



CBO's Record of Projecting Subsidies for Health Insurance Under the Affordable Care Act: 2014 to 2016

When it was enacted in March 2010, the Affordable Care Act (ACA) made major changes to the U.S. health care and health insurance systems. At that time, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimated the budgetary effects of the legislation to provide that information to the Congress and to update overall projections of the budget.

CBO and JCT originally estimated that the gross costs of the ACA would be more than offset by reductions in Medicare spending, increases in revenues, and other changes—such that enacting the legislation would reduce the federal budget deficit over the 2010–2019 period. This document compares projections and subsequent outcomes for health care subsidies that account for the majority of such costs and concludes the following:

- The agencies' estimates of those subsidies proved to be close to actual amounts for 2014 and 2015 but were much too high for 2016, and
- In general, other organizations' estimates of health care subsidies produced around the time of the ACA's enactment were much too high for all three years.

The report does not examine the effects of other provisions of the ACA; for many of them, the actual outcomes cannot be separately identified in administrative or survey data, nor can the law's overall effects on the deficit.

What Aspects of Their Estimates Did CBO and JCT Analyze for This Report?

The ACA significantly expanded eligibility for Medicaid; created health insurance marketplaces through which certain individuals and families receive federal subsidies;

established a mandate for most legal residents of the United States to obtain health insurance or pay a penalty if they are not exempt; reduced the growth of Medicare's payment rates for most services; imposed an excise tax on insurance plans with relatively high premiums; made changes to the federal tax code—including an increase in the Hospital Insurance payroll tax rate for high-income taxpayers, a surtax on those taxpayers' net investment income, and annual fees imposed on health insurers; and made various other changes to Medicare, Medicaid, and other programs. Isolating the budgetary effects of the ACA (or of any complex legislation) is difficult because they are often embedded in the spending for existing programs—Medicare, for example—and in broad categories of federal tax revenues.

This report focuses mainly on CBO and JCT's estimates of subsidies for which total amounts can be separately identified in administrative or survey data—specifically, federal spending for people made newly eligible for Medicaid by the ACA and subsidies for health insurance received through the marketplaces and the Basic Health Program. (The Basic Health Program allows states to offer subsidies to certain low-income people that are based on the subsidies available through the marketplaces.)

To examine the factors that caused CBO and JCT's estimates of those identifiable subsidies to differ from actual amounts during the 2014–2016 period, this document compares projections and subsequent outcomes for the following groups of people:

- Those made newly eligible for Medicaid under the ACA,

- Those receiving subsidies through the marketplaces or the Basic Health Program,
- Those enrolled in nongroup insurance coverage purchased through the marketplaces or with coverage obtained through the Basic Health Program, and
- Those without coverage.

Because a decision by the Supreme Court in 2012 significantly affected eligibility for subsidies for health insurance by making the expansion of Medicaid optional for states, this document compares actual results with two sets of projections: those that CBO and JCT made in May 2013 (after the Supreme Court decision but before the coverage expansions under the ACA were implemented in 2014) and the original projections the agencies made in March 2010.¹

How Did CBO and JCT's Estimates Compare With Actual Results?

In CBO and JCT's March 2010 and May 2013 projections, the agencies' estimates of federal spending for people made newly eligible for Medicaid by the ACA and of subsidies for health insurance received through the marketplaces and the Basic Health Program were close to the actual amounts for 2014 and 2015 but much too high for 2016. In total, for 2014 and 2015 combined, the estimate of those identifiable subsidies that CBO and JCT prepared in March 2010 was 14 percent above the actual amount. The May 2013 estimate of that total was 14 percent below the actual amount. But for 2016, the March 2010 and May 2013 estimates were above the actual amount by 43 percent and 29 percent, respectively.

To a great extent, the differences arose because actual results deviated from the agencies' expectations about

1. Other CBO reports comparing projections with actual results include these: Congressional Budget Office, *An Evaluation of CBO's Past Outlay Projections* (November 2017), www.cbo.gov/publication/53328, *CBO's Economic Forecasting Record: 2017 Update* (October 2017), www.cbo.gov/publication/53090, and *CBO's Revenue Forecasting Record* (November 2015), www.cbo.gov/publication/50831. Those evaluations are offered as background information to assist Members of Congress in their use of the agency's current estimates. Such reports supplement the agency's standard practice, during every update of its projections for the economy or budget as a whole, of comparing past projections with the actual results in order to improve its estimating.

how the economy would change and how people and employers would respond to the law. To a lesser extent, the differences were caused by judicial decisions, statutory changes, and administrative actions that followed the ACA's enactment. (For additional information, see "Notes" at the end of this document.)

How Did CBO and JCT's Estimates Compare With Those of Other Organizations?

Compared with estimates produced in 2010 by other organizations—namely, the Office of the Actuary in the Centers for Medicare & Medicaid Services (CMS), RAND Corporation, and The Lewin Group—CBO and JCT's March 2010 estimate for 2014 and 2015 combined was much closer to what actually happened. And CBO and JCT's March 2010 estimate for 2016 was about the same as the average of estimates by the other organizations, though both amounts were substantially too high.

Those other organizations produced estimates in 2010 of a broader category of subsidies than those that can be separately identified in administrative data. Specifically, the broader category combines two types of subsidies:

- Identifiable subsidies for federal spending for people made newly eligible for Medicaid by the ACA and subsidies for health insurance received through the marketplaces and the Basic Health Program and
- Other changes in spending for Medicaid and the Children's Health Insurance Program (CHIP) that stemmed from the ACA's health insurance coverage provisions but that cannot be separately identified in administrative data.

