Center for Health and Economy

Health and Economy Baseline Estimates

February 18, 2016

In the third year of the Affordable Care Act's implementation, focus continues to be on outreach efforts to the uninsured along with the enduring problems of American health care: increasing and unpredictable costs, large numbers of uninsured individuals, and adequate 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:

- In 2016, the change in average individual market premiums will vary by plan type, with projected premium increase ranging between 4 percent and 7 percent. In 2017, the increase in average premiums is projected to range between 4 and 8 percent.
- Average subsidized premiums are expected to increase ranging from 4 percent to 17 percent in 2016. After 2017, average subsidized premiums are expected to increase by 5 to 12 percent annually, driven by rising health care costs and indexed subsidy adjustments.
- The individual market includes an estimated average of 31 million members in 2015, with 10 million lives covered through subsidized insurance offered in the Marketplace. Subsidized enrollment is projected to grow to 16 million in 2017, and the total size of the individual market is estimated to expand to 36 million by 2017.
- As premiums and health care costs rise, plans chosen in the individual market are expected to shift towards lower cost options. 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 households between 200 and 400 percent of the Federal Poverty Level (FPL) which are eligible for subsidies but not silver-plan cost-sharing.
- The health insurance coverage provisions under current law for the non-elderly are estimated to increase Federal outlays by $4.269 trillion between 2017 and 2026.

INSURANCE COVERAGE

Table 1. Health Insurance Coverage (millions)

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Individual Market	31	34	36	33	32	31	29	28	28	27	27	27
Health Insurance Marketplace	10	13	16	17	16	15	14	13	13	12	12	12
Other Non-group Insurance	20	22	19	16	16	15	15	15	15	15	15	15
Employer Sponsored Insurance	146	145	145	145	145	145	145	145	145	145	145	144
Medicaid	49	51	51	51	51	52	52	52	52	53	53	53
Other Public Insurance[2]	9	10	10	11	12	12	13	13	14	14	15	16
Total Non-Elderly Population	**270**	**271**	**273**	**274**	**275**	**277**	**278**	**280**	**281**	**282**	**284**	**285**
Total Insured[1]	**234**	**239**	**241**	**240**	**240**	**239**	**239**	**239**	**239**	**239**	**239**	**240**
Uninsured[1]	**36**	**32**	**32**	**34**	**36**	**37**	**39**	**41**	**42**	**43**	**45**	**46**
Percent Uninsured[1]	**13%**	**12%**	**12%**	**12%**	**13%**	**13%**	**14%**	**15%**	**15%**	**15%**	**16%**	**16%**

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

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

H&E estimates there were 234 million non-elderly US residents with health insurance in 2015—86 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 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 Services, and other federal health care programs for specific populations.

The rollout of the Marketplace is based on a four-year implementation period and initial estimates of the uninsured population are benchmarked using the Congressional Budget Office (CBO) estimates for 2015 and 2016. By 2017, the number of insured, non-elderly Americans is projected to increase to 241 million—89 percent of the total non-elderly population. The increase in insured Americans is primarily the result of three factors: the expansion of Medicaid, the continuing implementation of the subsidized Marketplace,

and an increasingly costly tax penalty for remaining uninsured. The average population of non-elderly Medicaid beneficiaries is estimated to be 49 million in 2015 and will rise to 53 million by the end of the analysis period. These estimates are subject to the uncertainty of each state's decision regarding Medicaid expansion.

The individual market is estimated to expand from 31 million covered lives in 2015 to 36 million in 2017, driven largely by expansion in the Marketplace. The increase in coverage through Medicaid and the individual market is in part offset by a decrease in those insured through employer sponsored coverage.

As seen in Table 1, the number of individuals with unsubsidized, individual market insurance is expected to decrease after 2016. In 2017, the discontinuation of non-qualified health plans currently available in the market are expected to lead to 3 million fewer individuals with unsubsidized, non-group plans. Rising costs and higher income contributions for subsidized enrollees are estimated to lead to higher uninsured numbers later in the analysis period.

