CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Keith Hall, Director

July 20, 2017

Honorable Mike Enzi
Chairman
Committee on the Budget
United States Senate
Washington, DC 20510

Re: H.R. 1628, the Better Care Reconciliation Act of 2017: An Amendment in the Nature of a Substitute [ERN17500], as Posted on the Website of the Senate Committee on the Budget on July 20, 2017

Dear Mr. Chairman:

At your request, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have prepared an estimate of the direct spending and revenue effects of the version of H.R. 1628, the Better Care Reconciliation Act, posted today on the Senate Budget Committee's website.

By the agencies' estimates, this legislation would lower the federal budget deficit by reducing spending for Medicaid and subsidies for nongroup health insurance. Those effects would be partially offset by the effects of provisions not directly related to health insurance coverage (mainly reductions in taxes), the repeal of penalties on employers that do not offer insurance and on people who do not purchase insurance, and spending to reduce premiums and for other purposes.

Compared with the June 26 cost estimate for a previous version of the legislation, this cost estimate shows savings over the next 10 years that are larger—as well as estimated effects on health insurance coverage and on premiums for health insurance that are similar.[1] The current version of the legislation would result in greater deficit reduction mostly because it would retain certain taxes that the previous version of the legislation would have eliminated. (For a full comparison with the June 26 estimate, see page 9.)

1. See Congressional Budget Office, cost estimate for H.R. 1628, the Better Care Reconciliation Act of 2017, an amendment in the nature of a substitute [LYN17343], as posted on the website of the Senate Committee on the Budget on June 26, 2017 (June 26, 2017), www.cbo.gov/publication/52849.

The description of the legislation and of CBO and JCT's methodology and results that appeared in the agencies' previous estimate largely applies to this one as well.

Effects on the Federal Budget

CBO and JCT estimate that enacting this legislation would reduce federal deficits by $420 billion over the 2017–2026 period (see Figure 1). That reduction is the net result of a $903 billion decrease in direct spending partly offset by a $483 billion decrease in revenues (see Tables 1 and 2, at the end of this document).[2]

The largest savings would come from a reduction in total federal spending for Medicaid resulting both from provisions affecting health insurance coverage and from other provisions. By 2026, spending for that program would be reduced by 26 percent (see Table 3, at the end of this document).[3] About three-quarters of that reduction would result from scaling back the expansion of eligibility enacted in the Affordable Care Act (ACA). In 2026, for people who are made newly eligible under the ACA (certain adults under the age of 65 whose income is less than or equal to 138 percent of the federal poverty level [FPL]), Medicaid spending would be reduced by 87 percent, from $134 billion to $17 billion—mainly because the penalty associated with the individual mandate would be repealed and the enhanced federal matching rate for spending on that group would be phased out. As a result of the reduced matching rate, some states would roll back their expansion of eligibility and others that would have expanded eligibility under current law would choose not to do so. All other federal spending on Medicaid in that year would be reduced by 9 percent, from $490 billion to $447 billion.

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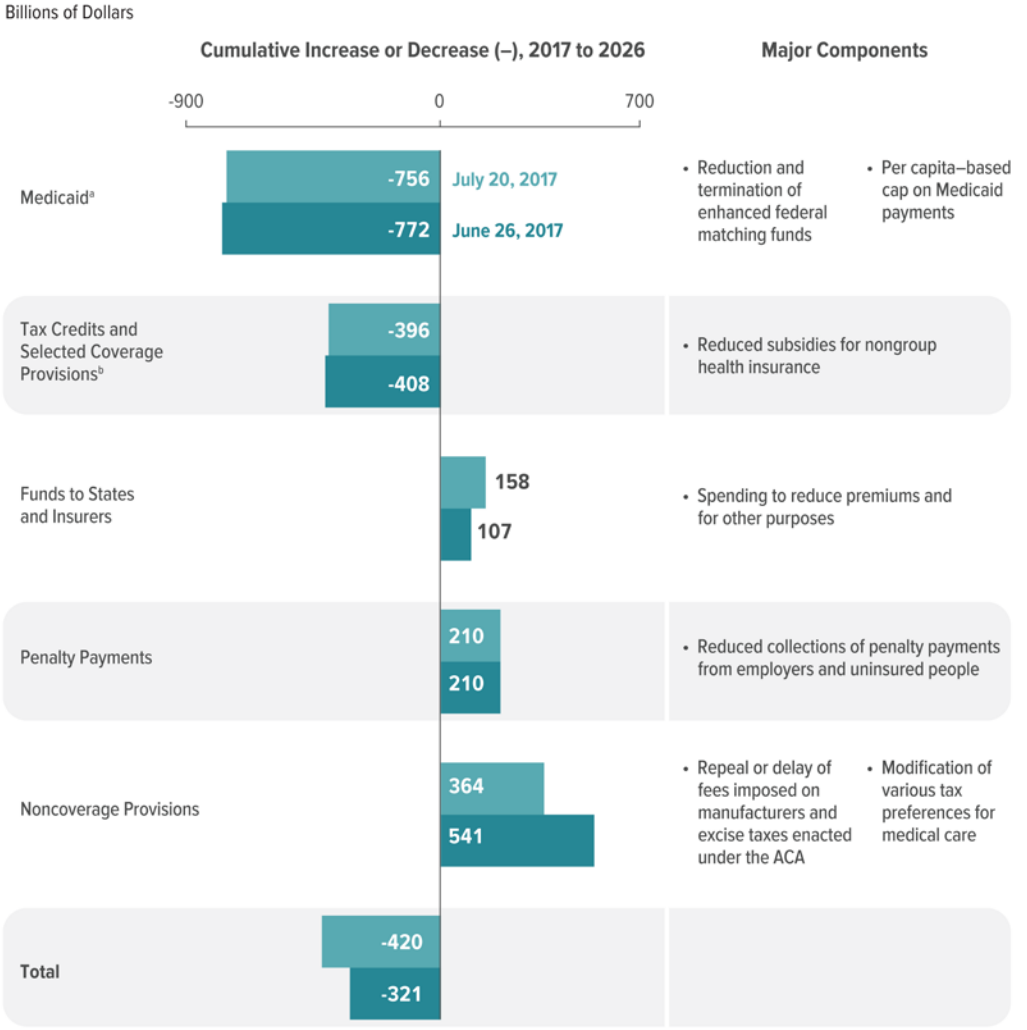
2. See also Joint Committee on Taxation, *Estimated Revenue Effects of an Amendment in the Nature of a Substitute to the Tax Provisions Contained in Title I of H.R. 1628, the Better Care Reconciliation Act of 2017, as posted on the website of the Senate Committee on the Budget on July 20, 2017*, JCX-39-17 (July 20, 2017), www.jct.gov/publications.html?func=startdown&id=5018.

