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Report

Federal Tax Compliance Research:
Tax Gap Estimates for Tax Years 2008–2010

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Federal Tax Compliance Research: Tax Gap Estimates for Tax Years 2008–2010

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Federal Tax Compliance Research: Tax Gap Estimates for Tax Years 2008–2010

Executive Summary

This report presents estimates of the tax gap for the Tax Year (TY) 2008—2010 timeframe. The tax gap and associated concepts are a particular way of defining and analyzing compliance and noncompliance and are based on tax year liability. The tax gap provides a rough gauge of the level of overall noncompliance and voluntary compliance given all the events that occurred during the relevant tax periods and the Internal Revenue Code (IRC) provisions in effect at the time. Tax gap estimates provide the Internal Revenue Service (IRS) with periodic appraisals about the nature and extent of noncompliance for use in formulating tax administration strategies. The word "tax" in the phrase "tax gap" is used broadly to encompass both tax and refundable and non-refundable tax credits. The IRS last issued tax gap estimates covering TY 2006.

Unlike prior tax gap estimates that pertain to a single tax year, these estimates reflect an estimated average compliance rate and associated average annual tax gap for the TY 2008—2010 timeframe. This approach was motivated by the decision to pool multiple years of compliance data from the annual individual income tax reporting compliance component of the National Research Program (NRP) to provide greater reliability of individual income tax underreporting tax gap estimates by sources of noncompliance.

The estimates were prepared by the IRS and are based on original research and analysis conducted or sponsored by the IRS. Estimating the tax gap is inherently challenging and requires assessing the merits of alternative methods, assumptions, and data sources. There is no single approach for estimating all the components of the tax gap. Each approach is subject to non-sampling error; the component estimates that are based on samples are further subject to sampling error. The uncertainty of the estimates is not readily captured by standard errors that typically accompany estimates based on sample data. For that reason, standard errors, confidence intervals, and statistical comparisons across years are not reported. This report provides summary information about the estimation methodology used to produce these estimates of the tax gap. More detailed information about the underlying approaches and assumptions can be found in forthcoming technical papers.

The gross tax gap is the amount of true tax liability that is not paid voluntarily and timely. The estimated gross tax gap is $458 billion. The net tax gap is the gross tax gap less tax that will be subsequently collected, either paid voluntarily or as the result of IRS administrative and enforcement activities; it is the portion of the gross tax gap that will not be paid. It is estimated that $52 billion of the gross tax gap will eventually be collected resulting in a net tax gap of $406 billion. The voluntary compliance rate (VCR) is a ratio measure of relative compliance and is defined as the amount of tax paid voluntarily and timely divided by total true tax, expressed as a percentage. The VCR corresponds to the gross tax gap. The estimated VCR is 81.7 percent. The net compliance rate (NCR) is a ratio measure corresponding to the net tax gap. The NCR is defined as the sum of "tax paid voluntarily and timely" and "enforced and other late payments" divided by "total true tax", expressed as a percentage. The estimated NCR is 83.7 percent.

Many factors contribute to differences over time in both the gross tax gap and the VCR. These include factors such as the overall level of economic activity, changes in the composition of economic activity with shifts toward those with higher or lower compliance rates, changes in tax law and administration, updated data and improved methodologies, and changes in underlying compliance behavior on the part of taxpayers and preparers. Since the tax gap typically moves with the economy, the December 2007 through June 2009 recession and the weak recovery that followed contributed to the gross tax gap remaining substantially unchanged from the previously released TY 2006 estimate. Gross collections as reported in the IRS Data Book

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show that the average annual gross collections for the Fiscal Year (FY) 2008—2010 timeframe was very close to the gross collections for FY 2006. Gross collections were $2.52 trillion in FY 2006 and increased to $2.69 trillion in FY 2007 and $2.75 trillion in FY 2008. They declined to $2.35 trillion in FY 2009 and remained at that level in FY 2010. Thus the average gross collection for the FY 2008—2010 timeframe and for FY 2006 were both about $2.5 trillion.

The new estimates suggest that compliance is substantially unchanged since last estimated for TY 2006. Although the TY 2008–2010 gross and net tax gap estimates ($458 billion, $406 billion) are 1.8 percent and 5.5 percent higher, respectively, than the previously released TY 2006 estimates ($450 billion, $385 billion), those increases are driven by improvements in the accuracy and comprehensiveness of the estimates through updates in methods and the inclusion of new tax gap components. Had the improvements not been made, the TY 2008–2010 tax gap estimates would have been slightly lower than the previous TY 2006 estimates (but still suggesting that compliance is substantially unchanged).

The estimated VCR (81.7%) is lower than the previous TY 2006 estimate (83.1%). About half of the 1.4 percentage point difference is attributable to the updated methods. Given the challenges in estimating the tax gap and given the many factors that contribute to differences over time, the remaining 0.7 percentage point difference from the TY 2006 estimate does not support concluding that noncompliance has increased.

The gross tax gap is composed of three components: nonfiling, underreporting, and underpayment. The estimated gross tax gaps for these components are $32 billion, $387 billion, and $39 billion respectively. The gross tax gap estimates can also be grouped by type of tax. The estimated gross tax gap for individual income tax is $319 billion, for corporation income tax is $44 billion, for employment tax is $91 billion, and for estate and excise tax combined is $4 billion.

Because of improvements in methods and data, estimates of the net tax gap by type of tax are available for the first time. The estimated net tax gap for individual income tax is $291 billion, for corporation income tax is $35 billion, for employment tax is $79 billion, and for estate and excise tax combined is $1 billion.

Findings from earlier tax gap analyses that compliance is higher when amounts are subject to information reporting and even higher when also subject to withholding continue to hold. The extent of coverage by information reporting and/or withholding is called "visibility" because incomes that are reported to the IRS are more "visible" to both the IRS and taxpayers. Misreporting of income amounts subject to substantial information reporting and withholding is 1 percent; of income amounts subject to substantial information reporting but not withholding, it is 7 percent; and of income amounts subject to little or no information reporting, such as nonfarm proprietor income, it is 63 percent.

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Section 1. Introduction

This report presents estimates of the tax gap for the Tax Year (TY) 2008—2010 timeframe. The tax gap and associated concepts are a particular way of defining and analyzing compliance and noncompliance and are based on tax year liability. The tax gap provides a rough gauge of the level of overall noncompliance and voluntary compliance given all the events that occurred during the relevant tax periods and the Internal Revenue Code (IRC) provisions in effect at the time. Tax gap estimates provide the Internal Revenue Service (IRS) with periodic appraisals about the nature and extent of noncompliance for use in formulating tax administration strategies. The IRS last issued tax gap estimates covering TY 2006.

The gross tax gap is the amount of true tax liability that is not paid voluntarily and timely. The net tax gap is the gross tax gap less tax that will be subsequently collected, either paid voluntarily or as the result of IRS administrative and enforcement activities; it is the portion of the gross tax gap that will not be paid. The word "tax" in the phrase "tax gap" is used broadly to encompass both tax and refundable and non-refundable tax credits. The IRC allows for various refundable and non-refundable tax credits, and the tax gap estimates account for noncompliance with these credits as well as the tax that these credits offset. Thus for some taxpayers the word tax, in the sense that it is used for tax gap estimation, is zero or negative.

The tax gap paradigm separates noncompliance into components by type of tax and source of noncompliance. The three primary sources of noncompliance that result in payment of less than the true tax are: (1) the nonfiling tax gap (the tax not paid on time by those who do not file required returns on time); (2) the underreporting tax gap (the net understatement of tax on timely filed returns); and (3) the underpayment tax gap (the amount of tax reported on timely filed returns that is not paid on time).

The unobservable nature of the tax gap makes its estimation difficult and the estimates subject to uncertainty. While the amount of tax paid by taxpayers can be observed, the counterfactual amount needed to estimate the tax gap—the amount of tax that should have been paid by taxpayers—is not. The asymmetry of information between taxpayers and the IRS, even with third-party information reporting and the authority to examine books and records to ascertain that the correct tax has been paid, leaves the IRS at a disadvantage in evaluating whether a taxpayer in fact has paid the correct tax.

