurers would exit the marketplaces in the middle of the year. Some of those marketplaces would have no insurers remaining—reducing federal costs but increasing the number of people who were uninsured. Also, subsequent lawsuits might result in outlays by the federal government. If the effective date for terminating CSR payments was the beginning of 2019 instead of 2018, the effects in 2018 would be much smaller.

Certainty

Implementation of the policy through legislation, as opposed to executive or judicial action, would provide greater certainty about how the ACA would be carried out in the short term. Executive or judicial action could very well be challenged in lawsuits that would take some time to resolve—potentially extending the number of years insurers might not participate in the marketplaces.

CBO's Baseline

In CBO and JCT's initial cost estimate for the ACA and in subsequent baseline projections, the agencies have recorded the CSR payments as direct spending (that is, spending that does not require appropriation action)—a conclusion reached because the cost-sharing subsidies were viewed as a form of entitlement authority. The statute that specifies construction of the baseline requires that CBO assume full funding of entitlement authority.[8]

In 2014, the government began making payments for cost-sharing subsidies, and the House of Representatives subsequently brought a lawsuit challenging the department's authority to make such payments. On May 12, 2016, the District Court for the District of Columbia held that the government did not have the authority to make payments for cost-sharing subsidies but allowed it to continue making payments pending appeal. On February 22, 2017, at the request of the House of Representatives and the Administration, the U.S. Court of Appeals for the District of Columbia Circuit agreed to hold the appeal in abeyance while the Congress and the Administration seek a resolution, presumably through legislation. On August 1, 2017, that court allowed 17 states and the District of Columbia to intervene in the case, so future actions in the case will now involve those parties in addition to the House of Representatives and the Administration.

8. See section 257(b)(1) of the Balanced Budget and Emergency Deficit Control Act of 1985; 2 U.S.C. §907(b)(1).

CBO has not made any changes to its baseline projections in response to that court case because the case is on appeal and the Administration has continued to make the payments for cost-sharing subsidies. CBO typically updates its baseline budget projections at specific times each year to reflect legislative action, economic changes, and other developments. During the course of a year, however, events occur (usually, the enactment of legislation, actions by the courts, or decisions by executive branch agencies) that are different from those anticipated in developing the baseline projections. If new information indicates that an action or event that would affect CBO's baseline has happened or definitely will happen, CBO incorporates that information in its next regular update of its baseline. In addition, CBO immediately takes that information into account in assessing what will happen under current law when it analyzes the effects of legislation being considered by the Congress, even if the agency has not published new baseline projections.

If the Administration stopped making CSR payments because of executive or judicial action, CBO's typical procedures for updating its baseline would not necessarily apply because of the conflict between that action and the statutory requirements for constructing the baseline. Specifically, because the CSR payments are considered an entitlement, projections incorporating that action would differ from ones reflecting the statutory requirement that CBO assume full funding of entitlement authority. Hence, CBO would consult with the Budget Committees to decide whether and how to reflect the action in the agency's baseline and cost estimates. If the policy was implemented through legislation, no such conflict would arise, and its effects would be reflected in the baseline and cost estimates immediately.

Methodology

This policy's effects would depend in part on how individuals responded to changes in the prices, after subsidies, they had to pay for nongroup insurance and on their underlying desire for such insurance. Effects would also stem from how businesses responded to changes in those prices for nongroup insurance and in the attractiveness of other aspects of nongroup alternatives to employment-based insurance.

To capture those complex interactions, CBO uses a microsimulation model to estimate how rates of coverage and sources of insurance would change as a result of alterations in eligibility and subsidies for—and thus the net cost of—various insurance options. Based on survey data, that model incorporates a wide range of information about a representative sample of individuals and families, including their income, employment, health status, and health insurance coverage. The model also incorporates information from the research literature about the responsiveness of individuals and employers to price changes and the responsiveness of individuals to changes in eligibility for public coverage. CBO regularly updates the model so that it incorporates information from the most recent administrative data on insurance coverage and premiums. CBO and JCT use that model—in combination with models to project tax revenues, models of spending and actions by states, projections of trends in early retirees' health insurance coverage, and other available information—to inform their estimates of the numbers of people with certain types of coverage and the associated federal budgetary costs.[9]

This document was requested by the House Democratic Leader and the House Democratic Whip. Kate Fritzsche, Jeffrey Kling, Sarah Masi, Eamon Molloy, and Allison Percy prepared it with guidance from Jessica Banthin and Holly Harvey and with contributions from Ezra Porter, Lisa Ramirez-Branum, Robert Stewart, and the staff of the Joint Committee on Taxation. Chad Chirico, Theresa Gullo, Mark Hadley, Alexandra Minicozzi, Robert Sunshine, and David Weaver reviewed the document; John Skeen edited it; and Casey Labrack prepared it for publication.

