AIRA Association of Insolvency & Restructuring Advisors

Patient Protection and Affordable Care Act's Impact on Small Businesses

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Denver, CO

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Patient Protection and Affordable Care Act (PPACA)

as Modified by the Reconciliation Act of 2010 and Politics

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Overview of PPACA

Coverage

- Goal of expanding healthcare coverage to 32 million uninsured; through
  - Health Insurance Exchanges
  - Subsidies
  - Cost reductions
  - Insurance Reform
  - Mandates to purchase health insurance

Update: As of the March 31, 2014 enrollment deadline approximately 7.1 million people signed up (Reuters – 4/1/14)

Health Insurance Exchanges

- Population purchases insurance through federal or state based exchanges
- Subsidies available to individuals and families based on 133% and 400% of poverty level, respectively
- Separate exchanges for small business (eff. 2014)
  - Postponed until 2015
- Funding available to state to establish exchanges within one year of enactment until January 2015

Update: 16 states have set up exchanges while 25 are relying on federal exchanges and nine mixed exchanges

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Subsidies

- Individuals and families can purchase own health insurance through exchanges, provided;
  - Not eligible for Medicare or Medicaid
  - Cannot be covered by employer
  - Cap on premiums on a sliding scale based on means

Update: 36% of covered workers are enrolled in a "grand-fathered" health plan in 2013, down from 56% in 2011 (Kaiser Family Foundation).

Paying for the Plan

- Tax on health insurance providers
- Payroll tax on investment income
- Excise tax on “Cadillac” plans (delayed until 2016)
- Tanning Tax – (10% excise tax)
- Expand RAC (Recovery Audit Contractor)
  - Empowers auditors to seek overpayments on contingency basis
- Reduce Medicare payments $500+ billion over ten years
  - Phases out disproportionate share payments to hospitals
- Eliminate Part D tax deductions for retiree benefits

Update: the cost of subsidies expected to cost $1.1 Trillion (Congressional Budget Office)

Paying for the Plan

- Requires states to expand Medicaid coverage
- Feds pay 100% of cost of newly eligible Medicaid individuals through 2016
  - Federal subsidy declines over time
  - Certain states have opted not to accept Federal funds
- Undocumented immigrants not eligible for Medicaid or Medicare, yet
  - Under EMTALA (Emergency Treatment and Active Labor Act) cannot be refused treatment

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Insurance Reform

- Cannot deny coverage to children with pre-existing conditions (6 mos. post enactment)
- 2014, cannot deny anyone coverage
- Children can stay on parent's plan until the age of 26
- Segregates private insurance from governmental for abortion
- Health plans not required to offer abortion coverage
- Employers must offer plans with affordable premiums

Update: private premiums increased 20% to 200% across the country; Deductibles soared for most plans (WSJ report of Manhattan Institute – 5/1/2014)

Mandates

- By 2014 everyone must purchase health insurance
- Employers with 50 or more employees must provide insurance or pay fee/fine of $2000/worker/year (if any worker receives federal subsidies)
  - Premiums cannot exceed 9.5% of employee income
  - Must cover 60% of costs
  - Fail either requirement; fine increases to $3000/worker
- Undocumented immigrants cannot buy health insurance

Update: Federal government intends to collect fees from individuals only by recouping from federal tax refunds….

The average health premium exceeds $5,000/worker (Kaiser Family Foundation)

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Small Business Issues

Small business issues

- Small business exchanges won't offer plans until 2015
- Reporting requirements will be time consuming
  - Lack of HR Departments in small businesses
- Costs covered through taxes and fees
  - Ability to pass on to employees limited
  - Costs passed on to customers or suffer lower profits
- Cadillac tax on premium plans
- Use of part-time employees limited
  - 30 hour week considered full-time
  - Feds calculate full-time equivalents to overcome part-time use
- High deductibles will strain "middle-class" employees

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Impact on Delivery of Healthcare Services and Employer Decisions

Impact on Delivery of Healthcare Services and Employer Decisions

- Two tiered system developing like U.K. and Canada
- Lack of choice given reduction in physicians accepting
  - Lower reimbursed plans
  - Medicare/Medicaid
  - Growth in concierge services
    - Increased 30% last year and growing
    - Cash only medical practices not accepting insurance
- Elimination of tertiary facilities from networks
  - World class medical centers deemed too costly
  - Outcomes/quality could be impacted

Impact on Delivery of Healthcare Services and Employer Decisions

- Focus on low cost providers, yet
  - punitive penalties against low quality providers
  - Employees choices for quality care will be limited
- Health benefits/wages will drive employee decisions
  - Potential for higher wages to offset high deductibles
  - Standardization of plans will make other benefits critical
- Higher premiums for health plans
  - Limited ability to pass on to employees given “affordable rule”
  - Health premiums across U.S. have increased more than 25% over the past five years (Kaiser Family Foundation)
  - Pass costs to consumers or accept lower profitability

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Case Study

Case study

- Client: Not-For-Profit Organization
- Key Statistics: $30MM in revenue, $65MM in assets, $2MM of EBITDA
- Dependent on part-time workers not eligible for benefits
- Currently evaluating pro-forma financial position
  - Declining revenues and performance a critical concern
  - Part of consensual debt restructuring
- New health benefit costs estimated at $150 - $300K
  - Represents potentially 1% of revenue
  - Reduce EBIDA by 15%
  - Impacts pro-forma debt service capabilities which are already constrained due to market pressures

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Update on Litigation Related to ACA

Update on Litigation related to the ACA

- Halbig v. Sebelius – DC Circuit
- Hotze v. Sebelius – 5th Circuit
- Kawa v. Lew – 11th Circuit
- Sebelius v. Hobby Lobby –Supreme Court
- Constega v. Sebelius – Supreme Court
- Little Sisters v. Sebelius – Supreme Court
- Sissel v. HHS - DC Circuit
- Indiana v. IRS – Federal District Court
- Johnson v. OPM – Federal District Court
- Curative Legislation – more regulation?

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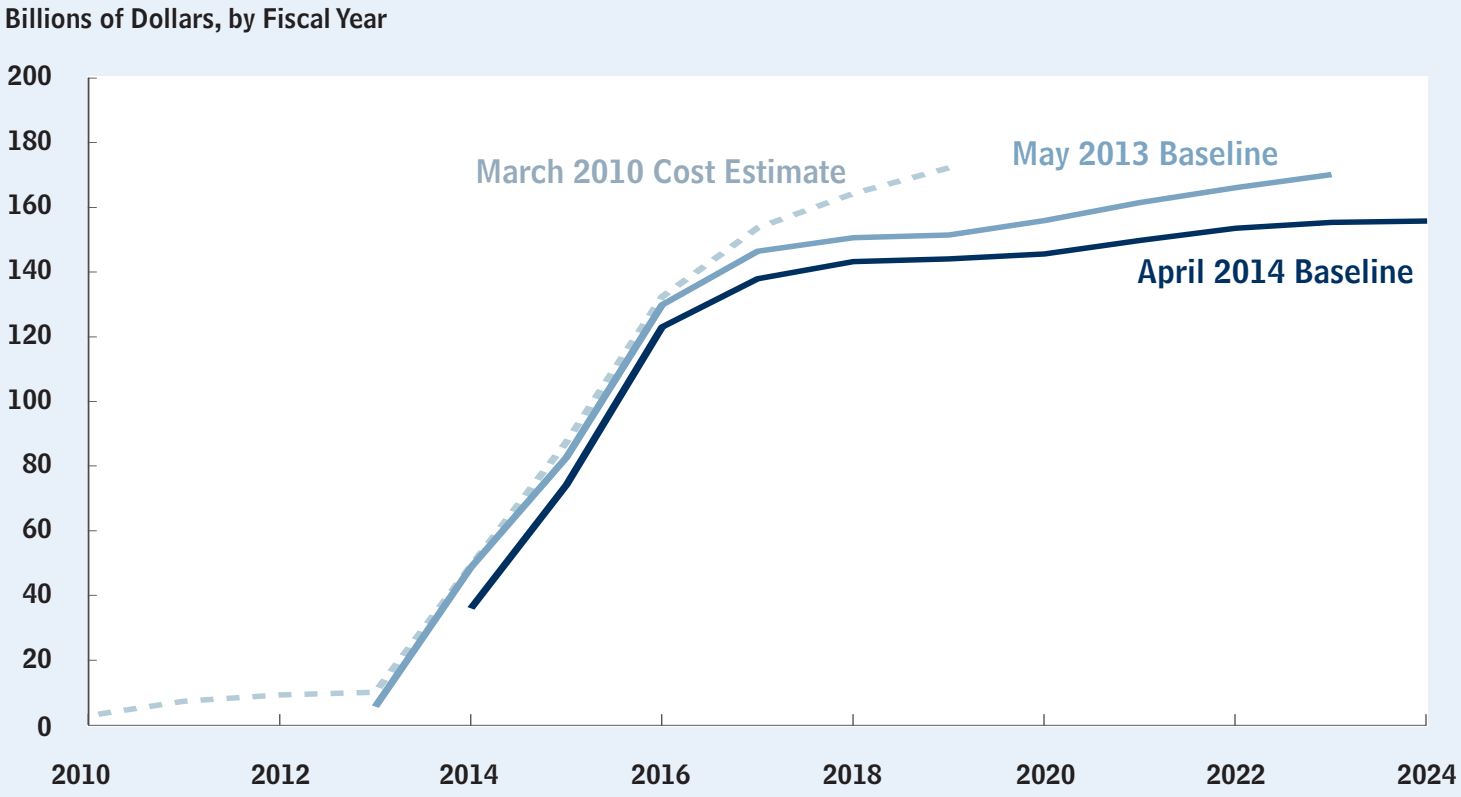
CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

CBO

Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014



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

APRIL 2014

Notes

As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act and the health care provisions of the Health Care and Education Reconciliation Act of 2010, as affected by subsequent judicial decisions, statutory changes, and administrative actions.

Numbers in the text and tables may not add up to totals because of rounding.

Unless otherwise indicated, all years are federal fiscal years, which run from October 1 to September 30.

Unless otherwise indicated, estimates of insurance coverage throughout this report reflect average enrollment over the course of a calendar year and include spouses and dependents covered under family policies; people with multiple sources of coverage are placed in a single category based on their primary coverage.

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Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014

Summary

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have updated their estimates of the budgetary effects of the provisions of the Affordable Care Act (ACA) that relate to health insurance coverage. The new estimates, which are included in CBO's latest baseline projections, reflect CBO's most recent economic forecast, account for administrative actions taken and regulations issued through March 2014, and incorporate new data and various modeling updates.[1]

Relative to their previous projections, CBO and JCT now estimate that the ACA's coverage provisions will result in lower net costs to the federal government: The agencies now project a net cost of $36 billion for 2014, $5 billion less than the previous projection for the year; and $1,383 billion for the 2015–2024 period, $104 billion less than the previous projection.[2]

The estimated net costs for 2014 stem almost entirely from spending for subsidies that are to be provided through insurance exchanges (often called marketplaces) and from an increase in spending for Medicaid (see Table 1). For the 2015–2024 period, the projected net costs consist of the following:

- Gross costs of $1,839 billion for subsidies and related spending for insurance obtained through the exchanges, Medicaid, the Children's Health Insurance Program (CHIP), and tax credits for small employers; and
- A partial offset of $456 billion in receipts from penalty payments, additional revenues resulting from the excise tax on high-premium insurance plans, and the effects on income and payroll tax revenues and associated outlays arising from projected changes in employer coverage.

Those estimates address only the insurance coverage provisions of the ACA, which do not generate all of the act's budgetary effects. Many other provisions, on net, are expected to reduce budget deficits. Considering all of the provisions—including the coverage provisions—CBO and JCT estimated in July 2012 (their most recent comprehensive estimate) that the ACA's overall effect would be to reduce federal deficits.[3]

1. For CBO's latest baseline projections, see Congressional Budget Office, *Updated Budget Projections: 2014 to 2024* (April 2014), www.cbo.gov/publication/45229.

2. For CBO and JCT's previous projections of the effects of the ACA's insurance coverage provisions, see Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, Appendix B (February 2014), www.cbo.gov/publication/45010.

3. See Congressional Budget Office, letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act (July 24, 2012), www.cbo.gov/publication/43471. CBO and JCT can no longer determine exactly how the provisions of the ACA that are not related to the expansion of health insurance coverage have affected their projections of direct spending and revenues. The provisions that expand insurance coverage established entirely new programs or components of programs that can be isolated and reassessed. In contrast, other provisions of the ACA significantly modified existing federal programs and made changes to the Internal Revenue Code. Isolating the incremental effects of those provisions on previously existing programs and revenues four years after enactment of the ACA is not possible.

Table 1.

Effects on the Deficit of the Insurance Coverage Provisions of the Affordable Care Act

(Billions of dollars, by fiscal year)

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total, 2015-2024
Exchange Subsidies and Related Spending[a]	17	36	77	94	101	107	112	119	125	129	132	1,032
Medicaid and CHIP Outlays[b]	20	42	62	70	77	82	84	87	91	96	101	792
Small-Employer Tax Credits[c]	1	2	1	1	1	1	1	2	2	2	2	15
Gross Cost of Coverage Provisions	38	80	141	164	180	190	197	208	218	227	235	1,839
Penalty Payments by Uninsured People	*	-2	-4	-4	-4	-5	-5	-5	-5	-6	-6	-46
Penalty Payments by Employers[c]	0	0	-8	-12	-13	-15	-16	-17	-18	-20	-21	-139
Excise Tax on High-Premium Insurance Plans[c]	0	0	0	0	-5	-10	-13	-16	-20	-25	-30	-120
Other Effects on Revenues and Outlays[d]	-2	-3	-6	-11	-14	-16	-18	-20	-21	-21	-22	-152
Net Cost of Coverage Provisions	**36**	**74**	**123**	**138**	**143**	**144**	**146**	**150**	**153**	**155**	**156**	**1,383**
Memorandum:												
Changes in Mandatory Spending	35	92	147	173	181	192	200	211	221	230	238	1,885
Changes in Revenues[e]	-1	18	24	35	37	48	54	61	68	75	83	503

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

Notes: These numbers exclude effects on the deficit of provisions of the Affordable Care Act that are not related to insurance coverage. They also exclude federal administrative costs subject to appropriation. (CBO has previously estimated that the Internal Revenue Service would need to spend between $5 billion and $10 billion over the 2010–2019 period to implement the Affordable Care Act and that the Department of Health and Human Services and other federal agencies would also need to spend $5 billion to $10 billion over that period.) In addition, the Affordable Care Act included explicit authorizations for spending on a variety of grant and other programs; that funding is also subject to future appropriation action.

Unless otherwise noted, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

CHIP = Children's Health Insurance Program; * = between zero and -$500 million.

a. Includes spending for exchange grants to states and net collections and payments for risk adjustment, reinsurance, and risk corridors.

b. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP over the 2015–2024 period will be about $46 billion higher because of the coverage provisions of the Affordable Care Act than it would be otherwise.

c. These effects on the deficit include the associated effects of changes in taxable compensation on revenues.

d. Consists mainly of the effects of changes in taxable compensation on revenues. CBO estimates that outlays for Social Security benefits will increase by about $7 billion over the 2015–2024 period and that the coverage provisions will have negligible effects on outlays for other federal programs.

e. Positive numbers indicate an increase in revenues, and negative numbers indicate a decrease in revenues.

CBO and JCT have updated their baseline estimates of the budgetary effects of the ACA's insurance coverage provisions many times since that legislation was enacted in March 2010. As time has passed, the period spanned by the estimates has changed. But a year-by-year comparison shows that CBO and JCT's estimates of the net budgetary impact of the ACA's insurance coverage provisions have decreased, on balance, over the past four years.

This report describes the insurance coverage provisions of the ACA and CBO and JCT's current estimates of the budgetary effects of those provisions. That discussion is followed by an explanation of how and why those estimates differ from the interim estimates in CBO's February 2014 baseline. The report concludes with a discussion of the ways in which current estimates of the ACA's coverage provisions differ from those made when the law was enacted in March 2010.

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

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

- The ACA allows many individuals and families to purchase subsidized insurance through the exchanges (or marketplaces) operated either by the federal government or by a state government.
- States are permitted but not required to expand eligibility for Medicaid.
- Most legal residents of the United States must either obtain health insurance or pay a penalty for not doing so (under a provision known as the individual mandate).
- Certain employers that decline to offer their employees health insurance coverage that meets specified standards will be assessed penalties.
- A federal excise tax will be imposed on some health insurance plans with high premiums.
- Most insurers offering policies either for purchase through the exchanges or directly to consumers outside of the exchanges must meet several requirements: For example, they must accept all applicants regardless of health status; they may vary premiums only by age, smoking status, and geographic location; and they may not limit coverage for preexisting medical conditions.[4]
- Certain small employers that provide health insurance to their employees will be eligible to receive a tax credit of up to 50 percent of the cost of that insurance.

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

CBO and JCT estimate that the insurance coverage provisions of the ACA will increase the proportion of the nonelderly population with insurance from roughly 80 percent in the absence of the ACA to about 84 percent in 2014 and to about 89 percent in 2016 and beyond (see Table 2). CBO and JCT project that 12 million more nonelderly people will have health insurance in 2014 than would have had it in the absence of the ACA. They also project that 19 million more people will be insured in 2015, 25 million more will be insured in 2016, and 26 million more will be insured each year from 2017 through 2024 than would have been the case without the ACA.

Those gains in coverage will be the net result of many changes in insurance coverage relative to what would have occurred in the absence of the ACA. In 2018 and later years, 25 million people are projected to have coverage through the exchanges, and 13 million more, on net, are projected to have coverage through Medicaid and CHIP than would have had it in the absence of the ACA. Partly offsetting those increases, however, are projected net decreases in employment-based coverage and in coverage in the nongroup market outside the exchanges.