Because the actual outcomes for those other changes cannot be identified, in this report, the estimates by other organizations (and corresponding ones by CBO and JCT) are compared with an estimated outcome for the broader category that combines actual amounts for the identifiable subsidies (90 percent of the outcome for 2016, for example) with estimates, from CBO's March 2016 projections, of other spending on health insurance coverage provided through Medicaid and CHIP that was probably attributable to the ACA (10 percent of the outcome for 2016).

Those other changes in spending on coverage provided through Medicaid and CHIP stem primarily from higher

enrollment among people eligible for those programs under rules in effect before enactment of the ACA but who were prompted to enroll by that legislation. The actual amounts of spending for those enrollees are not identifiable in administrative data because distinguishing which previously eligible enrollees were induced to enroll by the ACA and which would have enrolled in the absence of the law is impossible. So, for this analysis, CBO estimated the outcomes for those enrollees in Medicaid and CHIP using updated data and methods.

How Do CBO and JCT Analyze Subsidies for Health Insurance?

CBO and JCT used a multistep process to produce their original estimates of the effects of the ACA on health insurance coverage and federal costs. As with all major legislative proposals affecting health insurance coverage, analysts read the proposal to understand and identify its aims, consulted with outside experts, reviewed the empirical evidence from existing studies, analyzed states' relevant behavior, and used several models to capture the complex interactions in the markets for health care and health insurance. The agencies have followed a similar process to produce subsequent baseline projections of the budget under current law, incorporating new data and methodological improvements each time.

CBO and JCT use a microsimulation model to estimate how the number of people with coverage and sources of insurance would be affected by changes in eligibility and subsidies for—and thus the net cost of—various insurance options. On the basis of administrative and 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

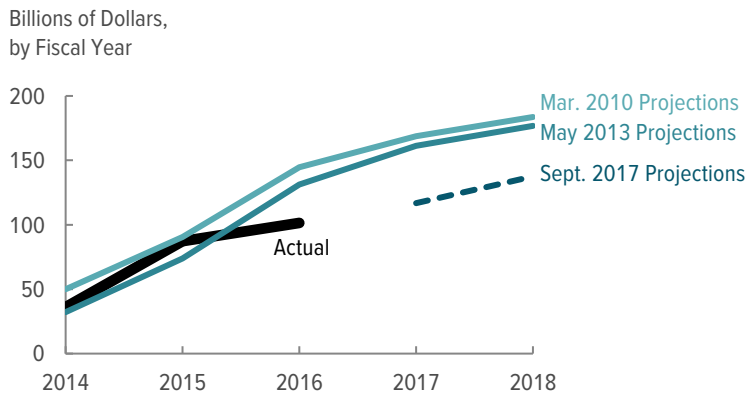
individuals to changes in eligibility for public coverage. The role of employers is particularly important because more than half of the U.S. population under age 65 has employment-based health insurance coverage and because offers of health insurance from employers affect eligibility for subsidized insurance in the nongroup market.

CBO and JCT regularly update that model so that it incorporates information from the most recent administrative and survey data on insurance coverage and premiums as well as information from CBO's most recent macroeconomic forecast. In addition, they update it to incorporate the effects of relevant judicial decisions, statutory changes, and administrative actions. The agencies use the 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 number of people with various types of coverage and the associated federal budgetary costs. For example, in their March 2010 estimates, CBO and JCT projected that 92 percent of people under 65 would have some type of health insurance in 2016; in their May 2013 estimates, the agencies projected 89 percent. According to the National Health Interview Survey, 90 percent of the population had health insurance in that year. (By comparison, three years earlier, in 2013, 83 percent had health insurance.)

CBO and JCT always aim to provide estimates in the middle of the distribution of potential outcomes, and they actively seek to apply the lessons of experience. Such estimates are inherently imprecise, however, because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other parties respond to policies affecting health care are all difficult to predict.

Figure 1.

Federal Subsidies for People Made Eligible for Medicaid by the ACA and for Coverage Received Through the Marketplaces or the Basic Health Program



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

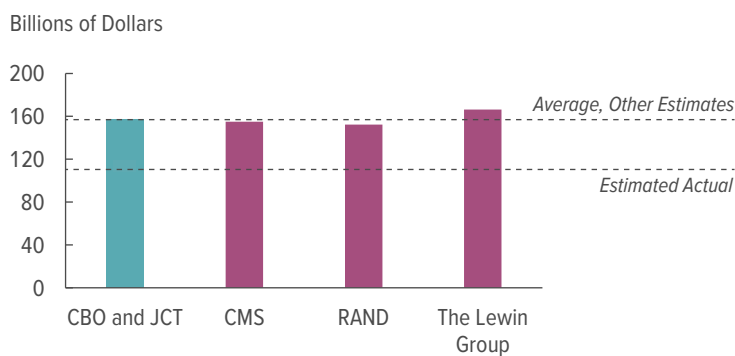
ACA = Affordable Care Act.

CBO and JCT’s March 2010 and May 2013 estimates of Medicaid expenditures for people made newly eligible for the program by the ACA plus subsidies for health insurance received through the marketplaces and the Basic Health Program were close to the actual amounts in 2014 and 2015 but well above the actual amounts in 2016.

