# CONGRESSIONAL BUDGET OFFICE
# COST ESTIMATE

May 24, 2017

# H.R. 1628
## American Health Care Act of 2017

*As passed by the House of Representatives on May 4, 2017*

## SUMMARY

The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have completed an estimate of the direct spending and revenue effects of H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives. CBO and JCT estimate that enacting that version of H.R. 1628 would reduce the cumulative federal deficit over the 2017-2026 period by $119 billion. That amount is $32 billion less than the estimated net savings for the version of H.R. 1628 that was posted on the website of the House Committee on Rules on March 22, 2017, incorporating manager's amendments 4, 5, 24, and 25. (CBO issued a cost estimate for that earlier version of the legislation on March 23, 2017.)[1]

In comparison with the estimates for the previous version of the act, under the House-passed act, the number of people with health insurance would, by CBO and JCT's estimates, be slightly higher and average premiums for insurance purchased individually—that is, nongroup insurance—would be lower, in part because the insurance, on average, would pay for a smaller proportion of health care costs. In addition, the agencies expect that some people would use the tax credits authorized by the act to purchase policies that would not cover major medical risks and that are not counted as insurance in this cost estimate.

### Effects on the Federal Budget

CBO and JCT estimate that, over the 2017-2026 period, enacting H.R. 1628 would reduce direct spending by $1,111 billion and reduce revenues by $992 billion, for a net reduction of $119 billion in the deficit over that period (see Table 1, at the end of this document). The provisions dealing with health insurance coverage would reduce the

1. Congressional Budget Office, cost estimate for H.R. 1628, the American Health Care Act, incorporating manager's amendments 4, 5, 24, and 25 (March 23, 2017), www.cbo.gov/publication/52516.

deficit, on net, by $783 billion; the noncoverage provisions would increase the deficit by $664 billion, mostly by reducing revenues.

The largest savings would come from reductions in outlays for Medicaid and from the replacement of the Affordable Care Act's (ACA's) subsidies for nongroup health insurance with new tax credits for nongroup health insurance (see Figure 1). Those savings would be partially offset by other changes in coverage provisions—spending for a new Patient and State Stability Fund, designed to reduce premiums, and a reduction in revenues from repealing penalties on employers who do not offer insurance and on people who do not purchase insurance. The largest increases in the deficit would come from repealing or modifying tax provisions in the ACA that are not directly related to health insurance coverage—such as repealing a surtax on net investment income, repealing annual fees imposed on health insurers, and reducing the income threshold for determining the tax deduction for medical expenses.

Pay-as-you-go procedures apply because enacting H.R. 1628 would affect direct spending and revenues. CBO and JCT estimate that enacting H.R. 1628 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027. CBO has not completed an estimate of the potential impact of the legislation on discretionary spending, which would be subject to future appropriation action.

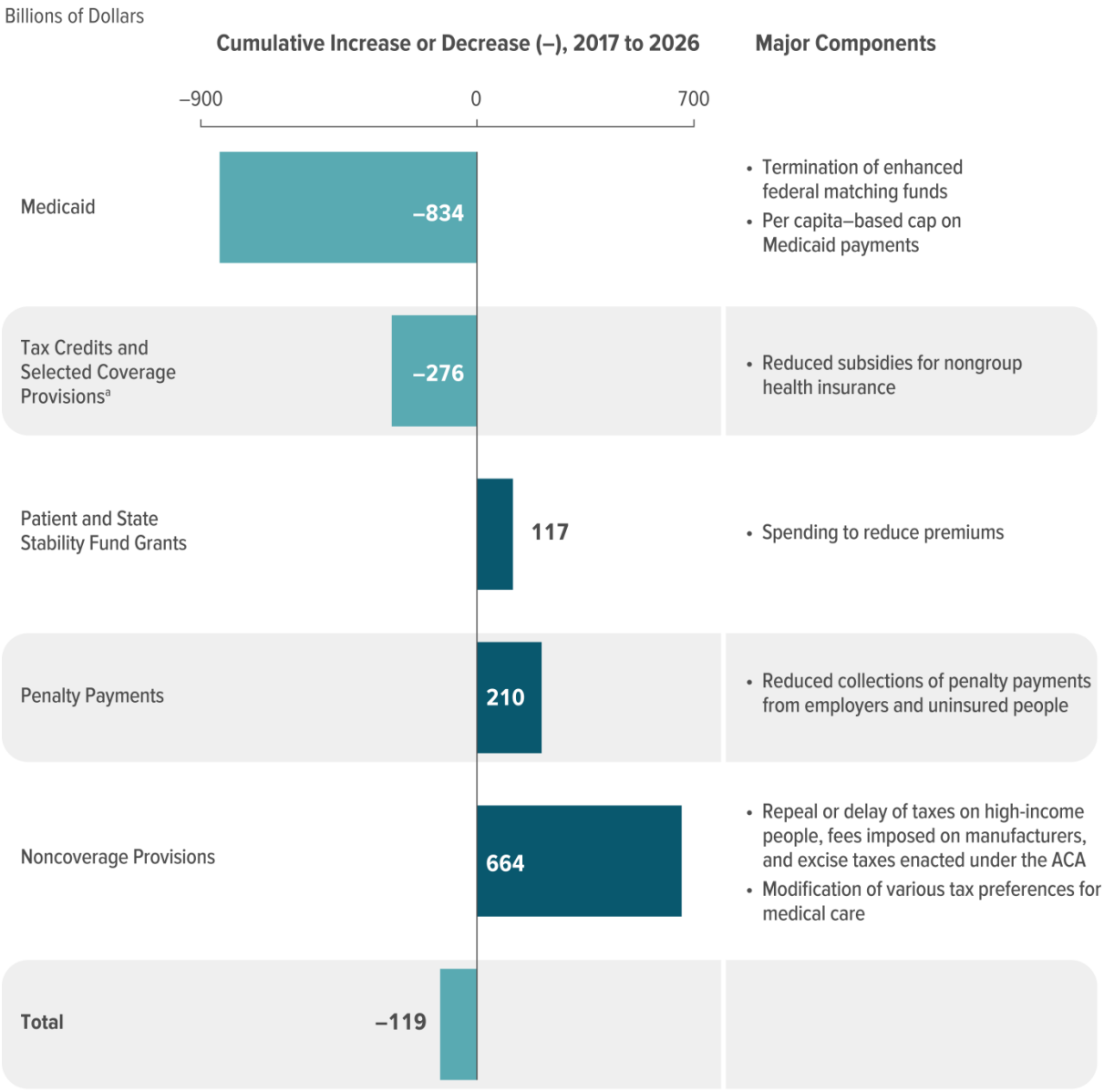
## Effects on Health Insurance Coverage

CBO and JCT broadly define private health insurance coverage as consisting of a comprehensive major medical policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals. The agencies ground their coverage estimates on that widely accepted definition, which encompasses most private health insurance plans currently offered in the group and nongroup markets. The definition excludes policies with limited insurance benefits (known as mini-med plans); "dread disease" policies that cover only specific diseases; supplemental plans that pay for medical expenses that another policy does not cover; fixed-dollar indemnity plans that pay a certain amount per day for illness or hospitalization; and single-service plans, such as dental-only or vision-only policies. In this estimate, people who have only such policies are described as uninsured because they do not have financial protection from major medical risks.[2]

2. For additional discussion, see Congressional Budget Office, "How Does CBO Define and Estimate Health Insurance Coverage for People Under Age 65?" *CBO Blog* (December 20, 2016), www.cbo.gov/publication/52352, and "Challenges in Estimating the Number of People With Nongroup Health Insurance Coverage Under Proposals for Refundable Tax Credits," *CBO Blog* (December 20, 2016), www.cbo.gov/publication/52351.

Figure 1.

## Net Effects of H.R. 1628 on the Budget Deficit




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

These estimates are for H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017.

ACA = Affordable Care Act.

a. Includes subsidies for coverage through marketplaces and related spending and revenues, small-employer tax credits, tax credits for nongroup insurance, Medicare, and other effects of coverage provisions on revenues and outlays.

CBO and JCT estimate that, in 2018, 14 million more people would be uninsured under H.R. 1628 than under current law. The increase in the number of uninsured people relative to the number projected under current law would reach 19 million in 2020 and 23 million in 2026. In 2026, an estimated 51 million people under age 65 would be uninsured, compared with 28 million who would lack insurance that year under current law. Under the legislation, a few million of those people would use tax credits to purchase policies that would not cover major medical risks.

**Stability of the Health Insurance Market**

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—that is, nongroup coverage without medical underwriting—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.

**Under Current Law.** Although premiums have been rising under current law, most subsidized enrollees purchasing health insurance coverage in the nongroup market are largely insulated from increases in premiums because their out-of-pocket payments for premiums are based on a percentage of their income; the government pays the difference between that percentage and the premiums for a reference plan. The subsidies to purchase coverage, combined with the effects of the individual mandate, which requires most individuals to obtain insurance or pay a penalty, 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.

Nevertheless, some areas of the country have limited participation by insurers in the nongroup market under current law. Several factors could lead insurers to withdraw from the market—including lack of profitability and substantial uncertainty about enforcement of the individual mandate and about future payments of the cost-sharing subsidies to reduce out-of-pocket payments for people who enroll in nongroup coverage through the marketplaces established by the ACA.

**Under the Legislation.** CBO and JCT anticipate that, under H.R. 1628, nongroup insurance markets would continue to be stable in many parts of the country. Although substantial uncertainty about how the new law would be implemented could lead insurers to withdraw from or not enter the nongroup market, several factors would bring about market stability in most states before 2020. In the agencies' view, those key factors include subsidies to purchase insurance, which would maintain sufficient demand for insurance by people with low health care expenditures, and grants to states from the

Patient and State Stability Fund, which would lower premiums by reducing the costs to insurers of people with high health care expenditures.

The agencies expect that the nongroup market in many areas of the country would continue to be stable in 2020 and later years as well, including in some states that obtain waivers from market regulations. Even though the new tax credits, which would take effect in 2020, would be structured differently from the current subsidies and would generally be less generous for those receiving subsidies under current law, other changes (including the money available through the Patient and State Stability Fund) would, in the agencies' view, lower average premiums enough to attract a sufficient number of relatively healthy people to stabilize the market.

However, the agencies estimate that about one-sixth of the population resides in areas in which the nongroup market would start to become unstable beginning in 2020. That instability would result from market responses to decisions by some states to waive two provisions of federal law, as would be permitted under H.R. 1628. One type of waiver would allow states to modify the requirements governing essential health benefits (EHBs), which set minimum standards for the benefits that insurance in the nongroup and small-group markets must cover. A second type of waiver would allow insurers to set premiums on the basis of an individual's health status if the person had not demonstrated continuous coverage; that is, the waiver would eliminate the requirement for what is termed community rating for premiums charged to such people. CBO and JCT anticipate that most healthy people applying for insurance in the nongroup market in those states would be able to choose between premiums based on their own expected health care costs (medically underwritten premiums) and premiums based on the average health care costs for people who share the same age and smoking status and who reside in the same geographic area (community-rated premiums). By choosing the former, people who are healthier than average would be able to purchase nongroup insurance with relatively low premiums.

CBO and JCT expect that, as a consequence, the waivers in those states would have another effect: Community-rated premiums would rise over time, and people who are less healthy (including those with preexisting or newly acquired medical conditions) would ultimately be unable to purchase comprehensive nongroup health insurance at premiums comparable to those under current law, if they could purchase it at all—despite the additional funding that would be available under H.R. 1628 to help reduce premiums. As a result, the nongroup markets in those states would become unstable for people with higher-than-average expected health care costs. That instability would cause some people who would have been insured in the nongroup market under current law to be uninsured. Others would obtain coverage through a family member's employer or through their own employer.

## Effects on Premiums and Out-of-Pocket Payments

CBO and JCT projected premiums for single policyholders under H.R. 1628 (before any tax credits were applied) and compared those with the premiums projected under current law for policies purchased in the nongroup market. H.R. 1628, as passed by the House, would tend to increase such premiums before 2020, relative to those under current law—by an average of about 20 percent in 2018 and 5 percent in 2019, as the funding provided by the act to reduce premiums had a larger effect on pricing.

