Center for Health and Economy

Health and Economy Baseline Estimates

April 5, 2017

Entering the fourth year of the implementation of the Affordable Care Act (ACA), the insurance market continues to see increasing and unpredictable costs, large numbers of uninsured individuals, and inadequate access to care. The Center for Health and Economy (H&E) is dedicated to assessing the impact of proposed reforms that attempt to address these issues. The following report details the most recent updates to the H&E baseline estimates of insurance coverage, federal budgetary impact, plan choice, and the premium landscape of health insurance for Americans under the age of 65.

Key Findings:

- It is estimated that the individual market includes 30 million members in 2017, with 10 million lives covered through subsidized insurance offered in the Health Insurance Marketplace. Subsidized enrollment is expected to peak at 11 million in 2018, and the total size of the individual market is estimated to decline throughout the budget window—sinking to 16 million in 2027.
- As premiums and health care costs rise, plans chosen in the individual market are expected to shift towards lower cost options. After an initial jump in 2017, highly subsidized enrollment in Silver plans is projected to fade as a percentage of enrollment on the individual market, while enrollment in Bronze plans grows among both subsidized and unsubsidized consumers.
- The health insurance coverage provisions under current law for the non-elderly are estimated to increase Federal outlays by $4.08 trillion and decrease Federal revenue by $52 billion between 2018 and 2027

Insurance Coverage

Table 1. Health Insurance Coverage (millions)

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Individual Market*	30	24	23	22	21	20	19	18	17	17	17	16
Health Insurance Marketplace	10	10	11	11	10	10	9	8	8	7	7	7
Other Non-Group Insurance	20	13	12	12	11	10	10	10	10	10	10	10
Employer Sponsored Insurance	145	146	146	146	146	146	145	145	145	145	144	144
Medicaid	52	52	52	52	53	53	53	54	54	54	54	55
Other Public Insurance[1]	10	10	11	11	11	12	12	12	12	13	13	13
Total Non-Elderly Population	**271**	**273**	**274**	**275**	**277**	**278**	**280**	**281**	**282**	**284**	**285**	**287**
Total Insured[2]*	**237**	**232**	**232**	**232**	**231**	**230**	**229**	**229**	**229**	**228**	**228**	**228**
Uninsured[2]	**34**	**41**	**42**	**44**	**46**	**48**	**50**	**52**	**54**	**55**	**57**	**59**
Percent Uninsured	**13%**	**15%**	**15%**	**16%**	**17%**	**17%**	**18%**	**19%**	**19%**	**20%**	**20%**	**21%**

[1] Other Public Insurance includes under-65 Medicare enrollment.

[2] All insurance coverage estimates refer only to the under-65 population.

* Individual Market and Total Insured numbers may not equal the sum of other sub-categories due to rounding.

H&E estimates there were 237 million non-elderly US residents with health insurance in 2016—87 percent of the total non-elderly population. Estimates of health insurance coverage encompass four primary categories: the individual market, employer sponsored insurance, Medicaid, and other public insurance. The individual market is divided into two subsets: subsidized and unsubsidized coverage. Subsidized coverage is purchased through the Health Insurance Marketplace, and unsubsidized coverage is comprised of similar insurance plans purchased either directly from the insurer (represented in Other Non-Group Insurance) or through the Marketplace without financial assistance. H&E makes no distinction between unsubsidized enrollees through the Marketplace and households that purchase individual market insurance directly from an insurer. Estimates concerning Medicaid also include beneficiaries of the Children's Health Insurance Program. Other public insurance is primarily comprised of Medicare coverage for disabled persons, but also includes Tricare, the Indian Health Service, and other federal health care programs for specific populations.

The enrollment for the Health Insurance Marketplace in 2016 is benchmarked to the effectuated enrollment reported by the Centers for Medicare and Medicaid Service for the

first half of 2016.[1] By 2017, the number of uninsured, non-elderly Americans is projected to increase to 41 million—15 percent of the total non-elderly population. The decrease in insured Americans is primarily the result of 2017 premium increases in the individual market. The average population of non-elderly Medicaid beneficiaries is estimated to be 52 million in 2016 and will rise to 55 million by 2027. These estimates are subject to the uncertainty of each state's decision regarding Medicaid expansion.