The estimates in this report were prepared by the IRS and are based on original research and analysis conducted or sponsored by the IRS. Estimating the tax gap is inherently challenging and requires assessing the merits of alternative methodologies, assumptions, and data sources. This report provides summary information about the estimation methodology used to produce these estimates of the tax gap. More detailed information about the underlying approaches and assumptions can be found in forthcoming technical papers listed in Footnote 1.

Unlike prior tax gap estimates that pertain to a single tax year, the estimates presented in this report reflect an estimated average compliance rate and associated average annual tax gap for the TY 2008—2010 timeframe. This approach was motivated by the decision to pool multiple years of compliance data from the annual individual income tax reporting compliance component of the National Research Program (NRP) to provide greater reliability of individual income tax underreporting gap estimates by sources of noncompliance.

Each annual individual income tax return NRP sample is representative of that year's filing population and contains compliance information on many tax return line items, making NRP the richest source of data for compliance analysis. However, the NRP sample design is based on dividing equally among three tax years the number of sample returns needed to achieve a certain precision in the resulting estimates. In using the NRP data for the individual income tax underreporting tax gap estimates, the NRP data were pooled over three years, resulting in estimates that reflect an annual average covering a period of three tax years, rather than just one.

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The next section of the report presents an overview of the tax gap concepts and estimates. It contains the updated schematic representation of the estimates, known as the tax gap "map" and an updated chart displaying the relationship between individual income tax reporting compliance and third-party information reporting and withholding. It also includes a summary of significant tax law and other changes since the TY 2006 estimates. The final section of the report includes a general summary of the estimation methods and greater detail on the estimates for each of the three primary sources of noncompliance—nonfiling, underreporting, and underpayment. Technical papers with more detail than contained in this report are forthcoming.[1]

Section 2: Tax Gap Estimates for Tax Years 2008–2010

Tax Gap Concepts: Dollar Measures

As explained in the Introduction section of this report, tax gap concepts are defined on a tax year basis. These dollar concepts are measures of the extent of noncompliance. The gross tax gap is defined as the dollar amount of true tax that is not paid on time. The gross tax gap measure is defined and estimated at an aggregate level that incorporates all types of tax and all sources of noncompliance. Gross tax gap measures are also defined and estimated by type of tax, the three primary sources of noncompliance, and other subcomponents.

Enforced and other late payments are defined as the amount of the gross tax gap that will eventually be paid. This report presents estimates of the payments at an aggregate level and also (for the first time) by type of tax.

The net tax gap is defined as the gross tax gap less enforced and other late payments. It is the amount of the gross tax gap that will not be paid. Given estimates of enforced and other late payments for each type of tax, this report (for the first time) presents net tax gap estimates by type of tax. The use of the word "net" in this context reflects the subtraction of enforced and other late payments from the gross tax gap.

The net misreported amount, or NMA, is a tax gap concept associated with the underreporting tax gap. The NMA is the dollar amount of misreporting on a particular tax return or schedule line item. The NMA is also defined for the total amount of tax underreported, which is the underreporting tax gap. Since amounts reported and misreported on tax return and schedule lines can be either positive or negative, the actual method of calculation depends on whether the line item is an income item or an offset item (such as a deduction, expense, or credit). For an income item, the NMA is defined as the sum of all amounts underreported minus the sum of all amounts overreported. In general, income items are underreported in the aggregate, so the NMA for income items generally is positive. For an offset item, the NMA is defined as the sum of all amounts overstated minus the sum of all amounts understated. In general, offset items are overstated in the aggregate, so the NMA for offsets is typically positive. For this concept, the word net refers to the offsetting of overstated and understated amounts and not the subtraction of enforced and other late payments.

[1] Internal Revenue Service, Research, Analysis & Statistics. *Estimation of the Underreporting Tax Gap for TY 2008-2010: Methodology.* Publication 5161, forthcoming.
Internal Revenue Service, Research, Analysis & Statistics. *Estimation of the Individual Income and Self-Employment Nonfiling Tax Gaps for TY 2008-2010: Methodology.* Publication 5161, forthcoming .
Internal Revenue Service, Research, Analysis & Statistics. *Estimation of the Underpayment Tax Gap for TY 2008-2010: Methodology.* Publication 5161, forthcoming.
Internal Revenue Service, Research, Analysis & Statistics. *Estimation of Enforced and Other Late Payments and the Net Tax Gap for TY 2008-2010: Methodology.* Publication 5161, forthcoming.

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Tax Gap Concepts: Ratio Measures

Tax gap concepts include several ratio measures expressed as rates or percentages. The purpose of these measures is to provide a relative measure of compliance or noncompliance. These measures are ratios of dollar amounts for the entire population.[2]

The voluntary compliance rate (VCR) is defined as the amount of tax paid voluntarily and timely divided by total true tax, expressed as a percentage. The VCR is a complement to the gross tax gap.

The net compliance rate (NCR) is defined as the sum of all timely and enforced and late payments divided by total true tax, expressed as a percentage. The NCR is a complement to the net tax gap. It is also equal to 1 minus the ratio of the net tax gap to total true tax.

The net misreporting percentage (NMP) is an underreporting tax gap concept. The NMP for a given line item is the NMA divided by the sum of the absolute values of the amounts that should have been reported. For most return or schedule line items, amounts that should have been reported can be positive only. However, amounts can be either positive or negative for business-related net income and certain other lines. So for those line items where amounts can be negative, the denominator of the NMP is not the net of positive and negative amounts, but instead it is the total of all the amounts disregarding the sign in the calculation—that is, the sum of the absolute value. The NMP is a complement to the NMA.

The voluntary reporting rate, or VRR, is another underreporting tax gap concept. It is a measure of the overall extent of reporting compliance for a particular type of tax. It is defined as the amount of reported tax divided by the amount of tax that should have been reported. It reflects reporting compliance on timely filed returns.

Significant Tax Law and Other Changes Since Tax Year 2006

Tax law and the level of economic activity can affect the tax gap. As noted earlier in the report, the timeframe covered by the estimates includes the recession of 2007—2009. The recession was followed by a slower than usual recovery. Components of the stimulus designed to help move the economy out of the recession included the Recovery Rebate Credit (TY 2008), the Making Work Pay and Government Retiree Credits (TY 2009 and TY 2010), and the First Time Homebuyers Credit (TYs 2008—2010). According to IRS Statistics of Income (SOI) data[3], the aggregate value of the Recovery Rebate Credit was about $12 billion for TY 2008. The Making Work Pay Credit was $51 billion and $54 billion in TY 2009 and TY 2010 respectively. The First-Time Home Buyer Credits amounted to $8 billion, $10 billion, and $2 billion in TY 2008, TY 2009, and TY 2010 respectively. TY 2009 saw an expansion of the Earned Income Tax Credit (EITC), an expansion of the refundable portion of the Child Tax Credit (Additional Child Tax Credit), and the creation of an additional education credit—the American Opportunity Credit. The Residential Energy Credit was also expanded for TY 2009 and TY 2010 and increased from $1 billion in TY 2006 to $6 billion in both TY 2009 and TY 2010. The total of refundable and nonrefundable credits grew 64 percent from TY 2006 to the average for TY 2008—2010; credits grew 32 percent when the Recovery Rebate Credit and Making Work Pay and Government Retiree Credit are excluded.

There have been significant changes in the estate tax since TY 2006. The Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) began a phase-out of the estate tax through increases to the effective

[2]At a tax return level, these ratios may be undefined or have limited meaning because the numerator, denominator, or both may be zero.
[3] Statistics on reported credits are compiled from the Statistics of Income Individual Income Tax Returns Publication 1304 (Complete Report), Table A.