Starting in 2020, however, average premiums would depend in part on any waivers granted to states and on how those waivers were implemented and in part on what share of the funding available from the Patient and State Stability Fund was applied to premium reduction. To facilitate the analysis, CBO and JCT examined three general approaches states could take to implement H.R. 1628. Because a projection of a specific state's actions would be highly uncertain, the agencies' estimates reflect an assessment of the probabilities of different outcomes, without any explicit predictions about which states would make which decisions. CBO and JCT estimate the following:

- About half the population resides in states that would not request waivers regarding the EHBs or community rating, CBO and JCT project. In those states, average premiums in the nongroup market would be about 4 percent lower in 2026 than under current law, mostly because a younger and healthier population would be purchasing the insurance.[3] The changes in premiums would vary for people of different ages. A change in the rules governing how much more insurers can charge older people than younger people, effective in 2019, would directly alter the premiums faced by different age groups, substantially reducing premiums for young adults and raising premiums for older people.

- About one-third of the population resides in states that would make moderate changes to market regulations. In those states, CBO and JCT expect that, overall, average premiums in the nongroup market would be roughly 20 percent lower in 2026 than under current law, primarily because, on average, insurance policies would provide fewer benefits. Although the changes to regulations affecting community rating would be limited, the extent of the changes in the EHBs would vary widely; the estimated reductions in average premiums range from 10 percent to 30 percent in different areas of the country. The reductions for younger people would be substantially larger and those for older people substantially smaller.

3. In their previous cost estimates, CBO and JCT projected that premiums for single policyholders in the nongroup market would be roughly 10 percent lower under H.R. 1628 than under current law. That figure encompassed a range of possible effects on premiums. For the half of the population in states that would not request waivers, the effects that CBO and JCT estimate for the House-passed version are similar to those in the prior estimates.

- Finally, about one-sixth of the population resides in states that would obtain waivers involving both the EHBs and community rating and that would allow premiums to be set on the basis of an individual's health status in a substantial portion of the nongroup market, CBO and JCT anticipate. As in other states, average premiums would be lower than under current law because a younger and healthier population would be purchasing the insurance and because large changes to the EHB requirements would cause plans to a cover a smaller percentage of expected health care costs. In addition, premiums would vary significantly according to health status and the types of benefits provided, and less healthy people would face extremely high premiums, despite the additional funding that would be available under H.R. 1628 to help reduce premiums. Over time, it would become more difficult for less healthy people (including people with preexisting medical conditions) in those states to purchase insurance because their premiums would continue to increase rapidly. As a result of the narrower scope of covered benefits and the difficulty less healthy people would face purchasing insurance, average premiums for people who did purchase insurance would generally be lower than in other states—but the variation around that average would be very large. CBO and JCT do not have an estimate of how much lower those premiums would be.

Although premiums would decline, on average, in states that chose to narrow the scope of EHBs, some people enrolled in nongroup insurance would experience substantial increases in what they would spend on health care. People living in states modifying the EHBs who used services or benefits no longer included in the EHBs would experience substantial increases in out-of-pocket spending on health care or would choose to forgo the services. Services or benefits likely to be excluded from the EHBs in some states include maternity care, mental health and substance abuse benefits, rehabilitative and habilitative services, and pediatric dental benefits. In particular, out-of-pocket spending on maternity care and mental health and substance abuse services could increase by thousands of dollars in a given year for the nongroup enrollees who would use those services. Moreover, the ACA's ban on annual and lifetime limits on covered benefits would no longer apply to health benefits not defined as essential in a state. As a result, for some benefits that might be removed from a state's definition of EHBs but that might not be excluded from insurance coverage altogether, some enrollees could see large increases in out-of-pocket spending because annual or lifetime limits would be allowed. That could happen, for example, to some people who use expensive prescription drugs. Out-of-pocket payments for people who have relatively high health care spending would increase most in the states that obtained waivers from the requirements for both the EHBs and community rating.

## Uncertainty Surrounding the Estimates

The ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by the legislation are all difficult to predict, so the estimates discussed in this document are uncertain. In particular, states would have a wide range of options—notably, the optional waivers discussed above that would allow them to modify the minimum set of benefits that must be provided by insurance sold in the nongroup and small-group markets and that would permit medical underwriting for people who did not demonstrate continuous coverage. The array of market regulations that states could implement makes estimating the outcomes especially uncertain. But, throughout, CBO and JCT have endeavored to develop estimates that are in the middle of the distribution of potential outcomes.

## Macroeconomic Effects

Because of the magnitude of its budgetary effects, this legislation is "major legislation," as defined in the rules of the House of Representatives. Hence, it triggers the requirement that the cost estimate, to the greatest extent practicable, include the budgetary impact of its macroeconomic effects. However, because of the limited time available to prepare this cost estimate, quantifying and incorporating those macroeconomic effects have not been practicable.

## Intergovernmental and Private-Sector Mandates

JCT and CBO have determined that H.R. 1628, as passed by the House, would impose no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA).

JCT and CBO have determined that the legislation would impose private-sector mandates as defined in UMRA. On the basis of information from JCT, CBO estimates the aggregate cost of the mandates would exceed the annual threshold established in UMRA for private-sector mandates ($156 million in 2017, adjusted annually for inflation).

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## MAJOR PROVISIONS OF THE LEGISLATION

Most of the provisions of H.R. 1628 are the same in the version that was passed by the House and in the previous two versions of the act for which CBO prepared estimates.[4] In addition, the version of H.R. 1628 passed by the House contains several modifications related to insurance coverage and the Internal Revenue Code.

### Provisions That Are the Same as Those in the Prior Versions of H.R. 1628

In this cost estimate, as in the preceding estimates, the budgetary effects related to health insurance coverage would stem primarily from the following provisions:

- Reducing the federal matching rate for adults made eligible for Medicaid by the ACA to equal the rate for other enrollees in the state, beginning in 2020.

- Capping the growth in per-enrollee payments for most children and nondisabled adults enrolled in Medicaid at no more than the medical care component of the consumer price index (CPI-M) and for most enrollees who are disabled or age 65 or older to no more than CPI-M plus 1 percentage point, starting in 2020.

- Repealing current-law subsidies for health insurance coverage obtained through the nongroup market—which include refundable tax credits for premium assistance and subsidies to reduce cost-sharing payments—beginning in 2020.

- Creating a new refundable tax credit for health insurance coverage purchased through the nongroup market beginning in 2020.

- Eliminating penalties associated with the requirements that most people obtain health insurance coverage and that large employers offer their employees coverage that meets specified standards.

- Appropriating funding for grants to states through the Patient and State Stability Fund beginning in 2018.

- Relaxing the current-law requirement that prevents insurers from charging older people premiums that are more than three times larger than the premiums charged younger people in the nongroup and small-group markets. Unless a state sets a

4. Congressional Budget Office, cost estimate for H.R. 1628, the American Health Care Act, incorporating manager's amendments 4, 5, 24, and 25 (March 23, 2017), www.cbo.gov/publication/52516, and cost estimate for the American Health Care Act (March 13, 2017), www.cbo.gov/publication/52486.

different limit, H.R. 1628 would allow insurers to charge older people five times more than younger ones beginning in 2018.

- Removing the requirement, beginning in 2020, that insurers who offer plans in the nongroup market generally must offer plans that cover at least 60 percent of the cost of covered benefits.

- Requiring insurers to impose a 30 percent surcharge on premiums for people who enroll in insurance in the nongroup market if they have been uninsured for more than 63 days within the past year.

Other parts of the legislation would repeal or delay many of the changes the ACA made to the Internal Revenue Code that were not directly related to the law's insurance coverage provisions. Those with the largest budgetary effects include:

- Repealing the surtax on certain high-income taxpayers' net investment income;

- Repealing the annual fee on health insurance providers;

- Reducing the income threshold for determining the medical care deduction;

- Delaying when the excise tax imposed on some health insurance plans with high premiums would go into effect; and

- Repealing the increase in the Hospital Insurance payroll tax rate for certain high-income taxpayers.

In addition, the legislation would make several changes to other health-related programs that would have smaller budgetary effects.

**Modifications to H.R. 1628**

H.R. 1628, as passed by the House, includes several modifications to the previous version of the legislation that were not reflected in CBO's earlier cost estimates. The modification causing the largest change in budgetary effects relative to those described in the March 23rd estimate is a delay—to 2023—in repealing the increase in the payroll tax, boosting by $68 billion JCT's estimate of the revenues that would be collected over the 2017-2026 period.

The other changes incorporated in the House-passed act that would have the largest effects on the federal budget or insurance coverage include the following:

- Allowing states to waive the ACA's requirement establishing essential health benefits;

- Permitting states to waive the requirement for community rating, which is the prohibition against setting premiums on the basis of an individual's health status, if the person had not maintained continuous coverage;

- Providing $15 billion for what the legislation calls the Federal Invisible Risk Sharing Program, which would be implemented by insurers and the government in a way that was not apparent to beneficiaries;

- Providing $15 billion in funding to states to use for maternity coverage, newborn care, and prevention, treatment, or recovery services for people with mental or substance use disorders; and

- Providing $8 billion in funding to states that obtain a waiver from the requirement for community rating to use for reducing premiums or out-of-pocket costs for people who would face higher premiums as a result of the waiver.

## ESTIMATED COST TO THE FEDERAL GOVERNMENT

CBO and JCT estimate that, on net, enacting the legislation would decrease federal deficits by $119 billion over the 2017-2026 period. That change would result from a $1,111 billion decrease in direct spending, largely offset by a $992 billion reduction in revenues.

The largest budgetary effects would stem from provisions affecting insurance coverage. Those provisions, taken together, would reduce projected deficits by $783 billion over the 2017-2026 period. That estimate includes spending from the new Patient and State Stability Fund, which would receive substantially more funding than what would have been provided by the previous version of the bill. Other provisions would increase deficits by $664 billion, mostly by reducing tax revenues. (See Table 2, at the end of this document, for the estimated budgetary effects of each major provision.)

### Budgetary Effects of Health Insurance Coverage Provisions

The $783 billion in estimated deficit reduction over the 2017-2026 period that would result from the insurance coverage provisions is $100 billion less than what CBO estimated on March 23. That difference is mostly due to changes in the amount of funding provided to the Patient and State Stability Fund and changes in the number of people estimated to have nongroup and employment-based insurance. These estimates also account for difficulties in implementation and enforcement of the tax credit

associated with increased decentralization of eligibility verification and administration of advanced payments due to states' ability to obtain waivers. The total deficit reduction includes the following amounts (shown in Table 3, at the end of this document):

- A reduction of $834 billion in federal outlays for Medicaid;

- Savings of $665 billion stemming mainly from eliminating, in 2020, the ACA's subsidies for nongroup health insurance—which include refundable tax credits for premium assistance and subsidies to reduce cost-sharing payments;

- Savings of $23 billion, mostly associated with shifts in the mix of taxable and nontaxable compensation resulting from net decreases in most years in the number of people estimated to enroll in employment-based health insurance coverage; and

- Savings of $6 billion from repealing a tax credit for certain small employers who provide health insurance to their employees.

Those decreases in the deficit would be partially offset by:

- A cost of $375 billion for the new tax credit for nongroup insurance established by the legislation in 2020;

- A reduction in revenues of $210 billion from eliminating the penalties paid by uninsured people ($38 billion) and employers ($171 billion);

- An increase in spending of $117 billion for the Patient and State Stability Fund grant program; and

- A net increase in spending of $43 billion for the Medicare program stemming from changes in payments to hospitals that serve a disproportionate share of low-income patients.

The following discussion focuses primarily on the provisions with the largest changes from the prior versions of H.R. 1628. More information about other budgetary effects of the act was included in CBO's earlier estimates.