The estimated increase in insurance coverage in 2014 represents the number of people who are expected to be insured this year under current law minus the number who would have been insured this year in the absence of the ACA. That number may differ from the number of people who are expected to be insured this year minus the number who were insured last year, because people move in and out of insurance coverage over time as a result of changes in employment, family circumstances, and other factors. In particular, some people who had insurance coverage in 2013 and would have become uninsured in 2014 for one reason or another in the absence of the ACA will, under the ACA, be covered in 2014 through the exchanges, Medicaid, or CHIP. Those people are included in CBO and JCT's estimate of the increase in insurance coverage in 2014 that stems from the ACA.[5] CBO and JCT have not estimated the number of people who were uninsured in 2013 and will be insured in 2014.

4. Premiums charged for adults 21 or older may not vary according to age by a ratio of more than 3:1.

5. Correspondingly, people who were uninsured in 2013 but would have obtained insurance in 2014 in the absence of the ACA are not counted as part of the increase in insurance coverage resulting from the ACA.

Table 2.

Effects of the Affordable Care Act on Health Insurance Coverage

(Millions of nonelderly people, by calendar year)

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Insurance Coverage Without the ACA[a]											
Medicaid and CHIP	35	35	34	33	33	34	34	34	35	35	35
Employment-based coverage	156	158	160	163	164	165	165	165	166	166	166
Nongroup and other coverage[b]	24	24	25	25	26	26	26	26	27	27	27
Uninsured[c]	54	55	55	55	55	56	56	56	57	57	57
Total	270	272	274	277	278	280	281	282	283	284	285
Change in Insurance Coverage Under the ACA											
Insurance exchanges	6	13	24	25	25	25	25	25	25	25	25
Medicaid and CHIP	7	11	12	12	13	13	13	13	13	13	13
Employment-based coverage[d]	*	-2	-7	-7	-8	-8	-8	-8	-8	-7	-7
Nongroup and other coverage[b]	-1	-3	-4	-4	-4	-4	-4	-4	-4	-5	-5
Uninsured[c]	-12	-19	-25	-26	-26	-26	-26	-26	-26	-26	-26
Uninsured Under the ACA											
Number of uninsured nonelderly people[c]	42	36	30	30	29	30	30	30	31	31	31
Insured as a percentage of the nonelderly population											
Including all U.S. residents	84	87	89	89	89	89	89	89	89	89	89
Excluding unauthorized immigrants	86	89	91	92	92	92	92	92	92	92	92
Memorandum:											
Exchange Enrollees and Subsidies											
Number with unaffordable offer from employer[e]	**	**	**	**	**	**	**	**	**	**	**
Number of unsubsidized exchange enrollees (Millions of people)[f]	1	3	5	6	6	6	6	6	6	6	6
Average exchange subsidy per subsidized enrollee (Dollars)	4,410	4,250	4,830	4,930	5,300	5,570	5,880	6,220	6,580	6,890	7,170

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

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

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

a. Figures reflect average enrollment over the course of a year and include spouses and dependents covered under family policies; people reporting multiple sources of coverage are assigned a primary source.

b. "Other" includes Medicare; the changes under the ACA are almost entirely for nongroup coverage.

c. The uninsured population includes people who will be unauthorized immigrants and thus ineligible either for exchange subsidies or for most Medicaid benefits; people who will be ineligible for Medicaid because they live in a state that has chosen not to expand coverage; people who will be eligible for Medicaid but will choose not to enroll; and people who will not purchase insurance to which they have access through an employer, an exchange, or directly from an insurer.

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

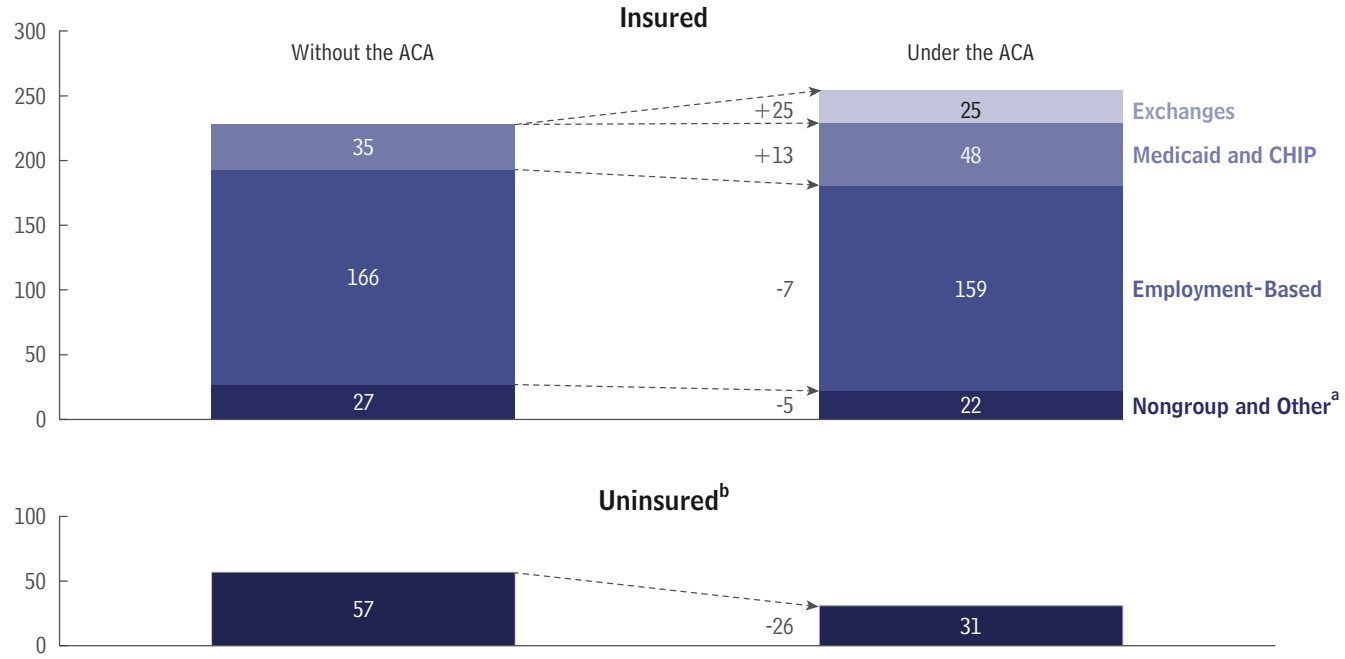
e. Workers who would have to pay more than a specified share of their income (9.5 percent in 2014) for employment-based coverage could receive subsidies through an exchange.

f. Excludes coverage purchased directly from insurers outside of an exchange.

Figure 1.

Effects of the Affordable Care Act on Health Insurance Coverage, 2024

(Millions of nonelderly people)



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

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

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

a. "Other" includes Medicare; the changes under the ACA are almost entirely for nongroup coverage.

b. The uninsured population includes people who will be unauthorized immigrants and thus ineligible either for exchange subsidies or for most Medicaid benefits; people who will be ineligible for Medicaid because they live in a state that has chosen not to expand coverage; people who will be eligible for Medicaid but will choose not to enroll; and people who will not purchase insurance to which they have access through an employer, an exchange, or directly from an insurer.

Despite the substantial projected increases in insurance coverage under the ACA, CBO and JCT estimate that in 2024, 31 million people, or roughly one in nine nonelderly U.S. residents, will be without health insurance (see Figure 1). In that year, about 30 percent of those uninsured people are expected to be unauthorized immigrants and thus ineligible either for exchange subsidies or for most Medicaid benefits; about 5 percent will be ineligible for Medicaid because they live in a state that has chosen not to expand coverage; about 20 percent will be eligible for Medicaid but will choose not to enroll; and the remaining 45 percent will not purchase insurance to which they have access through an employer, an exchange, or directly from an insurer.

Estimated Effects on Sources of Insurance Coverage and the Federal Budget

Most of the budgetary effects of the ACA's coverage provisions will stem from the subsidies for insurance purchased through the exchanges and from increased costs for Medicaid. That additional spending will be partially offset by penalty payments made by individuals and employers, by additional revenues resulting from the excise tax on high-premium insurance plans, and by the effects on income and payroll tax revenues and associated outlays stemming from a reduction in employment-based insurance coverage.

Coverage Through the Exchanges and Premiums and Subsidies for Such Coverage

Subsidies and related spending for insurance obtained through the exchanges constitute the largest share of the costs of the ACA's coverage provisions.

Coverage Through the Exchanges. CBO and JCT estimate that, over the course of calendar year 2014, an average of 6 million people will be covered by insurance obtained through the exchanges. The total number who will have such coverage at some points during the year is expected to be more than the average because some people will be covered for only part of the year.

Coverage through the exchanges will vary over the course of 2014 not only because of the increase during open enrollment in the first few months of the year but also because people who experience qualifying life events, such as the loss of employment-based insurance or the birth of a child, will be allowed to purchase coverage later in the year, and because some people will drop their exchange-based coverage as they become eligible for employment-based insurance. The estimate of 6 million people does not include people who enrolled through the exchanges but failed to pay their initial premiums, because they will not be covered; it also does not include people in any part of the year for which they lose coverage because of nonpayment of premiums.

Thus, CBO and JCT's estimate of 6 million people receiving such coverage in 2014 cannot be compared directly with the number of people who have enrolled through the exchanges as of any given date.[6] The number of people who will have coverage through the exchanges in 2014 will not be known precisely until after the year has ended.

CBO and JCT anticipate that coverage through the exchanges will increase substantially over time as more people respond to subsidies and to penalties for failure to obtain coverage. Coverage through the exchanges is projected to increase to an average of 13 million people in 2015, 24 million in 2016, and 25 million in each year between 2017 and 2024. Roughly three-quarters of those enrollees are expected to receive exchange subsidies.

Premiums for Exchange Coverage. CBO and JCT estimate that the average cost of individual policies for the second-lowest-cost "silver" plan in the exchanges—the benchmark for determining exchange subsidies—is about $3,800 in 2014.[7] That estimate represents a national average, and it reflects CBO and JCT's projections of the age, sex, health status, and geographic distribution of those who will obtain coverage through the exchanges in 2014. That benchmark premium is projected to rise slightly in 2015, to about $3,900, and then to rise more rapidly thereafter, reaching about $4,400 in 2016 and about $6,900 in 2024.[8] Thus, premiums are projected to increase by about 6 percent per year, on average, from 2016 to 2024. The current projection of the average premium for the benchmark silver plan in 2016 of about $4,400 is 15 percent below the comparable estimate of $5,200 published by CBO in November 2009.[9]

CBO and JCT anticipate that rising health care costs per person will continue to be the primary factor raising health insurance premiums over the next decade. Projecting the growth in health care spending per person always involves uncertainty, however, and it is particularly challenging in light of the recent slowdown in that growth that has been experienced by private insurers, as well as by the Medicare and Medicaid programs. Moreover,

6. See, for example, Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace: March Enrollment Report for the Period: October 1, 2013–March 1, 2014*, ASPE Issue Brief (March 2014), http://go.usa.gov/Ksc4.

7. The size of the tax credit (or premium subsidy) that someone will receive will be based in part on the premium of the second-lowest-cost silver plan (which covers about 70 percent of the costs of covered benefits) offered through the exchange in which that person participates.

8. The average premium for all plans purchased through the exchanges will differ from the average for the benchmark plans because people can purchase plans with higher or lower actuarial value than the benchmark and with premiums that are more or less expensive than those for the second-lowest-cost silver plan.

9. See Congressional Budget Office, letter to the Honorable Evan Bayh providing an analysis of health insurance premiums under the Patient Protection and Affordable Care Act (November 30, 2009), www.cbo.gov/publication/41792. Similarly, the current projection of the average premium for a self-only policy in the employment-based market in 2016 of about $6,400 is 14 percent below the comparable estimate of $7,400 published by CBO in November 2009. See Congressional Budget Office, *Selected CBO Publications Related to Health Care Legislation, 2009–2010* (December 2010), p. 222, www.cbo.gov/publication/21993.

views differ on how much of the slowdown is attributable to the recession and its aftermath and how much to other factors. Exchange premiums will be affected not only by underlying growth in health care costs but also by changes in the average health status of enrollees, changes in federal programs that spread risk, and changes in plan characteristics. Those three factors are discussed in more detail below.

Effects of the Health Status of Exchange Enrollees. The premiums for policies sold in the exchanges will be influenced by the expected health status of enrollees in the exchanges, and CBO and JCT anticipate that exchange enrollees in the future will be healthier, on average, than the smaller number of people who are obtaining such coverage in 2014. Such an outcome would be expected if people who are less healthy are more eager to obtain insurance, and it would be consistent with enrollment and medical claims in Massachusetts after that state introduced subsidized exchanges in 2006.[10] That factor is expected to lower premiums in 2015 relative to those in 2014.

CBO and JCT do not expect any further significant shifts in the average health status of exchange enrollees after 2015 under current law. As a result, that factor is not expected to raise or lower premiums after 2015.

Actual exchange premiums for 2015 may differ from those CBO and JCT have projected because insurers could have different expectations of their costs for that year. For example, if enrollees in exchange plans in 2014 are significantly less healthy than insurers had expected, and their care therefore is significantly more costly, insurers could project notably higher costs in 2015 and charge correspondingly higher premiums in 2015 than in 2014. However, anecdotal reports to date have been mixed and provide no clear evidence that insurers have been substantially surprised by the health status of their enrollees. Moreover, CBO and JCT's projections are national averages, and premiums in some places in the country will probably be much higher or lower in 2015 than CBO and JCT have projected for the nation as a whole.

Effects of the Reinsurance Program. The premiums for policies sold in the exchanges also are affected by the reinsurance payments that the government will make to plans whose enrollees incur particularly high costs for medical care—that is, costs that are above a specified threshold and up to a certain maximum. The reinsurance program applies to all nongroup insurance that complies with the ACA's market and benefit standards and that is issued from 2014 through 2016, either within or outside of the exchanges. (For more information on the ACA's provisions governing the nongroup market, see Box 1.)

Under the reinsurance program, CBO and JCT project, the government will collect $10 billion in 2015, $6 billion in 2016, and $4 billion in 2017 (for insurance issued in 2014, 2015, and 2016) through a per-enrollee assessment on most private insurance plans, including self-insured plans and plans that are offered in the large-group market.[11] CBO and JCT expect that reinsurance payments scheduled for insurance provided in 2014 are large enough to have reduced exchange premiums this year by approximately 10 percent relative to what they would have been without the program. However, such payments will be significantly smaller for 2015 and 2016, and they will not occur for the years following. Therefore, that program is expected to have resulted in lower premiums in 2014, to reduce premiums by smaller amounts in 2015 and 2016 than in 2014, and to have no direct effect thereafter.

Effects of the Characteristics of Exchange Plans. The plans being offered through exchanges in 2014 appear to have, in general, lower payment rates for providers, narrower networks of providers, and tighter management of their subscribers' use of health care than employment-based plans do.[12] Those features allow insurers that offer plans through the exchanges to charge lower premiums (although they also make plans somewhat less attractive

10. See Amitabh Chandra, Jonathan Gruber, and Robin McKnight, "The Importance of the Individual Mandate—Evidence From Massachusetts," *New England Journal of Medicine* (January 2011), vol. 364, no. 4, pp. 293–295, http://tinyurl.com/496lfct. CBO analyzed unpublished data provided by the authors of that article.

11. Under reinsurance, an additional $5 billion will be collected from health insurance plans and deposited into the general fund of the U.S. Treasury. That amount is the same as the amount appropriated for the Early Retiree Reinsurance Program (which was in operation before 2014) and is not included here as part of the budgetary effects of the ACA's insurance coverage provisions.

12. See McKinsey & Company, *Exchanges Go Live: Early Trends in Exchange Dynamics* (October 2013), http://tinyurl.com/qd3kqfl, and *Emerging Exchange Dynamics: Temporary Turbulence or Sustainable Market Disruption?* (September 2013), http://tinyurl.com/og3tu9d.

Box 1.

Nongroup Health Plans Under the Affordable Care Act

Starting in 2014, companies that sell nongroup insurance plans, whether through the exchanges or not, must—in most cases—follow certain rules specified in the Affordable Care Act (ACA).[1] All new plans, for example, must cover a set of essential health benefits, and their premiums may not vary among enrollees on the basis of health. Insurers selling nongroup plans through the exchanges must offer at least one "silver" plan (with an actuarial value of 70 percent) and one "gold" plan (80 percent).[2] Insurers selling plans outside of the exchanges must follow the same system of "metal" tiers, ranging from 60 percent ("bronze") to 90 percent ("platinum"), but, unlike insurers in the exchanges, they are exempt from the requirement to offer at least one silver and one gold plan.[3] Plans must be available for anyone to purchase during specified annual open-enrollment periods and, outside of those periods, to anyone who experiences a qualifying life event, such as the birth of a child or a change in employment. States may impose additional requirements on insurers that offer nongroup coverage inside or outside of the exchanges.

Because of the uncertainty about average health care costs for people enrolling under the new rules governing the nongroup market, plans that comply with the ACA's rules are protected from some of the risk that they will attract enrollees whose health care costs will prove to be especially high.[4] The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) expect that people who purchase ACA-compliant plans outside of the exchanges would probably not have been eligible for subsidies had they obtained coverage through the exchanges and that many would have purchased coverage in the nongroup market in the absence of the ACA.

1. Nongroup plans are those sold to individuals and families rather than to employers or groups of people.
2. A plan's actuarial value is the share of costs for covered services that it would pay, on average, with a broadly representative group of people enrolled.
3. People under 30 years of age and those who qualify for certain exemptions from the individual mandate penalty also may purchase catastrophic coverage inside or outside of the exchanges. Such plans incorporate the ACA's set of essential health benefits, but they are not required to meet a minimum actuarial value of 60 percent. Catastrophic plans have a high deductible that is equal to the plan's out-of-pocket maximum and do not qualify for premium or cost-sharing subsidies, even when offered through the exchanges.
4. Among the federal safeguards that reduce the risk are the risk adjustment and reinsurance programs (which apply to all ACA-compliant nongroup plans), and risk corridors (which cover all exchange plans and also include certain plans offered outside the exchanges); for more discussion, see Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, Appendix B (February 2014), www.cbo.gov/publication/45010.