In May 2013, for example, CBO and JCT projected that those subsidies would total \$106 billion for 2014 and 2015 combined; that estimate turned out to be \$17 billion below the actual total for those years. However, the agencies’ May 2013 estimate of those subsidies for 2016—\$131 billion—turned out to be \$30 billion too high. The projection error for 2016 resulted primarily from estimates of marketplace subsidies that were too high mostly because estimates of enrollment in insurance purchased through the marketplaces were too high.

Figure 2.

Comparison of Organizations’ 2010 Estimates of the Net Change in Certain Federal Subsidies for Health Insurance Coverage in 2016



Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation, using data from CMS, RAND Corporation, and The Lewin Group.

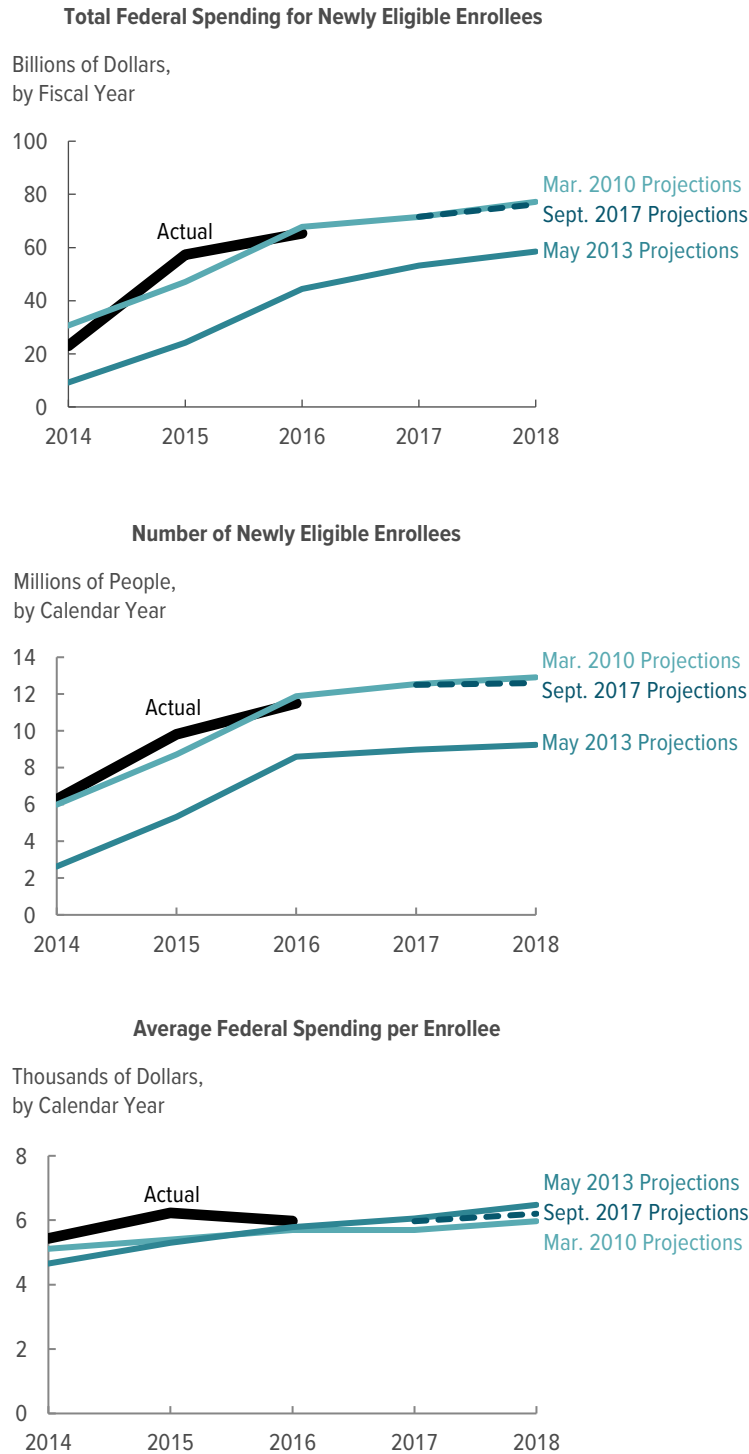
The estimates apply to coverage received through the marketplaces established by the ACA and the Basic Health Program and to effects on Medicaid and the Children’s Health Insurance Program.

ACA = Affordable Care Act; CMS = Centers for Medicare & Medicaid Services; JCT = Joint Committee on Taxation.

Other organizations’ estimates published in 2010 included projections for a broader category of subsidies that combined estimates of identifiable subsidies—Medicaid expenditures for people made newly eligible for the program by the ACA plus subsidies for health insurance received through the marketplaces and the Basic Health Program—with estimates of other changes in spending for Medicaid and CHIP that stemmed from the ACA’s health insurance coverage provisions and that cannot be separately identified in administrative data. (Those other changes are mainly attributable to higher enrollment among people eligible for Medicaid and CHIP under rules in effect before enactment of the ACA.)

CBO and JCT’s estimate for that broader category of spending in 2016 was about the same as the average of the estimates from those other organizations. Like CBO and JCT, the other organizations all projected amounts for marketplace subsidies (and enrollment through the marketplaces) that turned out to be too high.

Figure 3.
Projections and Actual Amounts for People Made Newly Eligible for Medicaid Under the ACA



Source: Congressional Budget Office.

ACA = Affordable Care Act.