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exemption amount and reductions in the maximum marginal tax rate until the estate tax was eliminated for one year in TY 2010. The estate tax exclusion increased from $1.5 million for TY 2004 estates to $3.5 million for TY 2009. The maximum marginal estate tax rate gradually decreased one percentage point per year from 48 percent in TY 2004 to 45 percent in TY 2007, and then remained flat through TY 2009. One of the provisions in the estate tax law had been an unlimited step-up in basis for income tax purposes for inherited assets from the decedent's basis to the fair market value of the asset at the time of death. Along with the elimination of the estate tax for TY 2010, EGTRRA limited the step-up in basis to $1.3 million in TY 2010.

The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (TRA 2010) reinstated the estate tax for TY 2010 with a $5 million effective exclusion and 35 percent maximum marginal tax rate, along with an unlimited step-up in basis. TRA 2010, however, gave estates the option of choosing the prior law under EGTRRA for TY 2010.

EGTRRA had a significant impact on estate tax reporting through the increase in the effective exclusion amount from $1.5 million in TY 2004 to $5.0 million in TY 2010 and the reduction in the maximum tax rate from 48 percent to 35 percent.

The number of corporation income tax returns filed continued to decline over the TY 2008–2010 timeframe. Annual corporation income tax return filings generally have declined since peaking at 2.9 million filed in 1988. The average annual decline was about 1.5 percent from TY 1999—2006 and 3.9 percent from TY 2006—2010. Reported tax declined each year for the TY 2007—2009 timeframe but increased for TY 2010.

Estimates for Tax Years 2008–2010

As described in the Introduction, unlike prior tax gap estimates, the estimates presented in this report reflect an estimated average compliance rate and associated average annual tax gap for the TY 2008—2010 timeframe. The motivation for combining multiple years of annual NRP data of individual income tax compliance is to increase the reliability of the resulting estimates. Starting with TY 2006, the NRP individual income tax sample design moved from larger periodic samples to smaller annual samples. Accompanying this change was an expectation that multiple years will be combined when analyzing the data for certain purposes. The sample design allocated evenly over three tax years the total number of returns that previously would have formed a single larger periodic sample.

The tax gap map schematic on the following page shows the gross tax gap, enforced and other late payments, and net tax gap for all types of taxes and components combined and also by type of tax and component separately.

Overall Gross and Net Tax Gap

As shown in Table 1, the estimated gross tax gap is $458 billion. An estimated $52 billion of the gross tax gap eventually will be collected resulting in a net tax gap of $406 billion. The voluntary compliance rate (VCR) is 81.7 percent. The estimated net compliance rate (NCR) is 83.7 percent.

The new estimates suggest that compliance is substantially unchanged. Although the TY 2008—2010 gross and net tax gap estimates are higher than the previously released TY 2006 estimates, the increase is primarily due to improvements in the accuracy and comprehensiveness of the estimates through updates in methods and the inclusion of new tax gap components. Had the improvements not been made, the TY 2008—2010 tax gap estimates would have been slightly lower than the previous TY 2006 estimates. Table 1 shows the breakout of

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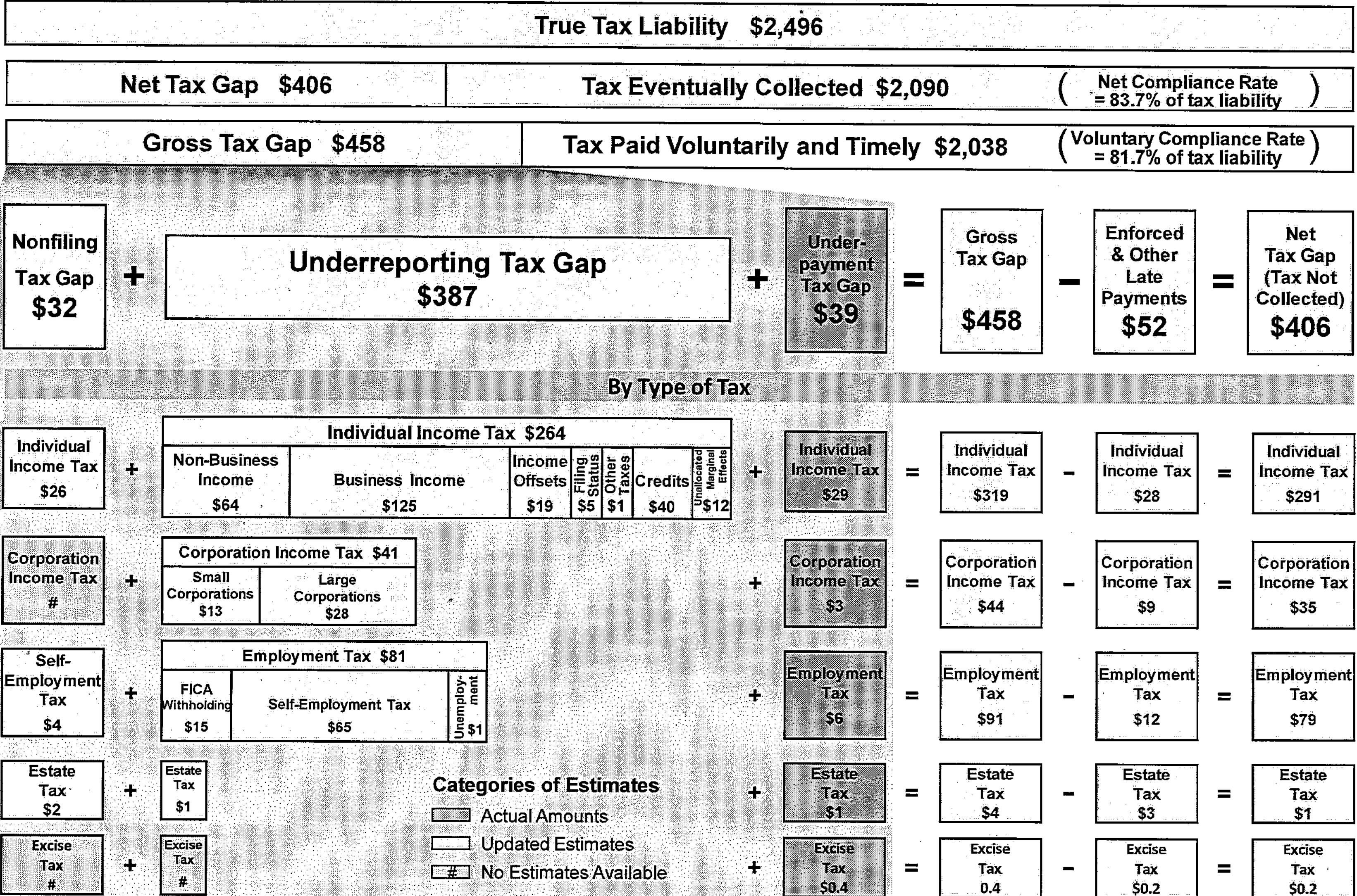

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the changes into the portion attributable to change in methods (including the new components) and the portion attributable to other factors.

The estimated VCR is lower than the previous TY 2006 estimate. About half of the 1.4 percentage point difference is attributable to the updated methods. Given the challenges in estimating the tax gap and given the many factors that contribute to differences over time, the remaining 0.7 percentage point difference from the TY 2006 estimate does not support concluding that noncompliance has increased.

Table 1. Tax Gap Estimates for Tax Years 2006 and 2008–2010[1] and Decomposition of Change

[Money amounts are in billions of dollars]

Tax Gap Component	TY2006	TY2008-2010 [1]	Total Change	Change Due To: Updated Methods[2]	Change Due To: Other Factors[3]
Estimated Total True Liability	**2,660**	**2,496**	**-164**	**14**	**-178**
Gross Tax Gap	**450**	**458**	**8**	**22**	**-14**
Nonfiling Tax Gap	28	32	4	4	[5]
Underreporting Tax Gap	376	387	11	24	-13
Underpayment Tax Gap	46	39	-7	-6	-1
Overall Voluntary Compliance Rate	**83.1%**	**81.7%**	**-1.4%**	**-0.8%**	**-0.7%**
Enforced and Other Late Payments	**65**	**52**	**-13**	**-12**	**-1**
Net Tax Gap [4]	**385**	**406**	**21**	**34**	**-13**
Overall Net Compliance Rate	**85.5%**	**83.7%**	**-1.8%**	**-1.2%**	**-0.6%**

[1] The estimates are the annual averages for the Tax Year 2008-2010 timeframe.