**Effects of the Patient and State Stability Fund**

Beginning in 2018 and ending after 2026, the federal government would make a total of $138 billion in allotments to states that they could use for a variety of purposes, including reducing premiums for insurance that people purchase individually, that is, in the nongroup market. That amount is $38 billion more than the amount that would have been

provided under the previous version of the act. The additional funding includes $15 billion for the Federal Invisible Risk Sharing Program; $8 billion to reduce expenses for premiums and out-of-pocket costs for people who face an increase in premiums for health insurance as a result of a waiver affecting community rating; and $15 billion in additional funding for maternity care, mental health care, and substance abuse treatment. CBO and JCT estimate that federal outlays for grants from the Patient and State Stability Fund would total $117 billion over the 2018-2026 period.

H.R. 1628 would give states flexibility in how to use their allotments from the Patient and State Stability Fund. CBO and JCT expect that, with the exception of the $15 billion provided to states for maternity care, mental health care, and substance abuse treatment, most of the funding would be used by states to reduce premiums or increase benefits in the nongroup market. As discussed below, the conditions under which states could use different parts of the fund would vary.

**Funding for the Patient and State Stability Fund Included in Previous Versions of the Act.** States could use their allotments from the $100 billion provided in the prior versions of H.R. 1628 for a variety of purposes. For states that did not develop plans to spend the funds, the federal government would make payments to insurers in the nongroup market who had enrollees with relatively large medical claims. CBO estimates that most states would rely on the federal default program for one or more years, until they had more time to establish their own programs.

As a condition of the grants, beginning in 2020, states would be required to provide matching funds, which would generally increase from 7 percent of the federal funds provided in 2020 to 50 percent of the federal funds provided in 2026. The grants' effects on premiums after 2020 would be limited by the share of states that took action and decided to pay the required matching funds in order to receive federal money and by the extent to which states chose to use the money for purposes that directly helped to lower premiums in the nongroup market. Nevertheless, CBO and JCT estimate that the grants would exert substantial downward pressure on premiums in the nongroup market and would help encourage insurers' participation in the market.

**Funding for the Federal Invisible Risk Sharing Program.** The act would provide $15 billion beginning on January 1, 2018, to be used to implement a program to provide payments to health insurers for claims for eligible individuals, as defined by the Secretary of Health and Human Services. CBO and JCT expect that the funds would be directed to insurers to reduce their risk of having high-cost enrollees. As a result, the agencies project that the program would result in lower premiums for health insurance coverage in the nongroup market and would encourage insurers to continue to sell insurance in that market. The program would have a small effect on premiums in 2018 and a larger effect on premiums in 2019 after insurers had time to incorporate the availability of the funds

into their prices. CBO and JCT estimate that all $15 billion of the funding would be spent over the 2017-2026 period.

**Funding for Individuals Subject to an Increase in Premiums.** The act would provide an additional $8 billion in funding for states to use to lower premiums or out-of-pocket costs for people who would be subject to an increase in premiums because their state elected a waiver of the requirement for community rating. CBO and JCT estimate that $6 billion of this funding would be spent over the 2017-2026 period.

Because the additional funds would be available only to states that had a waiver of the community-rating requirement, CBO and JCT expect the availability of the funding would increase the number of states choosing such a waiver. States could target the funds using several different mechanisms, and CBO and JCT have not attempted to predict the precise manner in which states would use the money. The agencies expect that a majority of the funds would be paid to insurers, resulting in somewhat lower premiums.

**Funding for Maternity Care, Mental Health Care, and Substance Abuse Treatment.** Beginning in 2020, the act would also provide $15 billion to be used for maternity coverage and newborn care and for prevention, treatment, or recovery support services for people with mental or substance use disorders. CBO expects states to award those funds to health care providers rather than to insurers. Some individuals receiving services from those providers would benefit from lower out-of-pocket costs for those services. The funds could be used in a variety of ways and would not be restricted to states using waivers or to services provided to participants in the nongroup market. Therefore, CBO anticipates that the funds would not significantly affect premiums in the nongroup market. CBO estimates that this provision would cost $14 billion over the 2017-2026 period.

### Revenue Effects of Other Provisions

JCT estimates that the legislation would reduce revenues by $661 billion over the 2017-2026 period by repealing many of the revenue-related provisions of the ACA (apart from those related to health insurance coverage discussed above), about $69 billion less than the sum projected in the March 23rd cost estimate. That difference results primarily from shifting to a later effective date for repealing the increase in the Hospital Insurance payroll tax rate for high-income taxpayers.

### Direct Spending Effects of Other Provisions

The legislation would also make changes to spending for other federal health care programs. CBO and JCT estimate that those provisions would increase direct spending, on net, by about $3 billion over the 2017-2026 period, about the same as estimated on March 23rd.

### Changes in Spending Subject to Appropriation

CBO has not completed an estimate of the potential impact of the legislation on discretionary spending, which would be subject to future appropriation action.

## BASIS OF ESTIMATE

For this cost estimate, CBO and JCT assume that the legislation will be enacted by July 31, 2017. On the basis of consultation with the budget committees, costs and savings are measured relative to CBO's March 2016 baseline projections, with adjustments for legislation that was enacted after that baseline was produced.

CBO's cost estimates for previous versions of the legislation and various publications by JCT have provided considerable information about the basis of the estimates that remains applicable.[5] Consequently, this section focuses on health insurance coverage and premiums, which were affected by changes in the legislation in the most complex ways, and describes the basis for the revisions to the estimates for them.

Those revisions result mainly from decisions by states regarding waivers and the resulting changes in market regulations that CBO and JCT expect would occur. The agencies examined three general approaches to market regulations projected to be in force in different states. Adding together the effects in the various markets, CBO and JCT estimated the number of people with different types of insurance coverage and without coverage; those numbers underlie the estimates of the budgetary effects.

### Estimated Effects on Insurance Coverage

CBO and JCT estimate that, in 2018, 14 million more people would be uninsured under H.R. 1628 than under current law. The increase in the number of uninsured people relative to the number under current law would reach 19 million in 2020 and 23 million in 2026 (see Table 4, at the end of this document). In 2026, an estimated 51 million people under age 65 would be uninsured, compared with 28 million who would lack

5. See Congressional Budget Office, cost estimate for H.R. 1628, the American Health Care Act, incorporating manager's amendments 4, 5, 24, and 25 (March 23, 2017), www.cbo.gov/publication/52516, and cost estimate for the American Health Care Act (March 13, 2017), www.cbo.gov/publication/52486. The latter described the methodology, effects of repealing mandate penalties, major changes to Medicaid, changes to subsidies and market rules for nongroup health insurance, market stability, effects on Medicare, and other budgetary effects. See also Joint Committee on Taxation, "JCT Publications 2017," www.jct.gov/publications.html?func=select&id=76. On March 7, 2017, JCT published 10 documents relating to the legislation—JCX-7-17 through JCX-16-17—which are posted there. In addition, see Joint Committee on Taxation, *Estimated Revenue Effects of the Tax Provisions Contained in Title II of H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives*, JCX-27-17 (May 24, 2017).

insurance that year under current law. Those people would not have a comprehensive major medical policy that would cover high-cost medical events and a range of services.

Although the agencies expect that the legislation would increase the number of uninsured broadly, the increase would be disproportionately larger among older people with lower income—particularly people between 50 and 64 years old with income of less than 200 percent of the federal poverty level (see Figure 2).

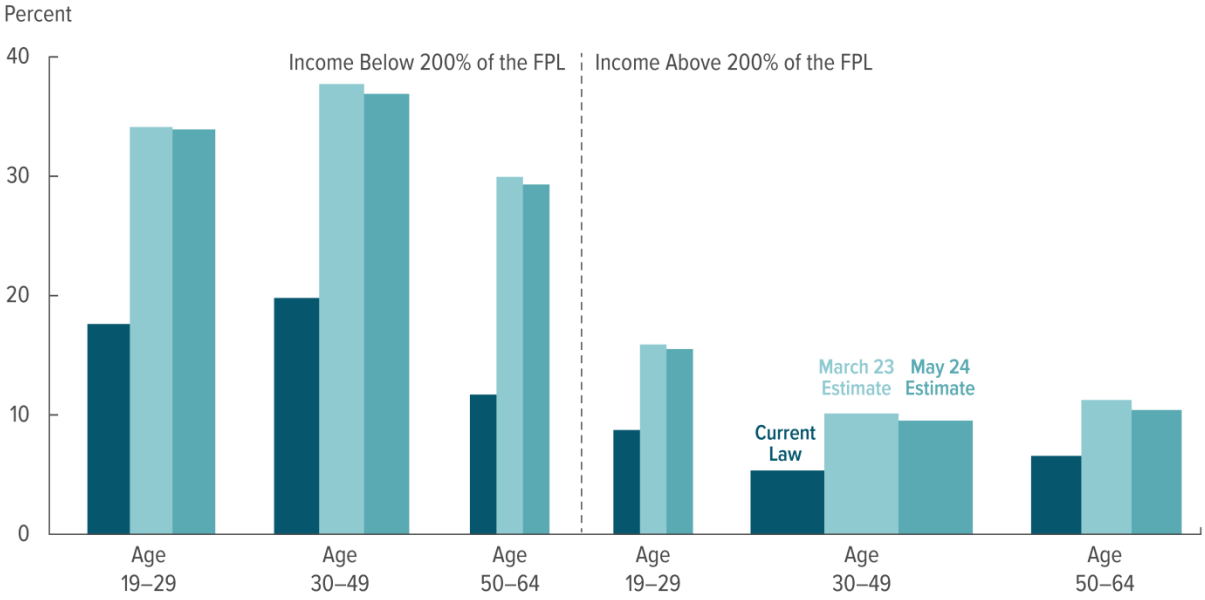
Medicaid enrollment would be lower throughout the coming decade, culminating in 14 million fewer Medicaid enrollees by 2026, a reduction of about 17 percent relative to the number under current law (see Figure 3). Some of that decline would be among people who are currently eligible for Medicaid benefits, and some would be among people who CBO projects would, under current law, become eligible in the future as additional states adopted the ACA's option to expand eligibility.

On net, CBO and JCT estimate, roughly 8 million fewer people would obtain coverage through the nongroup market in 2018 than would under current law; that figure would be about 10 million in 2020, when the new tax credits would first be available, and about 6 million in 2026. Fewer people would enroll in the nongroup market because the penalty for not having insurance would be eliminated and, starting in 2020, because the average subsidy for coverage in that market would be substantially lower for most people currently eligible for subsidies. Also, more employers would offer coverage to their employees because the available nongroup coverage would tend to have higher out-of-pocket premiums for people currently eligible for subsidies and because the plans would tend to provide fewer benefits.

The reduction in enrollment in the nongroup market relative to current-law projections would shrink over the 2020-2026 period partly because of issues with implementation. Beginning in 2020, several changes to how advance payments for tax credits for nongroup insurance premiums are administered would require the establishment of new systems for enrolling people in nongroup insurance, verifying eligibility for tax credits, certifying insurance as eligible for credits, and ultimately ensuring that the payments to insurers were correct. Those adaptations could be particularly challenging in the states that chose to apply for waivers and conduct their own certification programs. CBO and JCT expect that such implementation difficulties would result in some reduction in coverage and some occasions when individuals purchasing coverage would fail to get the credits. Those difficulties would probably decline over time in most markets. In addition, over time, some employers would respond to the availability of those tax credits by declining to offer insurance to their employees.

Figure 2.

**Share of Nonelderly Adults Without Health Insurance Coverage Under Current Law and Two Versions of H.R. 1628, by Age and Income Category, 2026**




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

For these estimates, CBO and JCT consider individuals to be uninsured if they would not be enrolled in a policy that provides financial protection from major medical risks.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. The May 24 estimate is for H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017. The March 23 estimate is for the American Health Care Act, incorporating manager's amendments 4, 5, 24, and 25.

Estimates reflect the average number of people under age 65 without insurance coverage over the course of the year in the noninstitutionalized civilian population of the 50 states and the District of Columbia.

The width of each bar represents the relative share of the population in each age and income category. In CBO's projections, 200 percent of the FPL in 2026 would amount to $30,300 for a single person.