H&E does not make any assumptions about future state take-up of the Medicaid expansion due to the many variables involved in projecting the magnitude of the effects of potential future expansions. Because of this, the Medicaid enrollment and spending reflected in this baseline only reflect the projected costs and enrollment of the Medicaid program if it were to remain as it currently is.

The individual market is estimated to decline from 30 million covered lives in 2016 to 24 million in 2017, driven by premium increases in the Marketplace. The decrease in coverage through the individual market is in part offset by an increase in those insured through Medicaid.

As seen in Table 1, the number of individuals with unsubsidized, individual market insurance is expected to decrease substantially in 2017. Unsubsidized enrollment will continue to slide throughout the budget window with 10 million enrolled in 2027. Rising costs and higher income contributions for subsidized enrollees are estimated to lead to higher uninsured numbers later in the analysis period.

Premiums

Table 2. Average Premiums in the Individual Market

		2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Single Coverage	Platinum	5,000	6,100	6,500	6,900	7,400	7,800	8,300	8,800	9,300	9,800	10,400	11,000
	Gold	3,800	4,900	5,200	5,600	5,900	6,200	6,600	7,000	7,400	7,900	8,400	8,900
	Silver[2]	3,900	4,700	5,000	5,300	5,700	6,000	6,400	6,700	7,100	7,600	8,000	8,500
	Silver	3,000	3,700	3,900	4,200	4,400	4,700	4,900	5,200	5,500	5,900	6,200	6,600
	Bronze	2,400	3,300	3,400	3,500	3,600	3,700	3,900	4,000	4,100	4,200	4,300	4,500
	Catastrophic	1,700	2,100	2,100	2,500	2,600	2,600	2,700	2,800	2,900	3,000	3,000	3,100
Family Coverage[1]	Platinum	21,700	26,700	29,000	31,300	33,600	35,900	38,100	40,400	42,900	45,400	48,200	51,000
	Gold	16,600	21,400	22,700	24,100	25,600	27,100	28,700	30,500	32,300	34,200	36,300	38,400
	Silver[2]	16,500	19,000	20,100	21,300	22,600	24,000	25,500	27,000	28,700	30,500	32,300	34,300
	Silver	13,200	16,000	17,000	18,100	19,200	20,300	21,600	22,900	24,200	25,700	27,200	28,800
	Bronze	11,200	14,100	14,500	15,000	15,400	15,900	16,400	16,800	17,300	17,900	18,400	18,900
	Catastrophic	6,600	7,000	7,200	8,400	8,700	8,900	9,200	9,500	9,800	10,100	10,400	10,700

[1] Family coverage estimates are based on a family size of four persons

[2] Silver plans offered to low income households receive cost-sharing benefits that alter the effective premium relative to un-assisted Silver plans

Estimates of the subsidy-eligible premiums available in the Marketplace are calculated using publicly available data on plans offered in the 36 Federally Facilitated Marketplaces. Premium estimates for unsubsidized health insurance are calculated from a sample of plans available on ehealthinsurance.com. In both cases, H&E uses the default age rating curve put forth by the Department of Health and Human Services to impute the applicable premium for a particular household. For simplification and comparability, H&E uses a standard family size of four (two adults and two children) when estimating family premiums. Subsidy payments and tax revenue are adjusted for the appropriate average family size in budget impact estimates.

Subsidized insurance plans offered in the Marketplace are divided into four categories—Platinum, Gold, Silver, and Bronze—that correspond to four approximate actuarial values—90 percent, 80 percent, 70 percent, and 60 percent. The actuarial value refers to the expected percentage of annual medical expenses covered by the insurance plan.