PREMIUMS

able 2. Average Premiums in the Individual Market

		2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2
ngle verage	Platinum	4,800	4,900	5,200	5,500	5,800	6,100	6,500	6,900	7,300	7,700	8,200	8,
	Gold	3,800	3,900	4,100	4,300	4,600	4,900	5,200	5,500	5,800	6,100	6,500	6,
	Silver[2]	4,400	4,500	4,800	5,000	5,300	5,600	5,900	6,300	6,600	7,000	7,400	7,
	Silver	3,200	3,200	3,400	3,600	3,800	4,100	4,300	4,600	4,800	5,100	5,400	5,
	Bronze	2,600	2,400	2,500	2,700	2,800	2,900	3,000	3,100	3,200	3,300	3,300	3,
	Catastrophic	1,700	1,700	1,800	1,900	2,000	2,100	2,100	2,200	2,300	2,300	2,400	2,
ily verage[1]	Platinum	19,400	19,400	20,500	21,700	23,000	24,400	25,800	27,400	29,000	30,700	32,600	34,
	Gold	15,600	15,700	16,600	17,600	18,700	19,800	21,000	22,200	23,600	25,000	26,500	28,
	Silver[2]	16,500	16,800	17,800	18,900	20,100	21,400	22,700	24,100	25,500	26,900	28,200	29,
	Silver	13,100	13,200	14,100	14,900	15,800	16,800	17,800	18,800	20,000	21,200	22,400	23,
	Bronze	10,800	10,500	10,900	11,500	11,800	12,100	12,500	12,900	13,300	13,700	14,100	14,
	Catastrophic	6,300	6,500	6,700	6,600	6,800	7,000	7,200	7,400	7,600	7,900	8,100	8,

amily coverage estimates are based on a family size of four persons.
ilver plans offered to low income households receive cost-sharing benefits that alter the effective emium 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

		2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	202
Single Coverage	Platinum	4,200	4,100	4,400	4,600	4,900	5,200	5,600	5,900	6,300	6,600	7,100	7,50
	Gold	3,300	3,200	3,400	3,600	3,900	4,100	4,300	4,600	4,900	5,200	5,500	5,90
	Silver[2]	1,100	1,200	1,400	1,600	1,700	1,900	2,100	2,300	2,500	2,700	3,000	3,20
	Silver	2,800	2,700	2,800	3,000	3,200	3,400	3,600	3,800	4,100	4,300	4,600	4,90
	Bronze	2,000	2,000	2,000	2,100	2,100	2,200	2,200	2,300	2,300	2,400	2,500	2,50
Family Coverage[1]	Platinum	15,300	15,400	16,400	17,400	18,600	19,800	21,000	22,400	23,800	25,300	27,000	28,70
	Gold	11,700	11,800	12,600	13,400	14,200	15,200	16,200	17,200	18,400	19,600	20,900	22,20
	Silver[2]	4,700	5,500	6,000	6,500	6,900	7,400	8,000	8,500	9,000	9,600	10,300	11,20
	Silver	9,800	9,900	10,600	11,200	12,000	12,700	13,600	14,500	15,400	16,400	17,500	18,60
	Bronze	6,800	6,900	7,100	7,200	7,400	7,600	7,800	8,000	8,200	8,400	8,600	8,80

[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 2.03 to 9.66 percent in 2016, 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 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 in order to certify as qualified coverage. However, some non-qualified health plans already in existence are available to consumers until 2017. Before the qualified health plan regulations are enforced, lower cost plan options are available to consumers who seek unsubsidized health insurance coverage outside of the Marketplace.

PLAN CHOICE

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

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Platinum	7%	7%	6%	6%	5%	5%	4%	4%	3%	3%	3%	2%
Gold	16%	17%	14%	15%	13%	11%	10%	8%	6%	5%	5%	4%
Silver[2]	44%	41%	43%	47%	44%	40%	35%	30%	25%	20%	16%	14%
Bronze	14%	19%	22%	30%	35%	40%	46%	52%	58%	64%	69%	72%
Catastrophic	19%	17%	15%	2%	3%	4%	5%	6%	7%	7%	7%	7%
Total Enrollment (millions)	**31**	**34**	**36**	**33**	**32**	**31**	**29**	**28**	**27**	**27**	**27**	**27**

Table 5. Plan Choice Distribution in the Health Insurance Marketplace

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Platinum	2%	4%	5%	4%	4%	4%	3%	3%	3%	3%	2%	2%
Gold	5%	10%	9%	8%	7%	6%	5%	4%	3%	3%	3%	2%
Silver[2]	74%	66%	62%	58%	54%	48%	42%	35%	29%	23%	18%	14%
Bronze	19%	20%	24%	30%	36%	42%	50%	57%	65%	72%	77%	81%
Total Enrollment (millions)	**10**	**13**	**16**	**17**	**16**	**15**	**14**	**13**	**13**	**12**	**12**	**12**

[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.