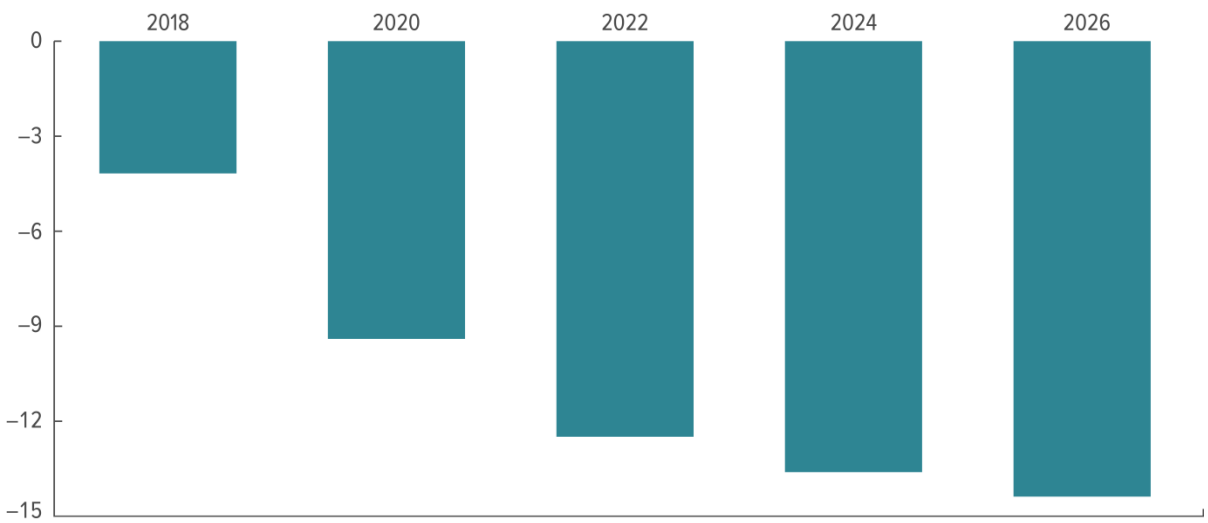
FPL = federal poverty level.

## Differences From Previous Estimates Regarding Coverage and Premiums

According to CBO and JCT's estimate, fewer people would be uninsured under the House-passed version of H.R. 1628 than under the previous version—about 2 million fewer people in 2020 and about 1 million fewer in 2026. That difference in 2026 reflects the net result of two effects: 4 million more people with employment-based coverage, as employers in states making changes to market regulations would probably view the insurance products in the nongroup market as less desirable alternatives and decide to offer insurance to their employees, and 3 million fewer people with nongroup coverage, as some would enroll in employment-based coverage, and others would become uninsured.

Figure 3.

**Changes in Medicaid Enrollment Under H.R. 1628, Selected Years**




Source: Congressional Budget Office.

These estimates are for H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect average enrollment over the course of a year. Under CBO's current-law projections, additional states would expand Medicaid eligibility to people who are made newly eligible under the Affordable Care Act (adults under the age of 65 whose income is below 138 percent of the federal poverty level). The projected effects of the act on enrollment that might result from such future expansions are included in the figure.

For half of the population—residing in states that did not pursue a waiver for the EHB or community-rating requirements—CBO and JCT expect that the effects on premiums in the nongroup market would be similar to those described in the March 23rd cost estimate. For the other half of the population—in states that obtained waivers—CBO and JCT anticipate that, on average, premiums would be lower and related out-of-pocket costs would be higher than they were in the agencies' prior estimates. The agencies expect that premiums would be substantially higher than previously estimated for less healthy people in some states and somewhat lower for the healthier people in those states.

H.R. 1628 would result in significant changes in premiums according to people's age—on net, after accounting for tax credits—that are similar to those illustrated in the March 13th cost estimate.[6] Under the act, premiums for older people could be five times larger

6. CBO and JCT's illustrations of how premiums would vary by age differ slightly in this estimate because the agencies undertook separate analyses for the population residing in states that would not pursue waivers and those that would make moderate changes to market regulations. (The agencies do not have an estimate of how much lower premiums would be, on average, in states making more substantial changes to market regulations.) In states not pursuing waivers, premiums are slightly higher than in the agencies' previous illustration, which used the national averages as its basis. The average reductions in the states not pursuing waivers would be smaller than that national average under prior versions of H.R. 1628 and this one—but similar for all versions of

than those for younger people in many states, but the size of the tax credits for older people would be only twice the size of the credits for younger people.[7] As a result:

- For older people with lower income, net premiums would be much larger than under current law, on average (see Table 5, at the end of this document).

- For younger people with lower income, net premiums would be about the same or smaller, depending on the state's approach to regulation.

- For people with higher income, net premiums would be reduced among people of most ages, on average.

As a result of the narrower scope of benefits included in many plans, however, enrollees who would use services that were not covered by the available plans would face substantial increases in their out-of-pocket costs under the act.

### Decisions by States Regarding Waivers

H.R. 1628, as passed by the House, would allow states to waive the federal requirement establishing essential health benefits and the requirement prohibiting insurers from setting premiums on the basis of an individual's health status if the person had not maintained continuous coverage. To estimate the budgetary effects of the act, CBO and JCT projected how the population would be affected by decisions about those waivers.

**Essential Health Benefits.** Under current law, insurance coverage in the nongroup and small-group markets must include 10 major categories of EHBs, and that coverage must be equal to the scope of benefits provided under a typical employment-based plan.[8] To implement that requirement, each state uses a benchmark plan, and most insurance plans in that state's nongroup and small-group markets must include all of the services provided by the benchmark plan. In addition, several important restrictions on insurers apply to services that are included in the EHBs: For such services, the maximum out-of-pocket payment that an insurer can require each year is limited, and insurers cannot limit

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the legislation. In other states, premiums would also differ because of the changes those states would make in regulations.

7. The new tax credits would vary on the basis of age by a factor of 2 to 1: Someone age 60 or older would be eligible for a tax credit of $4,000 in 2020, while someone younger than age 30 would be eligible for a tax credit of $2,000.

8. Small-group coverage generally is that offered by employers with up to 50 employees. The 10 major categories of essential health benefits are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

the cost or amount of services that they cover within a year or over the course of a lifetime. Benefits included in an insurance plan that are not part of the EHBs may have higher out-of-pocket payments or may include caps on the amount of services that are covered.

Under H.R. 1628, as passed by the House, states would be allowed to waive the EHB requirements beginning in 2020 by submitting their own set of EHBs. States could establish alternative EHB requirements in many different ways. For example, a state could choose a specific set of categories of included benefits or select a different insurance plan as the benchmark for benefits. Thus, a state might eliminate certain services from the current list of 10 EHBs. Alternatively, a state could give significant flexibility to insurers to offer plans that vary in the scope and type of benefits they include. Thus, a state might specify that a plan provide only major medical benefits or might not specify any particular benefit requirements and approve plans on a case-by-case basis.

**Community Rating.** Under current law, premiums in the nongroup market cannot be based on an individual's health and may vary only on the basis of age, smoking status, and geographic location—that is, they are community rated. Beginning with special enrollment periods in 2018, the previous version of H.R. 1628 would require insurers to impose a penalty on people who enrolled in insurance in the nongroup market if they had been uninsured for more than 63 days within the past year. When they then purchased insurance in the nongroup market, they would be subject to a surcharge equal to 30 percent of their monthly premium for up to 12 months.

H.R. 1628, as passed by the House, would allow states to choose a waiver from the requirement for community rating and permit insurers to set premiums based on an individual's expected health care costs (often called medical underwriting). Under that waiver, insurers would be allowed to charge underwritten premiums to enrollees who failed to demonstrate continuous coverage for the past 12 months rather than charging a flat 30 percent surcharge on their premiums. One way to implement that approach would be to allow a premium increase based on medical underwriting for people without continuous coverage—which would only be charged to less healthy people—but to maintain community-rated premiums for others without continuous coverage. Another way would be to allow medical underwriting for *anyone* who did not demonstrate continuous coverage, which could result in increased or reduced premiums relative to community-rated premiums.

**Projected Decisions by States Regarding EHB and Community-Rating Waivers.** For this estimate, CBO and JCT considered states' possible behavior in response to the potential waivers. States would probably have varying preferences about whether to request a waiver and how to change existing regulations. Those that would request a waiver might also have different preferences about the timing; some might want to seek

one or both waivers starting in 2020, and others might prefer to wait. Some states could also apply for a waiver starting in 2020 and later decide to modify the terms of their waiver. In addition, the effects of a state's waiver or waivers on the nongroup market would depend on the specific rules the state established and on insurers' and consumers' responses to them.

Although states' responses would vary, to project the budgetary effects of H.R. 1628, CBO and JCT estimated the average outcomes for people in three broad groups of states:

- One group of states would choose not to apply for any waivers regarding the EHBs or community rating.

- A second group of states would opt to make moderate changes to market regulations. They would apply for a waiver to change how the EHBs were defined and might also apply for a waiver to modify the community-rating rule in a way that strictly limited the impact on overall premiums.

- A third group of states would decide to apply for waivers to substantially modify both the EHB and community-rating rules; those states would implement larger changes to how the EHBs were defined and would allow changes to the community-rating rule to affect premiums throughout the nongroup market.

The agencies anticipate that, despite their availability starting in 2018 under the act, community-rating waivers would not go into effect until 2020, as states and insurers would need time to prepare.[9]

Many factors would influence states' decisions, as discussed below, and a projection of a specific state's actions would be highly uncertain. As a result, CBO and JCT's estimates reflect an assessment of the probabilities of different outcomes (without any explicit predictions about which states make which choices) and are, by the agencies' judgment, in the middle of the distribution of potential outcomes. Moreover, CBO and JCT's assessments in this analysis should not be viewed as representing a single definitive interpretation of how H.R. 1628 should or would be implemented.

9. Specifically, if a state allowed medical underwriting in 2018 or 2019, many implementation challenges would arise. For example, the premium tax credits used to subsidize insurance purchased through a marketplace would be based on income and would depend on the cost of the second-lowest cost "silver" plan available in an individual's area—but if insurers practiced medical underwriting, how such a plan would be identified would not be clear without substantial additional regulations or guidance.

For the 2020-2026 period, CBO and JCT estimate that:

- About half of the population would be in states that would not seek waivers to the EHB or community-rating rules;

- About one-third of the population would be in states that would choose to make moderate changes to market regulations; and

- The remainder, about one-sixth of the population, would be in states that would choose to substantially alter the EHBs and also waive the community-rating rule and allow medical underwriting in the nongroup market.

**Key Factors in States' Decisions About EHB and Community-Rating Waivers.** CBO and JCT's estimates incorporate many factors that would influence states' decisions to apply for one or both waivers. In developing their projections of states' behavior, the agencies took into account states' past behavior regarding the nongroup market (including the rules that existed or exist in state law) as well as current market conditions.

Before the ACA was enacted, states varied widely in the types of services and benefits that nongroup insurance plans were required to cover. For example, 18 states mandated the coverage of maternity care in the nongroup market before 2014, and 23 states mandated some mental health benefits.[10] CBO and JCT expect that states that previously mandated fewer benefits would be more likely to apply for a waiver to modify the EHBs.

In addition, states used a variety of approaches to regulate the nongroup market prior to the enactment of the ACA. For example, before the implementation of the ACA, when community rating became required nationally, 7 states prohibited medical underwriting based on health status, 11 states placed other limits on medical underwriting, and 32 states placed no restrictions on medical underwriting.[11] CBO and JCT expect that states with no restrictions on medical underwriting and fewer regulations governing the nongroup market before 2014 would be more likely to apply for a community-rating waiver.

Current market conditions—such as the number of people likely to enroll in nongroup coverage, insurers' participation, and anticipated premiums in local markets—would also affect states' decisions to apply for waivers. CBO and JCT expect that states with smaller markets, fewer insurers, and higher premiums would be more likely to apply for one or

10. Henry J. Kaiser Family Foundation, "State Health Facts (Health Insurance & Managed Care Indicators: Pre-ACA State Mandated Health Insurance Benefits)" (accessed May 24, 2017), http://tinyurl.com/m527l6x.