Continued

to potential enrollees). As projected enrollment in exchange plans grows from an average of 6 million in 2014 to 24 million in 2016, CBO and JCT anticipate that many plans will not be able to sustain provider payment rates that are as low or networks that are as narrow as they appear to be in 2014. CBO and JCT expect that exchange plans will still have lower provider payment rates, more limited provider networks, and stricter management of care, on average, than employment-based plans but that the differences between employment-based plans and exchange plans will narrow as exchange enrollment increases. That pattern will put upward pressure on exchange premiums over the next couple of years, although CBO and JCT anticipate that the plans' characteristics will stabilize after 2016.

Subsidies for Exchange Coverage and Related Spending. Exchange subsidies depend both on benchmark premiums in the exchanges and on certain characteristics of enrollees, such as age, family size, geographic location, and income. CBO and JCT project that the average subsidy will be $4,410 in 2014, that it will decline to $4,250 in 2015, and that it will then rise each year to reach $7,170 in 2024 (see Table 2 on page 4).[13] The projected decrease from 2014 to 2015 stems from the small projected increase in premiums in 2015 and a shift in the income of people who are projected to enroll in the

13. The average exchange subsidy per subsidized enrollee includes premium subsidies and cost-sharing subsidies and thus may exceed the average benchmark premium in the exchanges.

Box 1. Continued

Nongroup Health Plans Under the Affordable Care Act

Under certain limited circumstances, insurers are allowed to continue to sell policies that do not comply with the ACA's rules. Such noncompliant policies, for example, might not cover all of the essential benefits specified in the ACA, might have an actuarial value of less than 60 percent, or might charge lower premiums for people in better health.[5] Those limited circumstances include the following:

- Some policies can be "grandfathered" in. Policies that were in effect in March 2010 and that have been maintained continuously without substantial changes in benefits or in costs to enrollees are exempt from most of the ACA's rules.
- Some states permitted insurers to allow enrollees to renew policies that did not comply with certain market and benefit rules for 2014 so long as the policy year began before January 1, 2014.
- Some policies can qualify under what is known as transitional relief. In November 2013, the Administration announced that states could accept renewals of noncompliant policies for a policy year starting between January 1, 2014, and October 1, 2014. In March 2014, that transitional relief was extended for two more years. (More detail on recent administrative actions that affect noncompliant plans is provided in "Availability of Noncompliant Plans" in the main text.)

CBO and JCT estimate that relatively few people will be enrolled in noncompliant nongroup plans. The agencies project that, under the ACA, in 2014 about 2 million people will purchase noncompliant plans; they anticipate that enrollment in such plans will decline to negligible numbers by 2016. They also project that enrollment in nongroup plans *through the exchanges* will average 6 million people in 2014, 13 million in 2015, and 24 million or 25 million each year thereafter, and that roughly 5 million people will enroll in ACA-compliant plans *outside of the exchanges* each year from 2014 through 2024. That last estimate is especially uncertain because information on the number of people who have purchased coverage in the nongroup market in past years is incomplete and varies widely by data source.

In the absence of the ACA, 9 million to 10 million people would have enrolled in nongroup coverage each year from 2014 through 2024, CBO and JCT estimate. With roughly 5 million people expected to enroll in nongroup plans in years after 2015 under the ACA (excluding those people who purchase policies through the exchanges), that number will be 4 million to 5 million lower under the ACA than the number projected in the absence of the law (see the change in coverage labeled "Nongroup and other coverage" in Table 2 of the main text).

5. Insurers may also sell other policies that are service specific (including dental and vision), that cover accidental injury or specific diseases, or that are in effect for only a short time; such plans do not, on their own, count as providing minimum essential coverage under the ACA. Such plans are not included in CBO and JCT's estimates of coverage under the ACA.

exchanges in 2015 compared with those enrolling in 2014. The increases after 2015 stem largely from the projected increase in premiums.

CBO and JCT estimate that subsidies provided through the exchanges and related spending will total $17 billion in 2014. That estimate is uncertain in part because the number of people who will have such coverage is not yet known and in part because detailed information on the demographics and family income of the people who have such coverage—and on the subsidies they will receive—is not yet available. Over the 10 years from 2015 to 2024, exchange subsidies and related spending are projected to total $1,032 billion, distributed as follows:

- Outlays of $726 billion and a reduction in revenues of $129 billion for premium assistance tax credits (to cover a portion of eligible individuals' and families' health insurance premiums), which sum to $855 billion (see Table 3);[14]

14. The subsidies for health insurance premiums are structured as refundable tax credits; following the usual procedures for such credits, the portions that exceed taxpayers' income tax liabilities are classified as outlays in CBO's baseline projections, and the portions that reduce tax payments are classified as reductions in revenues.

Table 3.

Enrollment in, and Budgetary Effects of, Health Insurance Exchanges

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total, 2015-2024
						Exchange Enrollment						
						(Millions of nonelderly people, by calendar year)[a]						
Individually Purchased Coverage												
Subsidized	5	10	19	19	20	19	19	19	19	19	19	n.a.
Unsubsidized[b]	1	3	5	6	6	6	6	6	6	6	6	n.a.
Total	**6**	**13**	**24**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**n.a.**
Employment-Based Coverage Purchased Through Exchanges[b]	2	3	3	4	4	4	4	4	4	4	4	n.a.
						Budgetary Effects						
						(Billions of dollars, by fiscal year)						
Changes in Mandatory Spending												
Outlays for premium credits	10	23	51	65	71	75	79	84	89	93	95	726
Cost-sharing subsidies	3	7	13	16	17	18	19	20	21	22	22	175
Exchange grants to states	2	2	1	*	*	0	0	0	0	0	0	2
Payments for risk adjustment, reinsurance, and risk corridors	0	18	19	22	15	17	18	19	19	20	19	186
Total	**15**	**50**	**84**	**104**	**103**	**109**	**116**	**123**	**129**	**134**	**137**	**1,089**
Changes in Revenues												
Reductions in revenues from premium credits	-2	-5	-10	-12	-13	-14	-14	-15	-15	-15	-15	-129
Collections for risk adjustment, reinsurance, and risk corridors	0	19	18	22	15	17	18	19	19	20	19	186
Total	**-2**	**14**	**7**	**10**	**2**	**3**	**4**	**4**	**4**	**5**	**5**	**56**
Net Increase in the Deficit From Exchange Subsidies and Related Spending	17	36	77	94	101	107	112	119	125	129	132	1,032
Memorandum:												
Total Subsidies Through Premium Credits (Billions of dollars, by fiscal year)	12	29	62	78	84	89	93	99	104	108	110	855
Total Exchange Subsidies (Billions of dollars, by calendar year)	21	42	89	95	104	108	114	121	127	130	133	1,064
Average Exchange Subsidy per Subsidized Enrollee (Dollars, by calendar year)	4,410	4,250	4,830	4,930	5,300	5,570	5,880	6,220	6,580	6,890	7,170	n.a.

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

Note: n.a. = not applicable; * = between zero and $500 million.

a. Figures reflect average enrollment over the course of a year and include spouses and dependents covered under family policies. Figures for the nonelderly population include residents of the 50 states and the District of Columbia who are younger than 65.

b. Excludes coverage purchased directly from insurers outside of an exchange.

- Outlays of $175 billion for cost-sharing subsidies (to reduce out-of-pocket payments for low-income enrollees);
- Outlays of $2 billion for grants to states for operating exchanges; and
- Outlays and revenues each totaling $186 billion related to payments and collections for risk adjustment, reinsurance, and risk corridors (having no net budgetary effect).

The ACA's provisions for risk adjustment, reinsurance, and risk corridors generate payments by the federal government to insurers and collections by the federal government from insurers that reflect differences in health status and costs among insurers' enrollees.[15] CBO treats the payments as outlays and the collections as revenues and projects that, over the 2015–2024 period, risk adjustment payments and collections will total $156 billion each and reinsurance payments and collections will total $20 billion each. Over that same period, CBO estimates, risk corridor payments from the federal government to health insurers will total $9 billion and the corresponding collections from insurers will amount to $9 billion, thus having no net budgetary effect. (The section below, "Changes From Previous Estimates," discusses the changes in those figures from the previous projection and the reasons for the changes.)

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

CBO and JCT project that substantially more people will be enrolled in Medicaid and CHIP than would have been the case in the absence of the ACA—7 million more in calendar year 2014, 11 million more in 2015, and 12 million to 13 million more people in each year between 2016 and 2024 (see Table 2 on page 4).[16] Some of those additional enrollees will be people who become eligible for Medicaid because of the ACA's coverage expansion; others will be people who would have been eligible for Medicaid or CHIP in the absence of the ACA but would not have enrolled. CBO expects that the ACA's individual mandate, increased outreach, and new opportunities to enroll in those programs through exchanges will increase enrollment among people who were previously eligible.

The anticipated increase in Medicaid enrollment after 2014 reflects the expectation that more people in states that have already expanded Medicaid eligibility will enroll in the program and that more states will expand Medicaid eligibility. Those increases will be partially offset by lower enrollment in CHIP, starting in 2016; in CBO's baseline, funding projected for that program is lower in 2016 and following years than is anticipated for the next two years.[17]

As with exchange enrollment, the projected figures represent averages over the course of those years and differ from estimates of enrollment at any particular point during a year. CBO and JCT expect that, once the ACA is fully phased in, enrollment in Medicaid and CHIP will vary over the course of each year. Unlike exchange plans, which offer limited annual open-enrollment periods, Medicaid and CHIP are open to eligible people at any time. As a result, people move in and out of coverage for many reasons, including a change in their need for health care; a change in their awareness of the availability of coverage; or a change in circumstances that affects program eligibility, such as a change in income or the birth of a

15. For more details, see Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, Appendix B (February 2014), www.cbo.gov/publication/45010.

16. Early in April 2014, the Department of Health and Human Services issued the fifth in a series of monthly reports on state Medicaid and CHIP enrollment, providing a preliminary estimate of 3 million additional Medicaid and CHIP enrollees at the end of February in 46 states (compared with enrollment in the months before the ACA's coverage expansions began). That number is noted to include people who were newly eligible for Medicaid because of the ACA's coverage expansion as well as those who were eligible for Medicaid and CHIP in the absence of the ACA but would not have signed up, and those who were re-enrolling. It does not, however, include new enrollees who applied for Medicaid through federally facilitated marketplaces. See Centers for Medicare & Medicaid Services, *Medicaid & CHIP: February 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report* (April 4, 2014), http://go.usa.gov/k2az (PDF, 688 KB).

17. Annual spending for CHIP is projected to reach $12.5 billion in 2015—the final year in which the program is fully funded under current law. Under the rules governing baseline projections for expiring programs, CBO projects funding for CHIP after 2015 at an annualized amount of about $6 billion. For more details about the CHIP baseline, see Congressional Budget Office, "Children's Health Insurance Program Spending and Enrollment Detail for CBO's April 2014 Baseline," www.cbo.gov/publication/45229.

child. Therefore, the number of people who receive coverage through Medicaid and CHIP in any year will not generally be known precisely until well after the year has ended and state enrollment data have become available.

Furthermore, it will never be possible to determine how many people who sign up for Medicaid would have been eligible but not enrolled in the absence of the ACA. The number of people who sign up who are newly eligible *can* be determined because states that expand coverage under the act will report the number of enrollees who became eligible as a result of that expansion in order to receive the additional federal funding that will be provided for such enrollees. But there will be no way to tell whether people who sign up who would have been eligible without the ACA would, or would not, have enrolled anyway.

CBO and JCT estimate that the added costs to the federal government for Medicaid and CHIP attributable to the ACA will be $20 billion in 2014 and will total $792 billion for the 2015–2024 period (see Table 1 on page 2).

The extent of the expansion of insurance coverage through all sources in 2014 as a result of the ACA will not be clear until more time has elapsed and more data are available. The government is collecting data on the number of people who sign up for coverage in the exchanges, Medicaid, and CHIP; moreover, the ACA requires additional information on coverage to be reported by employers and health insurance providers. In addition, CBO and JCT monitor various sources of survey data—including large, federally sponsored surveys of households and employers as well as smaller, privately funded surveys that use telephone and online questionnaires.[18] However, some data will be available only after a delay—anywhere from a few months to a few years. Moreover, differences must be reconciled within and among data sets to arrive at a clear picture of changes in overall insurance coverage and the sources of such coverage.

18. Among the sources that CBO and JCT will consult in their analyses of the ACA's effects are the Department of Health and Human Services' National Health Interview Survey, results from Gallup polls, the Urban Institute's Health Reform Monitoring Survey, and RAND's American Life Panel Survey. Also, more detailed information on changes in coverage by family income will come later from the Census Bureau's Current Population Survey and the Department of Health and Human Services' Medical Expenditure Panel Survey.

Tax Credits for Small Employers

Under the ACA, certain small employers are eligible to receive tax credits to defray the cost of providing health insurance to their employees. CBO and JCT project that those tax credits will total $1 billion in 2014 and $15 billion over the 2015–2024 period.

Penalty Payments by Uninsured People

Beginning in 2014, the ACA requires most legal residents of the United States to obtain health insurance or pay a penalty. People who do not obtain coverage will pay the greater of two amounts: either a flat dollar penalty per adult in a family, rising from $95 in 2014 to $695 in 2016 and indexed to inflation thereafter (the penalty for a child is half the amount, and an overall cap will apply to family payments); or a percentage of a household's adjusted gross income in excess of the income threshold for mandatory tax-filing—a share that will rise from 1.0 percent in 2014 to 2.5 percent in 2016 and subsequent years (also subject to a cap). CBO and JCT estimate that such payments from individuals will total $46 billion over the 2015–2024 period.

Some people, such as unauthorized immigrants, are not subject to the requirement to obtain health insurance. Other people face the requirement but are exempt from the penalty, for example, because their income is low enough that they do not file income tax returns, their income is below 138 percent of federal poverty guidelines and they are ineligible for Medicaid because their state did not expand the program, they are members of an Indian tribe, or their premiums would exceed a specified share of their income (8 percent in 2014 and indexed for inflation over time). Certain other exemptions are described below in the section "Regulations and Other Administrative Actions."

Penalty Payments by Employers

Beginning in 2015, certain large employers who do not offer health insurance that meets specified standards will pay a penalty if they have full-time employees who receive a subsidy through an exchange. The specified standards involve affordability and the share of the cost of covered benefits paid by the insurance plan.[19] Employers with at least 50 full-time-equivalent (FTE) employees will generally be subject to that requirement. In 2015

19. To meet the standards, the cost to the employee for self-only coverage must not exceed a specified share of income (9.5 percent in 2014 and indexed over time), and the plan must pay at least 60 percent of the cost of covered benefits.

only, however, employers with at least 50 but fewer than 100 FTE employees will be exempt from the requirement if they certify that they have not made certain reductions to health insurance coverage or reduced their number of FTE employees to avoid the penalties. (Recent changes to this aspect of the ACA are discussed below in "Employers' Responsibilities in 2015.") CBO and JCT estimate that penalty payments by employers will total $139 billion over the 2015–2024 period.

Excise Tax on High-Premium Insurance Plans

According to CBO and JCT's estimates, federal revenues will increase by $120 billion over the 2015–2024 period because of the excise tax on high-premium insurance plans. Roughly one-quarter of that increase stems from excise tax receipts, and roughly three-quarters is from the effects on revenues of changes in employees' taxable compensation and, to a lesser extent, in employers' deductible expenses. In particular, CBO and JCT anticipate that many employers and workers will shift to health plans with premiums that are below the specified thresholds to avoid paying the tax, resulting generally in higher taxable wages for affected workers.

Other Effects on Revenues and Outlays

The ACA also will affect federal tax revenues because fewer people will have employment-based health insurance and thus more of their income will take the form of taxable wages. CBO and JCT project that, as a result of the ACA, between 7 million and 8 million fewer people will have employment-based insurance each year from 2016 through 2024 than would have been the case in the absence of the ACA. That difference is the net result of projected increases and decreases in offers of health insurance from employers and of choices about enrollment by active workers, early retirees (people under the age of 65 at retirement), and their families.

In 2019, for example, an estimated 13 million people who would have enrolled in employment-based coverage in the absence of the ACA will not have an offer of such coverage under the ACA; an estimated 3 million people who would have enrolled in employment-based coverage will have such an offer but will choose not to enroll. Some of those 16 million people are expected to gain coverage through some other source; others will forgo health insurance. Those decreases in employment-based coverage will be partially offset, however. About 8 million people who would not have had employment-based coverage in the absence of the ACA are expected to receive such coverage under the ACA; they will either take up an offer of coverage they would have received anyway or take up a new offer. Some of those enrollees would have been uninsured in the absence of the ACA.

Because of the net reduction in employment-based coverage, the share of workers' pay that takes the form of nontaxable benefits (such as health insurance premiums) will be smaller—and the share that takes the form of taxable wages will be larger—than would otherwise have been the case. That shift in compensation will boost federal tax receipts. Partially offsetting those added receipts will be an estimated $7 billion increase in Social Security benefits that will arise from the higher wages paid to workers. All told, CBO and JCT project, those effects will reduce federal budget deficits by $152 billion over the 2015–2024 period.

Changes From Previous Estimates

CBO and JCT currently estimate that the insurance coverage provisions of the ACA will have a smaller budgetary cost than those agencies estimated in February 2014.[20] CBO and JCT now estimate that the net cost to the federal government of those provisions for fiscal year 2014 will be $36 billion, $5 billion less than the previous estimate of $41 billion, and that the net cost for the 2015–2024 period will be $1,383 billion, $104 billion (or 7 percent) below the previous estimate of $1,487 billion (see Table 4).

CBO and JCT have updated their baseline estimates of the budgetary effects of the ACA's insurance coverage provisions many times since that legislation was enacted in March 2010. As time has passed, the period spanned by the estimates has changed, but a year-by-year comparison shows that CBO and JCT's estimates of the net budgetary impact of the ACA's insurance coverage provisions have decreased, on balance, over the past four years.