Table 3. Average Marketplace Premiums After Credits

		2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Single Coverage	Platinum	4,900	6,000	6,400	6,700	7,100	7,500	7,900	8,300	8,800	9,300	9,800	10,300
	Gold	3,500	4,300	4,500	4,800	5,000	5,300	5,600	5,900	6,200	6,500	6,900	7,200
	Silver[2]	1,800	1,500	1,500	1,600	1,700	1,800	1,900	2,000	2,100	2,200	2,300	2,400
	Silver	2,800	3,100	3,300	3,400	3,600	3,800	4,000	4,200	4,500	4,700	5,000	5,200
	Bronze	2,400	2,700	2,800	2,800	2,900	3,000	3,000	3,100	3,100	3,200	3,200	3,300
Family Coverage1	Platinum	18,500	22,700	24,000	25,400	26,800	28,400	30,000	31,800	33,600	35,600	37,600	39,800
	Gold	13,000	15,700	16,600	17,500	18,500	19,500	20,600	21,800	23,100	24,400	25,800	27,300
	Silver[2]	5,200	4,500	4,600	4,800	5,000	5,200	5,400	5,600	5,700	5,900	6,100	6,300
	Silver	10,400	11,200	11,800	12,500	13,200	13,900	14,700	15,500	16,400	17,300	18,300	19,300
	Bronze	8,100	9,200	9,300	9,500	9,700	9,900	10,100	10,300	10,500	10,800	11,000	11,300

[1] Family coverage estimates are based on a family size of four persons

[2] Silver plans that receive cost-sharing assistance have exceptionally low, after-credit premiums, primarily because they are only offered to households that receive generous premium subsidies

Eligible households may purchase subsidized coverage for a specified percentage of household income that ranges from 2.04 to 9.69 percent in 2017, depending on income. A federal subsidy pays the remaining portion of the premium that is not covered by the household's specified income contribution. This specified income contribution is also subject to annual increases if the annual increase in health insurance costs exceeds a measure of household income growth. H&E also projects an additional cost control measure, which prescribes further increases in the income contribution if total subsidy spending exceeds .504 percent of GDP, will be triggered after 2018, the first year in which it is eligible to take effect.

It is important to note that, because of additional cost-sharing assistance, the plan designs categorized as Silver vary significantly in actuarial value across different income categories. For enrollees in the marketplace that earn between 100 and 150 percent of the Federal Poverty Level (FPL), Silver plans have an actuarial value of 94 percent, the highest of any plan offered in the Marketplace. For enrollees earning between 150 and 200 percent of FPL, Silver plans have an actuarial value of 87 percent, and for enrollees earning between 200 and 250 percent of FPL, Silver plans have a 73 percent actuarial value. H&E estimates the unsubsidized premiums for these high-value Silver plans using the true actuarial value of the plan, rather than the Silver plan price.

Unsubsidized insurance plans, purchased in the Marketplace or directly from an insurer, are similar in design and price to those eligible for subsidies. The ACA requires that all health insurance plans meet certain requirements to certify as qualified coverage.

Despite the 25 percent increase in benchmark premiums in 2017, average subsidized premiums for Silver plans with cost sharing assistance is expected to drop from 2016 to 2017. This comes largely as a result of decreased enrollment in Silver 73 plans. Because increased cost sharing for these plans is much smaller than the cost sharing offered for the Silver 87 and Silver 94 plans, and the premium increases for 2017 were so large, there is less incentive to use subsidies to purchase these plans instead of a cheaper Silver plan or a Bronze plan. The result is that a larger portion of the enrollment for cost-sharing eligible Silver plans are those eligible for larger subsidies—leading to a smaller average paid premium for those plans.