An electronic version is available on CBO's website (www.cbo.gov/publication/53009).

Keith Hall
Director
August 2017

9. For additional information, see Congressional Budget Office, "Methods for Analyzing Health Insurance Coverage" (accessed August 14, 2017), www.cbo.gov/topics/health-care/methods-analyzing-health-insurance-coverage.

Table 1. Illustrative Examples, for Single Individuals With Income Under 200 Percent of the FPL, of Subsidies for Nongroup Health Insurance in 2026 Under CBO's Baseline and Under a Policy Eliminating CSR Payments

Dollars

	Bronze Plan				Gold Plan				Silver Plan			
	Premium[a]	- Premium Tax Credit[b]	= Net Premium Paid	Actuarial Value of Plan (Percent)[c]	Premium[a]	- Premium Tax Credit[b]	= Net Premium Paid	Actuarial Value of Plan (Percent)[c]	Premium[a]	- Premium Tax Credit[b]	= Net Premium Paid	Actuarial Value of Plan After Cost-Sharing Subsidies (Percent)[c]
Single Individual With Annual Income of $18,900 (125 percent of FPL) and Not Eligible for Medicaid[d]												
Under the Baseline												
21 years old	4,300	4,300	0		*6,550*	*4,650*	*1,900*		5,100	4,650	450	
40 years old	5,500	5,500	0	60	*8,350*	*6,050*	*2,300*	80	6,500	6,050	450	94
64 years old	12,900	12,900	0		*19,650*	*14,850*	*4,800*		15,300	14,850	450	
Under the Policy, in the Marketplaces												
21 years old	4,700	4,700	0		6,200	5,900	300		6,400	5,900	500	
40 years old	6,000	6,000	0	65	7,900	7,700	200	80	8,200	7,700	500	94
64 years old	*14,100*	*14,100*	*0*		18,600	18,600	0		19,200	18,700	500	
Single Individual With Annual Income of $26,500 (175 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	3,400	900		*6,550*	*3,400*	*3,150*		5,100	3,400	1,700	
40 years old	5,500	4,800	700	60	*8,350*	*4,800*	*3,550*	80	6,500	4,800	1,700	87
64 years old	12,900	12,900	0		*19,650*	*13,600*	*6,050*		15,300	13,600	1,700	
Under the Policy, in the Marketplaces												
21 years old	4,700	4,550	150		6,200	4,550	1,650		6,400	4,550	1,850	
40 years old	6,000	6,000	0	65	7,900	6,350	1,550	80	8,200	6,350	1,850	87
64 years old	14,100	14,100	0		18,600	17,350	1,250		19,200	17,350	1,850	

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

All dollar figures have been rounded to the nearest $50. Amounts in light italic type show premiums for plans that very few people would buy because either more comprehensive coverage would be available at the same or a lower cost or equivalent coverage would be available at a lower cost.

CSR = cost-sharing reduction; FPL = federal poverty level.

a. For this illustration, CBO projected the average national premiums for a 21-year-old in the nongroup health insurance market in 2026 both under the baseline and under a policy in which CSR payments to insurers are eliminated. On the basis of those amounts, CBO calculated premiums for a 40-year-old and a 64-year-old, assuming that the person lives in a state that uses the federal default age-rating methodology, under which 64-year-olds can be charged premiums that are three times as much as those for 21-year-olds. CBO projects that, under both the baseline and the policy, most states will use the default 3-to-1 age-rating curve.

b. Premium tax credits are calculated as the difference between the reference premium and a specified percentage of income for a person with income at a given percentage of the FPL. That specified percentage grows over time. The reference premium under current law is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which the person resides. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 takes into account the difference in the probability, as estimated in CBO's March 2016 baseline and under the policy eliminating CSR payments, that the specified percentages of income would be increased. Such an increase would apply if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceeded 0.504 percent of gross domestic product in the preceding year. CBO projects that the probability of reaching that percentage would be higher under the policy than it is under the baseline.