The first part of this section describes the factors that led to changes in CBO and JCT's estimates since February 2014, the second part summarizes the changes themselves, and the third part discusses changes in projected budgetary effects since the legislation was enacted in March 2010.

20. See Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, Appendix B (February 2014), www.cbo.gov/publication/45010.

Table 4.

Comparison of CBO and JCT's Current and Previous Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act

	February 2014 Baseline	April 2014 Baseline	Difference
	Change in Insurance Coverage Under the ACA in 2024 (Millions of nonelderly people, by calendar year)[a]		
Insurance Exchanges	24	25	*
Medicaid and CHIP	13	13	1
Employment-Based Coverage[b]	-7	-7	-1
Nongroup and Other Coverage[c]	-5	-5	*
Uninsured[d]	-25	-26	-1
	Effects on the Cumulative Federal Deficit, 2015 to 2024[e] (Billions of dollars)		
Exchange Subsidies and Related Spending[f]	1,197	1,032	-164
Medicaid and CHIP Outlays	792	792	**
Small-Employer Tax Credits[g]	15	15	**
Gross Cost of Coverage Provisions	2,004	1,839	-165
Penalty Payments by Uninsured People	-52	-46	6
Penalty Payments by Employers[g]	-151	-139	12
Excise Tax on High-Premium Insurance Plans[g]	-108	-120	-12
Other Effects on Revenues and Outlays[h]	-206	-152	54
Net Cost of Coverage Provisions	**1,487**	**1,383**	**-104**
Memorandum:			
Net Collections and Payments for Risk Adjustment, Reinsurance, and Risk Corridors[i]	-8	0	8

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

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

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

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

c. "Other" includes Medicare; the changes under the ACA are almost entirely for nongroup coverage.

d. The uninsured population includes people who will be unauthorized immigrants and thus ineligible either for exchange subsidies or for most Medicaid benefits; people who will be ineligible for Medicaid because they live in a state that has chosen not to expand coverage; people who will be eligible for Medicaid but will choose not to enroll; and people who will not purchase insurance to which they have access through an employer, an exchange, or directly from an insurer.

e. Positive numbers indicate an increase in the deficit; negative numbers indicate a decrease in the deficit. They also exclude effects on the deficit of other provisions of the ACA that are not related to insurance coverage, and they exclude federal administrative costs subject to appropriation.

f. Includes spending for exchange grants to states and net collections and payments for risk adjustment, reinsurance, and risk corridors (see "Memorandum").

g. These effects on the deficit include the associated effects of changes in taxable compensation on revenues.

h. Consists mainly of the effects of changes in taxable compensation on revenues.

i. These effects are included in "Exchange Subsidies and Related Spending."

Factors That Led to Changes in the Estimates Since February 2014

The reductions in estimated federal costs are the net result of a combination of factors. The current projections:

- Incorporate the economic forecast that CBO published in February 2014; because the projections of the effects of the ACA's coverage provisions published in February were partial and preliminary, they did not incorporate the economic forecast published by CBO at that time.
- Incorporate further analyses by CBO and JCT of exchange premiums and the characteristics of exchange plans.
- Include revisions to estimates of the number of early retirees with employment-based coverage under the ACA.
- Account for regulations and other administrative actions that were put in place between early December 2013 and the end of March 2014.

Because of the way that various factors interact, it is not possible to isolate the effects of changes in individual factors on specific components of the budgetary effects.

Changes From Incorporating the February 2014 Economic Forecast. In CBO's most recent economic forecast, published in February 2014, the agency revised its projections of various economic factors that will affect the number of people who will be eligible for subsidized insurance coverage under the ACA.[21] Changes in estimates of labor force participation, wages and salaries, and population had the largest effects on projections of eligibility for subsidized coverage.

The projected labor force participation rate among people younger than age 65 is lower throughout the next decade than it was in the forecast CBO published in 2013. In 2020, for example, CBO now anticipates that this participation rate will be 75.9 percent, compared with the 76.5 percent it projected previously.[22] The downward revision stems from a variety of factors, and it results in a slightly larger projection of the number of people who will be eligible for Medicaid, CHIP, and subsidies in the exchanges.

Wages and salaries also are projected to be lower through most of the next decade than they were in CBO's previous forecast—by between 4 percent and 5 percent, for example, from 2018 through 2023. The result of that and other changes to the income projections, including changes to the projected distribution of income, is a slight increase in Medicaid eligibility and a slight decrease in eligibility for premium subsidies.

CBO revised its projection of the total population under the age of 65 as a result of incorporating recently available information from the 2010 decennial census. Under the revised projection, the nonelderly population during the years from 2014 to 2024 is 2 million to 4 million people smaller than it was in the previous projection. Taken together with information on the employment-based health insurance market, that change resulted most notably in a downward revision of CBO and JCT's projection of the number of people without insurance in the absence of the ACA during the early years of the coming decade.

In addition, CBO and JCT made a related technical adjustment on the basis of a more detailed analysis of survey data. The agencies altered their projections of the age mix of people who would have been without insurance in the absence of the ACA, reducing the projected share of children in that group. As discussed later, that change affects CBO and JCT's projection of the number of people who will enroll in Medicaid and CHIP under the ACA.

Changes in Estimated Exchange Premiums. In the February 2014 projections, CBO and JCT reduced their estimate of exchange premiums for 2014. However, no changes were made to premium projections for later years because the February update was partial and preliminary. The current update of the baseline incorporates the results of additional analyses of the premiums charged for

21. See Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, Chapter 2 (February 2014), www.cbo.gov/publication/45010.

22. CBO regularly publishes forecasts of labor force participation for people of all ages, but not for people under age 65. Those published rates show a similar revision.

2014, resulting in changes to the estimates for 2014 and for later years.

A crucial factor in the current revision was an analysis of the characteristics of plans offered through the exchanges in 2014. Previously, CBO and JCT had expected that those plans' characteristics would closely resemble the characteristics of employment-based plans throughout the projection period. However, the plans being offered through the exchanges this year appear to have, in general, lower payment rates for providers, narrower networks of providers, and tighter management of their subscribers' use of health care than employment-based plans do.

CBO and JCT anticipate that, as enrollment in the exchanges rises, the differences between employment-based plans and exchange plans will narrow. Therefore, projected premiums during the next few years were revised downward more than were premiums for the later years of the coming decade.

The lower exchange premiums and revisions to the other characteristics of insurance plans that are incorporated into CBO and JCT's current estimates have small effects on the agencies' projections of exchange enrollment. Although lower premiums will tend to increase enrollment, narrower networks and more tightly managed benefits will tend to reduce the attractiveness of plans and thereby decrease enrollment. The net effect on projected enrollment in the exchanges is small.

Lower premiums also have the effect of reducing the federal cost of exchange subsidies. The current estimate of the average subsidy for 2014 is about $300 (or 6 percent) less than the estimate in the February 2014 baseline, and the estimate for 2024 is about $1,200 (or 14 percent) below the earlier projection. The reductions in subsidies relative to the previous baseline are smaller for 2014 than for later years because, in February, CBO and JCT updated their estimates of exchange premiums and subsidies for 2014 but did not make changes to those estimates for 2015 or later years.

Changes in the Estimates of the Number of People With Employment-Based Coverage. CBO and JCT have revised their projections both of the number of people and of the groups of people who will obtain coverage from current or former employers. As a result of several technical modeling adjustments, the agencies' estimates of active workers and their dependents with such coverage have been revised upward by about 1 million people in most years. At the same time, CBO and JCT have revised downward their estimates of the number of nonelderly retirees with health insurance from a previous employer. Part of that revision stems from a reevaluation of the decline in retiree coverage over the past decade in the absence of the ACA. Another part is attributable to an assessment that more employers than previously thought will decide not to offer retiree coverage under the ACA—both because of the availability of the exchanges and other new sources of coverage and because they face no penalty for declining to offer coverage to retirees. Those considerations led CBO and JCT to reduce their projections—by about 2 million people in most years—of the number of early retirees and their dependents who will be covered by employment-based health insurance under the ACA and to increase their projections of the number who will enroll in the exchanges.

The net effect of the upward revision in coverage of active workers and the downward revision in coverage of retired workers is a downward revision—by about 1 million people for most years—in the projection of the number of people with employment-based coverage under the ACA.

CBO and JCT anticipate that the effect on tax revenues from employers' declining to offer coverage to retirees will be significantly smaller than the effect of such a decision regarding active employees. The decision of employers not to offer health insurance to active employees generally boosts federal revenues in two ways—by raising employees' taxable compensation and by raising penalties paid by employers who are subject to the ACA's requirements concerning employment-based coverage. For retirees' coverage, however, a smaller portion of premium costs tends to be excluded from taxable income, so replacing retirees' coverage with an increase in other forms of employee compensation generates less additional tax revenue than would a similar change involving active employees. Also, as noted, employers face no penalty for not offering coverage to retirees.

Regulations and Other Administrative Actions. The Administration has released several proposed and final regulations and announced other actions regarding implementation of the ACA since early December 2013, when CBO's February 2014 baseline projections were completed. The implications for CBO and JCT's projections of four significant actions are described here.

Employers' Responsibilities in 2015. Under the ACA, certain employers with 50 or more FTE employees that do not offer health insurance coverage that meets the standards specified in law will be subject to penalties. That requirement initially was to take effect in January 2014, but in July 2013 the Administration delayed the requirement by one year and set it to take effect in January 2015.[23] That delay was incorporated into CBO and JCT's February 2014 projections.

In February 2014, the Department of the Treasury issued a final regulation providing additional transitional relief to employers. Employers with at least 50 but fewer than 100 FTE employees will be exempt from the employer requirement in 2015 if they certify that they have not made certain reductions to health insurance coverage or reduced their number of FTE employees to avoid the penalties. That final regulation also provided for a one-year relaxation of a related coverage requirement for employers subject to the requirement. That change took two forms. First, in 2015, those employers must offer coverage to at least 70 percent of their full-time employees—rather than the 95 percent specified in the proposed regulation. Second, in 2015, employers with at least 100 FTE employees are permitted to exclude the first 80 full-time employees from the penalty calculation (rather than the first 30 full-time employees, as will be the case in subsequent years).

That additional transitional relief was not included in the February 2014 projections. Incorporating the effects of that regulation led CBO and JCT to estimate slightly lower enrollment in employment-based coverage in 2015 and to estimate slightly less in revenues from penalties paid by employers in 2016. (Because penalties are collected the year after they are assessed, the 2015 delay will reduce collections in 2016.)

Availability of Noncompliant Plans. Under the ACA, health insurance policies sold by insurers must—in most cases—comply with certain rules, among them a prohibition on adjusting premiums on the basis of an applicant's health status and a requirement that insurers in the nongroup and small-group markets offer plans to all applicants that cover certain essential health benefits and that pay a specified minimum share of the cost of covered benefits. Those requirements apply to plans sold both within and outside of the exchanges. (For more information on the nongroup market under the ACA, see Box 1 on page 8.) However, in March 2014, the Department of Health and Human Services announced that, through October 1, 2016, state insurance commissioners could permit health insurers to re-enroll individuals and small businesses in existing plans that do not comply with certain market and benefit rules that took effect in 2014, allowing such coverage to continue through September 2017. That announcement extended an action announced in November 2013 that permitted the renewal of noncompliant policies through October 1, 2014 (extending that coverage through September 2015).

CBO and JCT estimate that the March 2014 announcement will slightly reduce enrollment in ACA-compliant plans because some people will take advantage of this option by renewing their coverage in noncompliant plans. CBO and JCT also estimate that the March announcement will slightly reduce spending for exchange subsidies because some people who would have enrolled in a subsidized plan through the exchanges will instead renew coverage in noncompliant plans (which cannot be sold through the exchanges and are not subsidized). In addition, the lower premiums that small employers and self-employed people are likely to pay for noncompliant plans will generate a small amount of additional tax revenues because of those enrollees' resulting increased taxable income.

CBO and JCT expect that people who renew noncompliant plans will be healthier, on average, than people who enroll in ACA-compliant plans, leading to slightly higher medical claims per enrollee among ACA-compliant plans. However, CBO and JCT expect that such adjustments will have a negligible effect on average premiums in exchange plans because the number of people who re-enroll in noncompliant plans will probably be small relative to total enrollment in exchange plans.

Risk Corridors. The ACA established several programs to reduce the risk of financial losses faced by insurers. Under the temporary risk corridor program, the government will make payments during the next few years to companies that offer individual and small-group plans sold on the exchanges (and will make payments for certain plans sold outside of the exchanges if the plans are substantially the

23. For an estimate of the budgetary effects of that delay, see Congressional Budget Office, letter to the Honorable Paul Ryan providing an analysis of the Administration's announced delay of certain requirements under the Affordable Care Act (July 30, 2013), www.cbo.gov/publication/44465.

same as plans sold by the same carriers within the exchanges) when actual costs for medical claims exceed expected costs by certain percentages. At the same time, the government will receive payments from those plans whose actual costs for medical claims fall short of their expected costs by certain percentages.[24]

In March 2014, the Department of Health and Human Services issued a final regulation stating that its implementation of the risk corridor program will result in equal payments to and from the government, and thus will have no net budgetary effect. CBO believes that the Administration has sufficient flexibility to ensure that payments to insurers will approximately equal payments from insurers to the federal government, and thus that the program will have no net budgetary effect over the three years of its operation. (Previously, CBO had estimated that the risk corridor program would yield net budgetary savings of $8 billion.)

Hardship Exemption. In December 2013, the Department of Health and Human Services announced that it was allowing people whose nongroup plans were canceled by their insurers for 2014 to apply for a hardship waiver that would allow them either to remain uninsured without paying a penalty or to purchase lower-cost catastrophic coverage (plans with particularly high out-of-pocket costs for which most people would not ordinarily be eligible under the ACA).[25] In March 2014, the Department of Health and Human Services announced that this hardship waiver would be extended until October 1, 2016.[26]

People who apply for this hardship waiver will need to verify that they had been covered by a health insurance plan that was canceled. Because CBO and JCT expect that most of the people whose plans have been canceled will seek alternative sources of coverage rather than become uninsured, the agencies expect that this additional hardship exemption will have a negligible effect on the amount of penalties collected from uninsured people. In addition, CBO and JCT expect that, for three reasons, a very small number of people who are permitted to enroll in a catastrophic plan will actually do so: Catastrophic plans have lower actuarial value than other types of coverage, people who enroll in catastrophic plans are ineligible for exchange subsidies, and CBO and JCT expect that many people either obtained coverage from another source for 2014 before the announcement or were unaware of that option at the time they sought coverage.

Changes in the Estimates Since February 2014

CBO and JCT currently estimate that the insurance coverage provisions of the ACA will have a net cost over the 2015–2024 period that is $104 billion less than the agencies estimated in February 2014. The difference stems from the following changes in estimates of the government's spending and collections (see Figure 2 on page 19 and Table 4 on page 14):

- A reduction of $165 billion (or 8 percent) in the gross cost of the coverage provisions, almost entirely because exchange subsidies and related spending are now projected to cost $1,032 billion, compared with the previous estimate of $1,197 billion; and

- A partially offsetting net reduction of $61 billion in savings as a result of lower expected penalty payments from uninsured people and employers, higher expected revenue resulting from the excise tax on certain high-premium employment-based insurance plans, and lower savings from other budgetary effects (mostly decreases in tax revenues).

Exchange Subsidies and Related Spending. CBO and JCT have not changed their previous estimate of the number of people who will purchase coverage through the exchanges in 2014. After 2014, however, CBO and JCT's estimates of enrollment are slightly higher than those in the previous projection—by less than 1 million people annually for most years. That increase has various origins, as discussed above, including lower expected premiums in the exchanges and less expected employment-based coverage for early retirees, both of which would increase the number of people purchasing insurance through the exchanges. Partially offsetting those factors are a slight downward shift in the expected income distribution (which reduces the number of people anticipated to be eligible for exchange subsidies) and

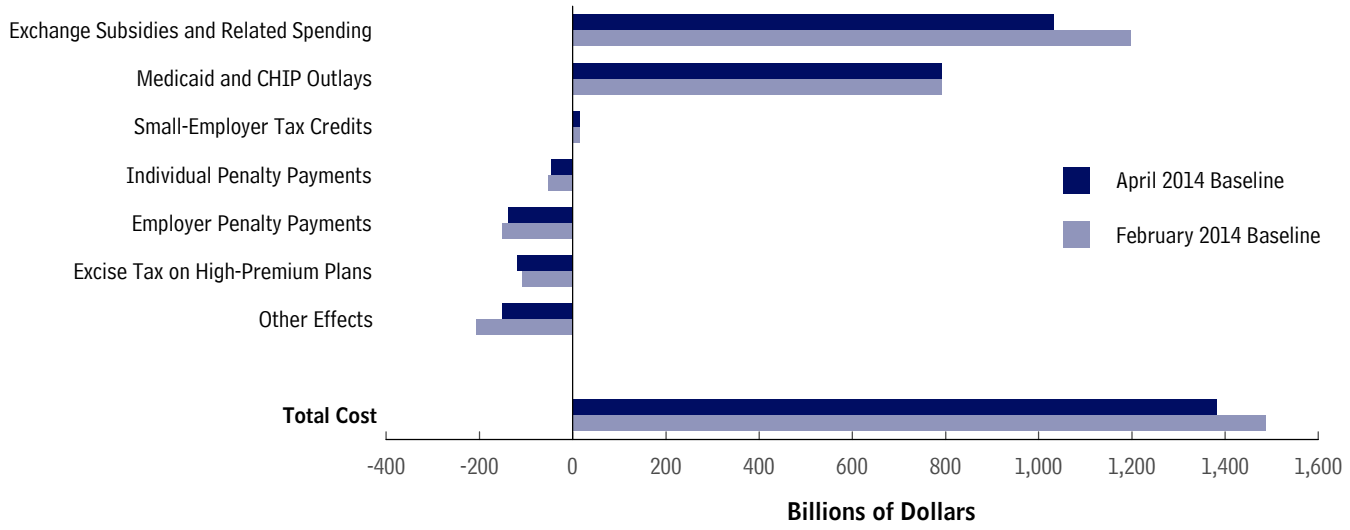
24. For more information, see Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, Appendix B (February 2014), www.cbo.gov/publication/45010.