H&E assumes an underlying health insurance cost growth of 6 percent throughout 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.[1] Actual year on year premium growth estimates vary as a result of changes in the enrollment mix and other factors. For example, the growing size of the individual market between 2015 and 2016—associated

in part with increased participation of the young and healthy—leads to lower estimated increases in average premiums for many plan design categories. 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 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 2015 among subsidized insurance plans will give way to higher enrollment in Platinum, Gold, and Bronze plans in 2015 and 2016. 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 more evenly distributed in 2017.

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. Bronze plans are expected to dominate the individual insurance market by 2021. Under the ACA, catastrophic coverage is not certified as qualified health insurance coverage for adults over the age of 30. However, that provision is not enforced for adults over the age of 30 that are already enrolled in catastrophic coverage until 2017.

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.[ii] 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, 2016. 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.

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

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	201 202
ources of Funds[2]													
Tax on Employer Sponsored Health Insurance	*	*	*	*	*	19	20	20	20	19	18	16	13
Individual and Employer Mandate Taxes	7	10	11	13	15	17	19	22	25	28	32	37	21
Subtotal	**7**	**10**	**11**	**13**	**15**	**35**	**38**	**42**	**45**	**47**	**50**	**53**	**35**
ses of Funds[3]													
Health Insurance Marketplace													
Cost Sharing Benefits	12	13	15	14	14	13	12	10	9	7	6	5	10
Premium Tax Credits	58	64	77	79	81	81	82	83	84	86	89	93	83
Medicaid	188	199	202	208	214	219	226	233	241	249	259	269	2,32
Medicare	65	76	76	89	93	97	100	104	107	111	114	117	1,00
Subtotal	**324**	**352**	**370**	**391**	**401**	**410**	**420**	**430**	**441**	**454**	**468**	**484**	**4,26**
et Budgetary Impact[4]	**-317**	**-343**	**-360**	**-377**	**-386**	**-376**	**-382**	**-388**	**-396**	**-407**	**-418**	**-431**	**3,92**

Cost estimates refer only for the under-65 population.

Positive values denote increases in revenue; negative values denote decreases in revenue.

Positive values denote increases in spending; negative values denote decreases in spending.

Positive values denote surplus; negative values denote deficit.

Over the decade spanning between 2017 and 2026, H&E estimates that non-elderly coverage provisions under current law will cost $4.269 trillion. The cost is partially off-set by $352 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. In 2012, CBO estimated non-coverage provisions of the ACA to reduce the deficit by $1.28 trillion over 10 years.[iii]

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

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Individual Market	2.5	2.4	2.4	2.2	2.2	2.3	2.3	2.3	2.3	2.4	2.4	2.4
Marketplace	2.0	2.1	2.1	2.1	2.1	2.1	2.1	2.2	2.2	2.2	2.2	2.2
Other Non-Group Insurance	2.8	2.8	2.8	2.4	2.4	2.5	2.6	2.7	2.8	2.9	2.9	3.0
Employer Sponsored Insurance	2.3	2.3	2.3	2.3	2.4	2.4	2.4	2.5	2.5	2.5	2.6	2.6
Private Insurance	**2.3**	**2.3**	**2.3**	**2.3**	**2.3**	**2.4**	**2.4**	**2.4**	**2.4**	**2.4**	**2.5**	**2.5**
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**	**2.1**	**2.1**	**2.1**	**2.1**	**2.2**	**2.2**	**2.2**	**2.2**	**2.2**	**2.2**	**2.3**

Table 9. Provider Access Index

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Individual Market	3.2	3.1	3.0	2.7	2.6	2.6	2.5	2.5	2.4	2.3	2.2	2.1
Marketplace	3.0	2.9	2.8	2.7	2.6	2.6	2.5	2.4	2.3	2.2	2.1	2.0
Other Non-Group Insurance	3.4	3.2	3.3	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.5	2.5
Employer Sponsored Insurance	3.8	3.8	3.8	3.8	3.8	3.7	3.7	3.7	3.7	3.7	3.6	3.6
Private Insurance	**3.7**	**3.7**	**3.7**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.5**	**3.5**	**3.5**	**3.5**
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**	**2.9**	**2.9**	**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 a new and improving 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 fifth 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 $343 billion in 2016, a decrease of $28 billion from the May 2015 baseline estimate. H&E also projects that, on average, 239 million individuals under the age of 65 will be insured during the year of 2016, which is 5 million less than the May 2015 baseline estimate due to a lower projected enrollment in the individual market. 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)