Plan Choice

Table 4. Plan Choice Distribution in the Individual Market[1]

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Platinum	3%	2%	2%	2%	1%	1%	1%	1%	1%	1%	1%	1%
Gold	9%	4%	3%	3%	3%	2%	2%	2%	2%	2%	1%	1%
Silver	69%	85%	85%	85%	84%	83%	81%	79%	77%	76%	74%	72%
Bronze	10%	8%	9%	10%	12%	13%	15%	17%	19%	21%	24%	26%
Catastrophic	9%	1%	1%	0%	0%	1%	1%	1%	1%	1%	1%	1%
Total Enrollment (millions)	**30**	**24**	**23**	**22**	**21**	**20**	**19**	**18**	**17**	**17**	**16**	**16**

Table 5. Plan Choice Distribution in the Health Insurance Marketplace

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Platinum	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Gold	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Silver[2]	92%	95%	94%	93%	92%	90%	89%	87%	84%	82%	79%	77%
Bronze	7%	4%	5%	6%	8%	9%	11%	13%	15%	17%	20%	23%
Total Enrollment (millions)	**10**	**10**	**11**	**11**	**10**	**9**	**9**	**8**	**8**	**7**	**7**	**6**

[1] The Individual Market refers to the commercial, non-group market and includes sales of insurance within the Marketplace and direct sales by insurers

[2] Silver plans include plans that receive cost-sharing assistance

After substantial premium increases in 2017, H&E assumes an underlying health insurance cost growth of 6 percent throughout the rest of the ten-year window as premiums increases were above 6 percent in 2014 and 2015 and are projected to increase at similar levels moving forward.[2] Actual year-over-year premium growth estimates vary as a result of changes in the enrollment mix and other factors. After 2017, premiums in the individual market are projected to grow annually at rates closer to the underlying

growth rate of 6 percent. Due to growing applicable income contribution rates, subsidized premium growth for some plan designs is expected to exceed the underlying health insurance growth rate. H&E further assumes that the individual mandate remains in effect and that the premium increases for 2017 have led to more stable equilibrium for plans remaining in the Marketplaces in future years where we expect 6% premium growth. This assumption could change if the individual mandate is not enforced or there is evidence of destabilizing risk pool that would create additional premium growth due to adverse selection.

H&E uses the subsidized and unsubsidized Marketplace enrollment in each metal level after the first year to calibrate plan preferences in the individual market and estimate plan choices throughout the ten-year analysis window.

H&E estimates that the large enrollment in Silver plans in 2017 among subsidized insurance plans will give way to higher enrollment in Bronze plans as premiums rise and consumers with less generous subsidy amounts adjust to higher premiums. The large majority of Silver plan enrollment is estimated to be largely comprised of households eligible for extra cost-sharing benefits. As the market grows to include more households that are eligible for premium credits but not cost sharing assistance (earning between 250 and 400 percent of FPL), the distribution of subsidized enrollment among the four metal levels is expected to become less evenly distributed later in the budget window.

Beyond 2017, lower cost insurance plans are estimated to gain market share, shifting away from more generous plans in response to the steadily rising cost of health insurance. Throughout the budget window, Silver plan enrollment is expected to dominate the marketplace as cost sharing benefits are only available for Silver plans in the Health Insurance Marketplace. However, as time passes and premiums rise, enrollment in Bronze plans are expected to increase.

Budget

H&E estimates the impact on the federal budget of the major health insurance coverage provisions of current law with regards to the non-elderly population. Budget impact estimates do not include estimates for non-ACA tax expenditures encoded in current law, such as the employer sponsored health insurance tax expenditure.[3] H&E does, however, estimate the additional revenue gained by removing the tax exclusion for high-cost employer sponsored insurance plans implemented by the ACA, known as the Cadillac tax.

Medicaid coverage and expenditure estimates are calculated based on the number of states that had chosen to implement Medicaid expansion by January 1, 2017. These predictions are sensitive to future state-level decisions on expansion as well as new program waivers that alter the design of a state's Medicaid program.