3. CBO has not estimated the longer-term effects of this legislation on Medicaid spending but expects that they would be very similar to those for a previous version of this legislation. For that version, CBO estimated that Medicaid spending would be about 35 percent lower in 2036 than it would be under the agency's extended baseline. See Congressional Budget Office, *Longer-Term Effects of the Better Care Reconciliation Act of 2017 on Medicaid Spending* (June 2017), www.cbo.gov/publication/52859.

Figure 1.

Net Effects of Two Versions of the Better Care Reconciliation Act on the Budget Deficit

The July 20 version of the legislation would result in greater deficit reduction mostly because it would retain certain taxes that the previous version would have eliminated.



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

These estimates are for two versions of H.R. 1628, the Better Care Reconciliation Act of 2017, a Senate amendment in the nature of a substitute.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation.

ACA = Affordable Care Act.

a. Includes the effects on health insurance coverage only. The effects on all Medicaid spending would be $739 billion for the current version of the legislation (in the July 20 estimate) and would have been $770 billion for the previous version (in the June 26 estimate).

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

CBO and JCT have considered the budgetary effects of the legislation in two broad categories—those stemming from provisions related to insurance coverage and those resulting from other types of provisions. The agencies estimate that the provisions dealing with health insurance coverage would reduce deficits, on net, by $784 billion (see Table 4, at the end of this document). The noncoverage provisions would increase deficits by $364 billion, mostly by reducing revenues.

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

Effects on Health Insurance Coverage

According to CBO and JCT's estimates, in 2018, 15 million more people would be uninsured under this legislation than under current law. The increase in the number of uninsured people relative to the number under current law would reach 19 million in 2020 and 22 million in 2026 (see Table 5, at the end of this document). In 2026, an estimated 82 percent of all U.S. residents under age 65 would be insured, compared with 90 percent under current law.

Effects on Premiums

CBO and JCT anticipate that, under this legislation, nongroup insurance markets would continue to be stable in most parts of the country. This legislation would, by CBO and JCT's estimates, increase average premiums in the nongroup market before 2020 and lower them thereafter, relative to projections under current law.

To arrive at those estimates, the agencies examined how the legislation would affect the premiums charged if people purchased benchmark plans in the nongroup market. (For a benchmark plan, the net premium paid by someone receiving tax credits is limited to a certain maximum depending on his or her income.). In a set of illustrative examples, CBO and JCT also analyzed how premiums would vary by income and age. (The effects on

premiums differ modestly from those that CBO and JCT reported in their June 26 estimate, as discussed further below.)

Effects on Average Premiums. In 2018 and 2019, under current law and under this legislation, benchmark plans generally have an actuarial value of at least 70 percent—that is, the insurance pays 70 percent or more of the total cost of covered benefits, on average. In the marketplaces established by the ACA, such coverage is known as a silver plan.[4]

Under this legislation, in 2018, average premiums for benchmark plans for single policyholders would be about 20 percent higher than under current law, mainly because the penalty for not having insurance would be eliminated, inducing fewer comparatively healthy people to sign up. In 2019, those premiums would be about 10 percent higher than under current law—less than in the year before in part because funding provided by this legislation to reduce premiums would have a greater effect and because changes in the limits on how premiums can vary by age would result in a larger share of younger enrollees paying lower premiums.

In 2020, average premiums for benchmark plans for single policyholders would be about 30 percent lower than under current law—a decrease brought about by several factors. Most important, this legislation specifies that benchmark plans would have an actuarial value of 58 percent (and, therefore, would pay for a smaller share of the total cost of covered benefits than the benchmark plans in 2018 and 2019).

The effects on premiums would vary in different areas of the country. Also, even though average premiums for benchmark plans would decline, some people enrolled in nongroup insurance would experience substantial increases in the net premiums that they paid for insurance. For example, under this legislation, 64-year-olds could be charged five times as much as 21-year-olds, CBO and JCT expect, compared with three times as much under current law—resulting in higher premiums for most older people.

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4. The percentage of the total cost of covered benefits paid by a silver plan depends on the policyholder's income. For most people, that actuarial value is 70 percent, but those with income between 100 percent and 250 percent of the FPL are eligible for silver plans with higher actuarial values: for people with income between 100 percent and 150 percent of the FPL, 94 percent; for people with income between 150 percent and 200 percent of the FPL, 87 percent; and for people with income between 200 percent and 250 percent of the FPL, 73 percent.

By 2026, under this legislation, average premiums for benchmark plans for single individuals in most of the country would be about 25 percent lower than under current law, CBO and JCT estimate—a smaller decrease than in 2020 for two main reasons: Federal funding to directly reduce premiums would amount to a smaller share of enrollees' total health care costs because of rising health care costs, and, the agencies expect, states would devote a smaller share of the federal funding provided to promote stability to reduce premiums.

Effects by Income in Illustrative Examples. For many lower-income people, the net premiums paid in the nongroup market under this legislation would be lower than those under current law if they purchased benchmark plans, but the plans would require them to pay a greater share of their health care costs. For example, CBO and JCT estimate that a 40-year-old with income at 175 percent of the FPL in 2026 could pay a net premium of $1,700 for a silver plan under current law and $1,450 for a plan with an actuarial value of 58 percent under this legislation. Those amounts incorporate tax credits the person would receive and a reduction in taxes resulting from the use of a health savings account for the person's share of premiums (see Table 6). Under this legislation, some purchasers of nongroup insurance—those who owe taxes and who cannot take a deduction for health insurance premium expenses as self-employed workers—would be able to set up health savings accounts to pay for their premiums with tax-deductible contributions to those accounts.

Because this legislation would change the benchmark plan (in part, by repealing the current-law federal subsidies to reduce cost-sharing payments), the average share of the cost of medical services paid by the plan would fall—for the 40-year-old with income at 175 percent of the FPL in 2026, from 87 percent to 58 percent—and his or her payments in the form of cost sharing would rise. And the person's net premiums would be higher under the legislation than under current law for plans of comparable actuarial value. Those changes, CBO and JCT estimate, would contribute significantly to a decrease in the number of lower-income people with coverage through the nongroup market under this legislation, compared with the number under current law.

People with income between 350 percent and 400 percent of the FPL would be eligible for premium tax credits under current law (if their premiums

exceeded a specified percentage of their income) but not under this legislation. People with income above 400 percent of the FPL would not receive premium tax credits in either case. Nevertheless, for many single policyholders with income at either 375 percent or 450 percent of the FPL, net premiums would be somewhat lower under the legislation than under current law for a plan with a similar actuarial value, in part because of the tax savings resulting from the use of health savings accounts. (However, many people with income between 350 percent and 400 percent of the FPL purchasing a family policy would receive several thousand dollars in premium tax credits under current law that they would not receive under this legislation.)