11. Henry J. Kaiser Family Foundation, "State Health Facts: Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals)" (accessed May 24, 2017), http://tinyurl.com/m8cehyl.

both waivers. States would consider applying at the same time that they would consider how to use funds available through the Patient and State Stability Fund, so those decisions would be intertwined.

Finally, CBO and JCT expect that the preferences of local insurers, hospitals, and medical providers would also influence states' decisions.

States would face some pressure to modify the EHBs in order to reduce premiums in the nongroup market. At the same time, countervailing pressure would also exist because people who use services or benefits that might be excluded from the EHBs would pay more for them and providers might be concerned that the share of patients who do not pay their medical bills would increase. Reducing the scope of the EHBs could also segment the nongroup market and potentially contribute to instability.[12]

States would also face some pressure from insurers to apply for a waiver from the community-rating requirement because it would provide them with an additional tool to manage the risk posed by people who wait to enroll in coverage until they face high medical expenses. Concerns of market participants about instability could generate opposing pressure.

### Effects of Different Approaches to Market Regulation

Among the three broad approaches to regulation that CBO and JCT considered, the effects on premiums and out-of-pocket costs in the nongroup market would be largest in states that significantly alter their regulations under waivers from current law. Changes in regulations would have smaller effects on employment-based coverage. In states that changed regulations, implementation would be particularly challenging. In addition, certain types of health plans that would be exempt from the terms of any waivers would nonetheless be affected by any significant changes to regulations.

**No Changes to EHB or Community-Rating Requirements.** CBO and JCT expect that under the current version of the legislation, the effects on health insurance coverage would be similar to those previously estimated for the half of the population that resides in states that would not obtain a waiver from the EHB or community-rating requirements. In general, under H.R. 1628, as passed by the House, fewer people would have coverage through the nongroup market, Medicaid, and employment-based coverage, and more people would be uninsured in those areas than under current law.

12. Although the risk-adjustment program that exists under current law would continue to operate and is designed to help stabilize the nongroup market by balancing risks among insurers, it is unclear how effective the program would be if the EHBs were modified because the scope of benefits among plans would probably vary.

**Moderate Changes to Market Regulations.** For the one-third of the population residing in states that CBO and JCT expect to obtain one or more waivers and make only moderate changes to the EHBs and possibly make limited use of medical underwriting, the plans for sale in the nongroup market would have lower premiums mainly because they would cover fewer benefits and therefore a smaller share of total health care costs than estimated for the previous versions of H.R. 1628. On average, premiums in those states are expected to be roughly 20 percent lower than under current law after 2019. Nevertheless, the agencies expect that insurance for sale in those states would still offer financial protection from most major health risks. Although relatively young and healthy people might prefer plans with fewer benefits and lower premiums, many older people and people who use the services that were no longer covered could face substantial out-of-pocket costs and would not find such plans attractive.

Because it would be less comprehensive overall, insurance offered in the nongroup market would tend to have lower premiums than what CBO and JCT estimated for the prior version of H.R. 1628. Those lower premiums could attract more enrollees to the nongroup market. However, because employers would be more likely to continue offering insurance coverage, fewer of their employees would enroll in coverage through the nongroup market. On net, the agencies expect that, relative to their previous estimates, slightly more people would have insurance in those states, but fewer of them would be enrolled through the nongroup market.

The effects on premiums in both the nongroup and small-group markets would depend on the ways states changed the EHBs. CBO and JCT expect that states making moderate changes to the EHBs would generally continue to require coverage for hospitalization and services provided by physicians but would eliminate requirements to cover some other services. The specific ways that states would attempt to reduce premiums might involve eliminating one or more categories of benefits in the federal definition of the EHBs that were not typically provided in the nongroup market before the ACA existed or that affect a small share of enrollees. Examples of such services include coverage for maternity care, mental health care, substance abuse, rehabilitative and habilitative treatment, and pediatric dental care. Prescription drug benefits might also be removed from a state's definition of the EHBs, but would be less likely to be excluded from a state's insurance coverage altogether. In response to such changes in minimum requirements, insurers would probably narrow the scope of benefits included in their plans. They could impose additional charges for additional benefits.

*The Scope of Benefits Included in Plans.* CBO and JCT expect that, because of the regulations still in place governing guaranteed issue, which requires insurers to offer coverage to any applicant, insurers generally would not want to sell policies that included benefits that were not required by state law. Plans with additional benefits that were not mandated would tend to attract enrollees who would use them and thus increase insurers' costs. However, if insurers raised premiums to pay for those costs, they would tend to

lose enrollees who did not expect to use those additional benefits. To avoid that outcome, insurers would probably offer plans that excluded such benefits entirely or limited the benefits substantially. As a result of the narrow scope of benefits, enrollees who use the services no longer covered or for which coverage was limited would face increases in their out-of-pocket costs. Some people would have increases of thousands of dollars in a year. For example, enrollees who use expensive drugs could see large increases in out-of-pocket spending because, in states that excluded prescription drug benefits from EHBs, the ban on annual and lifetime limits on covered benefits would no longer apply.

*Additional Charges for Nonessential Benefits.* An alternative to narrowing the scope of benefits would be for insurers to offer benefits that would otherwise be excluded from a policy in the form of a rider. A rider is an add-on provision to a basic insurance policy that provides additional benefits at an extra cost. For example, maternity benefits could be sold as a rider by some insurers in states that did not include maternity care as an EHB. Insurers would expect most purchasers to use the benefits and would therefore price that rider at close to the average cost of maternity coverage, which could be more than $1,000 per month.[13] (The average cost of pregnancy care and delivery is about $17,000 for women with private insurance coverage.)[14] Alternatively, insurers could offer a lower-cost rider providing less-than-comprehensive coverage—with, for example, a $2,000 limit. Either type of rider would result in substantially higher out-of-pocket health care costs for pregnant women who purchased insurance in the nongroup market.

Some people would still have an incentive to purchase riders because they could pay monthly for health services they anticipate using and they could gain access to prices negotiated by an insurer, which are generally much lower than the prices charged to uninsured individuals. In general, however, offering benefits in the form of riders segments people with certain health care risks from the larger pool of people purchasing nongroup insurance. That segmentation causes a small decrease in the premiums for the larger pool, but it substantially increases the out-of-pocket costs of those people who use health care benefits that are not on the mandated list.

**Substantial Changes to EHB and Community-Rating Requirements.** About one-sixth of the population resides in states that CBO and JCT expect would obtain waivers from EHB and community-rating requirements and make substantial changes to market regulations. In those states, the agencies expect more significant differences in coverage

13. See Dania Palanker, JoAnn Volk, and Justin Giovannelli, "Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers," *To the Point* (Commonwealth Fund, March 24, 2017), https://tinyurl.com/lgkyl6a.

14. See Truven Health Analytics, *The Cost of Having a Baby in the United States* (January 2013), http://transform.childbirthconnection.org/reports/cost. That study found that the average cost of pregnancy care and delivery, which excludes the cost of newborn care, was $13,494 for women with private insurance in 2010. To estimate the cost in 2017, that figure was adjusted for changes in medical care prices.

from what they estimated previously: By 2026, plans offered in the nongroup market would cover a substantially smaller share of benefits and premiums. Those changes would result in significantly lower premiums for those with low expected health care costs and higher nongroup enrollment by those individuals than under current law—and lower average premiums for such people than in states making moderate changes to regulations. However, over time, less healthy individuals (including those with preexisting or newly acquired medical conditions) would be unable to purchase comprehensive coverage with premiums close to those under current law and might not be able to purchase coverage at all.

On net, in those states, the increase in nongroup coverage for healthy people and the decrease in coverage for less healthy people would result in an overall decrease in nongroup coverage. Because of extensive changes to regulations and the inability of less healthy employees to obtain comprehensive coverage, the agencies expect that employers would be even more likely to continue offering coverage than in states making moderate changes. Consequently, some less healthy people would find coverage through an employer, but some other less healthy people would become uninsured.

CBO and JCT estimate that a few million people would buy policies that would not cover major medical risks. That estimate is highly uncertain. Although less healthy people might be able to purchase plans that would include a limited number of benefits, those policies would not provide sufficient financial protection to meet CBO's definition of insurance coverage. The existence of tax credits in the nongroup market would encourage a second market to emerge to sell policies priced to closely match the size of the credits. Although such plans would provide some benefits, the policies would not provide enough financial protection in the event of a serious and costly illness to be considered insurance.

States would vary in their implementation of changes under waivers from both the EHB and community-rating requirements. CBO and JCT estimated average effects for the population affected by substantial changes to both and incorporated projections of the effects of money in the Patient and State Stability Fund specifically directed toward helping stabilize markets affected by changes to the community-rating requirement in those estimates.

*Changes Related to the EHBs.* States could redefine the EHBs to allow insurance plans in the nongroup market to include a substantially smaller set of benefits than under current law in several ways. One way would be to define a very narrow set of benefits. Another option would be for a state to specify that a plan provide only major medical benefits or not specify any particular benefit requirements and approve plans on a case-by-case basis. Such an approach would probably limit the scope of benefits insurers would be willing to provide. As in instances of more moderate changes to EHBs, insurers generally would not want to sell policies that included benefits that were not required by state law

because such plans would attract enrollees who would use those benefits and thereby increase the insurers' costs.

*Changes Related to Community Rating.* Under H.R. 1628, as passed by the House, a waiver of the community-rating requirement would permit medical underwriting only for those unable to demonstrate continuous coverage and then only for the first 12 months of coverage. Because people move in and out of the nongroup market as their access to other sources of health insurance changes, a significant fraction of enrollees in the nongroup market would be enrolled for less than 12 months, so it would be straightforward for them to gain access to underwritten premiums.

CBO and JCT anticipate that, in states making substantial changes to market regulations, most healthy people applying for insurance in the nongroup market would be able to choose between underwritten premiums and community-rated premiums. If underwritten premiums were to their advantage, healthy applicants could fail to provide proof of continuous coverage when first applying for nongroup insurance—or allow their coverage to lapse for more than 63 days before applying. Moreover, insurers and states might have difficulty verifying that an applicant did not have continuous coverage. As a result, such a waiver would potentially allow the spread of medical underwriting to the entire nongroup market in a state rather than limiting it to those who did not have continuous coverage. If people with lower expected health care expenses purchased an underwritten plan instead of a community-rated one, the average costs for the community-rated plan would increase substantially—raising costs for people with higher expected health care expenses who remained in the community-rated pool.

Because many healthy individuals would be able to obtain plans with underwritten premiums as long as they remained healthy, CBO and JCT anticipate that less healthy people or those with preexisting medical conditions would opt for community-rated premiums and that those premiums would rise over time. Eventually, CBO and JCT estimate, those premiums would be so high in some areas that the plans would have no enrollment. Such a market would be similar to the nongroup market before the enactment of the ACA, in which premiums were underwritten and plans often included high deductibles and limits on insurers' payments and people with high expected medical costs were often unable to obtain coverage.

*Effects of Funding Directed Toward Stability.* To help stabilize nongroup markets, H.R. 1628, as passed by the House, would make available, from 2018 to 2023, an additional $8 billion of federal funding to states applying for a community-rating waiver. That funding could be used to lower premiums or out-of-pocket costs for people experiencing high costs and is intended to counteract the effects that market segmentation resulting from the community-rating waivers would have on premiums.

Although CBO and JCT expect that federal funding would have the intended effect of lowering premiums and out-of-pocket payments to some extent, its effect on community-rated premiums would be small because the funding would not be sufficient to substantially reduce the large increases in premiums for high-cost enrollees. To evaluate the potential effect of the $8 billion fund, looking back at the high-risk pool program funded by the ACA prior to 2014 is useful. Within two years, the combined enrollment of about 100,000 enrollees in that program resulted in federal spending of close to $2.5 billion.[15]

**Effects on Employment-Based Insurance.** CBO and JCT estimate that changes to market regulations would have a smaller effect on the scope of benefits offered by insurers (and thus on premiums) in the small-group market than in the nongroup market. Although most small-group plans are subject to the same EHB requirements as nongroup plans, insurers offering policies in the small-group market pool risks for more people and would feel less pressure to reduce the scope of benefits. In fact, in most states, the current EHB standards are based on fairly comprehensive small-group plans that were sold there before the federal standards took effect.