Table 7. Cost of Current Law Coverage Provisions (billions)[1]

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018-2027
Sources of Funds[2]													
Tax on Employer Sponsored Health Insurance	0	0	0	0	18	20	21	21	20	19	18	16	152
Individual and Employer Mandate Taxes	6	7	8	9	11	12	17	19	22	25	29	33	184
Subtotal	**6**	**7**	**8**	**9**	**29**	**32**	**37**	**40**	**42**	**44**	**46**	**48**	**336**
Uses of Funds[3]													
Health Insurance Marketplace													
Cost Sharing Benefits	12	14	15	15	16	16	16	16	16	16	16	15	156
Premium Tax Credits	37	47	53	56	57	59	62	63	66	68	70	72	626
Medicaid	203	207	213	218	223	229	235	241	247	253	260	265	2,384
Medicare	65	72	74	78	81	85	89	93	97	101	105	109	911
Subtotal	**317**	**340**	**355**	**367**	**377**	**389**	**401**	**413**	**425**	**438**	**450**	**463**	**4,077**
Net Budgetary Impact[4]	**-310**	**-333**	**-347**	**-358**	**-348**	**-357**	**-363**	**-373**	**-383**	**-393**	**-404**	**-414**	**-3,741**

[1] Cost estimates refer only for the under-65 population.

[2] Positive values denote increases in revenue; negative values denote decreases in revenue.

[3] Positive values denote increases in spending; negative values denote decreases in spending.

[4] Positive values denote surplus; negative values denote deficit.

Over the decade spanning between 2018 and 2027, H&E estimates that non-elderly coverage provisions under current law will cost $4.08 trillion. The cost is partially off-set by $336 billion in increased revenue through the tax on high-cost employer sponsored insurance, the individual shared responsibility tax, and the employer shared responsibility tax. The ACA introduced a number of taxes that are not directly related to the health insurance coverage of the non-elderly population and are therefore not included in this report. In 2012, The Congressional Budget Office estimated non-coverage provisions of the ACA to reduce the deficit by $1.28 trillion by 2014.[4]

Productivity and Access

In an effort to shed light on how health care policy and consumer choices affect health care quality, H&E estimates two measures: the Medical Productivity Index (MPI) and the Provider Access Index (PAI). Health insurance plan designs are associated with varying

degrees of access to desired physicians and facilities as well as incentives that promote or discourage efficient use of resources. H&E estimates each index by attributing productivity and access scores to the range of plan designs available and exploits changing plan choices to project the evolution of health care quality.

The Medical Productivity Index is designed to reflect the expected gains in health status in return for medical expenditures. Plan designs that encourage patients to consider the price of treatment when making health care decisions, such as high deductible plans, are ascribed high MPI scores, while plans with low cost-sharing requirements or first dollar coverage are ascribed low scores. The index ranges from a low of 1.0 to a high of 4.0.

Table 8. Medical Productivity Index

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Individual Market	2.5	2.5	2.5	2.4	2.4	2.5	2.5	2.6	2.7	2.7	2.8	2.8
Marketplace	2.1	2.2	2.3	2.3	2.4	2.4	2.5	2.5	2.6	2.6	2.7	2.7
Other Non-Group Insurance	2.8	2.8	3.0	2.5	2.6	2.7	2.8	2.9	2.9	3.0	3.0	3.1
Employer Sponsored Insurance	2.3	2.3	2.4	2.4	2.4	2.5	2.5	2.5	2.6	2.6	2.6	2.7
Private Insurance	**2.3**	**2.3**	**2.4**	**2.4**	**2.4**	**2.5**	**2.5**	**2.5**	**2.6**	**2.6**	**2.7**	**2.7**
Medicaid	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
Total Insured[1]	**2.1**	**2.2**	**2.2**	**2.2**	**2.2**	**2.2**	**2.3**	**2.3**	**2.3**	**2.3**	**2.4**	**2.4**

Table 9. Provider Access Index

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Individual Market	3.2	3.0	3.0	2.7	2.6	2.6	2.5	2.5	2.4	2.3	2.3	2.2
Marketplace	3.2	3.1	2.9	2.8	2.7	2.6	2.6	2.5	2.4	2.3	2.2	2.1
Other Non-Group Insurance	3.2	3.0	3.0	2.3	2.3	2.3	2.3	2.4	2.4	2.4	2.4	2.4
Employer Sponsored Insurance	3.8	3.8	3.7	3.7	3.7	3.7	3.7	3.7	3.6	3.6	3.6	3.6
Private Insurance	**3.7**	**3.7**	**3.6**	**3.6**	**3.5**	**3.5**	**3.5**	**3.5**	**3.5**	**3.4**	**3.4**	**3.4**
Medicaid	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total Insured[1]	**3.1**	**3.1**	**3.0**	**3.0**	**3.0**	**2.9**	**2.9**	**2.9**	**2.8**	**2.8**	**2.8**	**2.8**