Effects by Age in Illustrative Examples. Enacting this legislation would also result in significant changes in net premiums paid in the nongroup market according to people's age. In the illustrative examples, CBO and JCT estimate that, under current law, a 21-year-old, 40-year-old, and 64-year-old with income at 175 percent of the FPL in 2026 would all pay the same net premium of $1,700 for a plan with an actuarial value of 87 percent. Under this legislation, the net premium for a plan with an actuarial value of 58 percent would be less than $1,700 for younger people and about the same for older people, but the net premium for a plan with an actuarial value of 70 percent would be larger for people of any age, particularly for older people. For most single individuals with income at 375 percent or 450 percent of the FPL in 2026, net premiums would be lower for younger people but higher for 64-year-olds under the legislation.

For older people not eligible for premium tax credits, net premiums (after taking into account the tax savings from paying premiums from a health savings account) could be more than five times larger than those for younger people in many states, rather than only three times larger under current law. Because of such differences, CBO and JCT estimate that, under this legislation, a larger share of enrollees in the nongroup market would be younger people and a smaller share would be older people than would be the case under current law.

Effects on Deductibles

In 2026, CBO and JCT expect, the majority of people buying health insurance in the nongroup market would purchase a benchmark plan—a plan with an actuarial value of 58 percent under this legislation or a silver

plan under current law. For services defined as essential health benefits, the ACA sets limits on out-of-pocket spending and prohibits annual and lifetime limits on payments. As a result, all plans must pay for most of the cost of high-cost services, and people are insured against paying such costs out of pocket. Hence, to design a plan with an actuarial value of 58 percent and pay for required high-cost services, insurers must set high deductibles. (A deductible is the amount that a person must pay out of pocket before insurance makes any contribution during a year other than for selected benefits.)

Under this legislation, for a single policyholder purchasing an illustrative benchmark plan (with an actuarial value of 58 percent) in 2026, the deductible for medical and drug expenses combined would be roughly $13,000, the agencies estimate. CBO and JCT's projections are for benchmark plans that are illustrative in that they do not include any cost-sharing reductions that might be implemented through the State Stability and Innovation Program and they would not provide any benefits before the deductible was met, except for preventive care. For plans providing some benefits before the deductible was met, such as a limited number of primary care visits or generic drug purchases, the deductible would be higher. After meeting the deductible for one of the illustrative plans, the enrollee would pay 20 percent of all costs (except those for preventive care) until the limit on out-of-pocket spending was reached. For the many people who have relatively low health care costs in a given year, total out-of-pocket costs are often lower than their deductible.

The limit on out-of-pocket spending in 2026 is projected to be $10,900. (Under current regulations, the limit on out-of-pocket spending is defined by a formula based on projections of national health expenditures.) Therefore, plans with an actuarial value of 58 percent and a deductible of $13,000 would exceed that limit and would not comply with the law unless the formula used to calculate the limit was adjusted. CBO and JCT estimate that a plan with a deductible equal to the limit on out-of-pocket spending in 2026 would have an actuarial value of 62 percent. A person enrolled in such a plan would pay for all health care costs (except for preventive care) until the deductible was met and none thereafter until the end of the year.

Because a deductible of $13,000 would be a large share of their income, many people with low income would not purchase any plan even if it had very low premiums—on net, after accounting for premium tax credits—

CBO and JCT estimate. Under this legislation, in 2026, that deductible would exceed the annual income of $11,400 for someone with income at 75 percent of the FPL. For people whose income was at 175 percent of the FPL ($26,500) and 375 percent of the FPL ($56,800), the deductible would constitute about a half and a quarter of their income, respectively.

Under current law in 2026, the deductible for a single policyholder purchasing an illustrative benchmark plan with an actuarial value of 70 percent would be much lower—roughly $5,000. People with income at 75 percent and 375 percent of the FPL, for example, would both be eligible to purchase a benchmark plan with that actuarial value, and the deductible would constitute about 45 percent and 10 percent of their income, respectively.

Under current law, someone with income at 175 percent of the FPL is eligible to purchase a benchmark plan with a higher actuarial value—of 87 percent—because of cost-sharing reductions based on income. Such a person enrolled in the illustrative plan CBO and JCT analyzed would have a deductible of roughly $800 and would pay 20 percent of most health care costs up to an out-of-pocket maximum of $3,700. The estimated deductible for that person would constitute about 3 percent of his or her income.

Uncertainty Surrounding the Estimates

The ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by this legislation are all difficult to predict, so the estimates in this report are uncertain. But CBO and JCT have endeavored to develop budgetary estimates that are in the middle of the distribution of potential outcomes.

Comparison With the Previous Estimate

On June 26, CBO and JCT estimated that a previous version of the legislation would yield a net reduction in federal deficits of $321 billion over the 2017–2026 period. This legislation, the agencies estimate, would save $99 billion more over that period, reducing deficits by $420 billion, as a result of reduced net costs from noncoverage provisions that would be partially offset by reduced savings from coverage provisions.

Changes in Budgetary Effects of Noncoverage Provisions. CBO and JCT estimate that the net costs from changes to provisions not directly affecting health insurance coverage would be reduced by $177 billion under this legislation. The largest such changes would increase revenues, thereby reducing the net costs of those provisions by $231 billion. Two provisions that were in the previous version of H.R. 1628 but are not in this version—one that would have repealed a surtax on certain high-income taxpayers' net investment income (accounting for $172 billion) and one that would have eliminated an increase in the Hospital Insurance payroll tax rate for certain high-income taxpayers (accounting for $59 billion)—make up almost all of that difference. (A third revenue provision, also not in this version of the legislation, accounts for $0.5 billion.)

Net costs would increase by $39 billion through 2026 because of additional spending for grants to states to support treatment and recovery services for people with substance use disorders or mental health problems. Other smaller effects resulting from changes to noncoverage provisions would increase net costs by $15 billion over the period.

Changes in Budgetary Effects of Coverage Provisions. The net savings from changes to coverage provisions would be reduced by $78 billion over the 10-year period, primarily because of greater spending through the State Stability and Innovation Program. An additional $70 billion in funding would be provided to that program in the latter part of the coming decade. CBO and JCT expect that some of those funds would be used to reduce premiums, some would be used to reduce out-of-pocket spending by low-income people, and some would be used for other purposes. Outlays from that funding would be $51 billion higher under this legislation than under the previous version through 2026, the agencies estimate. (Most of the remaining $19 billion would be spent after 2026.)