[2] Difference between the TY2006 and TY2008-2010 tax gap estimates accounted for by updated methods and new tax gap components.

[3] Difference between the TY2006 and TY2008-2010 tax gap estimates accounted for by changes in economic activity, changes in compliance behavior and statistical variability.

[4] The net tax gap is the gross tax gap reduced by the amount of enforced and other late payments that will eventually be collected.

[5] Less than $0.5 billion.

Detail may not add to total due to rounding.

Many factors contribute to differences over time in both the gross tax gap and the VCR. These include factors such the overall level of economic activity, changes in the composition of economic activity with shifts toward those with higher or lower compliance rates, changes in tax law and administration, updated data and improved methodologies, and changes in underlying compliance behavior on the part of taxpayers and preparers. Since the tax gap typically moves with the economy, the December 2007 through June 2009 recession and the weak recovery that followed contributed to the gross tax gap remaining substantially unchanged from the previously released TY 2006 estimate. Gross collections as reported in the IRS Data Book show that the average annual gross collections for the Fiscal Year (FY) 2008—2010 timeframe was very close to the gross collections for FY 2006. Gross collections were $2.52 trillion in FY 2006 and increased to $2.69 trillion in FY 2007 and $2.75 trillion in FY 2008. They declined to $2.35 trillion in FY 2009 and remained at that level in FY 2010. Thus the average gross collection for the FY 2008—2010 timeframe and for FY 2006 were both about $2.5 trillion.

The estimate of enforced and late payments is $13 billion lower than the TY 2006 enforced and late payments estimate of $65 billion. Nearly all of this difference is attributable to new data on non-enforced late payments, which showed that assumptions made about these payments for prior estimates were too optimistic. The estimated net tax gap is $21 billion higher than the $385 billion net tax gap estimated previously for 2006. The

estimated net compliance rate (NCR) is 83.7 percent, which is 1.8 percentage points lower than the 85.5 percent NCR for TY 2006.

There is no single approach for estimating all the components of the tax gap. Each approach is subject to non-sampling error; the component estimates that are based on samples are further subject to sampling error. The uncertainty of the estimates is therefore not readily captured by standard errors that typically accompany estimates based on sample data. For that reason, standard errors, confidence intervals, and statistical comparisons across years are not reported.

Nonfiling Tax Gap

Sufficiently reliable information exists for developing estimates of the nonfiling tax gap for three types of tax: individual income tax, self-employment tax, and estate tax. The nonfiling tax gap is the tax gap associated with tax returns that were filed after the filing deadline or valid extension date—or were not filed at all.

Table 2 provides a breakout of the nonfiling, underreporting, and underpayment tax gaps into major subcomponents and reports their shares of the gross tax gap. As shown in Table 2 the nonfiling tax gap accounts for about 7 percent of the gross tax gap. The individual income tax nonfiling tax gap is estimated to be $26 billion, or about 81 percent of the total estimated nonfiling tax gap. The self-employment tax nonfiling tax gap is estimated to be $4 billion, or about 13 percent of the total estimated nonfiling tax gap. The estate tax nonfiling tax gap is estimated to be $2 billion.

Underreporting Tax Gap

Of the $458 billion gross tax gap, $387 billion (approximately 85 percent) is estimated to result from the underreporting of true tax on timely filed returns. The individual income tax underreporting tax gap estimate is $264 billion, or 68 percent of the overall gross underreporting tax gap. The corporation income tax underreporting tax gap estimate is $41 billion, or about 11 percent of the overall underreporting tax gap. The employment tax underreporting tax gap estimate is $81 billion and the estate tax estimate is $1 billion, representing 21 percent and less than one half of one percent of the overall underreporting tax gap, respectively.

Underpayment Tax Gap

About 9 percent of the gross tax gap results from taxpayers not timely paying in full the tax they report on timely filed returns. The estimated underpayment tax gap is $39 billion. About 74 percent of the underpayment tax gap, about $29 billion, is from underpayment of individual income tax. Underpayment of employment taxes (Federal Insurance Contributions Act, FICA and Federal Unemployment Tax Act, FUTA) and the railroad retirement tax accounts for 15 percent of the underpayment tax gap. Underpayment of corporation income taxes accounts for 8 percent of the underpayment tax gap. These shares correspond to $6 billion and $3 billion respectively. Excise tax and estate tax account for the remaining $1 billion.

Enforced and Other Late Payments

Some of the gross tax gap is collected through IRS enforcement and administrative efforts and some is paid late without any IRS action taken. The total amount of enforced and other late payments is $52 billion. About 54 percent of the total, or $28 billion, is associated with individual income tax. About 17 percent of the total is the $9 billion in corporation income tax enforced and other late payments. Employment tax enforced and other late payments are 23 percent of the total or $12 billion. Estate tax enforced and other late payments are $3 billion or about 6 percent of the total. Excise taxes enforced and other late payments account for less than one half of one percent of all enforced and late payments.

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Table 2. Tax Gap Estimates for Tax Years 2008–2010[1]

[Money amounts are in billions of dollars]

Tax Gap Component	TY 2008-2010[1]	Share of Gross Tax Gap
Estimated Total True Liability	**2,496**	
Gross Tax Gap	**458**	**100%**
Overall Voluntary Compliance Rate	**81.7%**	
Net Tax Gap	**406**	
Overall Net Compliance Rate	**83.7%**	
Nonfiling Tax Gap	**32**	**7%**
Individual Income Tax	26	6%
Self-Employment Tax	4	1%
Estate Tax	2	[2]
Underreporting Tax Gap	**387**	**85%**
Individual Income Tax	**264**	**58%**
Non-Business Income	64	14%
Business Income	125	27%
Adjustments, Deductions, Exemptions	19	4%
Filing Status	5	1%
Other Taxes	1	[2]
Unallocated Marginal Effects	12	3%
Credits	40	9%
Corporation Income Tax	**41**	**9%**
Small Corporations (assets under $10M)	13	3%
Large Corporations (assets of $10M or more)	28	6%
Employment Tax	**81**	**18%**
Self-Employment Tax	65	14%
FICA and Unemployment Tax	16	3%
Estate Tax	1	[2]
Underpayment Tax Gap	**39**	**9%**
Individual Income Tax	29	6%
Corporation Income Tax	3	1%
Employment Tax	6	1%
Estate Tax	1	[2]
Excise Tax	[3]	[2]

Detail may not add to total due to rounding.

[1] The estimates are the annual averages for the Tax Year 2008-2010 timeframe.

[2] Less than 0.5 percent.

[3] Less than $0.5 billion.

Net Tax Gap by Type of Tax

As noted earlier, new data on enforced and other late payments by type of tax enables the estimation of net tax gaps by type of tax. As shown on the Tax Gap Map, the net tax gap for individual income tax is $291 billion and for corporation income tax is $35 billion. The net tax gap for employment taxes is $79 billion. The estate tax net tax gap is $1 billion. The excise tax net tax gap is $0.2 billion.

Voluntary Compliance Rates by Type of Tax

Table 3 shows the VCRs by type of tax along with their distributions of tax liability. The VCR for most of the major types of tax remained largely unchanged from TY 2006. There was a decrease in the VCR for individual

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income tax from 77 percent for TY 2006 to 74 percent. This decline along with the individual income tax's increase in the share of liability contributes to the slight decline in the overall VCR.

Table 3. Voluntary Compliance Rates by Type of Tax, Tax Years 2006, and 2008–2010[1]

Tax Gap Component	Voluntary Compliance Rates		Distribution of Liability	
	TY2006	TY2008 - TY2010	TY2006	TY2008 - TY2010
Overall (all taxes combined)	*83%*	*82%*	*100%*	*100%*
Individual Income Tax	77%	74%	48%	50%
Corporation Income Tax	82%	83%	15%	10%
Employment Tax	91%	90%	33%	37%
Estate Tax	74%	74%	1%	1%
Excise Tax	N/A	N/A	2%	2%

Note: The Voluntary Compliance Rates reflect all three types of noncompliance: Nonfiling, underreporting, and underpayment.