For the large-group market, which generally consists of employers with more than 50 employees, current regulations allow employers to choose the EHB benchmark plan of any state in which they operate. Because of those regulations, a large employer operating in multiple states, including one that elected an EHB waiver, could base all of the plans it offers on the EHB requirements in a state with the waiver. That decision could allow annual and lifetime limits on benefits not included in the state's EHBs. However, large employers already have considerable flexibility in the range of the benefits they include in their plans, so CBO and JCT expect that their benefit offerings would probably not be noticeably affected by the actions of states.

**Effects on Administration and Compliance.** Under current law, to receive a tax credit, a person must buy a qualified insurance policy sold through one of the marketplaces established under the ACA. For the credit to be paid in advance, the person must be screened ahead of time through a process established by the marketplace through which he or she is purchasing the insurance. To do that screening, the marketplace must access information on the person's income, family size, and citizenship status through a federal data hub. In addition, the marketplace reports the amount of the credit paid on an enrollee's behalf throughout the plan year to the Internal Revenue Service (IRS), which uses the information to verify what appears on the person's tax return.

15. Karen Pollitz, *High-Risk Pools for Uninsurable Individuals*, Issue Brief (Henry J. Kaiser Family Foundation, February 22, 2017), http://tinyurl.com/zacsay8.

H.R. 1628, as passed by the House, would allow tax credits for policies not purchased through marketplaces beginning in 2019 and advanceable tax credits for such policies beginning in 2020. Beginning in 2020, states obtaining waivers for market regulations would be responsible for defining qualified health insurance plans. Those states would have the responsibility for administering the credit program. Implementation would include developing new processes to verify eligible individuals and certify eligible plans. In addition, in all states, implementation would involve establishing new requirements and systems for tracking and conveying to the IRS information on advance payments for policies not purchased through marketplaces.

It is unclear how quickly implementation could take place or what type of information would be provided to the IRS to enable it to match payment records against information reported on tax returns, particularly in states that would obtain waivers for market regulations. Therefore, relative to the previous estimate, the analysis of the current version of the act anticipates that, for states with such waivers, eligible people would initially be slower to take up the offer of tax credits, more claims would be made by people who are ineligible, and payments would be made for policies that do not qualify as insurance.

**Effects on CO-OP or Multistate Plans.** The act would exempt plans in the Consumer Operated and Oriented Plan (CO-OP) program established by the ACA, multistate plans established under the ACA, and Members of Congress and Congressional staff from the terms of any waiver approved in a state, as well as provide exemptions in a limited number of other circumstances. CBO and JCT expect that those plans would not be profitable because other insurers in the state would receive the majority of the healthier enrollees.

CBO and JCT expect that a CO-OP or multistate plan for sale in a state that obtained a waiver of the community-rating requirement would still be required to offer community-rated premiums to any applicant and would not be permitted to use medical underwriting to adjust premiums on the basis of an applicant's health status. Additionally, the agencies expect that a CO-OP or multistate plan for sale in a state that obtained a waiver from the EHB rules would still be required to meet the standards in current law. Those plans would be more appealing to people who were less healthy than average, because they would prefer community-rated premiums rather than underwritten premiums based on their health, and they would tend to prefer a plan that included a more generous set of benefits. As a result, the agencies expect that such CO-OPs and multistate plans would primarily enroll people who were less healthy than average. The agencies expect, therefore, that CO-OP or multistate plans would stop offering coverage in any state that obtained a waiver from the EHB or community-rating requirements.

## Differences in Estimates by Category of Coverage

CBO and JCT focused on four main categories of insurance coverage—Medicaid, nongroup, employment-based, and "other"—plus the uninsured. The differences in the estimates of Medicaid and other coverage between the March 23rd cost estimate and this one are small.

**Nongroup Coverage.** Compared with the previous estimates, projected enrollment in the nongroup market under the current version of the act is roughly 1 million lower in 2018 and about 3 million lower in 2026. Those changes are the net result of two influences: In states making changes to market regulations, more employers would continue to offer insurance coverage because the nongroup market would be less comparable to employment-based coverage and would have higher out-of-pocket costs for many of their employees. Partly offsetting that influence, more people who would otherwise be uninsured would enroll in nongroup coverage in states making changes to regulations, because of the resulting lower premiums.

**Employment-Based Coverage.** Compared with the previous estimates, projected enrollment in employment-based coverage under the current version of the act is about 1 million higher in 2018 and 4 million higher in 2026. In states making moderate changes to market regulations, employers would be more likely to continue offering coverage because the plans offered in the nongroup market would be less comparable to employment-based coverage. In states making substantial changes to the EHBs accompanied by use of medical underwriting, employers would also be more likely to continue offering coverage because comprehensive coverage for less healthy employees might not be available in the nongroup market.

In states that would not apply for either type of waiver, net enrollment in employment-based coverage would remain the same as projected in CBO's March 23rd estimate. In states that would not pursue a waiver of the EHB requirements, an employer's decision about the particulars of what insurance to offer might be influenced by the effects of waivers in other states, but the decision about whether or not to offer insurance would probably not be affected.

**Uninsured People.** Compared with what they estimated previously, CBO and JCT now estimate that under H.R. 1628, as passed by the House, 2 million fewer people would be uninsured in 2020, and 1 million fewer would be uninsured in 2026. Those changes are primarily attributable to lower premiums for nongroup coverage. Although, overall, the policies would offer fewer benefits, which would increase the out-of-pocket costs for people who needed to use the covered services, more people would choose to enroll rather than be uninsured. In addition, because the nongroup plans available in states making moderate changes in regulations would be less generous and the plans available in states with extensive use of medical underwriting would become very expensive for

people who were less healthy, CBO and JCT expect that fewer employers would stop offering coverage to their employees—and fewer of their employees would become uninsured.

A few million people among the uninsured would use tax credits to purchase policies that would not cover major medical risks, CBO and JCT estimate. Those policies would be priced to closely match the size of the credits. Although such policies would provide some benefits, they would not provide enough financial protection in the event of a serious and costly illness to be considered insurance.

## UNCERTAINTY SURROUNDING THE ESTIMATES

As in their estimates of prior versions of H.R. 1628, CBO and JCT have endeavored to develop estimates that are in the middle of the distribution of potential outcomes. Such estimates are inherently uncertain because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by the legislation are all difficult to predict. In addition, CBO and JCT's projections under current law itself are inexact. For example, enrollment in the marketplaces under current law could be lower than is projected, which would tend to decrease the budgetary savings of the legislation. Alternatively, the average subsidy per enrollee under current law could be higher than is projected, which would tend to increase the budgetary savings of the legislation.

In the current analysis, estimates of states' responses to the legislation are more uncertain than in the agencies' previous cost estimates. In addition to the challenge of estimating the fraction of the population living in states for which the different waivers would be approved, predicting the overall effects of the myriad ways that states could implement those waivers is especially difficult. Of course, the smaller the number of states choosing waivers, the less their responses would affect estimates for the nation as a whole.

Responses by states, insurers, employers, and individuals would depend upon how the provisions in the legislation were implemented in other ways—whether advance payments of the new tax credits were made reliably, for instance. Flaws in the determination of eligibility, for example, would keep subsidies from some people who were eligible and provide them to some people who were not, but the extent to which such problems might arise is unclear.

Despite the uncertainty, the direction of certain effects of the legislation is clear. For example, the amount of federal revenues collected and the amount of spending on Medicaid would almost surely both be lower than under current law. And the number of uninsured people under the legislation would almost surely be greater than under current law.

## INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2027.

## ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

JCT and CBO have determined that H.R. 1628, as passed by the House, would impose no intergovernmental mandates as defined in the Unfunded Mandates Reform Act.

## ESTIMATED IMPACT ON THE PRIVATE SECTOR

JCT and CBO have determined that the legislation would impose private-sector mandates as defined in UMRA. On the basis of information from JCT, CBO estimates that the aggregate direct cost of the mandates imposed by the legislation would exceed the annual threshold established in UMRA for private-sector mandates ($156 million in 2017, adjusted annually for inflation).

Specifically, the tax provisions of the legislation contain two mandates. The act would recapture excess advance payments of premium tax credits (so that the full amount of excess advance payments is treated as an additional tax liability for the individual) and would repeal the small business (health insurance) tax credit.

In addition, the nontax provisions of the legislation would also impose a private-sector mandate on insurers who offer health insurance coverage in the nongroup market. The act would require those insurers to charge a penalty equal to 30 percent of the monthly premium for a period of 12 months to individuals who enrolled in insurance in a given year after having allowed their health insurance to lapse for more than 63 days during the previous year. In states receiving a waiver from the community-rating requirement, insurers would be allowed to charge underwritten premiums instead of the flat 30 percent surcharge for people without continuous coverage. CBO estimates that the costs of complying with that mandate would be largely offset by the penalties insurers would collect.

**ESTIMATE PREPARED BY:**

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**Federal Revenues**

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**Impact on State, Local, and Tribal Governments**

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**Table 1 - SUMMARY OF THE DIRECT SPENDING AND REVENUE EFFECTS OF H.R. 1628, THE AMERICAN HEALTH CARE ACT OF 2017, AS PASSED BY THE HOUSE OF REPRESENTATIVES ON MAY 4, 2017**

Billions of Dollars, by Fiscal Year

| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2017-2021 | 2017-2026 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CHANGES IN DIRECT SPENDING[a]** | | | | | | | | | | | | |
| **Coverage Provisions** | | | | | | | | | | | | |
| Estimated Budget Authority | -4.5 | 13.5 | -21.4 | -74.1 | -129.5 | -148.2 | -162.7 | -176.3 | -189.2 | -201.6 | -215.9 | -1,094.0 |
| Estimated Outlays | -4.5 | -24.5 | -17.9 | -74.8 | -122.5 | -141.7 | -159.4 | -176.2 | -190.1 | -202.9 | -244.2 | -1,114.5 |
| **Noncoverage Provisions** | | | | | | | | | | | | |
| Estimated Budget Authority | 1.4 | -0.6 | -0.6 | 0.4 | 1.2 | 1.0 | -0.2 | -0.2 | -0.6 | -1.4 | 1.7 | 0.2 |
| Estimated Outlays | 0.0 | 0.2 | 0.3 | 0.9 | 1.5 | 1.6 | -0.1 | 0.3 | -0.1 | -1.1 | 2.8 | 3.4 |
| **Total Changes in Direct Spending** | | | | | | | | | | | | |
| Estimated Budget Authority | -3.1 | 12.9 | -22.0 | -73.7 | -128.3 | -147.2 | -163.0 | -176.5 | -189.8 | -203.1 | -214.2 | -1,093.8 |
| Estimated Outlays | -4.5 | -24.3 | -17.7 | -73.9 | -121.1 | -140.1 | -159.5 | -175.9 | -190.2 | -204.0 | -241.4 | -1,111.1 |
| **CHANGES IN REVENUES[b]** | | | | | | | | | | | | |
| **Coverage Provisions** | -4.0 | -14.3 | -18.4 | -28.3 | -38.1 | -42.7 | -45.2 | -46.6 | -46.7 | -47.2 | -103.2 | -331.6 |
| **Noncoverage Provisions** | -4.8 | -46.9 | -46.2 | -53.2 | -61.1 | -67.1 | -82.1 | -94.6 | -104.3 | -100.7 | -212.1 | -660.8 |
| **Total Changes in Revenues** | -8.8 | -61.2 | -64.6 | -81.5 | -99.2 | -109.8 | -127.3 | -141.1 | -151.1 | -147.9 | -315.3 | -992.4 |
| **INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES** | | | | | | | | | | | | |
| **Net Increase or Decrease (-) in the Deficit** | 4.3 | 36.9 | 46.9 | 7.7 | -21.9 | -30.3 | -32.2 | -34.8 | -39.1 | -56.2 | 73.9 | -118.7 |

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

Notes: The costs of this legislation fall within budget functions 550 (health), 570 (Medicare), 600 (Income Security), and 650 (Social Security).
Numbers may not add up to totals because of rounding.

a. For outlays, a positive number indicates an increase (adding to the deficit) and a negative number indicates a decrease (reducing the deficit).

b. For revenues, a negative number indicates a decrease (adding to the deficit).