c. The actuarial value of a plan is the percentage of costs for covered services that the plan pays on average. The federal government's CSR payments to insurers reduce the cost-sharing amounts (out-of-pocket payments required under insurance policies) for covered people whose income is generally between 100 percent and 250 percent of the FPL. The subsidy amounts in this example would range from $1,600 for a 21-year-old with income at 125 percent of the FPL to $4,750 for a 64-year-old at the same income level and from $1,100 for a 21-year-old with income at 175 percent of the FPL to $3,350 for a 64-year-old at the same income level. Under current law, CSRs generally have the effect of increasing the actuarial value of the plan from 70 percent for a typical silver plan to 94 percent for people whose income is at least 100 percent of the FPL and not more than 150 percent; to 87 percent for people with income greater than 150 percent of the FPL and not more than 200 percent; and to 73 percent for people with income greater than 200 percent of the FPL and not more than 250 percent. For people whose income is greater than 250 percent of the FPL, a silver plan would have a standard 70 percent actuarial value.

If CSR payments were eliminated, insurers would still have to provide plans with reduced cost-sharing to qualified individuals at the specified income levels. CBO projects that state insurance commissioners would most likely direct insurers to incorporate the amounts into the premiums only for silver plans because doing so would best take advantage of increases in premium tax credits. CBO anticipates that in most states, bronze plans available in the marketplaces would have an actuarial value of 65 percent, and gold plans, 80 percent. Silver plans would have an actuarial value of 70 percent for those not eligible for CSRs and 73 percent, 87 percent, or 94 percent for those eligible. Outside the marketplaces, plans would be available at actuarial values of 60 percent, 70 percent, and 80 percent, CBO anticipates.

The premiums for plans reflect not only the difference in the percentage of costs paid but also the effects of induced demand, as people in plans with a higher actuarial value tend to consume more health services, and risk selection, as people with higher expected health care costs are more likely to buy plans with higher actuarial values. A risk-adjustment program under the Affordable Care Act mitigates but does not fully eliminate the effect of risk selection.

d. Income levels reflect modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers. CBO projects that in 2026, a modified adjusted gross income of $18,900 will equal 125 percent of the FPL and an income of $26,500 will equal 175 percent of the FPL.

Table 2. Illustrative Examples, for Single Individuals With Income Over 200 Percent of the FPL, of Subsidies for Nongroup Health Insurance in 2026 Under CBO's Baseline and Under a Policy Eliminating CSR Payments

Dollars

	Bronze Plan				Silver Plan				Gold Plan			
	Premium[a]	- Premium Tax Credit[b]	= Net Premium Paid	Actuarial Value of Plan (Percent)[c]	Premium[a]	- Premium Tax Credit[b]	= Net Premium Paid	Actuarial Value of Plan After Cost-Sharing Subsidies (Percent)[c]	Premium[a]	- Premium Tax Credit[b]	= Net Premium Paid	Actuarial Value of Plan (Percent)[c]
Single Individual With Annual Income of $34,100 (225 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	2,050	2,250		5,100	2,050	3,050		6,550	2,050	4,500	
40 years old	5,500	3,450	2,050	60	6,500	3,450	3,050	73	8,350	3,450	4,900	80
64 years old	12,900	12,250	650		15,300	12,250	3,050		19,650	12,250	7,400	
Under the Policy, In the Marketplaces												
21 years old	4,700	3,050	1,650		*6,400*	*3,050*	*3,350*		6,200	3,050	3,150	
40 years old	6,000	4,850	1,150	65	*8,200*	*4,850*	*3,350*	73	7,900	4,850	3,050	80
64 years old	14,100	14,100	0		*19,200*	*15,850*	*3,350*		18,600	15,850	2,750	
Under the Policy, Outside the Marketplaces												
21 years old	*4,300*	*0*	*4,300*		*5,100*	*0*	*5,100*		*6,200*	*0*	*6,200*	
40 years old	*5,500*	*0*	*5,500*	60	*6,500*	*0*	*6,500*	73	*7,900*	*0*	*7,900*	80
64 years old	*12,900*	*0*	*12,900*		*15,300*	*0*	*15,300*		*18,600*	*0*	*18,600*	
Single Individual With Annual Income of $56,800 (375 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	0	4,300		5,100	0	5,100		6,550	0	6,550	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	8,350	0	8,350	80
64 years old	12,900	8,550	4,350		15,300	8,550	6,750		19,650	8,550	11,100	
Under the Policy, In the Marketplaces												
21 years old	4,700	0	4,700		*6,400*	*0*	*6,400*		6,200	0	6,200	
40 years old	6,000	800	5,200	65	*8,200*	*800*	*7,400*	70	7,900	800	7,100	80
64 years old	14,100	11,800	2,300		*19,200*	*11,800*	*7,400*		18,600	11,800	6,800	
Under the Policy, Outside the Marketplaces												
21 years old	4,300	0	4,300		5,100	0	5,100		6,200	0	6,200	
40 years old	*5,500*	*0*	*5,500*	60	6,500	0	6,500	70	*7,900*	*0*	*7,900*	80
64 years old	*12,900*	*0*	*12,900*		*15,300*	*0*	*15,300*		*18,600*	*0*	*18,600*	
Single Individual With Annual Income of $68,200 (450 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	0	4,300		5,100	0	5,100		6,550	0	6,550	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	8,350	0	8,350	80
64 years old	12,900	0	12,900		15,300	0	15,300		19,650	0	19,650	
Under the Policy, In the Marketplaces												
21 years old	4,700	0	4,700		*6,400*	*0*	*6,400*		6,200	0	6,200	
40 years old	6,000	0	6,000	65	*8,200*	*0*	*8,200*	70	7,900	0	7,900	80
64 years old	14,100	0	14,100		*19,200*	*0*	*19,200*		18,600	0	18,600	
Under the Policy, Outside the Marketplaces												
21 years old	4,300	0	4,300		5,100	0	5,100		6,200	0	6,200	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	7,900	0	7,900	80
64 years old	12,900	0	12,900		15,300	0	15,300		18,600	0	18,600	