Visibility: A Link Between Reporting Compliance and Third-Party Information Reporting

The estimates confirm the relationship between reporting compliance and third-party information reporting that was demonstrated in earlier tax gap estimates. For the individual income tax, reporting compliance is far higher when income items are subject to information reporting and even higher when also subject to withholding. As shown in Chart 1 on page 12, from the individual income tax underreporting tax gap estimates, the net misreporting percentage (NMP) for income amounts subject to substantial information reporting and withholding is 1 percent, for income amounts subject to substantial information reporting but not withholding is 7 percent; and for income amounts subject to little or no information reporting, such as nonfarm proprietor income, is 63 percent. The grouping of items into categories was changed slightly from prior analyses. The current categories include income items only. The prior analyses and categories included income offsets (adjustment, deductions, and exemptions).

Section 3: Data and Methodology

There is no single method for estimating all the components of the tax gap. Rather, the approach for each component varies according to the type of information available. Since the last tax gap estimates were released for TY 2006, new data have become available and these have been used in developing the current estimates. Although the general approaches are the same as for prior estimates, there have been some methodological enhancements. These changes are highlighted in the following methodological overviews for each tax gap component.

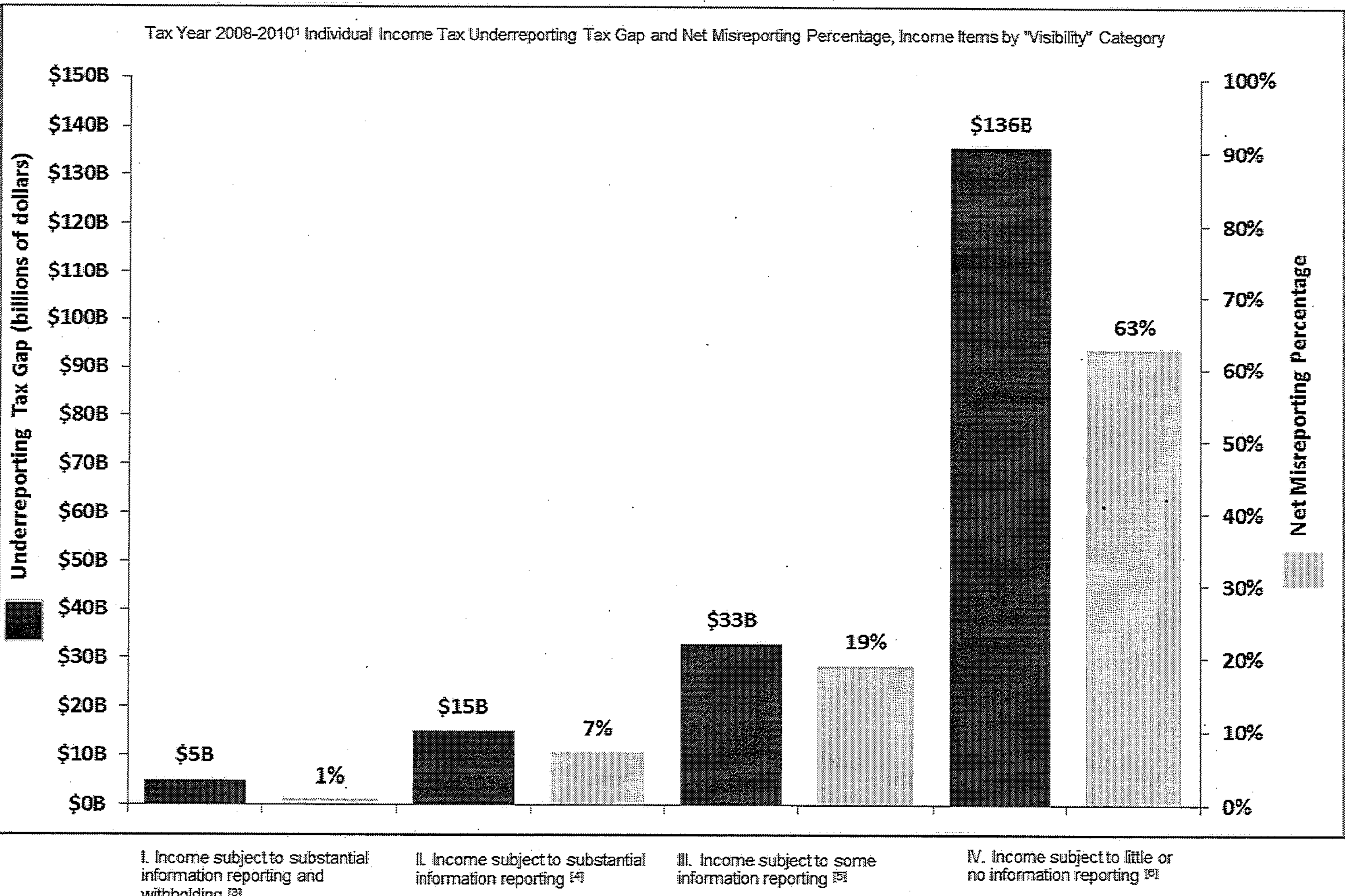
Nonfiling Tax Gap

Estimates of the nonfiling tax gaps were developed for individual income tax, self-employment tax, and estate tax. The methods used for each are described next. The IRS has been conducting research into estimating a corporation nonfiling tax gap, but has not yet found a sufficiently reliable method and data upon which to base an estimate.

Individual Income Tax Nonfiling Tax Gap

Taxpayers are required to prepay a significant share of their estimated liability for a given year through withholdings or estimated tax payments. Some taxpayers do not timely file required returns to self-assess their tax liability and to reconcile that with prepayments and credits. These prepayments and credits may exceed their true tax liability or cover it in full or in part. Only true tax in excess of timely payments and any credits for which they are estimated to be eligible is included in the nonfiling tax gap. Although those whose prepayments

Chart 1. Effect of Information Reporting on Individual Income Tax Reporting Compliance, Tax Years 2008–2010



[1] The TY 2008 – 2010 estimate is the annual average for the Tax Year 2008, 2009, and 2010 timeframe.
[2] The Net Misreporting Percentage is the net misreported amount as a ratio of the sum of the absolute values of the amounts that should have been reported expressed as a percentage. For the items included in this chart, the net misreported amount is understatements of income less overstatements of income. On net, income is understated.
[3] Includes wages & salaries.
[4] Includes pensions & annuities, unemployment compensation, dividend income, interest income, taxable Social Security benefits.
[5] Includes partnership/S corp. income, capital gains, alimony income. Prior definition also included deductions and exemptions.
[6] Includes nonfarm proprietor income, other income, rents and royalties, farm income, Form 4797 income. Prior definition also included adjustments to income.

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and credits fully satisfied their true tax liability are not in compliance with the filing requirements of the IRC, this noncompliance does not increase the tax gap since their tax was paid on time.

The individual income tax nonfiling tax gap was estimated using two methods, with the average of the two yielding the estimate of $26 billion. Each method accounts for late filers and "not-filers" (those who did not file by the time of the estimate). These two approaches incorporate improvements to the methods used to estimate the TY 2001 and the TY 2006 individual income tax nonfiling tax gaps.