25. See Centers for Medicare & Medicaid Services, "Options Available for Consumers With Cancelled Policies" (December 19, 2013), http://go.usa.gov/KHTw (PDF, 110 KB).

26. See Centers for Medicare & Medicaid Services, "Insurance Standards Bulletin Series—Extension of Transitional Policy Through October 1, 2016" (March 5, 2014), http://go.usa.gov/KHbh (PDF, 148 KB).

Figure 2.

Budgetary Effects of the Insurance Coverage Provisions of the Affordable Care Act, 2015 to 2024



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

Note: CHIP = Children's Health Insurance Program.

changes in the expected characteristics of plans that will be offered in the exchanges (which will make them less attractive than previously expected).

CBO and JCT project that the government's costs for exchange subsidies and related spending in 2014 will be $3 billion (or 16 percent) less than previously projected. Despite projecting that slightly more people will receive insurance coverage through exchanges over the 2015–2024 period than they had anticipated previously, CBO and JCT project that costs for exchange subsidies and related spending will be $164 billion (or 14 percent) below the previous projection, mainly because of the downward revision to expected exchange premiums, as follows:

- Premium assistance tax credits total $855 billion in the current projection, a reduction of $181 billion (or 17 percent) from the previous projection.[27]
- Cost-sharing subsidies are now projected to be $175 billion, about $8 billion more than in the previous projection; that change is attributable to the slight downward shift in the expected income distribution.
- The risk corridor program is expected to have no net budgetary effect over the three years of its operation, rather than the $8 billion in net savings to the government previously anticipated.

Medicaid and CHIP Outlays. CBO and JCT's projection of the federal cost of the additional enrollment in Medicaid and CHIP under the ACA has changed little since the February 2014 projection. For 2014, the projection was revised from $19 billion to $20 billion; for the 2015–2024 period, the projection remains at $792 billion. The negligible net revision reflects a combination of offsetting changes in enrollment and per capita costs.

For 2014 through 2016, CBO and JCT have reduced their projections of additional Medicaid and CHIP enrollment stemming from the ACA by about 1 million people each year. For those years, the changes discussed above in the estimated number of people without insurance in the absence of the ACA and the estimated mix of adults and children within that population generated a downward revision in the number of children expected to newly enroll in CHIP and a smaller upward revision in the number of adults expected to newly enroll in Medicaid as a result of the ACA. Because anticipated per capita

27. The current estimate is the sum of $726 billion in outlays for the premium credits and a $129 billion reduction in revenues resulting from those credits (see Table 3 on page 10).

costs are much higher for newly eligible adults than for children (and because of some other small technical changes), the projections for federal spending for Medicaid and CHIP have been revised upward by about $2 billion for the 2014–2016 period, despite the downward revision in projected enrollment.

CBO and JCT raised their projections of additional Medicaid enrollment stemming from the ACA by fewer than 1 million people in each year between 2018 and 2024 (for 2017, projected enrollment is essentially unchanged). That revision results mainly from the changes in the projected income distribution and projected labor force participation, discussed above. Higher enrollment would increase federal costs, all else being equal. However, the projection for spending per adult Medicaid recipient has been revised downward slightly on the basis of recent data. The combination of higher enrollment and lower costs per capita led to small upward revisions to projected outlays between 2018 and 2020, to essentially no change in 2021, and to small downward revisions to outlays projected for 2022 through 2024.

Small-Employer Tax Credits. CBO and JCT have made essentially no changes to their projections of small-employer tax credits since February 2014.

Penalty Payments by Uninsured People. Uninsured people are now expected to pay about $6 billion less in penalties during the 2015–2024 period than CBO and JCT projected previously. That reduction is attributable to several factors. First, because of various changes discussed above, the agencies now expect that, in most years, about 1 million fewer people will be uninsured than the agencies expected in February. In addition, a shift in the projected income distribution leaves a smaller share of the uninsured population subject to the penalty, and it leaves fewer people who are subject to the penalty with income high enough that they would pay a percentage of their income as a penalty rather than pay a lesser flat rate. The reduction in projected payments does not result from recent administrative actions to widen the hardship exemption; CBO and JCT expect that those actions will have only negligible effects on payments because most of the people eligible for that exemption will seek alternative sources of coverage rather than become uninsured.

Penalty Payments by Employers. Since preparing the February 2014 projection, CBO and JCT have reduced by $12 billion their estimate of penalty payments that will be collected from employers during the 2015–2024 period. About $3 billion of that reduction occurs in 2016, mainly as a result of the recently issued final rule providing transitional relief for employers (discussed above). The rest is attributable to a small increase in the number of active workers and their dependents who are expected to enroll in employment-based coverage compared with the number in the February baseline.

Excise Tax on High-Premium Insurance Plans. Since February, CBO and JCT have increased by $12 billion their projection of revenues resulting from the excise tax on certain insurance plans with high premiums collected over the 2015–2024 period. That upward revision resulted primarily from an expected increase in the number of active employees receiving employment-based coverage.

Other Effects on Revenues and Outlays. CBO and JCT now anticipate that the ACA's insurance coverage provisions will have other effects on revenues and outlays that will, on net, reduce the deficit by $54 billion less than was anticipated previously for the 2015–2024 period. The current projection is for a reduction in the deficit of $152 billion, rather than $206 billion, for that decade.

The downward revision in those savings stems principally from the projected increase in the number of active workers and their dependents with employment-based health insurance. An employer's decision not to offer insurance to active employees tends to result in higher taxable compensation in the form of wages and salaries. Conversely, an increase in employment-based health insurance tends to reduce taxable compensation. Therefore, the increase in the number of active workers and their dependents with employment-based coverage implies lower federal revenues than would otherwise be the case.

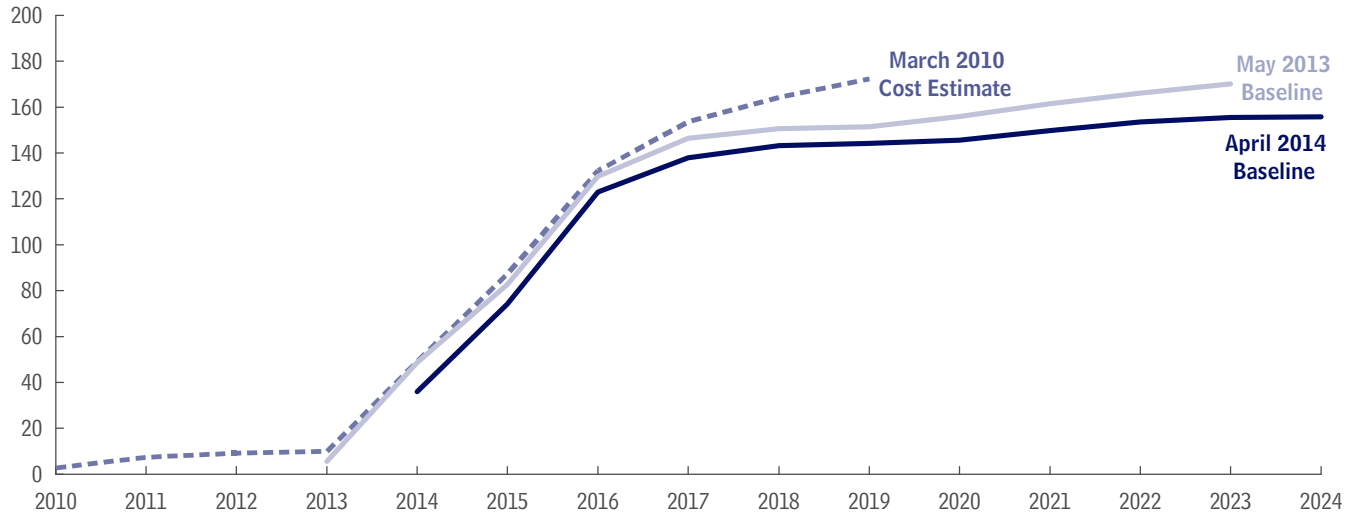
Changes in the Estimates Since the Enactment of the ACA

CBO and JCT have updated their baseline estimates of the budgetary effects of the ACA's insurance coverage provisions many times since that legislation was enacted

Figure 3.

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

(Billions of dollars, by fiscal year)



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

in March 2010 (see Figure 3). As time has passed, projected costs over the subsequent 10 years have risen because the period spanned by the estimates has changed: Each time a year goes by, a less expensive early year is replaced by a more expensive later year. But when compared year by year, CBO and JCT's estimates of the net budgetary impact of the ACA's insurance coverage provisions have decreased, on balance, over the past four years.[28]

In March 2010, CBO and JCT projected that the provisions of the ACA related to health insurance coverage would cost the federal government $759 billion during fiscal years 2014 through 2019 (2019 was the last year of the 10-year budget window used in that estimate). The newest projections indicate that those provisions will cost $659 billion over that same period, a reduction of 13 percent. For 2019, for example, CBO and JCT projected in March 2010 that the ACA's insurance coverage provisions would have a net federal cost of $172 billion; the current projections show a cost of $144 billion—a reduction of 16 percent.

The net downward revision since March 2010 to CBO and JCT's estimates of the net federal cost of the ACA's insurance coverage provisions (when measured on a year-by-year basis) is attributable to many factors. Changes in law, revisions to CBO's economic projections, judicial decisions, administrative actions, new data, and numerous improvements in CBO and JCT's modeling have all affected the projections. A notable influence is the substantial downward revision to projected health care costs both for the federal government and for the private sector. For example, since early 2010, CBO and JCT have revised downward their projections of insurance premiums for policies purchased through the exchanges in 2016 by roughly 15 percent, and CBO has revised downward its projection of total Medicaid spending per beneficiary in 2016 by roughly half that percentage.

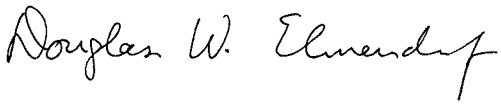
28. For an illustration of several baseline projections between March 2010 and May 2013, see Congressional Budget Office, "CBO's Estimate of the Net Budgetary Impact of the Affordable Care Act's Health Insurance Coverage Provisions Has Not Changed Much Over Time," *CBO Blog* (May 14, 2013), www.cbo.gov/publication/44176.

About This Document

This Congressional Budget Office (CBO) report was prepared in response to interest expressed by Members of Congress. In keeping with CBO's mandate to provide objective, impartial analysis, the report makes no recommendations.

Jessica Banthin, Sarah Masi, Eamon Molloy, and Allison Percy prepared the report, with contributions from Kirstin Blom, Stuart Hagen, Jean Hearne, Paul Jacobs, Alexandra Minicozzi, Robert Stewart, Ellen Werble, and the staff of the Joint Committee on Taxation and with guidance from Linda Bilheimer and Peter Fontaine. Philip Ellis and Holly Harvey provided comments.

Robert Sunshine reviewed the report, Kate Kelly edited it, and Maureen Costantino and Jeanine Rees prepared it for publication. The report is available on the agency's website (www.cbo.gov/publication/45231).



Douglas W. Elmendorf
Director

April 2014

APPENDIX

C

Labor Market Effects of the Affordable Care Act: Updated Estimates

Overview

The baseline economic projections developed by the Congressional Budget Office (CBO) incorporate the agency's estimates of the future effects of federal policies under current law. The agency updates those projections regularly to account for new information and analysis regarding federal fiscal policies and many other influences on the economy. In preparing economic projections for the February 2014 baseline, CBO has updated its estimates of the effects of the Affordable Care Act (ACA) on labor markets.[1]

The ACA includes a range of provisions that will take full effect over the next several years and that will influence the supply of and demand for labor through various channels. For example, some provisions will raise effective tax rates on earnings from labor and thus will reduce the amount of labor that some workers choose to supply. In particular, the health insurance subsidies that the act provides to some people will be phased out as their income rises—creating an implicit tax on additional earnings—whereas for other people, the act imposes higher taxes on labor income directly. The ACA also will exert conflicting pressures on the quantity of labor that employers demand, primarily during the next few years.

How Much Will the ACA Reduce Employment in the Longer Term?

The ACA's largest impact on labor markets will probably occur after 2016, once its major provisions have taken full effect and overall economic output nears its maximum sustainable level. CBO estimates that the ACA will reduce the total number of hours worked, on net, by about 1.5 percent to 2.0 percent during the period from 2017 to 2024, almost entirely because workers will choose to supply less labor—given the new taxes and other incentives they will face and the financial benefits some will receive. Because the largest declines in labor supply will probably occur among lower-wage workers, the reduction in aggregate compensation (wages, salaries, and fringe benefits) and the impact on the overall economy will be proportionally smaller than the reduction in hours worked. Specifically, CBO estimates that the ACA will cause a reduction of roughly 1 percent in aggregate labor compensation over the 2017–2024 period, compared with what it would have been otherwise. Although such effects are likely to continue after 2024 (the end of the current 10-year budget window), CBO has not estimated their magnitude or duration over a longer period.

The reduction in CBO's projections of hours worked represents a decline in the number of full-time-equivalent workers of about 2.0 million in 2017, rising to about 2.5 million in 2024. Although CBO projects that total employment (and compensation) will increase over the coming decade, that increase will be smaller than it would have been in the absence of the ACA. The decline in full-time-equivalent employment stemming from the ACA will consist of some people not being employed at all and other people working fewer hours; however, CBO has not tried to quantify those two components of the overall effect. The estimated reduction stems almost entirely from a net decline in the amount of labor that workers choose to supply, rather than from a net drop in businesses' demand for labor, so it will appear almost entirely as a reduction in labor force participation and in hours worked relative to what would have occurred otherwise

1. As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148); the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152); and the effects of subsequent judicial decisions, statutory changes, and administrative actions.

rather than as an increase in unemployment (that is, more workers seeking but not finding jobs) or underemployment (such as part-time workers who would prefer to work more hours per week).

CBO's estimate that the ACA will reduce employment reflects some of the inherent trade-offs involved in designing such legislation. Subsidies that help lower-income people purchase an expensive product like health insurance must be relatively large to encourage a significant proportion of eligible people to enroll. If those subsidies are phased out with rising income in order to limit their total costs, the phaseout effectively raises people's marginal tax rates (the tax rates applying to their last dollar of income), thus discouraging work. In addition, if the subsidies are financed at least in part by higher taxes, those taxes will further discourage work or create other economic distortions, depending on how the taxes are designed. Alternatively, if subsidies are not phased out or eliminated with rising income, then the increase in taxes required to finance the subsidies would be much larger.

CBO's estimate of the ACA's impact on labor markets is subject to substantial uncertainty, which arises in part because many of the ACA's provisions have never been implemented on such a broad scale and in part because available estimates of many key responses vary considerably. CBO seeks to provide estimates that lie in the middle of the distribution of potential outcomes, but the actual effects could differ notably from those estimates. For example, if fewer people obtain subsidized insurance coverage through exchanges than CBO expects, then the effects of the ACA on employment would be smaller than CBO estimates in this report. Alternatively, if more people obtain subsidized coverage through exchanges, then the impact on the labor market would be larger.

Why Will Those Reductions Be Smaller in the Short Term?

CBO estimates that the ACA will cause smaller declines in employment over the 2014–2016 period than in later years, for three reasons. First, fewer people will receive subsidies through health insurance exchanges in that period, so fewer people will face the implicit tax that results when higher earnings reduce those subsidies. Second, CBO expects the unemployment rate to remain higher than normal over the next few years, so more people will be applying for each available job—meaning that if some people seek to work less, other applicants will be readily available to fill those positions and the overall effect on employment will be muted. Third, the ACA's subsidies for health insurance will both stimulate demand for health care services and allow low-income households to redirect some of the funds that they would have spent on that care toward the purchase of other goods and services—thereby increasing overall demand. That increase in overall demand while the economy remains somewhat weak will induce some employers to hire more workers or to increase the hours of current employees during that period.

Why Does CBO Estimate Larger Reductions Than It Did in 2010?

In 2010, CBO estimated that the ACA, on net, would reduce the amount of labor used in the economy by roughly half a percent—primarily by reducing the amount of labor that workers choose to supply.[2] That measure of labor use was calculated in dollar terms, representing the approximate change in aggregate labor compensation that would result. Hence, that estimate can be compared with the roughly 1 percent reduction in aggregate compensation that CBO now estimates to result from the act. There are several reasons for that difference: CBO has now incorporated into its analysis additional channels through which the ACA will affect labor supply, reviewed new research about those effects, and revised upward its estimates of the responsiveness of labor supply to changes in tax rates.

Effects of the ACA on the Supply of Labor

CBO anticipates that the ACA will lead to a net reduction in the supply of labor. In the agency's judgment, the effects will be most evident in some segments of the workforce and will be small or negligible for most categories of workers. (The ACA also will slightly affect employers' demand for labor, as discussed below, and the total effect on labor use will consist of the combined effects on supply and on demand.) In CBO's view, the ACA's effects on labor supply will stem mainly from the following provisions, roughly in order of importance:

2. See Congressional Budget Office, *The Budget and Economic Outlook: An Update* (August 2010), Box 2-1, www.cbo.gov/publication/21670.

- The subsidies for health insurance purchased through exchanges;
- The expansion of eligibility for Medicaid;
- The penalties on employers that decline to offer insurance; and
- The new taxes imposed on labor income.

Some of those provisions will reduce the amount of labor supplied by some workers; other provisions will increase the amount of labor supplied by other workers. Several provisions also will combine to affect retirement decisions.

The ACA also could alter labor productivity—the amount of output generated per hour of work—which in turn would influence employment (for example, by affecting workers' health or firms' investments in training of workers). The effects on productivity could be positive or negative, however, and their net impact is uncertain, so they are not reflected in CBO's estimates of labor supply or demand. Because the ACA could affect labor markets through many channels, with substantial uncertainty surrounding the magnitude of the effects and their interactions, CBO has chosen not to report specific estimates for each of the channels encompassed by its analysis.