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Individual Market	-1	-5	-4	-6	-6	-6	-6	-6	-6	-6	-6
Health Insurance Marketplace	1	-2	-3	-3	-3	-3	-3	-3	-3	-3	-3
Other Non-group Insurance	-2	-3	*	-3	-3	-3	-3	-3	-3	-3	-3
Employer Sponsored Insurance	*	*	*	*	*	*	*	*	*	*	1
Medicaid	*	1	1	1	1	1	*	*	*	*	*
Other Public Insurance	*	*	*	*	*	*	*	*	*	*	*
May 2015 Total Insured[1]	236	244	245	245	245	245	245	245	245	245	245
Feb 2016 Total Insured[1]	234	239	241	240	240	239	239	239	239	239	239

[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 May 2015 baseline. Less 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 13 million people to purchase insurance through the Health Insurance Marketplace in 2016 which is 2 million less than was estimated in the May 2015 baseline. By 2018, H&E estimates the number of people insured through the individual market to be 6 million less than previously projected. This less-than-expected take up of insurance in the individual market is partially offset by Medicaid expansion, as three states expanded their Medicaid programs in 2015.

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

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016 - 2025
Change in Sources of Funds Baseline Estimates[2]												
Tax on Employer Sponsored Health Insurance	*	*	*	-21	-21	-2	-1	-1	*	*	1	-45
Individual and Employer Mandate Taxes	*	*	*	1	1	1	1	1	1	1	2	9
Subtotal	*****	*****	*****	**-20**	**-20**	**-1**	*****	*****	**1**	**2**	**3**	**-36**
Change in Uses of Funds Baseline Estimates[3]												
Cost Sharing Benefits	*	-4	-6	-5	-4	-3	-2	-1	*	1	1	-22
Premium Tax Credits	5	-21	-31	-30	-29	-30	-30	-30	-31	-32	-32	-296
Medicaid	-2	3	4	3	3	2	1	*	-1	-1	-3	13
Medicare	-6	1	-6	2	1	*	-1	-2	-3	-4	-4	-16
Subtotal	**-3**	**-21**	**-38**	**-29**	**-29**	**-31**	**-32**	**-33**	**-34**	**-36**	**-38**	**-321**
May 2015 Net Budgetary Impact[4]	**-324**	**-371**	**-404**	**-394**	**-403**	**-411**	**-420**	**-429**	**-440**	**-453**	**-467**	**-4,192**
Feb 2016 Net Budgetary Impact without Medicare Estimate[4]	**-256**	**-273**	**-289**	**-295**	**-300**	**-284**	**-288**	**-292**	**-297**	**-303**	**-312**	**-2,932**
Feb 2016 Net Budgetary Impact with Medicare Estimate[4]	**-317**	**-343**	**-360**	**-377**	**-386**	**-376**	**-382**	**-388**	**-396**	**-407**	**-418**	**-3,833**

[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. In particular, 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 and cost-sharing. As a result, H&E expects a substantial decrease in the amount of funds used relative to the May 2015 baseline. H&E projects $21 billion less in

spending on premium tax credits as a result of less-than-expected individual market enrollment for 2016. Over the next ten years, this number is expected to increase to $32 billion less than the May 2015 baseline. This decrease in spending is somewhat negated by increased spending in Medicaid due to increased expansion. Spending on Medicaid is expected to be $3 billion higher in 2016 than previously estimated. Over the course of the next ten years, this increased spending is expected to accumulate to roughly $13 billion of extra spending in Medicaid.

Lower expectations of individual market enrollment along with some technical changes have led to changes in H&E's estimate of source funds. Since the amount of uninsured individuals is expected to increase, the amount of funds raised by the ACA's individual mandate is expected to increase also. H&E expects a marginal yearly increase in revenue that would lead to a 10-year accumulated increase $9 billion in tax revenue relative to the previous baseline. Changes in the implementation of the excise tax on high-cost employer-sponsored plans have led to a projected decrease of funds raised by the tax. The tax was delayed for two years which leads to leads to $42 billion less in projected revenues for 2018 and 2019 combined. H&E also expects decreases in funds raised by the tax after 2019 as the tax is now deductible. In 2020, H&E's projection for the revenues raised by the tax to decrease $2 billion relative to the May 2015 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.[iv] 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. For instance, the uncertainty surrounding the implementation of the Affordable Care Act and similar obstacles facing the implementation of new health care overhauls affect the accuracy of short-term coverage estimates. Importantly, this uncertainty does not lead to biased results. H&E attempts to depict an unbiased, middle -ground representation of the future should the policy and economic environment remain constant. While the goal is to project the most likely scenario, actual events may differ significantly from published predictions.

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[i] 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.

[ii] 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

[iii] 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

[iv] 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.