Census Method

For the Tax Year 2001 tax gap estimates, the IRS estimated the individual nonfiling tax gap based on a match of Census and IRS data conducted by the Census Bureau. This approach involved identifying respondents in the Census survey who appeared not to have filed an income tax return. However, this approach lacked complete information on incomes not reported in the Census, as well as payments. The current method improves on the old Census-based method in several important ways: (a) it uses the anonymous Protected Identification Key (PIK) created by Census to create a better matched dataset, allowing us to identify "not-filers" more accurately;[4] (b) it uses the third-party information, together with demographic information about nonfilers contained in Census data, to make better imputations of certain income, deduction, and credit amounts;[5] and (c) it supplements this estimate of the tax gap derived from the Census-IRS matched data with a separate estimate for taxpayers who filed late, but before the date of the IRS data extract provided to Census. The reason for this supplemental estimate based on IRS administrative data is that the matched Census-IRS data include returns that were not timely filed, but were filed by December 31 of the ordinary filing year. There is no indicator to distinguish them from the returns filed on time; hence they appear in the matched dataset and are not included in the nonfiling estimate developed using the matched data. Since we can identify tax returns in the matched dataset that were filed after December 31 (and were therefore clearly late), estimating their contribution to the tax gap is much more straightforward. The method also accounts for income and payments that are not reported on late filed returns, but are reported to the IRS on third-party information documents.[6] The estimate based on the Census Method (accounting for all late filers) is $27 billion.

Administrative Data Method

To estimate the TY 2006 individual income tax nonfiling tax gap, the IRS assembled a sample of individuals not appearing on either timely filed tax returns or returns filed late through the date of the analysis, identified the income reported to the IRS for them by third parties, grouped them into family (tax) units guided by Census data, then estimated their tax liability less withholding and estimated credits. However, this approach lacked information on income not reported to the IRS by third parties and basing the estimate on a sample of individuals created challenges for grouping people together into presumed tax units.[7]

The main improvements to the TY 2006 methodology were to apply the approach to population data rather than to a sample and to impute self-employment income to the tax units. The methods developed for imputing self-

[4] See Maggie R. Jones and Amy O'Hara, "Do Doubled-Up Families Minimize Household-Level Tax Burden?" *2014 IRS Research Bulletin*, Publication 1500, and Wagner, D., & Layne, M. (2012). *Person Identification Validation System (PVS): Applying the Center for Administrative Records Research and Applications' Record Linkage Software,* Washington, DC: Center for Administrative Records Research and Applications Internal Document, U.S. Census Bureau.

[5] The methods developed for imputing income, deduction, and credit amounts to the matched dataset are described in greater detail in the technical report.

[6] We do not impute other kinds of income to them (such as from self-employment). However, late filers already report a significant amount of these kinds of income.

[7] See Internal Revenue Service, "Federal Tax Compliance Research: Tax Year 2006 Tax Gap Estimation" at http://www.irs.gov/pub/irs-soi/06rastg12workppr.pdf.

employment income, deductions, and credits to the administrative dataset, and methods for grouping individuals into tax units, are described in greater detail in the technical report.

The tax gap associated with late filers takes into account the filing status, dependents, deductions, and credits reported on their late returns. This was the same approach as that used to supplement the Census Method, but included all late filers, not just those who had filed by December 31. The estimate of the individual income tax nonfiling tax gap based on the Administrative Data Method (accounting for all late filers) is $25 billion.

Estimate for Tax Years 2008–2010

The individual income tax nonfiling tax gap estimates under both methods are reported in Table 4. Averaging the estimates from the two methods yields an estimate of $26 billion.

Table 4. Tax Year 2008–2010 Individual Income Tax Nonfiling Tax Gap Estimates[1]

[Money amounts are in billions of dollars]

Estimation Method	TY 2008-2010[1]
Final Nonfiling Gap Estimate	**26**
Census Method	27
Administrative Data Method	25

[1] The estimates are the annual averages for the Tax Year 2008-2010 timeframe.

Self-Employment Tax Nonfiling Tax Gap

The nonfiling tax gap associated with self-employment tax was a byproduct of estimating the underreporting tax gap associated with individual income tax. The self-employment tax due for each required return was straightforward to compute, given the self-employment income associated with the "not-filers" and late filers. Timely payments were allocated to income tax and self-employment tax in proportion to the two tax liabilities. The resulting estimate of the self-employment tax nonfiling tax gap (averaged across the Census and Administrative Data methods) is $4 billion. This component estimate is new this year.

Estate Tax Nonfiling Tax Gap

The estate tax nonfiling tax gap also accounts for late filers and those who never file a required return. The nonfiling tax gap associated with late filed returns (late-filer tax gap) is estimated from the tax reported on actual late filed returns and is $0.5 billion.

The estimate of the nonfiling tax gap for estate tax returns that will never be filed is a projection from the methodology used to estimate the prior TY 2006 estate tax nonfiling tax gap. The difference between the estimated number of returns with a filing obligation (based on wealth-adjusted mortality curves developed using data from the 2000 University of Michigan Health and Retirement Study and pre-2000 data from the National Center for Health Statistics and projected calendar year 2001 deaths) and the estimated number of estate tax returns filed (based on IRS Statistics of Income data) was the estimated number of estate tax nonfilers. Their tax liability was estimated by assuming that their noncompliance was the average tax liability reported on timely filed estate tax returns having similar characteristics.

The *Calendar* Year 2001 estimate was then converted to a *Tax* Year 2001 estimate and projected to TY 2008-2010 by assuming a constant filing noncompliance rate. The resulting estimate is $1 billion. The total estate tax nonfiling tax gap estimate is $2 billion.

Underreporting Tax Gap

Individual Income Tax and Self-Employment Tax Underreporting Tax Gaps

Overview

The basic approach for estimating the individual income tax and self-employment tax underreporting tax gaps is the same as that used for the TY 2006 estimate. NRP data from a statistically representative sample of individual income tax filers are the foundation of the estimates. The methodology includes adjustments to account for income that is not detected during the audits, an inherent limitation in situations where taxpayers are intentionally noncompliant or deal in cash with poor or non-existent record keeping. This methodological step is unique to estimating these components of the tax gap and sets these estimates apart from other analyses and estimates developed from NRP data that do not make such an adjustment. The adjustment results in estimates of noncompliance that are higher than those based on unadjusted NRP data.

Methodology for Tax Years 2008–2010

The IRS National Research Program designs and administers individual income tax reporting compliance studies. Beginning with TY 2006, the program moved from a larger periodic sample to smaller annual samples. The annual samples consist of approximately 13,000 returns—roughly one-third the size of prior periodic studies. The annual studies can be combined over several years to provide compliance estimates at a level of reliability similar to a much larger single-year study. The NRP uses a process called classification to determine the type of audit for each return selected and the mandatory issues to be examined.[8] In the case of simple returns where information can be easily reconciled with the information returns filed by third parties and there are no other indications of significant compliance issues, taxpayers are not audited and not contacted. Returns that have only a small number of simple issues identified in classification are routed to correspondence exams. More complicated returns are assigned to one of two types of audits that involve face-to-face interaction with the taxpayer: either an office audit handled by a Tax Compliance Officer at an IRS office or a field audit handled by a Revenue Agent, who may visit the taxpayer's place of business.

Not all underreported income is detected by every audit, even ones of the scope and quality of audits conducted under the NRP. For tax gap estimates prior to TY 2001, a multiplier approach was used to adjust the audit data for undetected income. Beginning with the TY 2001 estimate, an econometric technique termed Detection-Controlled Estimation (DCE) has been used. The current adaptation of the DCE methodology allows for greater variability in the average detection rates across line items.[9] The modeling approach for the detection component generally requires data that includes 15 or more returns audited by the same examiner. This required the pooling of data and TY 2006—2008 data were pooled in order to provide a sufficient number of observations. An imputation methodology was developed to allocate the DCE estimates derived from the pooled TY 2006—2008 NRP data to more recent TY 2008—2010 NRP data.

In addition to the detection equation, the second extension of the DCE methodology included a two-part specification for modeling the noncompliance of a line item. The first noncompliance equation modeled the likelihood of noncompliance while the second equation modeled the magnitude of noncompliance conditional on the presence of noncompliance. Since some income items with significant information reporting were not routinely classified, the extension also included an additional modeling step conditional on whether or not the line item was classified and whether there were mismatches with information documents for these items. The

[8] Examples of issues include line items on the return, filing status, number of dependents, whether an activity is engaged in for profit or as a hobby.

[9] Detection rate here is defined as the amount of unreported income detected as a percentage of the total unreported income. The smaller the detection rate, the larger the amount of total underreporting is relative to detected underreporting.