In addition, a number of changes to coverage provisions affecting the Medicaid program reduced CBO's estimate of savings by about $16 billion over the 2017–2026 period. This legislation includes two new provisions that account for most of the difference; they would do the following:

- Authorize a demonstration program that would make $8 billion available over the 2020–2023 period to states (selected by the Secretary of Health and Human Services [HHS]) to provide and improve the quality of home- and community-based services; and

- Permit up to $5 billion to be exempt from a per capita cap or block grant (at a state's option), over the 2020–2024 period, for Medicaid spending in areas of a state where the Secretary of HHS has declared a public health emergency under the Public Health Service Act.

Other changes to the coverage provisions would reduce savings by $12 billion over the 2017–2026 period, on net. As a result of the change to allow purchases of health insurance in the nongroup market to qualify as medical expenses for health savings accounts, CBO and JCT expect that about 75 percent of people able to set up those accounts would use them by 2026; thus, tax collections (and net savings) would be reduced. However, that reduction would be partially offset by an increase in revenues stemming from higher taxable compensation provided by employers who would not offer health insurance.

Changes in Effects on Health Insurance Coverage and Premiums. Compared with the previous version, this legislation would have similar effects on the number of uninsured people. Estimates differ by no more than half a million people in any year over the next decade.

Under this legislation, the decline in average premium for a benchmark plan in the nongroup market relative to those under current law would be about 25 percent in 2026, compared with 20 percent under the previous version, because of the increased funding for the State Stability and Innovation Program. As a result, more people would purchase nongroup coverage through the marketplaces, and fewer would receive coverage through their employer—resulting in little change in the number of people uninsured.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

Keith Hall
Director

Attachments

cc: Honorable Bernie Sanders
Ranking Member

Table 1 - SUMMARY OF THE DIRECT SPENDING AND REVENUE EFFECTS OF H.R. 1628, THE BETTER CARE RECONCILIATION ACT OF 2017, AN AMENDMENT IN THE NATURE OF A SUBSTITUTE [ERN17500], AS POSTED ON THE WEBSITE OF THE SENATE COMMITTEE ON THE BUDGET ON JULY 20, 2017

Billions of Dollars, by Fiscal Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
CHANGES IN DIRECT SPENDING[a]												
Coverage Provisions												
Estimated Budget Authority	-2.5	-5.7	-14.3	-59.8	-90.3	-111.1	-126.8	-148.4	-168.4	-184.4	-172.7	-911.9
Estimated Outlays	-4.4	-20.3	-24.5	-61.8	-90.2	-105.9	-126.1	-148.8	-168.7	-184.7	-201.3	-935.5
Noncoverage Provisions												
Estimated Budget Authority	0.9	5.7	4.4	7.2	6.9	5.7	11.4	-0.2	-1.3	-2.4	25.0	38.3
Estimated Outlays	*	1.2	3.3	8.3	8.2	7.0	3.7	1.2	0.3	-1.1	21.0	32.0
Total Changes in Direct Spending												
Estimated Budget Authority	-1.6	-0.1	-9.9	-52.7	-83.5	-105.4	-115.3	-148.6	-169.7	-186.9	-147.7	-873.6
Estimated Outlays	-4.5	-19.2	-21.2	-53.5	-81.9	-98.9	-122.5	-147.5	-168.5	-185.8	-180.3	-903.5
CHANGES IN REVENUES[b]												
Coverage Provisions	-4.0	-15.1	-17.4	-12.0	-13.8	-15.4	-16.8	-18.2	-19.4	-19.6	-62.2	-151.6
Noncoverage Provisions	-0.1	-23.6	-23.8	-28.9	-34.5	-37.8	-41.6	-46.2	-51.5	-43.9	-110.9	-331.8
Total Changes in Revenues	-4.1	-38.7	-41.2	-40.9	-48.3	-53.2	-58.4	-64.3	-70.8	-63.6	-173.1	-483.5
INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES												
Net Increase or Decrease (-) in the Deficit	-0.4	19.5	19.9	-12.6	-33.7	-45.7	-64.1	-83.2	-97.6	-122.2	-7.2	-420.0

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

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation.

The costs of this legislation fall within budget functions 550 (health), 570 (Medicare), 600 (income security), and 650 (Social Security).

Numbers may not add up to totals because of rounding.

* = between -$50 million and zero.

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

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

Table 2 - ESTIMATE OF THE DIRECT SPENDING AND REVENUE EFFECTS OF H.R. 1628, THE BETTER CARE RECONCILIATION ACT OF 2017, AN AMENDMENT IN THE NATURE OF A SUBSTITUTE [ERN17500], AS POSTED ON THE WEBSITE OF THE SENATE COMMITTEE ON THE BUDGET ON JULY 20, 2017

Billions of Dollars, by Fiscal Year	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
ESTIMATED CHANGES IN DIRECT SPENDING[a]												
Coverage Provisions												
Estimated Budget Authority	-2.5	-5.7	-14.3	-59.8	-90.3	-111.1	-126.8	-148.4	-168.4	-184.4	-172.7	-911.9
Estimated Outlays	-4.4	-20.3	-24.5	-61.8	-90.2	-105.9	-126.1	-148.8	-168.7	-184.7	-201.3	-935.5
On-Budget	*-4.4*	*-20.3*	*-24.5*	*-61.8*	*-90.1*	*-105.7*	*-125.8*	*-148.3*	*-168.3*	*-184.2*	*-201.3*	*-933.5*
Off-Budget	*0*	*	*	*	*	*-0.2*	*-0.4*	*-0.5*	*-0.5*	*-0.4*	*	*-2.0*
Title I												
Sec. 101 - Recapture of Excess Advance Payments of Premium Tax Credits												
Estimated Budget Authority	0	-2.2	-2.9	-1.6	-1.3	-1.6	-1.8	-2.2	-2.4	-2.6	-8.0	-18.7
Estimated Outlays	0	-2.2	-2.9	-1.6	-1.3	-1.6	-1.8	-2.2	-2.4	-2.6	-8.0	-18.7
Sec. 102 - Restrictions for the Premium Tax Credit												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 104 - Individual Mandate												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 105 - Employer Mandate												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 106 - State Stability and Innovation Program												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 107 - Better Care Reconciliation Implementation Fund												
Estimated Budget Authority	0.5	0	0	0	0	0	0	0	0	0	0.5	0.5
Estimated Outlays	0	*	0.1	0.1	0.1	0.1	*	*	0	0	0.4	0.5
Sec. 122 - Exclusion From HSAs of High-Deductible Health Plans Which Do Not Include Protections for Life												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 123 - Federal Payments to States[b]												
Estimated Budget Authority	*	-0.1	*	*	*	*	*	*	*	*	-0.2	-0.1
Estimated Outlays	*	-0.1	*	*	*	*	*	*	*	*	-0.2	-0.1
Sec. 124 - Medicaid Provisions[b]												
Estimated Budget Authority	0	0	0	-1.1	-1.9	-2.5	-3.2	-3.3	-3.5	-3.7	-3.0	-19.3
Estimated Outlays	0	0	0	-1.1	-1.9	-2.5	-3.2	-3.3	-3.5	-3.7	-3.0	-19.3
Sec. 125 - Medicaid Expansion												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 126 - Restoring Fairness in DSH Allotments												
Estimated Budget Authority	0	0.7	1.0	3.7	4.1	4.5	4.9	2.8	2.8	2.0	9.4	26.5
Estimated Outlays	0	0.7	1.0	3.7	4.1	4.5	4.9	2.8	2.8	2.0	9.4	26.5
Sec. 127 - Reducing State Medicaid Costs[b]												
Estimated Budget Authority	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.6	-1.4
Estimated Outlays	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.6	-1.4
Sec. 128 - Providing Safety Net Funding for Non-Expansion States												
Estimated Budget Authority	0	2.0	2.0	2.0	2.0	2.0	0	0	0	0	8.0	10.0
Estimated Outlays	0	1.8	2.0	2.0	2.0	2.0	0.2	0	0	0	7.8	10.0