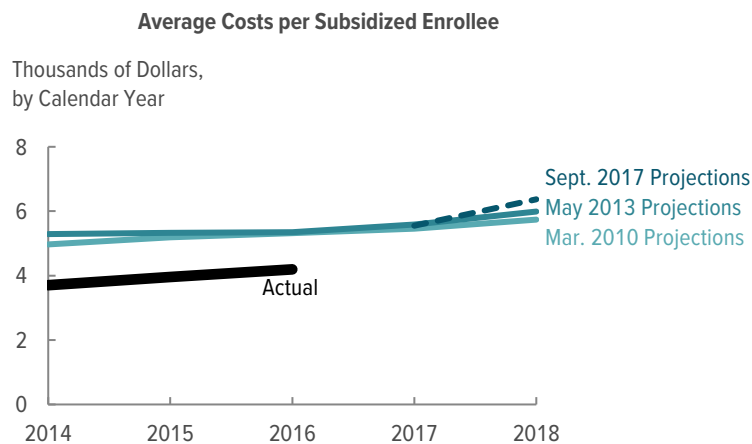
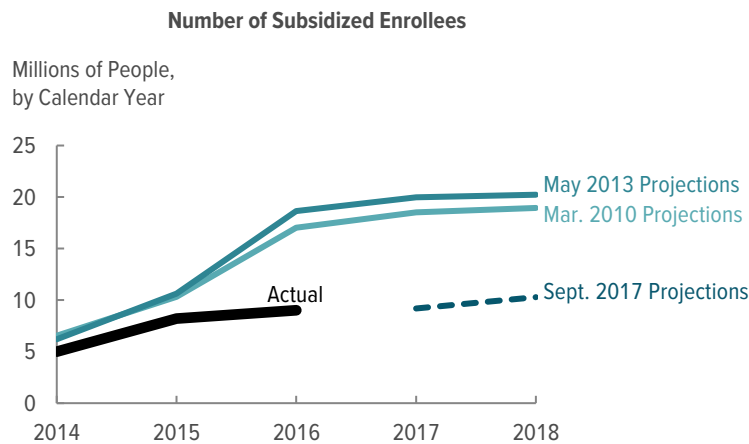
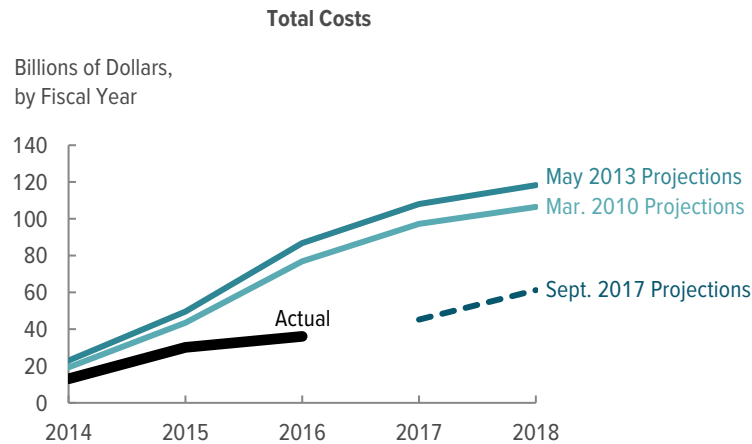
In May 2013, CBO projected that federal spending on people made newly eligible for Medicaid under the ACA would be \$9 billion in 2014, \$24 billion in 2015, and \$44 billion in 2016. Those estimates incorporated the effects of the Supreme Court ruling that essentially made the expansion of Medicaid optional for states. In actuality, the figures turned out to be much higher—\$23 billion, \$57 billion, and \$65 billion, respectively. In March 2010, the agency had projected that such spending would be \$31 billion in 2014, \$47 billion in 2015, and \$68 billion in 2016. However, those earlier estimates reflected an assumption that the ACA’s expansion of Medicaid would apply in all states.

In its May 2013 projection, CBO underestimated such spending mainly because it underpredicted the number of people who would enroll in Medicaid. Fewer states expanded eligibility for Medicaid under the ACA than CBO anticipated, but many more people enrolled in Medicaid in expansion states than CBO expected.

CBO also slightly underestimated average federal spending per new enrollee—by about one-tenth, on average, over the 2014–2016 period.

Figure 4.

Projections and Actual Amounts for People Receiving Subsidies Through the Marketplaces and the Basic Health Program



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

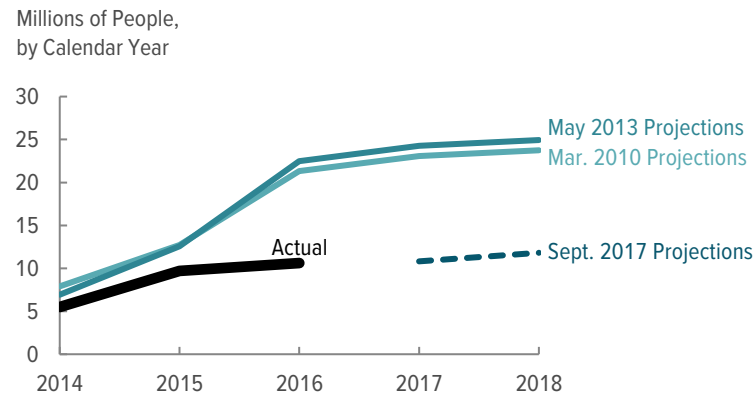
In May 2013, CBO and JCT projected that the cost to the federal government of premium tax credits and cost-sharing subsidies for health insurance purchased through the marketplaces as well as subsidies for the Basic Health Program would be \$23 billion in 2014, \$50 billion in 2015, and \$87 billion in 2016. The agencies overestimated costs in 2014 and 2015 by \$10 billion and \$19 billion, respectively. CBO and JCT’s projection for 2016 proved to be more than twice as large as the actual amount, about \$36 billion.