Effects of Insurance Subsidies on the Supply of Labor

Beginning in 2014, many people who purchase insurance through exchanges will be eligible for federal tax credits to defray the cost of their premiums, and some also will be eligible for cost-sharing subsidies to reduce out-of-pocket expenditures for health care. Those subsidies are largest for people whose income is near the federal poverty guideline (also known as the federal poverty level, or FPL), and they decline with rising income.[3]

In 2014, for example, a single person or a family whose income is 150 percent of the FPL and is eligible for subsidies will pay 4 percent of their income for a certain "silver" health care plan purchased through an exchange; if their income is 200 percent of the FPL, they will pay 6.3 percent of their income for that plan.[4] An increase in income thus raises the enrollee premium (and reduces the subsidy) both because the percentage-of-income formula applies to a larger dollar amount and because that percentage itself increases. People whose income exceeds 400 percent of the FPL are ineligible for premium subsidies, and for some people those subsidies will drop abruptly to zero when income crosses that threshold. Cost-sharing subsidies also phase out in steps with rising income, declining sharply at 150 percent, 200 percent, and 250 percent of the FPL.

CBO's estimate of the impact that the subsidies will have on labor supply has three components: the magnitude of the incentive, the number and types of people affected, and the degree of responsiveness to the incentive among those who are affected.

The Magnitude of the Incentive to Reduce Labor Supply. For some people, the availability of exchange subsidies under the ACA will reduce incentives to work both through a substitution effect and through an income effect. The former arises because subsidies decline with rising income (and increase as income falls), thus making work less attractive. As a result, some people will choose not to work or will work less—thus substituting other activities for work. The income effect arises because subsidies increase available resources—similar to giving people greater income—thereby allowing some people to maintain the same standard of living while working less. The magnitude of the incentive to reduce labor supply thus depends on the size of the subsidies and the rate at which they are phased out.

The Number and Types of Workers Likely To Be Affected. Subsidies clearly alter recipients' incentives to work and can certainly influence the labor supply of those who would gain eligibility by working and earning slightly less. But most full-time workers do not confront that particular choice—either their income is well above 400 percent of the FPL or they are offered employment-based health insurance and thus are generally ineligible for subsidies regardless of their income. Even so, one line of research indicates that the subsidies will affect the labor supply of many full-time workers with health insurance

3. In 2013, the FPL (which is indexed to inflation) was $11,490 for a single person and $23,550 for a family of four. Calculations of exchange subsidies for 2014 use the 2013 FPL schedule.

4. A silver plan pays about 70 percent of covered health costs, on average. For the second-least-expensive silver plan offered on the exchanges, the premium, net of subsidies, for a family of four in 2014 would be $1,413 at 150 percent of the FPL ($35,325) but would rise to $2,967 at 200 percent of the FPL ($47,100).

from their employer—precisely because they effectively forgo exchange subsidies when they take or keep a job with health insurance.[5] If instead a worker switched to a part-time job, which typically does not offer health insurance, that worker could become eligible for exchange subsidies. In that view, exchange subsidies effectively constitute a tax on labor supply for a broad range of workers.

In CBO's judgment, however, the cost of forgoing exchange subsidies operates primarily as an implicit tax on employment-based insurance, which does not imply a change in hours worked. Instead, the tax can be avoided if a worker switches to a different full-time job without health insurance (or possibly two part-time jobs) or if the employer decides to stop offering that benefit. The consequences of that implicit tax are incorporated into CBO's estimate of the ACA's effect on employment-based coverage—which is projected to decline, on net, by about 4 percent because of the ACA (see Appendix B).[6] Correspondingly, the negative effects of exchange subsidies on incentives to work will be relevant primarily for a limited segment of the population—mostly people who have no offer of employment-based coverage and whose income is either below or near 400 percent of the FPL.

Nonetheless, another subgroup that has employment-based insurance does seem likely to reduce their labor supply somewhat. Specifically, those people whose income would make them eligible for subsidies through exchanges (or for Medicaid), and who work less than a full year (roughly 10 to 15 percent of workers in that income range in a typical year), would tend to work somewhat less because of the ACA's subsidies. For those workers, the loss of subsidies upon returning to a job with health insurance is an implicit tax on working (and is equivalent to an average tax rate of roughly 15 percent, CBO estimates). That implicit tax will cause some of those workers to lengthen the time they are out of work—similar to the effect of unemployment benefits.

Responsiveness of Affected Groups. The implicit taxes that arise from the phaseout of the subsidies have effects on net income that are similar to the effects of direct taxes. With tax changes, however, the income and substitution effects typically work in opposite directions, whereas with the insurance subsidies the income and substitution effects work in the same direction to decrease labor supply.[7] CBO's estimate of the response of labor supply to the subsidies is based on research concerning the way changes in marginal tax rates affect labor supply and on studies analyzing how labor supply responds to changes in after-tax income.[8]

Effects of the Medicaid Expansion on Labor Supply

The ACA significantly increases eligibility for Medicaid for residents of states that choose to expand their programs. In states that adopt the expansion, Medicaid eligibility is extended to most nonelderly residents whose income is below 138 percent of the FPL—including childless adults who previously were ineligible for Medicaid in most states regardless of their income. In states that have not expanded Medicaid, people whose income is between 100 percent and 138 percent of the FPL become eligible for subsidies through the exchanges; in those states, subsidies could decline abruptly if an enrollee's income fell from just above the FPL to just below it (and vice versa). By 2018, CBO expects that around 80 percent of the potentially eligible population will live in states that have expanded Medicaid.

5. See Casey B. Mulligan, *Average Marginal Tax Rates Under the Affordable Care Act*, Working Paper 19365 (National Bureau of Economic Research, August 2013), www.nber.org/papers/w19365, and *Is the Affordable Care Act Different From Romneycare? A Labor Economics Perspective*, Working Paper 19366 (National Bureau of Economic Research, August 2013), www.nber.org/papers/w19366.

6. See Congressional Budget Office, *CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance* (March 2012), www.cbo.gov/publication/43082.

7. To see how the substitution and income effects can create counteracting pressures on people's willingness to work when tax rates change, consider the case of an increase in tax rates. The resulting reduction in take-home pay for an additional hour of work makes work less valuable relative to other uses of time and encourages people to work less. Reduced after-tax income from a given amount of work, however, encourages people to work more to limit the decline in their standard of living.

8. See Congressional Budget Office, *How the Supply of Labor Responds to Changes in Fiscal Policy* (October 2012), www.cbo.gov/publication/43674; Robert McClelland and Shannon Mok, *A Review of Recent Research on Labor Supply Elasticities*, Working Paper 2012-12 (Congressional Budget Office, October 2012), www.cbo.gov/publication/43675; and Felix Reichling and Charles Whalen, *Review of Estimates of the Frisch Elasticity of Labor Supply*, Working Paper 2012-13 (Congressional Budget Office, October 2012), www.cbo.gov/publication/43676.

Incentives to Change Labor Supply and Groups Affected. For some people, the ACA's expansion of Medicaid will reduce the incentive to work—but among other people it will increase that incentive. As with exchange subsidies, access to Medicaid confers financial benefits that are phased out with rising income or (more commonly) eliminated when income exceeds a threshold; some people will thus work fewer hours or withdraw from the labor force to become or remain eligible (the substitution effect). Moreover, those financial benefits will lead some people to work less because the increase in their available resources enables them to reduce work without a decline in their standard of living (the income effect).

At the same time, some people who would have been eligible for Medicaid under prior law—in particular, working parents with very low income—will work more as a result of the ACA's provisions. In 2013, the median income threshold for that group's Medicaid eligibility was 64 percent of the FPL (albeit with substantial state-to-state variation). The incentives and groups affected depend on whether a state has adopted the Medicaid expansion (and, in both cases, those incentives are intertwined with the effects of the exchange subsidies):

- In states that have chosen to expand Medicaid, the ACA now allows parents to qualify for Medicaid with income up to 138 percent of the FPL. And if their income rises above that threshold, those parents would generally be eligible for premium tax credits and cost-sharing subsidies for insurance purchased through the exchanges unless they are offered qualified employment-based health insurance. The subsidies will cover a smaller share of enrollees' medical costs than Medicaid would, but under prior law those participants ultimately would have become ineligible for Medicaid and lost all benefits. As a result, some people who would have curtailed their hours of work in order to maintain access to Medicaid under prior law will now be able to increase their hours and income while remaining eligible for subsidized insurance.

- In states that choose not to expand Medicaid, the availability of exchange subsidies also will lead some people to work more. Specifically, some people who would otherwise have income below the FPL will work more so that they can qualify for the substantial exchange subsidies that become available when income is equal to or just above the FPL

Responses of Affected Groups. A number of studies examining the impact of changes in Medicaid eligibility for parents and children have shown either no effects or small effects on the labor supply of single mothers; effects on two-parent households appear to be somewhat larger, in part because health insurance has stronger effects on the labor supply of secondary earners.[9]

More recently, several studies have examined changes in state policies that affect childless adults—who constitute the majority of those gaining coverage through the Medicaid expansion—and larger effects have been reported. Some reductions in employment are reported among people who have gained Medicaid eligibility, although the findings differ regarding the magnitude and statistical significance of that effect.[10] Similarly, other research shows a rise in employment rates with the withdrawal of Medicaid coverage from childless adults who had previously been turned down for private insurance.[11] Because those studies examined state-level policy initiatives affecting program eligibility—instead of changes in eligibility attributable to income changes, which could merely reflect changes in employment—the results provide some useful insights into the potential effects of the ACA (even though other aspects of the studies raise questions about their applicability to an analysis of the ACA).

Taking that research into account, CBO estimates that expanded Medicaid eligibility under the ACA will, on balance, reduce incentives to work. That effect has a relatively modest influence on total labor supply, however, because the expansion of eligibility for Medicaid primarily affects a relatively small segment of the total population—both because most people's income will

9. See Jonathan Gruber and Brigitte C. Madrian, *Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature*, Working Paper 8817 (National Bureau of Economic Research, February 2002), www.nber.org/papers/w8817.

10. See Katherine Baicker and others, *The Impact of Medicaid on Labor Force Activity and Program Participation: Evidence from the Oregon Health Insurance Experiment*, Working Paper 19547 (National Bureau of Economic Research, October 2013), www.nber.org/papers/w19547; and Laura Dague, Thomas DeLeire, and Lindsey Leininger, "The Effect of Public Insurance Coverage for Childless Adults on Labor Supply" (draft, March 2013), www.uh.edu/~achin/conference/dague.pdf (950 KB).

11. Craig Garthwaite, Tal Gross, and Matthew J. Notowidigdo, *Public Health Insurance, Labor Supply, and Employment Lock*, Working Paper 19220 (National Bureau of Economic Research, July 2013), www.nber.org/papers/w19220.

significantly exceed the cutoff for Medicaid eligibility and because some low-income people live in states that are not expected to expand Medicaid.

Effects of the Employer Penalty on Labor Supply

Under the ACA, employers with 50 or more full-time-equivalent employees will face a penalty if they do not offer insurance (or if the insurance they offer does not meet certain criteria) and if at least one of their full-time workers receives a subsidy through an exchange. Originally scheduled to take effect in 2014, that penalty is now scheduled to be enforced beginning in 2015. In CBO's judgment, the costs of the penalty eventually will be borne primarily by workers in the form of reductions in wages or other compensation—just as the costs of a payroll tax levied on employers will generally be passed along to employees.[12] Because the supply of labor is responsive to changes in compensation, the employer penalty will ultimately induce some workers to supply less labor.

In the next few years, however, when wages probably will not adjust fully, those penalties will tend to reduce the demand for labor more than the supply. In the longer run, some businesses also may decide to reduce their hiring or shift their demand toward part-time hiring—either to stay below the threshold of 50 full-time-equivalent workers or to limit the number of full-time workers that generate penalty payments. But such shifts might not reduce the overall use of labor, as discussed below.

Effects of Higher Marginal Tax Rates on Labor Supply

To cover part of the cost of the expansion of coverage, the ACA also imposes higher taxes on some people.[13] In particular, the payroll tax for Medicare's Hospital Insurance program has increased by 0.9 percentage points for workers whose earnings are above $200,000 ($250,000 for those filing a joint return).[14] As with other tax increases, those changes will exert competing pressures on labor supply: Lower after-tax compensation will encourage people to work more to make up for the lost income, but the decline in after-tax hourly compensation also will reduce the return on each additional hour of work, thus tending to reduce the incentive to work. On net, CBO anticipates, the second effect will be larger than the first, and the tax will yield a small net reduction in labor supply.

In addition, beginning in 2018, the ACA imposes an excise tax on certain high-cost health insurance plans. CBO expects that the burden of that tax will, over time, be borne primarily by workers in the form of smaller after-tax compensation. Some firms may seek to avoid or limit the amount of the excise tax they pay by switching to less expensive health plans, and in that case workers' wages should rise by a corresponding amount. Those wages will be subject to income and payroll taxes, however, so total tax payments by those workers will be higher than they would have been in the absence of the ACA. After-tax compensation will thus fall whether firms pay the excise tax or take steps to avoid it, and the resulting increases in average and marginal tax rates will cause a slight decline in the supply of labor, CBO estimates.

Under certain circumstances, the ACA also imposes a penalty tax on people who do not have qualified health insurance. That tax is to be phased in over time; by 2016, it will generally be the greater of $695 annually per adult or 2.5 percent of taxable income (each subject to a cap).[15] For people who are subject to the percentage-of-income penalty, that tax discourages work—but CBO estimates

12. By contrast, if employers add health insurance coverage as a benefit in response to the penalty or drop coverage despite it, CBO estimates that their workers' wages will adjust by roughly the employers' cost of providing that coverage—so total compensation would stay about the same and labor supply would not be affected by the change in employer coverage.

13. CBO and the staff of the Joint Committee on Taxation have estimated that, on balance, the ACA will reduce the cumulative deficit over the 2013–2022 period because cuts in other spending more than offset the rest of the cost of the expansion in coverage. Therefore, repealing the ACA would increase budget deficits by a corresponding amount over that period; see Congressional Budget Office, letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act (July 24, 2012), www.cbo.gov/publication/43471.

14. The ACA has also raised the tax rate on capital income for some higher-income households and imposed taxes on certain goods and services (such as medical devices), but CBO does not expect those provisions to have a noticeable effect on the overall labor market.

15. For families who are subject to the dollar penalty, the penalty per child is one-half the adult penalty, and in 2016 the payment is capped at $2,085; for people who are subject to the percentage-of-income penalty, the tax payment is capped at the average cost of a "bronze" insurance plan (which, on average, covers 60 percent of enrollees' health costs) offered through the exchanges. After 2016, the dollar penalty is indexed to general inflation.

that a relatively small number of workers will be affected. About 6 million workers and dependents will be subject to the penalty tax in 2016, and among the workers who pay it, a large share will be subject to the dollar penalty rather than the percentage-of-income penalty.[16] As a result, CBO estimates that its impact on aggregate labor supply will be negligible.

Effects on Retirement Decisions and Disabled Workers

Changes to the health insurance market under the ACA, including provisions that prohibit insurers from denying coverage to people with preexisting conditions and those that restrict variability in premiums on the basis of age or health status, will lower the cost of health insurance plans offered to older workers outside the workplace. As a result, some will choose to retire earlier than they otherwise would—another channel through which the ACA will reduce the supply of labor.

The new insurance rules and wider availability of subsidies also could affect the employment decisions of people with disabilities, but the net impact on their labor supply is not clear. In the absence of the ACA, some workers with disabilities would leave the workforce to enroll in such programs as Disability Insurance (DI) or Supplemental Security Income (SSI) and receive subsidized health insurance. (SSI enrollees also receive Medicaid; DI enrollees become eligible for Medicare after a two-year waiting period.) Under the ACA, however, they could be eligible for subsidized health insurance offered through the exchanges, and they cannot be denied coverage or charged higher premiums because of health problems. As a result, some disabled workers who would otherwise have been out of the workforce might stay employed or seek employment. At the same time, those subsidies and new insurance rules might lead other disabled workers to leave the workforce earlier than they otherwise would. Unlike DI applicants who are ineligible for SSI, they would not have to wait two years before they received the ACA's Medicaid benefits or exchange subsidies—making it more attractive to leave the labor force and apply for DI.

16. See Congressional Budget Office, *Payments of Penalties for Being Uninsured Under the Affordable Care Act* (September 2012), www.cbo.gov/publication/43628.

Possible Effects on Labor Supply Through Productivity

In addition to the effects discussed above, the ACA could shape the labor market or the operations of the health sector in ways that affect labor productivity. For example, to the extent that increases in insurance coverage lead to improved health among workers, labor productivity could be enhanced. In addition, the ACA could influence labor productivity indirectly by making it easier for some employees to obtain health insurance outside the workplace and thereby prompting those workers to take jobs that better match their skills, regardless of whether those jobs offered employment-based insurance.

Some employers, however, might invest less in their workers—by reducing training, for example—if the turnover of employees increased because their health insurance was no longer tied so closely to their jobs. Furthermore, productivity could be reduced if businesses shifted toward hiring more part-time employees to avoid paying the employer penalty and if part-time workers operated less efficiently than full-time workers did. (If the dollar loss in productivity exceeded the cost of the employer penalty, however, businesses might not shift toward hiring more part-time employees.)

Whether any of those changes would have a noticeable influence on overall economic productivity, however, is not clear. Moreover, those changes are difficult to quantify and they influence labor productivity in opposing directions. As a result, their effects are not incorporated into CBO's estimates of the effects of the ACA on the labor market.

Some recent analyses also have suggested that the ACA will lead to higher productivity in the health care sector—in particular, by avoiding costs for low-value health care services—and thus to slower growth in health care costs under employment-based health plans.[17] Slower growth in those costs would effectively increase workers' compensation, making work more attractive. Those effects could increase the supply of labor (and could increase the demand for labor in the near term, if some of the savings were not immediately passed on to workers).