**Table 2 - ESTIMATE OF THE DIRECT SPENDING AND REVENUE EFFECTS OF H.R. 1628, THE AMERICAN HEALTH CARE ACT OF 2017, AS PASSED BY THE HOUSE OF REPRESENTATIVES ON MAY 4, 2017**

Billions of Dollars, by Fiscal Year

| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2017-2021 | 2017-2026 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **ESTIMATED CHANGES IN DIRECT SPENDING[a]** | | | | | | | | | | | | |
| **Coverage Provisions** | | | | | | | | | | | | |
| Estimated Budget Authority | -4.5 | 13.5 | -21.4 | -74.1 | -129.5 | -148.2 | -162.7 | -176.3 | -189.2 | -201.6 | -215.9 | -1,094.0 |
| Estimated Outlays | -4.5 | -24.5 | -17.9 | -74.8 | -122.5 | -141.7 | -159.4 | -176.2 | -190.1 | -202.9 | -244.2 | -1,114.5 |
| *On-Budget* | *-4.5* | *-24.5* | *-17.9* | *-74.8* | *-122.5* | *-141.5* | *-159.0* | *-175.7* | *-189.6* | *-202.4* | *-244.2* | *-1,112.2* |
| *Off-Budget* | *0* | * | * | * | * | *-0.2* | *-0.4* | *-0.6* | *-0.5* | *-0.5* | * | *-2.3* |
| **Title I - Committee on Energy and Commerce** | | | | | | | | | | | | |
| Sec. 101 - Prevention and Public Health Fund | | | | | | | | | | | | |
| Estimated Budget Authority | 0 | -0.9 | -0.9 | -1.0 | -1.0 | -1.5 | -1.0 | -1.7 | -2.0 | -2.0 | -3.8 | -12.0 |
| Estimated Outlays | 0 | -0.1 | -0.4 | -0.7 | -0.9 | -1.0 | -1.1 | -1.3 | -1.4 | -1.7 | -2.2 | -8.8 |
| Sec. 102 - Community Health Center Program | | | | | | | | | | | | |
| Estimated Budget Authority | 0.4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.4 | 0.4 |
| Estimated Outlays | 0 | 0.2 | 0.2 | * | 0 | 0 | 0 | 0 | 0 | 0 | 0.4 | 0.4 |
| Sec. 103 - Federal Payments to States | | | | | | | | | | | | |
| Estimated Budget Authority | * | -0.2 | * | * | * | * | * | * | * | * | -0.2 | -0.1 |
| Estimated Outlays | * | -0.2 | * | * | * | * | * | * | * | * | -0.2 | -0.1 |
| Sec. 111 - Repeal of Medicaid Provisions[b] | | | | | | | | | | | | |
| Estimated Budget Authority | 0 | 0 | 0 | -1.1 | -1.9 | -2.5 | -3.2 | -3.3 | -3.5 | -3.7 | -3.0 | -19.3 |
| Estimated Outlays | 0 | 0 | 0 | -1.1 | -1.9 | -2.5 | -3.2 | -3.3 | -3.5 | -3.7 | -3.0 | -19.3 |
| Sec. 112 - Repeal of Medicaid Expansion | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 113 - Elimination of DSH Cuts | | | | | | | | | | | | |
| Estimated Budget Authority | 0 | 0.6 | 1.0 | 1.9 | 2.8 | 3.7 | 4.7 | 5.7 | 5.7 | 5.1 | 6.3 | 31.2 |
| Estimated Outlays | 0 | 0.6 | 1.0 | 1.9 | 2.8 | 3.7 | 4.7 | 5.7 | 5.7 | 5.1 | 6.3 | 31.2 |
| Sec. 114 - Reducing State Medicaid Costs[b] | | | | | | | | | | | | |
| Estimated Budget Authority | 0 | -0.3 | -0.5 | -0.7 | -0.7 | -0.7 | -0.8 | -0.8 | -0.8 | -0.9 | -2.2 | -6.2 |
| Estimated Outlays | 0 | -0.3 | -0.5 | -0.7 | -0.7 | -0.7 | -0.8 | -0.8 | -0.8 | -0.9 | -2.2 | -6.2 |
| Sec. 115 - Safety Net Funding for Nonexpansion States | | | | | | | | | | | | |
| Estimated Budget Authority | 0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 0 | 0 | 0 | 0 | 8.0 | 10.0 |
| Estimated Outlays | 0 | 1.8 | 2.0 | 2.0 | 2.0 | 2.0 | 0.2 | 0 | 0 | 0 | 7.8 | 10.0 |
| Sec. 116 - Providing Incentives for Increased Frequency of Eligibility Redeterminations | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 117 - Medicaid Work Requirement | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 121 - Per Capita Allotment for Medical Assistance | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 131 - Repeal of Cost-Sharing Subsidy | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |

Continued

| **Table 2 Continued.** | | | | | | | | | | | 2017- | 2017- |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Billions of Dollars, by Fiscal Year | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2021 | 2026 |
| Sec. 132 - Patient and State Stability Fund | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 133 - Continuous Health Insurance Coverage Incentive | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 134 - Increasing Coverage Options | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 135 - Change in Permissible Age Variation | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 136 - Permitting States to Waive Certain ACA Requirements | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 137 - Constructions | | | | | | | | | | | | |
| Estimated Budget Authority | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Estimated Outlays | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Sec. 141 - American Health Care Implementation Fund | | | | | | | | | | | | |
| Estimated Budget Authority | 1.0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1.0 | 1.0 |
| Estimated Outlays | 0 | * | 0.2 | 0.3 | 0.2 | 0.2 | 0.1 | * | 0 | 0 | 0.7 | 1.0 |
| **Title II - Committee on Ways and Means** | | | | | | | | | | | | |
| Sec. 201 - Recapture Excess Advance Payments of Premium Tax Credits | | | | | | | | | | | | |
| Estimated Budget Authority | 0 | -2.0 | -2.2 | -0.7 | 0 | 0 | 0 | 0 | 0 | 0 | -4.9 | -4.9 |
| Estimated Outlays | 0 | -2.0 | -2.2 | -0.7 | 0 | 0 | 0 | 0 | 0 | 0 | -4.9 | -4.9 |
| Sec. 202 - Additional Modifications to Premium Tax Credit | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 203 - Small Business Tax Credit | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 204 - Individual Mandate | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 205 - Employer Mandate | | | | | | | | | | | | |
| Estimated Budget Authority | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Estimated Outlays | *included in estimate of coverage provisions* | | | | | | | | | | | |
| **Total Changes in Direct Spending** | | | | | | | | | | | | |
| Estimated Budget Authority | -3.1 | 12.9 | -22.0 | -73.7 | -128.3 | -147.2 | -163.0 | -176.5 | -189.8 | -203.1 | -214.2 | -1,093.8 |
| Estimated Outlays | -4.5 | -24.3 | -17.7 | -73.9 | -121.1 | -140.1 | -159.5 | -175.9 | -190.2 | -204.0 | -241.4 | -1,111.1 |
| *On-Budget* | *-4.5* | *-24.4* | *-17.7* | *-73.9* | *-121.0* | *-139.9* | *-159.1* | *-175.4* | *-189.7* | *-203.5* | *-241.4* | *-1,108.8* |
| *Off-Budget* | *0* | * | * | * | * | *-0.2* | *-0.4* | *-0.6* | *-0.5* | *-0.5* | * | *-2.3* |

Continued

| **Table 2 Continued.** | | | | | | | | | | | 2017- | 2017- |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Billions of Dollars, by Fiscal Year | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2021 | 2026 |
| **ESTIMATED CHANGES IN REVENUES[c]** | | | | | | | | | | | | |
| **Coverage Provisions** | -4.0 | -14.3 | -18.4 | -28.3 | -38.1 | -42.7 | -45.2 | -46.6 | -46.7 | -47.2 | -103.2 | -331.6 |
| *On-Budget* | *-4.3* | *-17.1* | *-21.0* | *-29.0* | *-37.8* | *-41.9* | *-45.0* | *-47.4* | *-48.5* | *-50.0* | *-109.2* | *-341.9* |
| *Off-Budget* | *0.3* | *2.8* | *2.6* | *0.7* | *-0.3* | *-0.8* | *-0.3* | *0.8* | *1.8* | *2.8* | *6.0* | *10.2* |
| **Title II - Committee on Ways and Means** | | | | | | | | | | | | |
| Sec. 201 - Recapture Excess Advance Payments of Premium Tax Credits | 0 | 0.6 | 0.7 | 0.5 | 0 | 0 | 0 | 0 | 0 | 0 | 1.8 | 1.8 |
| Sec. 202 - Additional Modifications to Premium Tax Credit | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 203 - Small Business Tax Credit | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 204 - Individual Mandate | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 205 - Employer Mandate | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 206 - Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits[d] | 0 | 0 | 0 | -3.4 | -6.9 | -8.7 | -10.7 | -13.4 | -16.4 | -6.6 | -10.3 | -66.0 |
| Sec. 207 - Repeal of Tax on Over-the-Counter Medications | * | -0.5 | -0.5 | -0.6 | -0.6 | -0.6 | -0.6 | -0.7 | -0.7 | -0.7 | -2.3 | -5.6 |
| Sec. 208 - Repeal of Increase of Tax on HSAs | 0 | * | * | * | * | * | * | * | * | * | * | -0.1 |
| Sec. 209 - Repeal of Limitations on Contributions to Flexible Spending Accounts | * | -1.0 | -1.2 | -1.6 | -1.7 | -1.8 | -2.2 | -2.6 | -3.3 | -4.1 | -5.5 | -19.4 |
| Sec. 210 - Repeal of Medical Device Excise Tax | 0 | -1.4 | -1.9 | -2.0 | -2.1 | -2.2 | -2.3 | -2.4 | -2.6 | -2.7 | -7.4 | -19.6 |
| Sec. 211 - Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy | * | -0.2 | -0.2 | -0.2 | -0.2 | -0.2 | -0.2 | -0.2 | -0.2 | -0.2 | -0.7 | -1.8 |
| Sec. 212 - Reduction of Income Threshold for Determining Medical Care Deduction | -0.1 | -9.7 | -9.1 | -10.5 | -11.9 | -13.4 | -15.0 | -16.8 | -18.7 | -20.5 | -41.3 | -125.7 |
| Sec. 213 - Repeal of Medicare Tax Increase | 0 | 0 | 0 | 0 | 0 | -0.5 | -9.3 | -14.7 | -16.5 | -17.6 | 0.0 | -58.6 |
| Sec. 214 - Refundable Tax Credit for Health Insurance Coverage | *included in estimate of coverage provisions* | | | | | | | | | | | |
| Sec. 215 - Maximum Contribution Limit to HSAs | 0 | -1.0 | -1.6 | -1.7 | -1.9 | -2.1 | -2.3 | -2.5 | -2.7 | -2.9 | -6.2 | -18.6 |
| Sec. 216 - Allow Both Spouses to Make Catch-Up Contributions to the Same HSA | 0 | * | * | * | * | * | * | * | -0.1 | -0.1 | -0.1 | -0.4 |
| Sec. 217 - Special Rule for Certain Expenses Incurred Before Establishment of HSAs | 0 | * | * | * | * | * | * | * | * | * | -0.1 | -0.2 |
| Sec. 221 - Repeal of Tax on Prescription Medications | -3.0 | -4.0 | -2.7 | -2.7 | -2.7 | -2.7 | -2.7 | -2.7 | -2.7 | -2.7 | -15.0 | -28.5 |
| Sec. 222 - Repeal of Health Insurance Tax | 0 | -12.8 | -13.5 | -14.3 | -15.1 | -15.9 | -16.8 | -17.8 | -18.7 | -19.7 | -55.7 | -144.7 |
| Sec. 231 - Repeal of Tanning Tax | * | -0.1 | -0.1 | -0.1 | -0.1 | -0.1 | -0.1 | -0.1 | -0.1 | -0.1 | -0.3 | -0.6 |
| Sec. 241 - Remuneration From Certain Insurers | * | -0.1 | * | * | -0.1 | -0.1 | -0.1 | -0.1 | -0.1 | -0.1 | -0.2 | -0.5 |
| Sec. 251 - Repeal of Net Investment Tax | -1.6 | -16.7 | -15.9 | -16.7 | -17.8 | -18.7 | -19.7 | -20.7 | -21.7 | -22.7 | -68.7 | -172.2 |
| **Total Changes in Revenues** | -8.8 | -61.2 | -64.6 | -81.5 | -99.2 | -109.8 | -127.3 | -141.1 | -151.1 | -147.9 | -315.3 | -992.4 |
| *On-Budget* | *-9.0* | *-63.2* | *-66.2* | *-80.3* | *-96.3* | *-105.8* | *-123.3* | *-137.3* | *-147.0* | *-147.4* | *-315.1* | *-975.9* |
| *Off-Budget* | *0.3* | *2.0* | *1.6* | *-1.2* | *-2.9* | *-4.0* | *-4.1* | *-3.8* | *-4.0* | *-0.4* | *-0.2* | *-16.6* |
| **INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES** | | | | | | | | | | | | |
| **Net Increase or Decrease (-) in the Deficit** | 4.3 | 36.9 | 46.9 | 7.7 | -21.9 | -30.3 | -32.2 | -34.8 | -39.1 | -56.2 | 73.9 | -118.7 |
| *On-Budget* | *4.5* | *38.9* | *48.5* | *6.5* | *-24.7* | *-34.1* | *-35.8* | *-38.1* | *-42.6* | *-56.1* | *73.7* | *-133.0* |
| *Off-Budget* | *-0.3* | *-2.0* | *-1.6* | *1.2* | *2.8* | *3.8* | *3.7* | *3.3* | *3.5* | *-0.1* | *0.2* | *14.3* |