CBO and JCT overestimated costs to the federal government in part because the agencies overestimated the number of people who would enroll through the marketplaces and receive subsidies, particularly in 2016. In all of their projections through 2016, CBO and JCT foresaw a substantial increase in average subsidized enrollment from 2015 to 2016, as more people were expected to gain experience with the marketplaces, as the penalties for not having insurance coverage were scheduled to increase, and as more employers were expected to respond to the availability of subsidies by declining to offer insurance to their employees. In May 2013, CBO and JCT projected that average monthly subsidized enrollment in the marketplaces and the Basic Health Program would grow from 11 million people in 2015 to 19 million people in 2016. However, the estimated average number of subsidized enrollees increased only modestly—from 8 million people in 2015 to 9 million people in 2016. (That estimate reflects actual data from certain dates during the year. For additional information, see “About the Data” at the end of this document.)

CBO and JCT also overpredicted total costs for subsidized enrollees because the agencies estimated average costs per subsidized enrollee that were too high—by about one-third, on average, over the 2014–2016 period. However, on the basis of data on increases in premiums, CBO and JCT expect that the average costs per subsidized enrollee for 2017 will turn out to be similar to the amounts estimated in March 2010 and May 2013.

Figure 5.

Projections and Actual Numbers of People With Nongroup Insurance Coverage Purchased Through the Marketplaces and the Basic Health Program



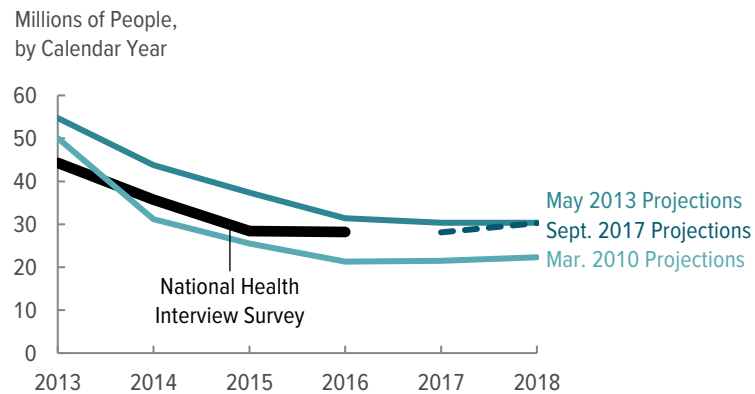
Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

In May 2013, CBO and JCT projected that the number of people who would purchase subsidized or unsubsidized nongroup coverage through the marketplaces or obtain coverage through the Basic Health Program would be 7 million in 2014, 13 million in 2015, and 22 million in 2016. (The projections were similar in March 2010.) CBO and JCT overestimated enrollment through the marketplaces and Basic Health Program by 1 million in 2014 and by 3 million in 2015. But for 2016, the agencies' estimate was twice as large as the actual number of people who enrolled, about 11 million.

Roughly four-fifths of the projection error for 2016 stems from the agencies' overestimate of subsidized enrollment, as described previously. The remaining one-fifth stems from an overestimate of the number of people who would enroll through the marketplaces without subsidies. In May 2013, CBO and JCT estimated that the total number of people purchasing unsubsidized coverage in the nongroup market (either through the marketplaces or not) would remain roughly unchanged between 2014 and 2016 but that the number of people purchasing such coverage through the marketplaces would increase from 1 million to 4 million over that period as people's experience with the marketplaces increased. Although the actual number of people purchasing coverage in the overall nongroup market remained relatively stable, as projected, the number of people purchasing unsubsidized coverage through the marketplaces increased to just 2 million in 2016.

Figure 6.

Projections and Actual Numbers of Uninsured People

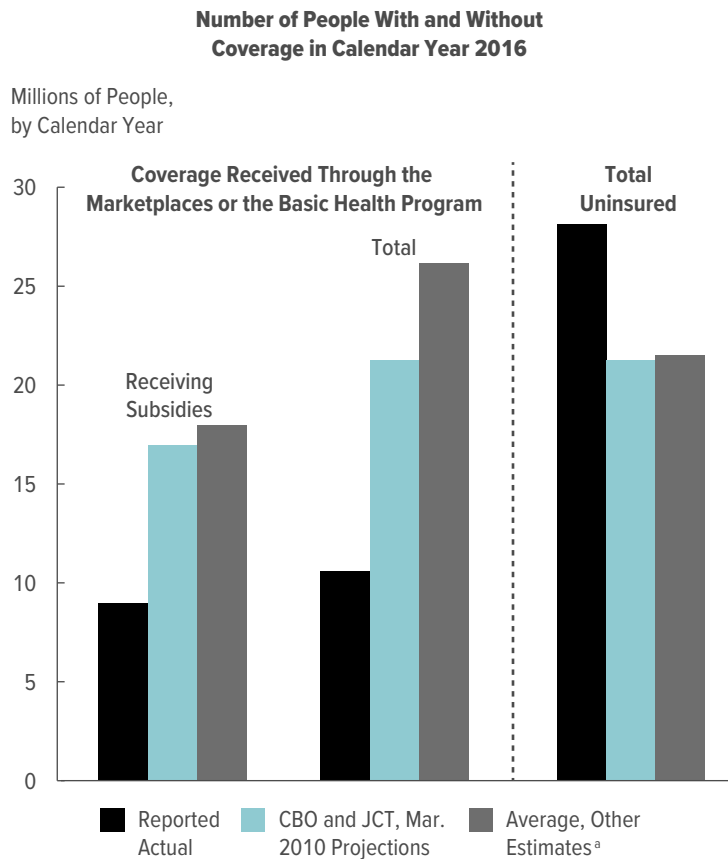
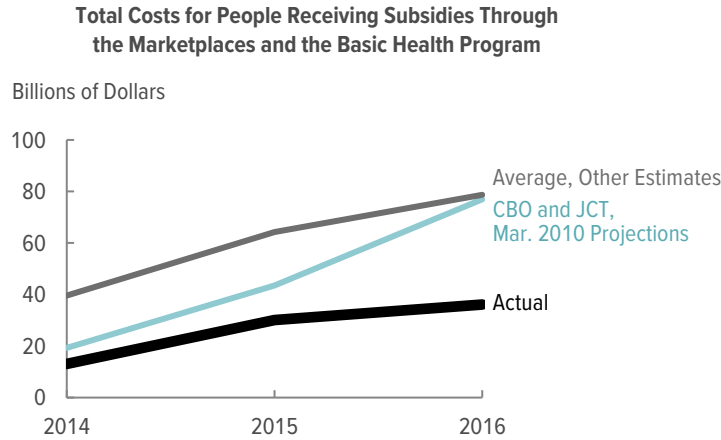


Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

In May 2013, CBO and JCT projected that 31 million people under age 65, or 11 percent of the population under 65, would be uninsured in 2016. In March 2010, before incorporating the Supreme Court's decision affecting Medicaid, the agencies estimated the number of uninsured people at 21 million, or 8 percent of the population under age 65. As reported by the National Health Interview Survey (conducted by the National Center for Health Statistics, which is part of the Centers for Disease Control and Prevention), the number turned out to be 28 million, or 10 percent of the 271 million people under age 65.

According to that survey, 44 million people were without insurance in 2013, and three years later, 16 million fewer people were uninsured. CBO and JCT had estimated, for that three-year period, a drop of 23 million people in their May 2013 estimate and a drop of 29 million people in their March 2010 estimate. The overestimates of the decline in the number of uninsured people occurred mostly because the projections of enrollment in insurance through the marketplaces turned out to be too high. The agencies' overestimate in May 2013 was smaller mostly because CBO's projection of enrollment in Medicaid turned out to be too low.

Figure 7.
Comparison of CBO and JCT's Estimates With Those by Other Organizations



Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation, using data from the Centers for Medicare & Medicaid Services, RAND Corporation, and The Lewin Group.

a. Like CBO and JCT's estimates, the other organizations' estimates were made around the time the Affordable Care Act was enacted in 2010.

JCT = Joint Committee on Taxation.

Among estimates published near the time the ACA was enacted, CBO and JCT's projections of the federal government's costs for 2014 and 2015 for subsidies for people obtaining coverage through the marketplaces and the Basic Health Program were significantly closer to actual amounts than was the average of other organizations' projections. CBO and JCT overpredicted subsidy costs in those two years by \$6 billion and \$13 billion, respectively, whereas other organizations' estimates were too high by an average of \$27 billion and \$34 billion, respectively.

For 2016, CBO and JCT's March 2010 estimate of those costs was similar to the estimates by other organizations. CBO and JCT projected costs in 2016 to be \$77 billion; other organizations, on average, projected costs to be \$79 billion. As previously discussed, the actual amount was about \$36 billion for that year.

Like CBO and JCT, other organizations overpredicted costs in 2016 largely because they overestimated the number of people who would enroll through the marketplaces and receive subsidies. For 2016, other organizations estimated, on average, that 26 million people would enroll in coverage through the marketplaces or the Basic Health Program and that 18 million of them would receive subsidies; in the March 2010 cost estimate, CBO and JCT projected that those numbers would be 21 million and 17 million, respectively. In actuality, an estimated 11 million people enrolled in coverage through the marketplaces or the Basic Health Program in 2016, and 9 million of them received subsidies for that coverage.

Those overestimates of enrollment through the marketplaces in 2016 contributed to CBO and JCT's and other organizations' underestimating the number of people who would be uninsured in that year by 7 million.



Appendix: Details About the Scope of and Data for This Report

As context and background for this report, the appendix provides additional details on the scope of coverage provisions of the Affordable Care Act (ACA) with readily identifiable effects and the sources of data and the values compared, along with relevant notes, particularly about the judicial decisions, statutory changes, and administrative actions since the ACA's enactment.

Other Coverage Provisions of the ACA With Readily Identifiable Effects

The ACA included requirements that most people obtain health insurance or pay a penalty if they are not exempt (also called the individual mandate) and that large employers offer their employees coverage that meets specified standards or face a penalty (also called the employer mandate). The penalties associated with those requirements allow for—or will allow for—a comparison of projections and outcomes, but those penalty collections are significantly smaller than the health insurance subsidies discussed in this report. (Besides the information previously discussed, the penalty collections are the only other outcomes related to the health coverage provisions of the ACA for which the Congressional Budget Office and the staff of the Joint Committee on Taxation [JCT] could compare previous projections with observable amounts.)