Continued

Table 2 Continued. Billions of Dollars, by Fiscal Year	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
Sec. 129 - Eligibility Redeterminations												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 130 - Optional Work Requirement for Nondisabled, Nonelderly, Nonpregnant Individuals												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 131 - Provider Taxes												
Estimated Budget Authority	0	0	0	0	-0.2	-0.4	-0.7	-1.0	-1.4	-1.5	-0.2	-5.2
Estimated Outlays	0	0	0	0	-0.2	-0.4	-0.7	-1.0	-1.4	-1.5	-0.2	-5.2
Sec. 132 - Per Capita Allotment for Medical Assistance												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 133 - Flexible Block Grant Option for States												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 134 - Medicaid and CHIP Quality Performance Bonus Payments												
Estimated Budget Authority	0	0	0	0	0	0	8.0	0	0	0	0	8.0
Estimated Outlays	0	0	0	0	0	0	0	1.0	1.0	1.0	0	3.0
Sec. 135 - Grandfathering Certain Medicaid Waivers; Prioritization of HCBS Waivers												
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	0	0	0	0	0	0	0	0	0	0	0
Sec. 136 - Coordination With States												
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	0	0	0	0	0	0	0	0	0	0	0
Sec. 137 - Optional Assistance for Certain Inpatient Psychiatric Services												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 138 - Enhanced FMAP for Medical Assistance to Eligible Indians												
Estimated Budget Authority	0	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	1.5	3.5
Estimated Outlays	0	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	1.5	3.5
Sec. 139 - Small Business Health Plans												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Title II												
Sec. 201 - Prevention and Public Health Fund												
Estimated Budget Authority	0	0	-0.9	-1.0	-1.0	-1.5	-1.0	-1.7	-2.0	-2.0	-2.9	-11.1
Estimated Outlays	0	0	-0.1	-0.4	-0.8	-1.0	-1.1	-1.3	-1.4	-1.7	-1.3	-7.9
Sec. 202 - Support for State Response to Opioid Crisis												
Estimated Budget Authority	0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	20.1	45.2
Estimated Outlays	0	0.5	2.8	5.4	6.0	5.7	5.1	5.0	5.0	5.0	14.8	40.7
Sec. 203 - Community Health Center Program												
Estimated Budget Authority	0.4	0	0	0	0	0	0	0	0	0	0.4	0.4
Estimated Outlays	0	0.2	0.2	*	0	0	0	0	0	0	0.4	0.4
Sec. 204 - Change in Permissible Age Variation in Health Insurance Premium Rates												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 205 - Medical Loss Ratio Determined by the State												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											