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data requirements for DCE[10] meant that some income items still needed to be grouped together for purposes of estimating the detection equation, even when using NRP data pooled across three years. Table 5 shows the specific groupings of income items used for estimation.

Table 5: Grouping of Income Items for Joint DCE Estimation of Undetected Income

Items Subject to Significant Information Reporting	Items Routinely Classified	
Estimated Jointly	***Estimated Jointly***	***Estimated Separately***
Wages and Salaries	Short-term Capital Gains	Schedule C
Interest	Long-term Capital Gains	Schedule F
Dividends	Rents and Royalties	
State and Local Tax Refunds	Partnership, S corp., Estate, Other	
Pension and IRA income	Form 4797 Net Gains	
Gross Social Security income	Other Income	
Unemployment compensation		

Imputation of Undetected Income

Although more recent NRP data are now available, DCE was estimated using data for TYs 2006—2008 due to the time and complexity of the estimation process. DCE undetected income was then imputed to more recent NRP data for TYs 2008—2010 under the assumption that the average propensity of examiners to detect underreported income remained stable over the two periods of time. The imputation consisted of two stages. The first stage generated ten simulated data sets with return-level predictions of undetected income for TYs 2006—2008. From those ten simulations, the probability of undetected income conditional on several factors and the average undetected income (when undetected income is present) were estimated. Those factors were used to impute undetected income to TY 2008—2010 NRP data in a second stage of ten simulations. The simulation approach is used to apply the DCE prediction formulas in a manner that results in a more realistic allocation of undetected income rather than having undetected income allocated to all returns or to a small number of returns.

Additional Tip Income Adjustments

For some line items, DCE is unlikely to account fully for all undetected income. Since tip income is relatively concentrated in a few industries and occupations, tip income represents a relatively small amount of overall wages, salaries, and tips. However, since a significant portion of tip income is paid in cash by customers, tip income is subject to less information reporting than most wages and salaries. The lack of complete information reporting and the cash nature of many tips suggest that tip income had a lower compliance rate than other wages and salaries and was harder to detect during an audit. Given the concentration of tip income and the nature of the NRP samples, DCE estimation did not support estimates of unreported tip income. Unreported tip income was assumed to have the same noncompliance rate as the detected noncompliance rate for sole proprietor net income or loss. Reported tip income was multiplied by an adjustment factor to estimate unreported tip income.

Tax Calculator

The imputation of return-level predictions of undetected income from the TY 2006—2008 simulations to the TY 2008—2010 NRP data provided estimates of total underreported income, but not underreported tax. To estimate underreported taxes resulting from the underreported income, a tax calculator was applied to individual observations (i.e. tax returns) from the ten simulated TY 2008—2010 data sets. This process provided ten underreporting tax gap estimates for each line item, which were then averaged to produce the final underreporting tax gap estimate. The final line-item underreporting tax gap estimates were summed to estimate

[10] For example, the need for at least 15 audits by the same auditor in which a given line item (or grouping of line items) was audited.

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the overall individual income tax underreporting tax gap. Estimating the underreporting tax gap for each income item involved a process in which the additional income for each income item was added to the reported amount of income and then the additional tentative tax[11] based on that additional income calculated. Then that additional income was dropped and the process repeated for the next income item.

For filing status, the tax gap is the difference in tentative tax based on reported income, deductions, and filing status and tentative tax based on income and deductions that should have been reported calculated using the filing status that should have been reported. For credits, the tax gap is the difference between credits based on reported income, deductions, and filing status and credits based on income, deductions, and filing status that should have been reported. Although there are no specific DCE adjustments for credits, the DCE adjustment to income items flows through to the calculation of the gap associated with credits.

Filing Status

The net misreported amount of tax associated with misreporting of filing status is now explicitly calculated. The tax gap associated with filing status does not include the effect of filing status on credits. Those effects are included in the tax gap associated with credits. For the TY 2008—2010 timeframe, the average annual tax gap associated with misreported filing status is $5 billion.

Unallocated Marginal Effects

The marginal tax rate used to estimate the tax gap associated with a given income line item is calculated holding all other line items at their reported amounts. This calculation understates the true marginal tax rate whenever more than one line item has been underreported on the same return and the combined underreporting results in a higher marginal tax rate than when the tax on the underreported amounts is calculated separately. For TY 2001 and TY 2006, the total individual income tax underreporting tax gap estimates were the sum of the tax gap amounts associated with each line item. Therefore, the TY 2001 and TY 2006 estimates understated the total individual income tax underreporting tax gap. For TYs 2008—2010, the total individual income tax underreporting tax gap is calculated based on the marginal tax rates associated with all misreporting for a given return. The difference between total individual income tax underreporting tax gap and the sum of the individual line item tax gaps is characterized in this report as "unallocated marginal effects." For the TY 2008—2010 timeframe, the average annual tax gap associated with unallocated marginal effects is $12 billion.

Change From Tax Year 2006 Method

The estimates incorporate new NRP data. NRP data through TY 2010 were available at the time the estimates were prepared. The DCE methodology was applied to NRP data for TYs 2006—2008 and the estimates of undetected income were then imputed to the NRP data for TYs 2008—2010. For the first time, the individual underreporting tax gap estimates reflect the annual average for a time frame (TY 2008—2010) instead of a single tax year. Pooling data across multiple tax years improves the reliability of estimates by sources of noncompliance (for example, by type of income or offset).

Another improvement in the estimation method was a change to the imputation categories used for imputing DCE estimates from TY 2006—2008 to TY 2008—2010 to better reflect the assumptions and structure of the DCE estimation methodology. The imputation categories for the TY 2006 tax gap estimates focused on deciles of the amounts reported and Adjusted Gross Income (AGI) reported. The new imputation categories link detection to information return (for example, Form W-2, Form 1099, etc.) document discrepancies, line item classification outcomes, line item reporting, and whether or not underreporting was detected in the audit.

[11] Tentative tax is the amount reported on TY 2010 Form 1040 line 44.

Table 6. Individual Income Tax Underreporting Tax Gap by Source of Income: Tax Years 2008–2010[1]

[Money amounts are in billions of dollars]

Tax Return Line Items	Tax Gap	Share of Gross Tax Gap	Share of Individual Income Tax Underreporting Tax Gap	Net Misreporting Percentage[2]
Gross Tax Gap	**458**	**100%**	**n.a.**	**n.a.**
Individual Income Tax Underreporting Tax Gap	**264**	**58%**	**100%**	**22%**
Items Subject to Substantial Information Reporting and Withholding	**5**	**1%**	**2%**	**1%**
Wages, salaries, tips	5	1%	2%	1%
Items Subject to Substantial Information Reporting	**15**	**3%**	**6%**	**7%**
Interest income	1	[3]	[3]	3%
Dividend income	1	[3]	[3]	7%
State income tax refunds	1	[3]	[3]	13%
Pensions & annuities	5	1%	2%	4%
Unemployment Compensation	1	[3]	[3]	6%
Taxable Social Security benefits	7	1%	2%	19%
Items Subject to Some Information Reporting	**33**	**7%**	**12%**	**19%**
Partnership, S-Corp, Estate & Trust, etc.	22	5%	8%	16%
Alimony income	[4]	[4]	[4]	[4]
Capital gains	11	2%	4%	27%
Short-term Capital Gains	*6*	*1%*	*2%*	*13%*
Long-term Capital Gains	*5*	*1%*	*2%*	*13%*
Items Subject to Little or No Information Reporting	**136**	**30%**	**51%**	**63%**
Form 4797 income	4	1%	1%	42%
Other income	29	6%	11%	49%
Nonfarm proprietor income	78	17%	29%	64%
Farm income	5	1%	2%	71%
Rents & royalties	20	4%	8%	62%
Other Taxes	**1**	[3]	[3]	**3%**
Unallocated Marginal Effects	**12**	**3%**	**4%**	**n.a.**
Income Offsets (Adjustments, Deductions, Exemptions)	**19**	**4%**	**7%**	**5%**
Total Credits	**40**	**9%**	**15%**	**26%**
Filing Status	**5**	**1%**	**2%**	**n.a.**

[1] The estimates are the annual averages for the Tax Year 2008-2010 timeframe.