Continued

Table 2 continued.

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

All dollar figures have been rounded to the nearest $50. Amounts in light italic type show premiums for plans that very few people would buy because either more comprehensive coverage would be available at the same or a lower cost or equivalent coverage would be available at a lower cost.

CSR = cost-sharing reduction; FPL = federal poverty level.

a. For this illustration, CBO projected the average national premiums for a 21-year-old in the nongroup health insurance market in 2026 both under the baseline and under a policy in which CSR payments to insurers are eliminated. On the basis of those amounts, CBO calculated premiums for a 40-year-old and a 64-year-old, assuming that the person lives in a state that uses the federal default age-rating methodology, under which 64-year-olds can be charged premiums that are three times as much as those for 21-year-olds. CBO projects that, under both the baseline and the policy, most states will use the default 3-to-1 age-rating curve.

b. Premium tax credits are calculated as the difference between the reference premium and a specified percentage of income for a person with income at a given percentage of the FPL. That specified percentage grows over time. The reference premium under current law is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which the person resides. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 takes into account the difference in the probability, as estimated in CBO's March 2016 baseline and under the policy eliminating CSR payments, that the specified percentages of income would be increased. Such an increase would apply if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceeded 0.504 percent of gross domestic product in the preceding year. CBO projects that the probability of reaching that percentage would be higher under the policy than it is under the baseline.

c. The actuarial value of a plan is the percentage of costs for covered services that the plan pays on average. The federal government's CSR payments to insurers reduce the cost-sharing amounts (out-of-pocket payments required under insurance policies) for covered people whose income is generally between 100 percent and 250 percent of the FPL. The subsidy amounts in this example would range from $150 for a 21-year-old with income at 225 percent of the FPL to $450 for a 64-year-old at the same income level. Under current law, CSRs generally have the effect of increasing the actuarial value of the plan from 70 percent for a typical silver plan to 94 percent for people whose income is at least 100 percent of the FPL and not more than 150 percent; to 87 percent for people with income greater than 150 percent of the FPL and not more than 200 percent; and to 73 percent for people with income greater than 200 percent of the FPL and not more than 250 percent. For people whose income is greater than 250 percent of the FPL, a silver plan would have a standard 70 percent actuarial value.

If CSR payments were eliminated, insurers would still have to provide plans with reduced cost-sharing to qualified individuals at the specified income levels. CBO projects that state insurance commissioners would most likely direct insurers to incorporate the amounts into the premiums only for silver plans because doing so would best take advantage of increases in premium tax credits. CBO anticipates that in most states, bronze plans available in the marketplaces would have an actuarial value of 65 percent, and gold plans, 80 percent. Silver plans would have an actuarial value of 70 percent for those not eligible for CSRs and 73 percent, 87 percent, or 94 percent for those eligible. Outside the marketplaces, plans would be available at actuarial values of 60 percent, 70 percent, and 80 percent, CBO anticipates.