17. See Council of Economic Advisers, *Trends in Health Care Cost Growth and the Role of the Affordable Care Act* (November 2013), http://go.usa.gov/ZJFJ; and David Cutler and Neeraj Sooj, *New Jobs Through Better Health Care* (Center for American Progress, January 2010), http://tinyurl.com/oc2zdta.

Whether the ACA already has or will reduce health care costs in the private sector, however, is hard to determine. The ACA's reductions in payment rates to hospitals and other providers have slowed the growth of Medicare spending (compared with projections under prior law) and thus contributed to the slow rate of overall cost growth in health care since the law's enactment. Private health care costs (as well as national health expenditures) have grown more slowly in recent years as well, but analysts differ about the shares of that slowdown that can be attributed to the deep recession and weak recovery, to provisions of the ACA, and to other changes within the health sector. Moreover, the overall influence of the ACA on the cost of employment-based coverage is difficult to predict—in part because some provisions could either increase or decrease private-sector spending on health care and in part because many provisions have not yet been fully implemented or evaluated.[18] Consequently, CBO has not attributed to the ACA any employment effects stemming from slower growth of premiums in the private sector.

Effects of the ACA on the Demand for Labor

The ACA also will affect employers' demand for workers, mostly over the next few years, both by increasing labor costs through the employer penalty (which will reduce labor demand) and by boosting overall demand for goods and services (which will increase labor demand).

Effects of the Employer Penalty on the Demand for Labor

Beginning in 2015, employers of 50 or more full-time-equivalent workers that do not offer health insurance (or that offer health insurance that does not meet certain criteria) will generally pay a penalty. That penalty will initially reduce employers' demand for labor and thereby tend to lower employment. Over time, CBO expects, the penalty will be borne primarily by workers in the form of reduced wages or other compensation, at which point the penalty will have little effect on labor *demand* but will reduce labor *supply* and will lower employment slightly through that channel.

Businesses face two constraints, however, in seeking to shift the costs of the penalty to workers. First, there is considerable evidence that employers refrain from cutting their employees' wages, even when unemployment is high (a phenomenon sometimes referred to as sticky wages).[19] For that reason, some employers might leave wages unchanged and instead employ a smaller workforce. That effect will probably dissipate entirely over several years for most workers because companies that face the penalty can restrain wage growth until workers have absorbed the cost of the penalty—thus gradually eliminating the negative effect on labor demand that comes from sticky wages.

A second and more durable constraint is that businesses generally cannot reduce workers' wages below the statutory minimum wage.[20] As a result, some employers will respond to the penalty by hiring fewer people at or just above the minimum wage—an effect that would be similar to the impact of raising the minimum wage for those companies' employees. Over time, as worker productivity rises and inflation erodes the value of the minimum wage, that effect is projected to decline because wages for fewer jobs will be constrained by the minimum wage. The effect will not disappear completely over the next 10 years, however, because some wages are still projected to be constrained (that is, wages for some jobs will be at or just above the minimum wage).

Businesses also may respond to the employer penalty by seeking to reduce or limit their full-time staffing and to hire more part-time employees. Those responses might occur because the employer penalty will apply only to businesses with 50 or more full-time-equivalent employees, and employers will be charged only for each full-time employee (not counting the first 30 employees). People are generally considered full time under the ACA if they work 30 hours or more per week, on average, so

18. Before the ACA was enacted, CBO estimated that the provisions of a similar proposal might cause a small increase or decrease in premiums for employment-based coverage, although that analysis did not take into account the effects of the excise tax on certain high-cost employment-based plans. See Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* (November 2009), www.cbo.gov/publication/41792.

19. See, for example, Peter Gottschalk, "Downward Nominal Wage Flexibility: Real or Measurement Error?" *Review of Economics and Statistics*, vol. 87, no. 3 (August 2005), pp. 556–568, http://tinyurl.com/k9bcxss; and Alessandro Brattieri, Susanto Basu, and Peter Gottschalk, *Some Evidence on the Importance of Sticky Wages*, Working Paper 16130 (National Bureau of Economic Research, June 2010), www.nber.org/papers/w16130.

20. As of January 2014, the federal minimum wage was $7.25 per hour. Roughly half of all workers, however, live in states or communities where the minimum wage is higher.

employers have an incentive, for example, to shift from hiring a single 40-hour, full-time employee to hiring two, 20-hour part-time employees to avoid bearing the costs of the penalty.

Such a change might or might not, on its own, reduce the total number of hours worked. In the example just offered, the total amount of work is unaffected by the changes. Moreover, adjustments of that sort can take time and be quite costly—in particular, because of the time and costs that arise in dismissing full-time workers (which may involve the loss of workers with valuable job-specific skills); the time and costs associated with hiring new part-time workers (including the effort spent on interviewing and training); and, perhaps most important, the time and costs of changing work processes to accommodate a larger number of employees working shorter and different schedules. The extent to which people would be willing to work at more than one part-time job instead of a single full-time job is unclear as well; although hourly wages for full-time jobs might be lower than those for part-time jobs (once wages adjust to the penalty), workers also would incur additional costs associated with holding more than one job at a time.

In CBO's judgment, there is no compelling evidence that part-time employment has increased as a result of the ACA. On the one hand, there have been anecdotal reports of firms responding to the employer penalty by limiting workers' hours, and the share of workers in part-time jobs has declined relatively slowly since the end of the recent recession. On the other hand, the share of workers in part-time jobs generally declines slowly after recessions, so whether that share would have declined more quickly during the past few years in the absence of the ACA is difficult to determine.[21] In any event, because the employer penalty will not take effect until 2015, the current lack of direct evidence may not be very informative about the ultimate effects of the ACA.

More generally, some employers have expressed doubts about whether and how the provisions of the ACA will unfold. Uncertainty in several areas—including the timing and sequence of policy changes and implementation procedures and their effects on health insurance premiums and workers' demand for health insurance—probably has encouraged some employers to delay hiring. However, those effects are difficult to quantify separately from other developments in the labor market, and possible effects on the demand for labor through such channels have not been incorporated into CBO's estimates of the ACA's impact.

Effects of Changes in the Demand for Goods and Services on the Demand for Labor

CBO estimates that, over the next few years, the various provisions of the ACA that affect federal revenues and outlays will increase demand for goods and services, on net. Most important, the expansion of Medicaid coverage and the provision of exchange subsidies (and the resulting rise in health insurance coverage) will not only stimulate greater demand for health care services but also allow lower-income households that gain subsidized coverage to increase their spending on other goods and services—thereby raising overall demand in the economy. A partial offset will come from the increased taxes and reductions in Medicare's payments to health care providers that are included in the ACA to offset the costs of the coverage expansion.

On balance, CBO estimates that the ACA will boost overall demand for goods and services over the next few years because the people who will benefit from the expansion of Medicaid and from access to the exchange subsidies are predominantly in lower-income households and thus are likely to spend a considerable fraction of their additional resources on goods and services—whereas people who will pay the higher taxes are predominantly in higher-income households and are likely to change their spending to a lesser degree. Similarly, reduced payments under Medicare to hospitals and other providers will lessen their income or profits, but those changes are likely to decrease demand by a relatively small amount.

The net increase in demand for goods and services will in turn boost demand for labor over the next few years, CBO estimates.[22] Those effects on labor demand tend to be especially strong under conditions such as those now prevailing in the United States, where output is so far below its maximum sustainable level that the Federal Reserve has kept short-term interest rates near zero for several years and probably would not adjust those rates to

21. See Congressional Budget Office, *The Slow Recovery of the Labor Market* (February 2014), www.cbo.gov/publication/45011.

22. For further discussion of CBO's analysis of the economic effects of budgetary policies, see Congressional Budget Office, *Economic Effects of Policies Contributing to Fiscal Tightening in 2013* (November 2012), pp. 2–5, www.cbo.gov/publication/43694.

offset the effects of changes in federal spending and taxes. Over time, however, those effects are expected to dissipate as overall economic output moves back toward its maximum sustainable level.

Why Short-Term Effects Will Be Smaller Than Longer-Term Effects

CBO estimates that the reduction in the use of labor that is attributable to the ACA will be smaller between 2014 and 2016 than it will be between 2017 and 2024. That difference is a result of three factors in particular—two that reflect smaller negative effects on the supply of labor and one that reflects a more positive effect on the demand for labor:

- The number of people who will receive exchange subsidies—and who thus will face an implicit tax from the phaseout of those subsidies that discourages them from working—will be smaller initially than it will be in later years. The number of enrollees (workers and their dependents) purchasing their own coverage through the exchanges is projected to rise from about 6 million in 2014 to about 25 million in 2017 and later years, and most of those enrollees will receive subsidies. Although the number of people who will be eligible for exchange subsidies is similar from year to year, workers who are eligible but do not enroll may either be unaware of their eligibility or be unaffected by it and thus are unlikely to change their supply of labor in response to the availability of those subsidies.

- CBO anticipates that the unemployment rate will remain high for the next few years. If changes in incentives lead some workers to reduce the amount of hours they want to work or to leave the labor force altogether, many unemployed workers will be available to take those jobs—so the effect on overall employment of reductions in labor supply will be greatly dampened.

- The expanded federal subsidies for health insurance will stimulate demand for goods and services, and that effect will mostly occur over the next few years. That increase in demand will induce some employers to hire more workers or to increase their employees' hours during that period.

CBO anticipates that output will return nearly to its maximum sustainable level in 2017 (see Chapter 2). Once that occurs, the net decline in the amount of labor that workers choose to supply because of the ACA will be fully reflected in a decline in total employment and hours worked relative to what would otherwise occur.

Differences From CBO's Previous Estimates of the ACA's Effects on Labor Markets

CBO's estimate that the ACA will reduce aggregate labor compensation in the economy by about 1 percent over the 2017–2024 period—compared with what would have occurred in the absence of the act—is substantially larger than the estimate the agency issued in August 2010.[23] At that time, CBO estimated that, once it was fully implemented, the ACA would reduce the use of labor by about one-half of a percent. That measure of labor use was calculated in dollar terms, representing the change in aggregate labor compensation that would result. Thus it can be compared with the reduction in aggregate compensation that CBO now estimates to result from the act (rather than with the projected decline in the number of hours worked).

The increase in that estimate primarily reflects three factors:

- The revised estimate is based on a more detailed analysis of the ACA that incorporates additional channels through which that law will affect labor supply. In particular, CBO's 2010 estimate did not include an effect on labor supply from the employer penalty and the resulting reduction in wages (as the costs of that penalty are passed on to workers), and it did not include an effect from encouraging part-year workers to delay returning to work in order to retain their insurance subsidies.

- CBO has analyzed the findings of several studies published since 2010 concerning the impact of provisions of the ACA (or similar policy initiatives) on labor markets. In particular, studies of past expansions or contractions in Medicaid eligibility for childless adults have pointed to a larger effect on labor supply than CBO had estimated previously.

23. See Congressional Budget Office, *The Budget and Economic Outlook: An Update* (August 2010), Box 2-1, www.cbo.gov/publication/21670.

- CBO made an upward revision in its estimates of the impact that changes in after-tax wages have on labor supply, reflecting a broad review of the tax literature that has informed several of CBO's estimates and analyses.[24]

CBO's updated estimate of the decrease in hours worked translates to a reduction in full-time-equivalent employment of about 2.0 million in 2017, rising to about 2.5 million in 2024, compared with what would have occurred in the absence of the ACA. Previously, the agency estimated that if the ACA did not affect the average number of hours worked per employed person, it would reduce household employment in 2021 by about 800,000.[25] By way of comparison, CBO's current estimate for 2021 is a reduction in full-time-equivalent employment of about 2.3 million.

The current estimate of the ACA's impact on hours worked and full-time-equivalent employment is considerably higher for two significant reasons.[26] First, as described above, CBO has boosted its estimate of the ACA's effect on aggregate labor compensation in the economy from about 0.5 percent to about 1 percent. Second, CBO has increased its estimate of the effect of a given reduction in aggregate compensation under the ACA on hours worked. CBO's earlier estimate was based on a simplifying assumption that affected workers would have average earnings—in which case the percentage reductions in compensation and hours worked would be roughly the same. However, people whose employment or hours worked will be most affected by the ACA are expected to have below-average earnings because the effects of the subsidies that are available through exchanges and of expanded Medicaid eligibility on the amount of labor supplied by lower-income people are likely to be greater than the effects of increased taxes on the amount of labor supplied by higher-income people. According to CBO's more detailed analysis, the 1 percent reduction in aggregate compensation that will occur as a result of the ACA corresponds to a reduction of about 1.5 percent to 2.0 percent in hours worked.

The reduction in full-time-equivalent employment that CBO expects will arise from the ACA includes some people choosing not to work at all and other people choosing to work fewer hours than they would have in the absence of the law; however, CBO has not tried to quantify those two components of the overall effect. Because some people will reduce the amount of hours they work rather than stopping work altogether, the number who will choose to leave employment because of the ACA in 2024 is likely to be substantially less than 2.5 million. At the same time, more than 2.5 million people are likely to reduce the amount of labor they choose to supply to some degree because of the ACA, even though many of them will not leave the labor force entirely.

24. See Congressional Budget Office, *How the Supply of Labor Responds to Changes in Fiscal Policy* (October 2012), www.cbo.gov/publication/43674.

25. See testimony of Douglas W. Elmendorf, Director, Congressional Budget Office, before the Subcommittee on Health of the House Energy and Commerce Committee, *CBO's Analysis of the Major Health Care Legislation Enacted in 2010* (March 30, 2011), pp. 31–33, www.cbo.gov/publication/22077.

26. The estimates also differ in that the first estimate was presented in terms of household employment and the current estimate is presented in terms of full-time-equivalent employment. However, that difference is relatively small when comparing CBO's previous estimate with the current one.

Report to Congress on the impact on premiums for individuals and families with employer-sponsored health insurance from the guaranteed issue, guaranteed renewal, and fair health insurance premiums provisions of the Affordable Care Act

February 21, 2014

Introduction

The "Department of Defense and Full-Year Continuing Appropriations Act, 2011" required this report to Congress on the impact of sections 2701 through 2703 of the Public Health Service (PHS) Act, as amended by the Affordable Care Act (ACA) on the premiums paid by individuals and families with employer-sponsored health insurance. Specifically, the Chief Actuary of the Centers for Medicare & Medicaid Services (CMS) is to provide an estimate of the number of individuals and families who will experience a premium increase and the number who will see a decrease as a result of these three provisions.

Section 2701 of PHS Act is titled "Fair Health Insurance Premiums" and requires adjusted community rating for plan years beginning on or after January 1, 2014. Specifically, premium rates in the individual and small group market charged for non-grandfathered health insurance coverage may only be varied on the basis of the following four characteristics:

- Individual or family enrollment.
- Geographic area – premium rates can vary by the area of the country.
- Age – premium rates can be higher for an older applicant than that for a younger applicant, but the ratio of premiums cannot exceed 3:1 for adults.
- Tobacco use – premium rates can be higher for smokers, but the ratio cannot exceed 1.5:1.

Section 2702 of the PHS Act requires the guaranteed issuance of health insurance coverage in the individual and group market subject to specified exceptions. This means that insurers that offer coverage in the individual or group market generally must accept all applicants for that coverage in that market. Under section 2703 of the PHS Act, group and individual health insurance coverage must be guaranteed renewable at the option of the plan sponsor or individual, subject to specified exceptions. These three sections do not apply to grandfathered health insurance coverage.

Background

Prior to the passage of the ACA, the insurance products in the small group market were already required to be guaranteed issue and renewable under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, large group policies are not subject to section 2701 of the PHS Act. Self-funded plans are also not subject to the provisions analyzed in this report. As a result, large group and self-funded plans will be unaffected by the new rating requirements. Since these three specific ACA provisions will not have any significant effect on the premium rates paid by individuals working for large sized employers, the remainder of this report will focus on health insurance policies in the small group market.

To help individuals with pre-existing conditions gain affordable insurance coverage, Sections 2702 and 2703 of PHS Act generally require guaranteed issuance and renewability of policies to any employer that applies for coverage offered in the applicable market within enrollment periods, regardless of the health histories of its employees or other prohibited factors. These requirements apply to all small group health insurance plans other than grandfathered plans (as defined by federal regulations at 45 CFR 147) beginning on or after January 1, 2014. Some analysts expect that these grandfathered plans will experience reduced enrollment as individuals leave for new plans that are not only cheaper due to lower administrative costs, but also offer more generous coverage, or leave for individual market coverage for which individuals may qualify for premium tax credits.[1] Under HIPAA, all states currently have adopted guaranteed issue and renewal requirements for small group policies.

[1] Linda Blumberg. July 2010. "How Will the PPACA Impact Individual and Small Group Premiums in the Short and Long Term?" Urban Institute. Washington, DC.

The Chief Actuary was required to estimate the impact of these three specific ACA provisions – fair health insurance premiums, guaranteed issue and renewability – on the premiums for individuals and families with employer sponsored health insurance. Since fully insured small group policies are already guaranteed issue and renewal in all states, we expect there is no material net impact of these two ACA provisions on premium rates. As a result, the premium rate impact in the small group market is expected to result from only the new adjusted community rating provision in section 2701 of the PHS Act.

Adjusted Community Rating for Small Employers

This new adjusted community rating criteria is a change from the current small group market industry practice that existed prior to when these criteria take effect. Previously, issuers in most states could vary premiums by factors such as: health status of the group, group size, and industry code or classification. Smaller firms, and those performing high-risk work, or firms with sick employees, received significantly higher premiums than those with a lower risk group. In addition, they could be subject to large premium increases based on a new diagnosis for a single employee.