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

Notes: Table is organized by the provisions of the bill incorporating the manager's amendments as posted on the House Committee on Rules website.
Numbers may not add up to totals because of rounding; DSH = Disproportionate Share Hospital; HSA = Health Savings Account;
ACA = Affordable Care Act; * = between -$50 million and $50 million.

a. For outlays, a positive number indicates an increase (adding to the deficit) and a negative number indicates a decrease (reducing the deficit).

b. Estimate interacts with the provision related to the Per Capita Allotment for Medical Assistance.

c. For revenues, a positive number indicates an increase (reducing the deficit) and a negative number indicates a decrease (adding to the deficit).

d. This estimate does not include effects of interactions with other subsidies; Those effects are included in estimates for other relevant provisions.

**Table 3 - ESTIMATE OF THE NET BUDGETARY EFFECTS OF THE INSURANCE COVERAGE PROVISIONS OF H.R. 1628, THE AMERICAN HEALTH CARE ACT OF 2017, AS PASSED BY THE HOUSE OF REPRESENTATIVES ON MAY 4, 2017**

Billions of Dollars, by Fiscal Year

| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | Total, 2017-2026 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicaid | * | -14 | -26 | -65 | -89 | -105 | -117 | -129 | -139 | -150 | -834 |
| Elimination of Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b] | -5 | -14 | -16 | -60 | -85 | -89 | -93 | -97 | -101 | -105 | -665 |
| Elimination of Small-Employer Tax Credits[b,c] | * | * | * | * | -1 | -1 | -1 | -1 | -1 | -1 | -6 |
| Tax Credits for Nongroup Insurance[b] | 0 | 0 | 0 | 33 | 48 | 51 | 55 | 59 | 62 | 66 | 375 |
| Elimination of Penalty Payments by Employers[c] | 2 | 16 | 20 | 15 | 16 | 18 | 19 | 20 | 22 | 23 | 171 |
| Elimination of Penalty Payments by Uninsured People | 3 | 3 | 3 | 3 | 4 | 4 | 4 | 4 | 4 | 5 | 38 |
| Patient and State Stability Fund Grants | 0 | 0 | 18 | 24 | 17 | 16 | 13 | 10 | 9 | 9 | 117 |
| Medicare[d] | 0 | 2 | 4 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 43 |
| Other Effects on Revenues and Outlays[e] | -1 | -3 | -4 | -2 | * | 2 | 1 | -2 | -5 | -8 | -23 |
| **Total Effect on the Deficit** | ***** | **-10** | **1** | **-46** | **-84** | **-99** | **-114** | **-130** | **-143** | **-156** | **-783** |
| **Memorandum: Additional Detail on Marketplace Subsidies and Related Spending and Revenues** | | | | | | | | | | | |
| Premium Tax Credit Outlay Effects | -3 | -9 | -11 | -39 | -57 | -60 | -62 | -65 | -68 | -70 | -445 |
| Premium Tax Credit Revenue Effects | -1 | -2 | -2 | -7 | -11 | -11 | -11 | -12 | -12 | -13 | -80 |
| Subtotal, Premium Tax Credits | -4 | -11 | -13 | -47 | -68 | -71 | -74 | -77 | -80 | -83 | -525 |
| Cost-Sharing Outlays | -1 | -2 | -2 | -9 | -13 | -13 | -14 | -14 | -15 | -16 | -98 |
| Outlays for the Basic Health Program | * | -1 | -1 | -5 | -5 | -5 | -6 | -6 | -6 | -7 | -42 |
| Collections for Risk Adjustment | 0 | * | 1 | 1 | 2 | 2 | 2 | 2 | 1 | 2 | 11 |
| Payments for Risk Adjustment | 0 | * | -1 | -1 | -2 | -2 | -2 | -2 | -1 | -2 | -11 |
| Total, Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b] | -5 | -14 | -16 | -60 | -85 | -89 | -93 | -97 | -101 | -105 | -665 |

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

Positive numbers indicate an increase in the deficit; 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 include 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 on revenues of changes in taxable compensation.

d. Effects arise mostly from changes in Disproportionate Share Hospital payments.

e. Consists mainly of the effects on revenues of changes in taxable compensation. CBO also estimates that outlays for Social Security benefits would decrease by about $2 billion over the 2017-2026 period.

**Table 4 - EFFECTS OF H.R. 1628, THE AMERICAN HEALTH CARE ACT OF 2017, AS PASSED BY THE HOUSE OF REPRESENTATIVES ON MAY 4, 2017, 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 AHCA | | | | | | | | | | |
| Medicaid[a] | * | -4 | -6 | -9 | -12 | -13 | -13 | -14 | -14 | -14 |
| Nongroup coverage, including marketplaces[b] | -1 | -8 | -8 | -10 | -9 | -9 | -8 | -7 | -6 | -6 |
| Employment-based coverage | * | -2 | -2 | * | 1 | 1 | * | -1 | -2 | -3 |
| Other coverage[c] | * | * | * | * | * | * | * | * | * | * |
| Uninsured | 1 | 14 | 16 | 19 | 21 | 21 | 21 | 22 | 23 | 23 |
| Uninsured Under the AHCA | 28 | 41 | 43 | 46 | 48 | 48 | 49 | 50 | 50 | 51 |
| Percentage of the Population Under Age 65 With Insurance Under the AHCA | | | | | | | | | | |
| Including all U.S. residents | 90 | 85 | 84 | 83 | 83 | 83 | 82 | 82 | 82 | 82 |
| Excluding unauthorized immigrants | 92 | 87 | 87 | 85 | 85 | 85 | 85 | 85 | 85 | 84 |

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 JCT consider individuals to be uninsured if they would not be enrolled in a policy that provides financial protection from major medical risks.

AHCA = American Health Care Act; * = between zero and 500,000.

a. Includes noninstitutionalized enrollees with full Medicaid benefits.

b. Under current law, many people can purchase subsidized health insurance coverage through the marketplaces (sometimes called exchanges) operated by the federal government, by state governments, or as partnerships between federal and state governments. People also can purchase unsubsidized coverage in the nongroup market outside of those marketplaces. Under the AHCA, people could receive subsidies for coverage purchased either inside or outside of the marketplaces.

c. 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.

**Table 5 - ILLUSTRATIVE EXAMPLES OF SUBSIDIES IN 2026 FOR NONGROUP HEALTH INSURANCE UNDER CURRENT LAW AND UNDER H.R. 1628, THE AMERICAN HEALTH CARE ACT, AS PASSED BY THE HOUSE OF REPRESENTATIVES ON MAY 4, 2017**

Dollars

| | Premium[a] | Premium Tax Credit[b] | Net Premium Paid |
|---|---|---|---|
| **SINGLE INDIVIDUAL WITH ANNUAL INCOME OF $26,500 (175 PERCENT OF FPL)[c]** | | | |
| **Current Law** | | | |
| 21 years old | 5,100 | 3,400 | 1,700 |
| 40 years old | 6,500 | 4,800 | 1,700 |
| 64 years old | 15,300 | 13,600 | 1,700 |
| **H.R. 1628 in an Illustrative State Not Requesting Waivers For Market Regulations** | | | |
| 21 years old | 4,200 | 2,450 | 1,750 |
| 40 years old | 6,550 | 3,650 | 2,900 |
| 64 years old | 21,000 | 4,900 | 16,100 |
| **H.R. 1628 in an Illustrative State with Moderate Changes to Market Regulations** | | | |
| 21 years old | 3,700 | 2,450 | 1,250 |
| 40 years old | 5,750 | 3,650 | 2,100 |
| 64 years old | 18,500 | 4,900 | 13,600 |
| **SINGLE INDIVIDUAL WITH ANNUAL INCOME OF $68,200 (450 PERCENT OF FPL)[c]** | | | |
| **Current Law** | | | |
| 21 years old | 5,100 | 0 | 5,100 |
| 40 years old | 6,500 | 0 | 6,500 |
| 64 years old | 15,300 | 0 | 15,300 |
| **H.R. 1628 in an Illustrative State Not Requesting Waivers for Market Regulations** | | | |
| 21 years old | 4,200 | 2,450 | 1,750 |
| 40 years old | 6,550 | 3,650 | 2,900 |
| 64 years old | 21,000 | 4,900 | 16,100 |
| **H.R. 1628 in an Illustrative State with Moderate Changes to Market Regulations** | | | |
| 21 years old | 3,700 | 2,450 | 1,250 |
| 40 years old | 5,750 | 3,650 | 2,100 |
| 64 years old | 18,500 | 4,900 | 13,600 |

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

All dollar amounts have been rounded to the nearest $50; FPL = federal poverty level.

About one-half of the population would reside in states not requesting waivers. About one-third of the population would reside in states with moderate changes to market regulations. Although the changes to regulations affecting community rating would be limited for that group, the extent of the changes in essential health benefits would vary widely.

a. For this illustration, CBO projected the average national premiums for a 21-year-old in the nongroup health insurance market in 2026 under current law and also projected how that premium would change under H.R. 1628. 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, which limits variation of premiums to a ratio of 3 to 1 for adults under current law and 5 to 1 for adults under H.R 1628. CBO projects that, under current law, most states will use the default 3-to-1 age-rating curve. Under H.R. 1628, CBO projects, most would use an age-rating curve with a maximum ratio of 5 to 1.

b. Under current law, 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. The reference premium is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which the person resides. A silver plan covers about 70 percent of the costs of covered benefits. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 for someone with income at 175 percent of the FPL takes into account the probability, estimated in CBO's March 2016 baseline, that additional indexing may apply. Under H.R. 1628, the premium tax credits offered for nongroup coverage would be indexed to the consumer price index for all urban consumers plus 1 percentage point. In 2026, CBO projects, those tax credits would be about 22 percent higher than the amounts specified in 2020.

c. 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. In 2026, CBO projects, a modified adjusted gross income of $26,500 would equal 175 percent of the FPL and $68,200 would equal 450 percent of the FPL.