In particular, for the penalty associated with the individual mandate, CBO and JCT estimated in May 2013 that \$2.3 billion and \$4.2 billion would be collected from people who were uninsured in 2014 and 2015, respectively. The actual amounts reported on tax returns were lower, at \$1.7 billion and \$3.1 billion.¹

For the penalty associated with the employer mandate, a comparison of projections and outcomes will probably be feasible at some point but is not currently possible

1. See Internal Revenue Service, “SOI Tax Stats—Historic Table 2” (accessed October 11, 2017), www.irs.gov/statistics/soi-tax-stats-historic-table-2.

because the penalties have yet to be collected. Penalties were not imposed on employers in 2014, as originally scheduled, and penalties for 2015 are expected to be assessed in fiscal year 2018.

About the Data

For this analysis, CBO and JCT used data on Medicaid, subsidies through the marketplaces and the Basic Health Program, other nongroup insurance, and uninsured people. The agencies also made comparisons with estimates by other organizations.

People Made Newly Eligible for Medicaid Under the ACA

Amounts for actual enrollment in Medicaid are based on data submitted by states to the Centers for Medicare & Medicaid Services (CMS) on Form CMS-64 regarding monthly enrollment for adults under age 65 made eligible by the ACA.² CBO estimated the average enrollment during all of calendar year 2016 on the basis of actual enrollment through September 2016.

The amount of actual spending for the program is derived from data on quarterly expenditures for medical services submitted on the same form.³ CBO estimated the total spending during all of fiscal year 2016 on the basis of actual spending through March 2016. CBO's estimates of actual spending per person, on average, are the ratios of spending to enrollment in a calendar year.

People Receiving Subsidies Through the Marketplaces and the Basic Health Program

CBO and JCT's estimates of the average number of people who purchased subsidized health insurance through

2. See Centers for Medicare & Medicaid Services, “Medicaid Enrollment Data Collected Through MBES” (accessed October 11, 2017), <https://go.usa.gov/xR7jy>.

3. See Centers for Medicare & Medicaid Services, “Expenditure Reports From MBES/CBES” (accessed October 11, 2017), <https://go.usa.gov/xR7jV>.

the marketplaces over the course of 2014 and 2015 are based on data published by CMS that provide enrollment as of certain dates in those years.⁴ CMS published information about average enrollment over the course of 2016, so the number for that year is as reported.⁵

CBO and JCT's estimates of the number of people who enrolled in coverage through the Basic Health Program are based on information published by the state governments of Minnesota (which reports average enrollment over the course of the year) and New York (which reports enrollment as of the close of the open enrollment period each year and as of September of each year).⁶ Those are the only states that have used the program.

Federal costs for subsidies for coverage obtained through the marketplaces and the Basic Health Program come from data published by the Office of Management and Budget.⁷ Estimates of actual spending per person are the ratios of spending to subsidized enrollment through

the health insurance marketplaces or the Basic Health Program in a calendar year.

People With Nongroup Insurance Coverage Purchased Through the Marketplaces or Coverage Through the Basic Health Program

CBO and JCT's estimates of the number of people who purchased health insurance through the marketplaces are based on the same sources of data as used in the analysis of the number of subsidized enrollees enrolled in the marketplaces (see footnotes 4 and 5).

Uninsured People

The number of uninsured people under age 65 with which CBO compared its projections comes from the National Health Interview Survey.⁸ CBO now uses the NHIS as its primary benchmark for that number; previously, it relied more heavily on estimates from the Medical Expenditure Panel Survey—Household Component (MEPS-HC).⁹ Because of differences in design and in the sample used, the surveys' numbers for particular years differ. For example, according to the NHIS, the estimated number of uninsured people in 2013 was 44 million; however, using the responses to questions in the MEPS-HC about coverage each month, CBO's May 2013 projection put that number at 52 million. The differences between the surveys is the main source of that discrepancy shown in Figure 6.

Estimates by Other Organizations

For this analysis, CBO compared its estimates with ones by the Office of the Actuary within CMS, RAND Corporation, and The Lewin Group.¹⁰ All of the estimates

4. See Centers for Medicare & Medicaid Services, "Total Effectuated Enrollment and Financial Assistance by State" (accessed August 23, 2017), <https://go.usa.gov/xR7jv>, and "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period" (accessed October 11, 2017), <https://go.usa.gov/xnah5>.
5. See Centers for Medicare & Medicaid Services, "2017 Effectuated Enrollment Snapshot" (accessed August 23, 2017), <https://go.usa.gov/xR7j7> (PDF, 489 KB).
6. See Minnesota Department of Human Services, "Medical Assistance and MinnesotaCare Eligible Persons and Person Months in Calendar Year 2015" (accessed October 11, 2017), <https://go.usa.gov/xR7js> (PDF, 222 KB), and "Medical Assistance and MinnesotaCare Eligible Persons and Person Months in Calendar Year 2016" (accessed October 11, 2017), <https://go.usa.gov/xR7jS> (PDF, 222 KB); and New York State Department of Health, *Essential Plan, New York's Basic Health Program: Annual Report to the Governor and Legislature* (December 2015), <https://go.usa.gov/xna7b>, "2016 Open Enrollment Report" (August 2016), <https://go.usa.gov/xR7jh>, and *Essential Plan, New York's Basic Health Program: Annual Report to the Governor and Legislature* (December 2016), www.health.ny.gov/health_care/managed_care/essential/.
7. Office of Management and Budget, *Budget of the U.S. Government: Appendix*, "Detailed Budget Estimates by Agency: Department of the Treasury" (February 2015), p. 1046, *Budget of the U.S. Government: Appendix*, "Detailed Budget Estimates by Agency: Department of the Treasury" (February 2016), p. 1061, and *Budget of the U.S. Government: Appendix*, "Detailed Budget Estimates by Agency: Department of the Treasury" (May 2017), p. 951. Those documents are available at <https://go.usa.gov/xR7Dc>.