The premiums for plans reflect not only the difference in the percentage of costs paid but also the effects of induced demand, as people in plans with a higher actuarial value tend to consume more health services, and risk selection, as people with higher expected health care costs are more likely to buy plans with higher actuarial values. A risk-adjustment program under the Affordable Care Act mitigates but does not fully eliminate the effect of risk selection.

Because plans and premiums available in and outside the marketplaces would differ more under the policy than they do under current law, individuals would have a greater incentive to compare options in both markets.

d. Income levels reflect modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers. CBO projects that in 2026, a modified adjusted gross income of $34,100 would equal 225 percent of the FPL, an income of $56,800 will equal 375 percent of the FPL, and an income of $68,200 will equal 450 percent of the FPL.

Table 3. Estimate of the Net Budgetary Effects of Terminating Payments for Cost-Sharing Reductions

Billions of Dollars, by Fiscal Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2026
Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	0	6	13	22	28	32	35	36	37	37	247
Medicaid	0	-1	-1	*	1	1	1	2	2	2	7
Change in Small-Employer Tax Credits[b,c]	0	*	*	*	*	*	*	*	*	*	*
Change in Penalty Payments by Employers[c]	0	0	*	*	-1	-1	-2	-2	-2	-3	-11
Change in Penalty Payments by Uninsured People	0	0	*	*	*	*	*	*	*	*	*
Medicare[d]	0	0	*	*	*	*	*	*	*	*	-2
Other Effects on Revenues and Outlays[e]	0	1	1	-1	-4	-7	-8	-9	-10	-10	-47
Total Effect on the Deficit	**0**	**6**	**14**	**21**	**24**	**25**	**26**	**26**	**26**	**26**	**194**
Memorandum:											
Total Changes in Direct Spending	0	4	9	17	23	26	30	31	31	31	201
Total Changes in Revenues[f]	0	-3	-5	-4	-1	2	3	5	5	5	7
Details of Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues											
Premium tax credits											
Effects on outlays	0	13	22	29	35	38	41	43	44	44	309
Effects on revenues	0	2	4	5	6	7	8	8	8	8	56
Subtotal	0	15	25	35	41	45	49	51	52	52	365
Cost-sharing outlays	0	-8	-12	-13	-13	-13	-14	-14	-15	-16	-118
Outlays for the Basic Health Program	0	*	*	*	*	*	*	*	*	*	*
Collections for risk adjustment	0	0	-1	-1	-1	-1	-1	-1	-1	-1	-6
Payments for risk adjustment	0	0	1	1	1	1	1	1	1	1	6
Total	0	6	13	22	28	32	35	36	37	37	247

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

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. Budget authority would be equal to the outlays shown.

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

Numbers may not add up to totals because of rounding.

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

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

b. Includes effects on both outlays and revenues.

c. Effects on the deficit include the associated effects that changes in taxable compensation would have on revenues.

d. Effects arise mostly from changes in payments to hospitals that treat a disproportionate share of uninsured or low-income patients.

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

f. Positive numbers indicate an increase in revenues; negative numbers indicate a decrease in revenues.

Table 4. Effects of Terminating Payments for Cost-Sharing Reductions on Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Population Under Age 65	273	274	275	276	276	277	278	279	279	280
Uninsured Under Current Law	26	26	27	27	27	27	27	28	28	28
Change in Coverage Under the Policy										
Medicaid[a]	0	*	*	*	*	*	*	*	*	*
Nongroup coverage, including marketplaces	0	-1	*	2	3	3	4	4	3	3
Employment-based coverage	0	1	*	-1	-2	-3	-3	-3	-3	-3
Other coverage[b]	0	*	*	*	*	*	*	*	*	*
Uninsured	0	1	*	-1	-1	-1	-1	-1	-1	-1
Uninsured Under the Policy	26	27	27	27	26	27	27	27	27	27
Percentage of the Population Under Age 65 With Insurance Under the Policy										
Including all U.S. residents	90	90	90	90	90	90	90	90	90	90
Excluding unauthorized immigrants	93	92	93	93	93	93	93	93	93	93

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

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

For these estimates, CBO and the staff of the Joint Committee on Taxation consider individuals to be uninsured if they would not be enrolled in a policy that provides financial protection from major medical risks.

Numbers may not add up to totals because of rounding.

* = between -500,000 and 500,000.

a. Includes noninstitutionalized enrollees with full Medicaid benefits.

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