The ACA created a new health insurance Exchange for small businesses called the SHOP (Small Business Health Options Program), to offer plans tailored for small employers with 100 or fewer employees.[2] All health plans (other than those offered through the SHOP) will be subject to the premium rating requirements of section 2701 of the PHS Act. Beginning 2014, most individuals must obtain a form of minimum essential coverage or face a penalty. [3] Individuals with income between 100 and 400 percent of federal poverty level (FPL) may be eligible for premium tax credits and cost sharing reductions on a sliding scale to help reduce the cost if the coverage is obtained through the Exchanges.

There is considerable uncertainty as to whether small employers will decide to terminate their existing offer of health insurance coverage and send their employees to individual market Exchanges. Many factors may be relevant to their decisions.[4] For example, the decision could depend heavily on the extent to which employees are eligible for a premium tax credit on the individual market Exchanges. Some expect that it would be cheaper for employees with income below 250 percent of FPL to buy coverage from the individual market Exchanges given the premium tax credits and cost-sharing reductions available at these income levels.[5] Small employers with predominantly low-wage, part-time and seasonal employees may find it to their financial advantage to terminate existing coverage. Small businesses with 50 or fewer workers may find terminating existing coverage particularly attractive since they are not required by the ACA to offer affordable minimum essential health insurance coverage, and their workers have access to health insurance in the new Exchanges. Alternatively, it may be financially attractive for small employers with relatively healthy employees to continue to provide coverage but convert to a self-insured arrangement with stop-loss coverage. If such coverage becomes widely available, some analysts expect a substantial increase in self-insured small employers.[6] However, small group employers will also have to consider employee resistance and administrative complexity to substitute alternative

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[2] States have the option to lower the threshold to 50 or fewer employees.

[3] ACA exempts certain groups of individuals from this mandate. They include members of an exempt religious sect or division, a health care sharing ministry, or Native American Tribes. Illegal immigrants, individuals or households who do not have file a tax return because their income is too low or cannot afford the cheapest health insurance are also exempt from this mandate.

[4] Alan Reuther. September 2011. "Workers and Their Health Care Plans." Center for American Progress. Washington, DC.

[5] Center for Labor Research and Education. 2010. "The Affordable Care Act and Collective Bargaining." UC Berkley.

[6] Christine Eibner, et al. 2011. "Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010." RAND. Santa Monica, CA.

types of compensation for employer's health benefits contributions, which may encourage small employers to continue to offer insurance coverage on a tax-favored basis.

Prior to 2014, insurers could set lower premiums for small employers with younger and healthier employees due to their low expected health care needs, and significantly higher rates for small employers with older and sicker employees with greater expected health care needs. The ratio of premiums charged between old and young ages was typically 5:1 or more, and could translate into much higher premiums for firms with older employees. In addition, gender could also be used as a rating factor. Before 2014, employers with more women of childbearing age were commonly charged higher premiums.

The adjusted community rating under ACA prohibits the use of gender, health status and claims history as rating factors, and restricts the premium rating ratio for adults to between young and old ages. These changes are expected to further relieve the financial burdens for older and sicker individuals as coverage could become more affordable for them. However, for younger and healthier individuals, premiums could increase since health status is no longer permitted as a rating factor and the new age rating band is limited to 3:1 for adults, less than what insurers typically have used.

Some analysts are concerned with the possibility of adverse selection, which prompts small employers with younger and healthier individuals to drop coverage or switch to other forms of coverage such as self-insurance, leaving the remaining risk pool with only the sickest individuals thereby raising premiums significantly. The propensity for adverse selection is mitigated by other ACA provisions that encourage small employers to offer coverage and premium stabilization programs in the fully insured market such as risk adjustment. For example, small employers with 25 or fewer employees whose average annual salary is less than $50,000 may be eligible for small business tax credit on a sliding scale if they contribute at least 50 percent of the total premium. Many analysts believe that these and other factors will help attract a broad and stable group of employers to reduce the negative impact on premiums and avoid the adverse selection problem.

Estimates by Independent Modelers

A number of independent modelers developed estimates of post-ACA premium rates and enrollment of small group coverage for a number of states and the country as a whole. For example, some of their findings are summarized below.

- Wisconsin – A study by Gorman Actuarial and Dr. Jonathan Gruber predicted that the small group market is expected to see relatively small premium rate increase – 1.3 percent. Fifty-three percent of small group plans, or 63 percent of the small group employees, will experience a premium rate increase of 15 percent, while 47 percent of small groups or 37 percent of the employees will experience a 16 percent decrease.[7] Most of the impact is due to elimination of health status as a rating factor.

- Maine – A study by Gorman Actuarial and Dr. Jonathan Gruber estimated that a large majority (89 percent) of small employers are expected to experience a premium rate increase of 12 percent on average, while the remaining 11 percent will experience an average premium rate decline of 17 percent.[8] The impact is largely due to the elimination of group size as a rating factor.

[7] Jennifer Smagula and Jonathan Gruber. July 2011. "The Impact of the ACA on Wisconsin's Health Insurance Market." http://www.dhs.wisconsin.gov/aboutdhs/docs/WI-Final-Report-July-18-2011.pdf.
[8] Jennifer Smagula and Jonathan Gruber. May 2011. "The Impact of the ACA on Maine's Health Insurance Markets." http://www.maine.gov/pfr/insurance/reports/pdf/Impact_ACA.pdf.

- Ohio – A study from Milliman estimates that, before the application of tax subsidies, the small group premium rates are going to increase by 5 to 15 percent.[9]

- National – Actuaries at Oliver Wyman examined the national impact on premium rates of adjusted community rating, guaranteed issue and renewal using a database of actual claims covering over 6 million people.[10] They predict that the small group premium rates will increase by 20 percent.

OACT Estimates

This analysis focuses on the number of people with health insurance coverage through their employer whose premium rates are expected to increase or decrease as a result of the guaranteed issue, guaranteed renewability, and premium rating provisions of the ACA only. Other factors affecting rates such as changes in product design, provider networks, or competition are not considered. In addition, other provisions of the ACA, including the coverage expansions, the extension of dependent coverage to age 26, the individual mandate, and the employer mandate will impact the availability of coverage, the take-up of that coverage, and the premium rates charged to those who currently have employer-sponsored insurance, but those impacts are not included in this estimate. We prepared a more complete report on the financial effects of the ACA in 2010.[11] As mentioned previously, the effect on large employers is expected to be negligible, therefore our evaluation examines the impact on employees of fully-insured small firms.

In 2012, about 18 million people were enrolled in the small group health insurance market through employers with 50 fewer employees.[12] About 8 percent of small firms offered a self-insured health plan[13], therefore about 17 million people received coverage in the fully-insured small group health market. These 17 million people will be affected by the new premium rating requirements contained in the ACA. Before the premium rating provision of the ACA took effect, firms with employees who had better than average health risks would typically pay lower premiums, and therefore, they were more likely to be the firms that offer health insurance. As a result, most of people with coverage in the small group market have premium rates that are below average. Based on our review of the available research and discussions with several actuarial experts[14], we have estimated that roughly 65 percent of small employers offering health insurance coverage have premium rates that are below average.

Once the new premium rating requirements go into effect, it is anticipated that the small employers that offer health insurance coverage to their employees and their families would have average premium rates. Therefore, we are estimating that 65 percent of the small firms are expected to experience increases in their premium rates while the remaining 35 percent are anticipated to have rate reductions. The individuals and families that receive health insurance coverage from their small employer generally contribute a portion of the premium. For this analysis, if the employer premium increases, it is assumed that the employee contribution will rise as well. Similarly, if the employer

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[9] Jeremy Palmer, Jill Herbold and Paul Houchens. August 2011. "Assist with the First Year of Planning for Design and Implementation of a Federally Mandated American Health Benefit Exchange." Milliman.

[10] Jason Grau and Kurt Giesa. December 2009. "Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets." http://www.oliverwyman.com/content/dam/oliver-wyman/global/en/files/archive/2011/YBS009-11-28_PPACA120309.pdf.

[11] Detailed estimates of the Medicare savings and costs by provision are available in an April 22, 2010 memorandum by Richard S. Foster titled "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended." This report also includes estimates by the Office of the Actuary for the effects of the health reform legislation on other Federal expenditures, insurance coverage of the U.S. population, and total national health expenditures.

[12] Medical Loss Ratio Data and System Resources, Public Use File for 2012, Centers for Consumer Information and Insurance Oversight, 2013. http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.

[13] See footnote 6.

[14] The estimates from the experts we consulted ranged from 60 to 67 percent.

premium is reduced, the employee contribution is assumed to decrease. This results in roughly 11 million individuals whose premiums are estimated to be higher as a result of the ACA and about 6 million individuals who are estimated to have lower premiums.

There is a rather large degree of uncertainty associated with this estimate. The impact could vary significantly depending on the mix of firms that decide to offer health insurance coverage. In reality, the employer's decisions to offer coverage will be based on far more factors than the three that are focused on in this report so understanding the effects of just these provisions will always be challenging. Using their Compare model, RAND analyzed the impact of the entire ACA on small group premiums and determined that the effect would be minimal.[15] Further, note that the number of affected individuals will be smaller in 2014 because (i) a number of small group plans were renewed early, and (ii) about half of the states have allowed extensions to their pre-ACA rating rules under the transitional policy announced by CMS on November 14, 2013.

Summary

The Affordable Care Act requires all non-grandfathered health insurance coverage in the individual and group markets to be guaranteed issue and guaranteed renewable. In addition, all non-grandfathered insurance plans and policies in the individual and group markets can vary premium rates based only on age, family status, geography, and tobacco use, and the variation in the age and tobacco use factors is limited. This new premium rating requirement will impact the premiums paid by individuals and families working for small employers who offer health insurance. Specifically, we have estimated that the premium rates for roughly 11 million people will increase and about 6 million people are expected to experience a premium rate reduction due to sections 2701 through 2703 of the PHS Act.

[15] Christine Eibner, et. al. 2013. "The Affordable Care Act and Health Insurance Markets: Simulating the Effects of Regulation." RAND. Santa Monica, CA.

How Small-Business Owners Are Coping With the Health Law (So Far)

Wall Street Journal readers weigh in on the Affordable Care Act

By
WSJ'S SMALL-BUSINESS TEAM
May 7, 2014 3:43 p.m. ET

The health-care law is changing the way many small employers run their businesses, for better or worse. Some are curbing hiring plans or making staff cuts, while others are revamping benefit plans.

As part of its "Face of the Affordable Care Act" multimedia feature, the Wall Street Journal in April asked small-business owners to share how they're coping with the law. Below, excerpts from some of the responses:

As a solo business owner who has a service-oriented business, I have been helped immensely by the Affordable Care Act. I had a spinal fusion in 2013 and was out of work for more than two months. I still had to pay rent, bills, health insurance premiums, business phone and YellowPages ads, and all other business and personal expenses, while receiving no income. I am still thousands in the hole and wouldn't be able to afford health insurance now without the ACA! It came not a moment too soon! -- *Cynthia Hull, Acupuncture and Massage Wellness Center, Flagstaff, Ariz.*

Our 440-employee business just received its initial premium from United Healthcare for our July 1 renewal. The renewal premium represents a 29% increase over the current premium. UHC indicated that our premiums are going up 11% to bring our deductibles and out of pocket maximums in line with the provisions of the ACA. In other words, without the ACA, our premiums would be going up approximately 18%, not 29%. Our strategy to this point has been to offer our employees a high-deductible plan and then fund part of the deductible with a company-sponsored Health Reimbursement Arrangement. This strategy no longer works under Obamacare. The premium increase excludes new fees (i.e. taxes) that we will have to pay -- $63.50 per member per year. For our company, that's another $22,797. The impact of bringing our plan design in compliance with the ACA was greater than I expected. -- *Rod Winter, Specialized Industries, New Berlin, Wis.*

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David T. Interdonato, CPA, CFF, CIRA, CDBV has over a decade of experience providing transaction advisory, detailed financial analysis and operational support to distressed companies and senior lenders. He had also provided carve-out financial statement, restatement and assurance services for clients across various industries.

Services

David specializes in restructuring and turnaround services, interim management, buy/sell side financial advisory, due diligence, valuation and forensic accounting.

Industries

David has been involved in major engagements for organizations in the airline, energy, financial services, healthcare, manufacturing, retail, telecommunications and transportation industries.

Representative Work Experience

- Provided financial advisory and restructuring support to a publically traded ATM operator
- Provided financial advisory, diligence, restructuring and transactional support to numerous distressed healthcare providers
- Involved in all facets of the Chapter 11 reorganization of an energy provider from pre-bankruptcy analysis through plan confirmation.
- Provided case management services to numerous middle market manufacturing entities.
- Played a lead role in a financial restatement for an international transportation company.
- Provided operational turnaround and restructuring analysis to a Midwest snack food manufacturer and distributor.
- Assisted a major US airline with the divestiture of non-core assets.

Prior to joining MorrisAnderson David was with Navigant Capital Advisors Restructuring and Investment Banking practice. While with NCA, he provided restructuring and advisory services to the firm's clients including strategic assessments, judicial process preparation, buy-side due diligence and valuation, sale transaction support and analysis, cash management and post transaction wind-down support.

Prior to NCA, he was with Huron Consulting Group's Restructuring and Turnaround practice where he gained engagement experience in bankruptcy and restructuring services, financial and transactional due diligence, forensic accounting, and operational turnarounds. Prior to Huron, David was with the Assurance and Business Advisory Services group of PricewaterhouseCoopers, LLP where he provided various assurance services to clients across a broad spectrum of industry groups specializing in the restatement and carve-out audits of distressed clients.

David earned a Bachelor's degree in Business Administration from the University at Buffalo, a Masters of Accounting from Ohio State and a MBA from the University of Chicago Booth School of Business. David is a CPA, Certified in Financial Forensics, is a Certified Insolvency and Restructuring Advisor and holds a Certificate in Distressed Business Valuation. He also holds FINRA Series 7, 63 and 79 licenses (inactive).

Professionals

Michael R. Lane
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Michael Lane has more than 33 years of industry experience providing financial advisory services to healthcare clients across the nation. During this time he has provided a variety of advisory services to healthcare providers including acquisition, divestiture, restructuring and operational improvement services for hospitals, health systems, physician group practices, long term care organizations and other ancillary services. His clients have included academic medical centers, multi-hospital systems, freestanding acute care hospitals, managed senior care providers, multi-specialty physician groups and home health organizations.

In the past 15 years, Mr. Lane has focused almost entirely on financial advisory services to distressed healthcare organizations. During this time he has provided restructuring services to providers out-of-court as well as within Chapter 11 bankruptcy proceedings. In providing these services, Mr. Lane has frequently been appointed Chief Restructuring Officer to lead organizations through operational turnaround and restructuring. He has also served in capacity as a court appointed receiver to take over a troubled healthcare provider while reporting to a superior court judge in the receivership proceeding

Prior to joining H2C, Mr. Lane was a Managing Director at Navigant Capital Advisors, LLC, in Chicago, where he led the healthcare restructuring efforts of the firm. Notable engagements included Brotman Medical Center in Culver City, CA where he led the organization through a successful plan of reorganization in a Chapter 11 proceeding and Madison Center, Inc. a multi-facility behavioral organization in a receivership proceeding in Indiana.

Mr. Lane has served on not-for-profit boards for educational organizations and is a frequent speaker at industry programs and seminars on topics related to healthcare including, access to capital, organizational restructuring and operational turnaround. Mr. Lane is a graduate of Southeast Missouri State University where he received both a Bachelor of Science and Masters in Business Administration degrees. He is married with an adult daughter.

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Steve's practice has been concentrated on complex commercial litigation, agribusiness transactions, and the enforcement of creditors' rights in bankruptcy and insolvency proceedings. Steve has been in private practice since 1977. Steve is accredited as a Business Bankruptcy Specialist and Creditor's Rights Specialist by the American Board of Certification. Steve is a member of the American Bankruptcy Institute, the Association of Insolvency Advisors, and the Turnaround Management Association. Steve has represented secured creditors, trustees, and unsecured creditors in well over a thousand bankruptcy proceedings. He has been involved in all aspects of bankruptcy, including relief from stay proceedings, cash collateral disputes, plan negotiations, and contested plan confirmation hearings. Although most of his experience has been in chapter 11 reorganizations, he has represented lenders in chapters 7, 12, and 13 cases as well. As counsel for secured creditors and trustees, he has been involved in hundreds of reorganization cases. Steve has also handled complex litigation for commercial and agricultural lenders, including the defense of numerous lender liability cases. He has handled a number of cases involving disputes between participants in loan syndicates. Besides representing creditors before various federal and state administrative agencies, Steve has served as a lobbyist for the interests of various financial institutions before the Colorado General Assembly. Steve earned his undergraduate degree from the University of Denver in 1974 and obtained his law degree from the University of Denver College of Law in 1977. Steve also holds a Master of Science degree in financial analysis. Steve is a Level II Candidate in the Chartered Financial Analyst program. Steve is admitted to the Colorado State Bar and is a member of the Denver, Colorado, and American Bar Associations.

Camisha, a member of the Bankruptcy & Insolvency practice group of Norton Rose Fulbright, focuses her practice on the representation of debtors, creditors and other stakeholders in complex restructuring, bankruptcy, litigation and finance matters.

In 2013, *Texas Lawyer* named Camisha to its inaugural list of *Legal Leaders on the Rise*. The recognition honors Texas' 25 most promising lawyers under the age of 40 whose accomplishments distinguish them from their peers. She has also been named a *Texas Rising Star* by *Super Lawyers*®. No more than 2.5 % of all Texas attorneys receive the Rising Star distinction.

After graduating from law school, Camisha was a judicial law clerk to the Honorable Mary F. Walrath, Judge of the United States Bankruptcy Court, District of Delaware.

Camisha frequently writes and speaks on topics related to her primary areas of practice. She has published numerous articles in various online and print journals. She is a contributing writer for the American Lawyer Media online news service Law.com and a coordinating editor of the American Bankruptcy Institute Journal.

She holds a J.D., *magna cum laude* and an M.B.A. from Texas Tech University, an M.Ed. from the University of Maryland, College Park and a B.B.A. from Campbell University. Prior to beginning her legal career, she served on active duty in the United States Army from 1999 to 2003.