8. See Tainya C. Clarke, Tina Norris, and Jeannine S. Schiller, *Early Release of Selected Estimates Based on Data From the January–March 2017 National Health Interview Survey* (National Center for Health Statistics, September 2017), www.cdc.gov/nchs/nhis/releases/released201709.htm.
9. For a related discussion, see Jared Maeda and Susan Yeh Beyer, "How Does CBO Define and Estimate Health Insurance Coverage for People Under Age 65?" CBO Blog (December 20, 2016), www.cbo.gov/publication/52352.
10. See Richard S. Foster, Chief Actuary, Centers for Medicare & Medicaid Services, memorandum on the estimated financial effects of the Patient Protection and Affordable Care Act, as amended" (April 22, 2010), <https://go.usa.gov/xnahF>; Jeanne Ringel and others, *Analysis of the Patient Protection and Affordable Care Act (H.R. 3590)* (RAND Corporation, 2010), www.rand.org/pubs/research_briefs/RB9514.html; and The Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long-Term Costs for Governments, Employers, Families and Providers*, Staff

compared were published in 2010. Because this analysis compares estimates of subsidies with actual values for 2014, 2015, and 2016, organizations that estimated subsidy costs for only one year were omitted.

RAND projected the effects of the Patient Protection and Affordable Care Act (H.R. 3590) as passed by the Senate, which included smaller subsidies for insurance purchased through the marketplaces and a lower income limit for people made newly eligible for Medicaid (133 percent of the federal poverty level instead of 138 percent) than those in the legislation that was enacted. RAND estimated that total spending on Medicaid for 2016 would increase by \$94 billion under the ACA. To estimate the increase in federal spending that RAND would have projected, CBO projected that state spending accounted for \$10 billion of the total.

The Lewin Group published multiyear projections of subsidies under the ACA but only one-year estimates of insurance coverage, as if the ACA was fully implemented in 2011 and changes in enrollment were complete in that year. To calculate the average of other organizations' estimates of the number of people receiving coverage through the marketplaces and the Basic Health Program in 2016, CBO used The Lewin Group's estimate (reflecting full implementation of the ACA's health insurance provisions) without modification.

Both CMS and RAND published estimates of total coverage obtained through the marketplaces for each year from 2014 to 2019 but estimates of subsidized enrollment only for 2019. To estimate the number of subsidized enrollees that CMS and RAND would have projected for 2016, CBO assumed that the same share of total enrollment through the marketplaces would be subsidized in 2016 as they estimated for 2019.

Notes

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

Estimates of health insurance coverage reflect average enrollment in any given month of a calendar year and

include spouses and dependents covered under family policies. The estimates are for the noninstitutionalized civilian population under age 65.

As referred to in this report, the ACA 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.

Among the judicial decisions, the June 2012 decision by the Supreme Court (*National Federation of Independent Business v. Sebelius*, 567 U.S. 519) is the one that has significantly affected outcomes for federal spending and revenues related to the health insurance coverage provisions of the ACA.

Examples of statutory changes that caused actual results to deviate from CBO and JCT's March 2010 estimate and, in some cases, the agencies' May 2013 estimate for the health insurance coverage provisions of the ACA include the following:

- The Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (P.L. 112-9), which upped the limits on the amounts people would have to repay if they received excess advance payments of premium tax credits, thereby reducing subsidies for insurance purchased through the marketplaces;
- The Three Percent Withholding Repeal and Job Creation Act (P.L. 112-56), which added nontaxable Social Security benefits to the definition of modified adjusted gross income for the purposes of determining eligibility for certain applicants for Medicaid and for subsidies for health insurance purchased through the marketplaces, thereby decreasing enrollment in and spending for Medicaid and increasing, on net, enrollment in and costs of subsidies for insurance purchased through the marketplaces; and
- The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10), which included a provision that provided funding for the Children's Health Insurance Program (CHIP) above the amount already assumed in CBO's baseline for fiscal years 2016 and 2017, thereby decreasing enrollment in and subsidies

Working Paper 11 (June 8, 2010), www.lewin.com/publications/publication/20100608.0409.html.

for coverage purchased through the marketplaces, because some people who enrolled in CHIP would have otherwise enrolled in subsidized coverage through the marketplaces.

Examples of administrative actions that caused actual results to deviate from CBO and JCT's March 2010 estimate and, in most cases, the agencies' May 2013 estimate for the health insurance coverage provisions of the ACA include the following:

- A delay in imposing penalties on large employers that do not offer their employees coverage meeting specified standards, which primarily reduced revenues arising from penalties paid by employers;
- An option for state insurance commissioners to permit health insurers to allow individuals and small businesses to temporarily reenroll in coverage that does not comply with certain requirements established by the ACA, which reduced enrollment in nongroup coverage purchased through the marketplaces; and
- An expansion of the hardship exemption from the individual mandate to include people who would be eligible for Medicaid if their state had expanded coverage under the ACA, which increased the number of uninsured people.

The Congressional Budget Office regularly evaluates the accuracy of its budget projections by comparing them with actual outcomes. Such evaluations help guide the agency's efforts to improve the quality of its projections and are offered as background information to assist Members of Congress in their use of the agency's estimates. In keeping with CBO's mandate to provide objective, impartial analysis, this report makes no recommendations.

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Keith Hall
Director