Continued

Table 2 Continued. Billions of Dollars, by Fiscal Year	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
Sec. 206 - Stabilizing the Individual Insurance Markets												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 207 - Waivers for State Innovation												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 208 - Catastrophic Plans												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 210 - Funding for Cost-Sharing Payments[c]												
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	0	0	0	0	0	0	0	0	0	0	0
Sec. 211 - Repeal of Cost-Sharing Subsidy Program												
Estimated Budget Authority[c]	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Total Changes in Direct Spending												
Estimated Budget Authority	**-1.6**	**-0.1**	**-9.9**	**-52.7**	**-83.5**	**-105.4**	**-115.3**	**-148.6**	**-169.7**	**-186.9**	**-147.7**	**-873.6**
Estimated Outlays	**-4.5**	**-19.2**	**-21.2**	**-53.5**	**-81.9**	**-98.9**	**-122.5**	**-147.5**	**-168.5**	**-185.8**	**-180.3**	**-903.5**
On-Budget	*-4.5*	*-19.2*	*-21.2*	*-53.5*	*-81.9*	*-98.7*	*-122.1*	*-147.0*	*-168.0*	*-185.4*	*-180.3*	*-901.5*
Off-Budget	*0*	*	*	*	*	*-0.2*	*-0.4*	*-0.5*	*-0.5*	*-0.4*	*	*-2.0*
ESTIMATED CHANGES IN REVENUES[d]												
Coverage Provisions	-4.0	-15.1	-17.4	-12.0	-13.8	-15.4	-16.8	-18.2	-19.4	-19.6	-62.2	-151.6
On-Budget	*-4.3*	*-18.2*	*-20.7*	*-14.0*	*-15.8*	*-17.8*	*-19.5*	*-21.1*	*-22.5*	*-23.1*	*-72.9*	*-177.0*
Off-Budget	*0.3*	*3.1*	*3.3*	*2.0*	*2.0*	*2.4*	*2.7*	*2.9*	*3.2*	*3.5*	*10.7*	*25.3*
Title I												
Sec. 101 - Recapture of Excess Advance Payments of Premium Tax Credits	0	0.2	1.1	0.9	0.4	0.5	0.6	0.7	0.8	1.0	2.7	6.3
Sec. 102 - Restrictions for the Premium Tax Credit	*included in estimate of coverage provisions*											
Sec. 103 - Modifications to Small Business Tax Credit	*included in estimate of coverage provisions*											
Sec. 104 - Individual Mandate	*included in estimate of coverage provisions*											
Sec. 105 - Employer Mandate	*included in estimate of coverage provisions*											
Sec. 106 - State Stability and Innovation Program	*included in estimate of coverage provisions*											
Sec. 108 - Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits[e]	0	0	0	-3.4	-6.9	-8.7	-10.7	-13.4	-16.4	-6.6	-10.3	-66.0
Sec. 109 - Repeal of Tax on Over-the-Counter Medications	*	-0.5	-0.5	-0.6	-0.6	-0.6	-0.6	-0.7	-0.7	-0.7	-2.3	-5.6
Sec. 110 - Repeal of Tax on HSAs	*	*	*	*	*	*	*	*	*	*	*	-0.1
Sec. 111 - Repeal of Limitations on Contributions to Flexible Spending Accounts	0	-0.3	-1.2	-1.6	-1.7	-1.8	-2.2	-2.6	-3.3	-4.1	-4.7	-18.6
Sec. 112 - Repeal of Tax on Prescription Medications	0	-4.0	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-12.1	-25.7
Sec. 113 - Repeal of Medical Device Excise Tax	0	-1.4	-1.9	-2.0	-2.1	-2.2	-2.3	-2.4	-2.6	-2.7	-7.4	-19.6
Sec. 114 - Repeal of Health Insurance Tax	0	-12.8	-13.5	-14.3	-15.1	-15.9	-16.8	-17.8	-18.7	-19.7	-55.7	-144.7
Sec. 115 - Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy	*	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.7	-1.8
Sec. 116 - Repeal of Chronic Care Tax	*	-3.5	-3.1	-3.4	-3.6	-3.9	-4.2	-4.5	-4.8	-5.1	-13.6	-36.1
Sec. 117 - Repeal of Tanning Tax	0	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
Sec. 118 - Purchase of Insurance from HSAs	*included in estimate of coverage provisions*											
Sec. 119 - Maximum Contribution Limit to HSAs Increased to Amount of Deductible and Out-of-Pocket Limitation	0	-1.0	-1.6	-1.7	-1.9	-2.1	-2.3	-2.5	-2.7	-2.9	-6.2	-18.6
Sec. 120 - Allow Both Spouses to Make Catch-Up Contributions to the Same HSA	0	*	*	*	*	*	*	*	-0.1	-0.1	-0.1	-0.4
Sec. 121 - Special Rule for Certain Expenses Incurred Before Establishment of HSAs	0	*	*	*	*	*	*	*	*	*	-0.1	-0.2
Sec. 122 - Exclusion From HSAs of High-Deductible Health Plans Which Do Not Include Protections for Life	*included in estimate of coverage provisions*											
Sec. 139 - Small Business Health Plans	*included in estimate of coverage provisions*											

Continued

Table 2 Continued. Billions of Dollars, by Fiscal Year	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
Title II												
Sec. 204 - Change in Permissible Age Variation in Health Insurance Premium Rates	*included in estimate of coverage provisions*											
Sec. 205 - Medical Loss Ratio Determined by the State	*included in estimate of coverage provisions*											
Sec. 206 - Stabilizing the Individual Insurance Markets	*included in estimate of coverage provisions*											
Sec. 207 - Waivers for State Innovation	*included in estimate of coverage provisions*											
Sec. 208 - Catastrophic Plans	*included in estimate of coverage provisions*											
Sec. 209 - Application of Enforcement Penalties	*included in estimate of coverage provisions*											
Sec. 210 - Repeal of Cost-Sharing Subsidy Program	*included in estimate of coverage provisions*											
Total Changes in Revenues	**-4.1**	**-38.7**	**-41.2**	**-40.9**	**-48.3**	**-53.2**	**-58.4**	**-64.3**	**-70.8**	**-63.6**	**-173.1**	**-483.5**
On-Budget	*-4.4*	*-41.3*	*-43.5*	*-41.0*	*-47.7*	*-52.4*	*-57.3*	*-62.6*	*-68.2*	*-63.9*	*-177.8*	*-482.1*
Off-Budget	*0.3*	*2.6*	*2.3*	*0.1*	*-0.6*	*-0.8*	*-1.1*	*-1.7*	*-2.7*	*0.3*	*4.8*	*-1.3*
INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES												
Net Increase or Decrease (-) in the Deficit	**-0.4**	**19.5**	**19.9**	**-12.6**	**-33.7**	**-45.7**	**-64.1**	**-83.2**	**-97.6**	**-122.2**	**-7.2**	**-420.0**
On-Budget	*-0.1*	*22.1*	*22.3*	*-12.5*	*-34.2*	*-46.3*	*-64.8*	*-84.4*	*-99.8*	*-121.5*	*-2.4*	*-419.3*
Off-Budget	*-0.3*	*-2.6*	*-2.3*	*-0.1*	*0.6*	*0.6*	*0.8*	*1.3*	*2.2*	*-0.7*	*-4.8*	*-0.7*

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

Numbers may not add up to totals because of rounding.

CHIP = Children's Health Insurance Program; DSH = Disproportionate Share Hospital; FMAP = Federal Medical Assistance Percentage; HSA = health savings account; HCBS = Home and Community Based Services.

* = between -$50 million and $50 million.

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

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

c. Section 210 would appropriate such sums as may be necessary to make payments for cost-sharing subsidies through 2019. Because such payments are already in CBO's baseline, CBO estimates that the provision would not affect direct spending or revenues, relative to that baseline.

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

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

Table 3 - ESTIMATES OF FEDERAL MEDICAID SPENDING UNDER CBO'S BASELINE AND H.R. 1628, THE BETTER CARE RECONCILIATION ACT OF 2017

Billions of Dollars, by Fiscal Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total, 2017-2026
Spending for People Who Are Made Newly Eligible Under the ACA											
CBO's Baseline	67	71	77	83	91	99	107	116	125	134	969
BCRA	67	59	56	46	41	36	32	22	17	17	394
All Other Spending											
CBO's Baseline	327	344	360	377	393	410	429	448	468	490	4,045
BCRA	327	347	361	373	380	392	405	418	432	447	3,881
Total Spending											
CBO's Baseline	393	415	437	459	484	509	536	564	593	624	5,013
BCRA	393	406	417	419	421	429	437	440	449	464	4,275
Memorandum:											
Difference Between CBO's Baseline and the BCRA (Percent)											
Spending for Newly Eligible People	*	-17	-27	-44	-55	-63	-71	-81	-86	-87	-59
All Other Spending	*	1	*	-1	-3	-4	-5	-7	-8	-9	-4
Total Medicaid Spending	*	-2	-5	-9	-13	-16	-18	-22	-24	-26	-15

Source: Congressional Budget Office.