[1] Productivity and access estimates refer only to the under-65, non-disabled population

The Provider Access Index is designed to reflect the availability of primary and specialty physicians and facilities. Plans with large networks, such as Platinum plans offered in the individual market, are ascribed high scores for providing exceptional access. Bronze and other low cost plans that afford access only to limited networks are ascribed low PAI scores. The index ranges from a low of 1.0 to a high of 5.0.

Changes from Previous Baseline Estimates

As an organization, H&E is constantly reevaluating the assumptions and technical methods that are used to create baseline and proposed estimates of health insurance coverage provisions under current law. This publication is the sixth comprehensive baseline report, and the fourth to include detailed estimates on the net budgetary impact of the ACA and Medicaid for individuals under 65. H&E currently projects that the under-65 coverage provisions of current law will increase the deficit by $333 billion in 2017, a decrease of $27 billion from the February 2016 baseline estimate. H&E also projects that, on average, 232 million individuals under the age of 65 will be insured during the year of 2017, which is 9 million less than the February 2016 baseline estimate. This is due to a lower projected enrollment in the individual market as a result of 2017 premium increases. The updates to baseline predictions are a result of growing information concerning the rollout of the ACA that inform many of the underlying assumptions in our modelling. However, some notable differences are a result of a few key technical changes.

Table 10. Change in Coverage Estimates (millions)

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Individual Market	-4	-12	-10	-10	-10	-9	-9	-10	-10	-10
Health Insurance Marketplace	-3	-6	-6	-5	-5	-5	-4	-5	-4	-5
Other Non-Group Insurance	-2	-6	-4	-4	-4	-5	-5	-5	-5	-5
Employer Sponsored Insurance	0	1	1	1	1	1	0	0	0	0
Medicaid	1	1	1	1	1	1	1	2	1	1
Other Public Insurance	0	0	0	-1	-1	-1	-1	-2	-2	-2
Feb 2016 Total Insured[1]	239	241	240	240	239	239	239	239	239	239
Feb 2017 Total Insured[1]	237	232	232	231	231	230	229	229	228	228

[1] All insurance coverage estimates refer only to the under-65 population

* Difference between baseline estimates is between 0 and 1 billion

A combination of many things have led to reduced projections in spending and coverage relative to the February 2016 baseline. Fewer people have purchased insurance in the individual marketplace than previously expected—opting to either go uninsured or to obtain insurance in another way. H&E expects 10 million people to purchase insurance through the Health Insurance Marketplace in 2017 which is 6 million less than was estimated in the February 2016 baseline. By 2019, H&E estimates the number of people insured through the individual market to be 10 million less than previously projected.

Table 11. Change in Budgetary Impact Estimates (billions)[1]

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017 - 2026
Change in Sources of Funds Baseline Estimates[2]											
Tax on Employer Sponsored Health Insurance	0	0	0	-1	0	1	1	1	1	2	5
Individual and Employer Mandate Taxes	-4	-5	-6	-6	-7	-5	-6	-6	-7	-8	-57
Subtotal	**-4**	**-5**	**-6**	**-7**	**-7**	**-5**	**-5**	**-5**	**-6**	**-7**	**-52**
Change in Uses of Funds Baseline Estimates[3]											
Cost Sharing Benefits	-1	1	1	3	4	6	7	9	10	11	50
Premium Tax Credits	-30	-26	-25	-24	-23	-21	-21	-20	-21	-23	-204
Medicaid	5	5	4	4	3	2	0	-2	-6	-9	0
Subtotal	**-4**	**-15**	**-15**	**-16**	**-15**	**-15**	**-14**	**-14**	**-13**	**-12**	**-130**
Feb 2016 Net Budgetary Impact[4]	**-360**	**-377**	**-386**	**-376**	**-382**	**-388**	**-396**	**-407**	**-418**	**-431**	**-3,561**
Feb 2017 Net Budgetary Impact[4]	**-333**	**-347**	**-358**	**-348**	**-357**	**-363**	**-373**	**-383**	**-393**	**-404**	**-3,326**

[1] Cost estimates refer only for the under-65 population.