Estimates are based on CBO's March 2016 baseline. (No adjustments were needed for subsequent legislation.) See Congressional Budget Office, "Detail of Spending and Enrollment for Medicaid for CBO's March 2016 Baseline" (accessed July 19, 2017), www.cbo.gov/sites/default/files/recurringdata/51301-2016-03-medicaid.pdf.

People made newly eligible under the ACA are certain adults under the age of 65 whose income is less than or equal to 138 percent of the federal poverty level.

Numbers may not add up to totals because of rounding.

ACA = Affordable Care Act; BCRA = Better Care Reconciliation Act; * = between zero and 0.5 percent.

Table 4 - ESTIMATE OF THE NET BUDGETARY EFFECTS OF THE INSURANCE COVERAGE PROVISIONS OF H.R. 1628, THE BETTER CARE RECONCILIATION ACT OF 2017

Billions of Dollars, by Fiscal Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total, 2017-2026
Medicaid	*	-12	-23	-45	-67	-84	-100	-123	-143	-158	-756
Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	-5	-12	-21	-49	-58	-57	-56	-55	-56	-58	-427
Elimination of Small-Employer Tax Credits[b,c]	*	*	*	*	-1	-1	-1	-1	-1	-1	-6
Elimination of Penalty Payments by Employers[c]	2	16	20	15	16	18	19	20	22	23	171
Elimination of Penalty Payments by Uninsured People	3	3	3	3	4	4	4	4	4	5	38
Funds Provided to States and Insurers	0	0	12	22	24	24	20	19	19	19	158
Medicare[d]	0	2	4	5	5	5	5	5	5	5	43
State Waiver Implementation Funding	*	*	1	*	*	*	*	0	0	0	2
Other Effects on Revenues and Outlays[e]	-1	-3	-3	-1	*	*	*	*	*	*	-8
Total Effect on the Deficit	*****	**-5**	**-7**	**-50**	**-76**	**-90**	**-109**	**-131**	**-149**	**-165**	**-784**
Memorandum: Additional Detail on Marketplace Subsidies and Related Spending and Revenues											
Premium Tax Credit Outlay Effects	-3	-6	-13	-28	-35	-33	-32	-29	-29	-30	-238
Premium Tax Credit Revenue Effects	-1	-1	-3	-6	-7	-7	-8	-8	-8	-8	-57
Subtotal, Premium Tax Credits	-4	-8	-16	-34	-42	-41	-39	-37	-37	-38	-295
Cost-Sharing Outlays	-1	-3	-4	-13	-13	-13	-14	-14	-15	-16	-105
Outlays for the Basic Health Program	*	-1	-1	-3	-3	-3	-3	-4	-4	-4	-27
Total, Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	-5	-12	-21	-49	-58	-57	-56	-55	-56	-58	-427

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

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation.
Positive numbers indicate an increase in the deficit; negative numbers indicate a decrease in the deficit.

Numbers may not add up to totals because of rounding.
* = between -$500 million and $500 million.

a. Related spending and revenues include spending for the Basic Health Program and net spending and revenues for risk adjustment.

b. Includes effects on both outlays and revenues.

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

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

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

Table 5 - EFFECTS OF H.R. 1628, THE BETTER CARE RECONCILIATION ACT OF 2017, ON HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER AGE 65

Millions of People, by Calendar Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Population Under Age 65	273	274	275	276	276	277	278	279	279	280
Uninsured Under Current Law	26	26	27	27	27	27	27	28	28	28
Change in Coverage Under the BCRA										
Medicaid[a]	*	-4	-5	-8	-10	-11	-12	-14	-14	-15
Nongroup coverage, including marketplaces	-1	-7	-8	-9	-7	-6	-6	-5	-5	-5
Employment-based coverage	*	-4	-2	-1	-1	-2	-2	-2	-2	-2
Other coverage[b]	*	*	*	*	*	*	*	*	*	*
Uninsured	1	15	15	19	19	20	20	21	22	22
Uninsured Under the BCRA	28	41	43	46	46	47	48	49	49	50
Percentage of the Population Under Age 65 With Insurance Under the BCRA										
Including all U.S. residents	90	85	84	83	83	83	83	82	82	82
Excluding unauthorized immigrants	92	87	87	86	86	86	85	85	85	85

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

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect average enrollment over the course of a year among noninstitutionalized civilian residents of the 50 states and the District of Columbia who are under the age of 65, and they include spouses and dependents covered under family policies.

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

BCRA = Better Care Reconciliation Act; * = between -500,000 and zero.

a. Includes noninstitutionalized enrollees with full Medicaid benefits.

b. Includes coverage under the Basic Health Program, which allows states to establish a coverage program primarily for people whose income is between 138 percent and 200 percent of the federal poverty level. To subsidize that coverage, the federal government provides states with funding that is equal to 95 percent of the subsidies for which those people would otherwise have been eligible.

Table 6 - ILLUSTRATIVE EXAMPLE OF SUBSIDIES AND DEDUCTIONS FOR NONGROUP HEALTH INSURANCE IN 2026 UNDER CURRENT LAW AND H.R. 1628, THE BETTER CARE RECONCILIATION ACT OF 2017, AN AMENDMENT IN THE NATURE OF A SUBSTITUTE [ERN17500], AS POSTED ON THE WEBSITE OF THE SENATE COMMITTEE ON THE BUDGET ON JULY 20, 2017