[2] Positive values denote increases in revenue; negative values denote decreases in revenue.

[3] Positive values denote increases in spending; negative values denote decreases in spending.

[4] Positive values denote surplus; negative values denote deficit.

* Difference between baseline estimates is between 0 and 1 billion.

Expectations regarding enrollment in the subsidized Health Insurance Marketplace have changed because of premium increases. The changes have led H&E to estimate fewer low-income enrollees in subsidized Marketplace plans, which in turn leads to lower estimates of income-based subsidies. As a result, H&E expects a substantial decrease in

the amount of funds used relative to the February 2016 baseline. H&E projects $30 billion less in spending on premium tax credits because of less-than-expected individual market enrollment for 2017. This decrease in spending is somewhat negated by increased spending in cost sharing subsidies due to higher costs in insurance and increased enrollment in plans eligible for cost-sharing subsidies. By 2026, spending on cost sharing subsidies are expected to reach $11 billion more relative to the February 2016 baseline. This increased spending total $50 billion over the 10-year window.

Some technical changes have led to changes in H&E's estimate of source funds. Though the number of uninsured individuals is expected to increase, the amount of funds raised by the ACA's individual mandate is expected to decrease. In previous estimates, the amount of exemptions claimed by households was underestimated. Therefore, despite an increase in the number of uninsured, H&E expects a yearly decrease in revenue that would lead to a 10-year accumulated decrease of $52 billion in tax revenue relative to the previous baseline.

Uncertainty in the Projections

The Center for Health and Economy uses a peer-reviewed micro-simulation model of the health insurance market to analyze various aspects of the health care system.[5] And as with all economic forecasting, H&E estimates are associated with substantial uncertainty. While the estimates provide good indication on the nation's health care outlook, there are a wide range of possible scenarios that can result from policy changes, and current assumptions are unlikely to remain accurate over the course of the next ten years.

Aside from the potential policy changes that are probable with a new administration, premium increases in the individual market are a substantial area of uncertainty in this report. From 2016 to 2017, it was reported by the Centers for Medicare and Medicaid Services that Silver benchmark premiums increased by 25 percent. Accordingly, 2017 premium increases were included in this report, yet double digit year-over-year premium increases were not assumed for any of the subsequent years—largely because of a lack of evidence. If future premium increases are similar to 2017 premium increases, there would be major implications for individual market enrollment, and federal spending and revenue.

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[1] Center for Medicare & Medicaid Services. First Half of 2016 Effectuated Enrollment Snapshot. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html?DLPage=3&DLEntries=10&DLSort=0&DLSortDir=descending October 19, 2016. Accessed February 8, 2017.

[2] Keehan, S. P., Cuckler, G. A., Sisko, A. M., Madison, A. J., Smith, S. D., Stone, D. A., . . . Lizonitz, J. M. (2015). National Health Expenditure Projections, 2014-24: Spending Growth Faster Than Recent Trends. *Health Affairs, 34*(8), 1407-1417.

[3] The CBO estimates that the tax exclusion for employer sponsored insurance will cost $3.4 trillion over 10 years. See *Distribution of Major Tax Expenditures in the Individual Income Tax System*, Congressional Budget Office, May 2013, at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43768_DistributionTaxExpenditures.pdf

[4] Elmendorf, Douglas W., "Letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act," Congressional Budget Office, July 24, 2012, available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf

[5] Parente, S.T., Feldman, R. "Micro-simulation of Private Health Insurance and Medicaid Take-up Following the U.S. Supreme Court Decision Upholding the Affordable Care Act." Health Services Research. 2013 Apr; 48(2 Pt 2):826-49.