Dollars

	Bronze Plan					Silver Plan				
	Premium[a]	- Premium Tax Credit[b]	- HSA Tax Savings[c]	= Net Premium Paid	Actuarial Value of Plan (Percent)[d]	Premium[a]	- Premium Tax Credit[b]	- HSA Tax Savings[c]	= Net Premium Paid	Actuarial Value of Plan After Cost-Sharing Subsidies (Percent)[d]
Single Individual With Annual Income of $11,400 (75 percent of FPL) and Not Eligible for Medicaid[e,f]										
Current Law in a State Not Expanding Medicaid										
21 years old	4,300	0	0	4,300		5,100	0	0	5,100	
40 years old	5,500	0	0	5,500	60	6,500	0	0	6,500	70
64 years old	12,900	0	0	12,900		15,300	0	0	15,300	
BCRA, as Amended, in a State Not Expanding Medicaid										
21 years old	3,100	2,850	*	250		3,950	2,850	*	1,100	
40 years old	4,800	4,550	*	250	58	6,150	4,550	*	1,600	70
64 years old	15,500	15,250	*	250		19,750	15,250	*	4,500	
Single Individual With Annual Income of $26,500 (175 percent of FPL)[e]										
Current Law										
21 years old	4,300	3,400	0	900		5,100	3,400	0	1,700	
40 years old	5,500	4,800	0	700	60	6,500	4,800	0	1,700	87
64 years old	12,900	12,900	0	0		15,300	13,600	0	1,700	
BCRA, as Amended										
21 years old	3,100	1,800	150	1,150		3,950	1,800	250	1,900	
40 years old	4,800	3,150	200	1,450	58	6,150	3,150	350	2,650	70
64 years old	15,500	13,550	200	1,750		19,750	13,550	700	5,500	
Single Individual With Annual Income of $56,800 (375 percent of FPL)[e]										
Current Law										
21 years old	4,300	0	0	4,300		5,100	0	0	5,100	
40 years old	5,500	0	0	5,500	60	6,500	0	0	6,500	70
64 years old	12,900	8,550	0	4,350		15,300	8,550	0	6,750	
BCRA, as Amended										
21 years old	3,100	0	550	2,550		3,950	0	700	3,250	
40 years old	4,800	0	900	3,900	58	6,150	0	1,150	5,000	70
64 years old	15,500	0	1,500	14,000		19,750	0	1,500	18,250	
Single Individual With Annual Income of $68,200 (450 percent of FPL)[e]										
Current Law										
21 years old	4,300	0	0	4,300		5,100	0	0	5,100	
40 years old	5,500	0	0	5,500	60	6,500	0	0	6,500	70
64 years old	12,900	0	0	12,900		15,300	0	0	15,300	
BCRA, as Amended										
21 years old	3,100	0	700	2,400		3,950	0	900	3,050	
40 years old	4,800	0	1,100	3,700	58	6,150	0	1,400	4,750	70
64 years old	15,500	0	1,850	13,650		19,750	0	1,850	17,900	

Continued

Table 6 continued.

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

All dollar figures have been rounded to the nearest $50.

BCRA = Better Care Reconciliation Act; FPL = federal poverty level; HSA = health savings account; * = between zero and $100.

a. For this illustration, CBO projected the average national premiums for a 21-year-old in the nongroup health insurance market in 2026 both under current law and under the BCRA. On the basis of those amounts, CBO calculated premiums for a 40-year-old and a 64-year-old, assuming that the person lives in a state that uses the federal default age-rating methodology, which limits variation of premiums to a ratio of 3 to 1 for adults under current law and 5 to 1 for adults under the BCRA. CBO projects that, under current law, most states will use the default 3-to-1 age-rating curve; under the BCRA, CBO projects, most would use an age-rating curve with a maximum ratio of 5 to 1.

b. Under current law, premium tax credits are calculated as the difference between the reference premium and a specified percentage of income for a person with income at a given percentage of the FPL. The reference premium under current law is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which the person resides. A silver plan covers about 70 percent of the costs of covered benefits. The reference premium under the BCRA in a state without a waiver would be the premium for a benchmark plan that covers 58 percent of the cost of covered benefits. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 takes into account the probability, estimated in CBO's March 2016 baseline and under the BCRA, that additional indexing may apply. Such additional indexing applies if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceeded a specified percentage of gross domestic product in the preceding year. Under current law, that percentage is 0.504; under the BCRA, that percentage would be 0.4.

c. Under current law, HSAs may be used to pay for qualifying medical expenses but not for health insurance premiums. This legislation would allow people to set up HSAs to pay their nongroup health insurance premiums if they owe taxes and do not take the deduction for premiums that is available to self-employed workers under current law. They could claim the contribution to such an HSA as a deduction on their federal income tax return. The tax savings amounts shown in this illustrative table are the amounts for a single tax filer with a marginal tax rate reflecting the average for people in that income group. The tax savings shown reflect only the savings from paying the premium from the HSA; individuals may qualify for additional tax savings on out-of-pocket expenditures paid from their HSA. Under this legislation, the maximum contribution to an HSA would be raised in 2017 to $6,550 for a single person and $13,100 for a family, and it would increase with inflation thereafter. CBO and JCT project that under the BCRA in 2026, the maximum HSA contribution for a single individual would be $8,100. The illustrative examples incorporate the assumption that the silver plan chosen under the BCRA would have a deductible high enough to qualify for the HSA tax deduction.

d. The actuarial value of a plan is the percentage of costs for covered services that the plan pays. Cost-sharing subsidies are payments made by the federal government to insurers that reduce the cost-sharing amounts (out-of-pocket payments required under insurance policies) for covered people whose income is generally between 100 percent and 250 percent of the FPL. The cost-sharing subsidy amounts in this example would range from $1,100 for a 21-year-old with income at 175 percent of the FPL to $3,350 for a 64-year-old at the same income level. Under current law, cost-sharing subsidies have the effect of increasing the actuarial value of the plan from 70 percent for a typical silver plan to 94 percent for people whose income is at least 100 percent of the FPL and not more than 150 percent; to 87 percent for people with income greater than 150 percent of the FPL and not more than 200 percent; and to 73 percent for people with income greater than 200 percent of the FPL and not more than 250 percent. For people whose income is greater than 250 percent of the FPL, a silver plan would have a standard 70 percent actuarial value. Under the BCRA, cost-sharing subsidies would be eliminated starting in 2020. Under current law and under the BCRA, insurers are required to offer at least one silver plan and one gold plan in each marketplace in which they offer coverage. Under the BCRA, CBO projects that plans with actuarial values of 58 percent, 70 percent, and 80 percent would be available. The premiums for plans at 70 percent and 80 percent reflect not only the difference in the percentage of costs paid but also the effect of "risk selection," as people with higher expected health care costs are more likely to buy plans with higher actuarial values, and such differences are not fully eliminated by risk adjustment payments.

e. Income levels reflect modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers. CBO projects that in 2026, a modified adjusted gross income of $11,400 will equal 75 percent of the FPL, an income of $26,500 will equal 175 percent of the FPL, an income of $56,800 will equal 375 percent of the FPL, and an income of $68,200 will equal 450 percent of the FPL.

f. The single individuals in this illustration are assumed to be ineligible for Medicaid in each case. Under the ACA, most nondisabled adults who are not pregnant and whose income is less than 138 percent of the FPL are eligible for Medicaid if their state has expanded Medicaid. In most states that have not expanded Medicaid, such people whose income is less than 100 percent of the FPL are not eligible for either Medicaid or marketplace subsidies. A small number of legal permanent residents who have lived in the United States for less than five years and whose income is less than 100 percent of the FPL are eligible for marketplace subsidies under current law; such circumstances are not reflected in this illustrative example. In CBO's projections, under current law, about 80 percent of the potential newly eligible population resides in a state that has expanded Medicaid eligibility by 2026; and under the BCRA, about 30 percent of the potential newly eligible population resides in a state that has expanded Medicaid eligibility by 2026.