[2] The net misreporting percentage is the net misreported amount divided by the sum of the absolute values of the amounts that should have been reported, expressed as a percentage.

[3] Less than 0.5 percent.

[4] Estimate is based on very small sample size. Estimated tax gap is less that $ 0.5 billion and NMP is 2%.

n.a : not applicable.

NOTE: Components might not sum to totals because of rounding.

Improvements were also made to the treatment of self-employment tax, taxable social security benefits, and filing status. The calculation of self-employment tax was updated to account for the primary and secondary taxpayers' shares of wages and self-employment income. The calculation of the tax gap associated with misreported taxable social security benefits was updated to account for the effects of misreported income on other line items on the taxable portion of social security benefits. And the net misreported amount of tax

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associated with misreporting of filing status is now explicitly calculated. The tax gap associated with filing status accounts for the effect of changes in both the marginal tax rate schedule and the standard deduction on tax, but does not include the effect of the change in filing status on credits. Those effects are included in the tax gap associated with credits.

Finally there is a separate estimate for the additional underreported tax attributable to the interaction of multiple reporting errors on the same return and the progressive marginal tax rate structure. The process for estimating the tax effect of each source of income misreporting calculates the tax effect of misreporting for that item only. The sum of these separate estimates will understate the tax effect of the total misreporting if the combined misreporting results in a higher marginal tax rate than when the misreported items are considered one at a time.

Self-Employment Tax Underreporting Tax Gap

Self-employment taxes are required to be reported by individuals with self-employment income on individual income tax returns. The underreporting of self-employment income, primarily income reported on Schedules C and F, results in underreported self-employment taxes. Each spouse on a joint return has a separate earned income threshold above which the combined wages and self-employment income are subject to Medicare taxes, but not social security taxes. Undetected self-employment income (Schedules C and F) was allocated to the primary taxpayer and secondary taxpayer according to each taxpayer's respective share of self-employment income as determined by the NRP examiner. Undetected wages, salaries, and tips were allocated similarly. The tax calculator then calculated the amount of self-employment taxes that should have been reported.

Estimates for Tax Years 2008–2010

The estimates in Table 6 provide a breakout of the components of the individual income tax underreporting tax gap. The income components are grouped by "visibility" category. For each component, the table shows the component's share of the individual income tax underreporting tax gap. The table also shows each component's share of the gross tax gap. Business income reported on Schedules C, E, and F accounts for 47 percent of the total individual income tax underreporting tax gap for TYs 2008—2010. This consists of nonfarm proprietor income which accounts for 29 percent, flow-through income (partnerships, S corporations, and estates and trusts) which accounts for 8 percent, rent and royalty income which accounts for 8 percent, and farm income which accounts for 2 percent. Credits account for the second largest share (15 percent) of the individual income tax underreporting tax gap. EITC accounts for 10 percent of the individual income tax underreporting tax gap, followed by the refundable and nonrefundable child tax credit (3 percent), and the refundable and nonrefundable education credits (2 percent).

Corporation Income Tax Underreporting Tax Gap

The corporation income tax underreporting tax gap estimates are developed separately for small corporations (those without a balance sheet or with assets less than $10 million) and all other corporations. The estimates are based on data from operational audits instead of a statistically representative sample of NRP selected audits. The limited scope and selection criteria for non-NRP audits introduce statistical bias, meaning that the corporation audit issues and results are not necessarily representative of the overall corporation population. Proposed adjustments on these examined returns are used as the basis for estimating the noncompliance for the entire population of corporation income tax filers. The IRS has developed methods to project the results of these audits to the population. However there is considerable uncertainty surrounding the estimates of this component of the tax gap because of data limitations, lack of information from which to develop a reasonable method to adjust for undetected noncompliance, and other issues. Because of this uncertainty, unlike the individual income tax underreporting tax gap component, the corporation income tax underreporting tax gap component estimate

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does not reflect any adjustments for income undetected on the examinations upon which the estimates are based. Using non-NRP data potentially biases the estimates upwards while not adjusting for undetected income biases the estimates downwards. Despite these limitations, the corporate estimates provide a rough gauge of corporation income tax noncompliance.

Small Corporation Income Tax Underreporting Tax Gap[12]

Since operational audits are selected for examination based on their expected compliance risk, the examination results are not broadly applicable to the general population without additional assumptions and modeling. The estimates included here were based on an econometric approach that controls for the bias from using non-representative operational audit data. The econometric model is estimated using the operational audit data and tax return data for TY 2008–2010 to develop underreporting tax gap estimates. The basic approach is to jointly estimate an econometric model consisting of five equations:

(1) the probability of a return being audited;
(2) the probability of detecting underreported tax conditional on an audit;
(3) the amount of underreported tax conditional on detected underreporting;
(4) the probability of detecting overreported tax conditional on an audit and no detected underreporting; and
(5) the amount of overreported tax conditional on an audit and no detected underreporting.

Given that less than one percent of small corporations are audited for any given year and the variation in examination results from year to year, a period estimate is expected to provide more consistent and accurate results than estimating each year separately. Furthermore, TYs 2009–2010 reflect relatively similar economic circumstances with TY 2008—the beginning of the economic recession. Given those reasons, data from TYs 2008–2010 are used to jointly estimate the model for the final estimates. Estimates based on alternative combinations of tax years are provided in a forthcoming technical report. The estimated small corporation income tax underreporting tax gap is $13 billion.

Large Corporation Income Tax Underreporting Tax Gap[13]

Similar to the small corporation income tax underreporting tax gap, the estimates for large corporations rely on operational audit data. The final estimate is based on the same pareto/extreme value method that was used for the TY 2006 large corporation income tax gap estimate.

Pareto/Extreme Value Methodology for Mid-Size and Large Corporations

The methodology adopted for the large corporation income tax underreporting tax gap used the general observation from operational audit results that the majority of audit adjustments is concentrated in a relatively small number of audits (Bloomquist 2008). Axtell (2001) found that the distribution of U.S. firm sizes follows a Pareto distribution. Both Krishnaji (1970) and Revankar (1974) show that underreported income also follows a Pareto distribution if: (a) income follows a Pareto distribution and (b) underreporting is a constant fraction of true income. A study by Axtell (2001) provides support for the two conditions.

[12] Small corporations are defined as corporations reporting less than $10 million in assets, including those with no balance sheet.
[13] Mid-size corporations are defined as corporations reporting at least $10 million in assets, but less than $250 million. Large corporations are defined as corporations reporting at least $250 million in assets. The large corporation income tax underreporting tax gap estimate consists of the income tax underreporting tax gaps of both groups.

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Through the use of the Pareto distribution applied to audit adjustment data, extreme values of noncompliance among large corporations can be used to estimate the noncompliance of the rest of the population. Operational audit data for large corporations for TYs 1999—2005 were used to identify the audits with extreme values in terms of the proposed audit adjustments to tax. The first step was to rank the audit results in descending order and identify the operational audits for corporations with assets over $250 million that account for all the net proposed audit adjustments. The proposed audit adjustments for all the other examined returns, which include both positive and negative amounts, offset each other. The parameters of a linear relationship between the log (base 10) of the audit recommendation and the log of the rank of the return (in descending order so that the largest recommendation received a rank of one) were then estimated. This linear relationship was then used to estimate the total tax gap and voluntary reporting rate (VRR)[14] for the large firms for TYs 1999—2005. The average VRR was then applied to the reported tax liability of all mid-size and large corporations (returns with reported assets over $10 million) arriving at an underreporting tax gap estimate of $28 billion.

Employment Tax Underreporting Tax Gap

The self-employment tax component of the employment tax underreporting tax gap estimate is based on underreported income data from the TY 2008–2010 NRP individual income tax reporting compliance studies, adjusted for undetected noncompliance. The tax effect was estimated by the tax calculator as described earlier in the report in the Tax Calculator section. Due to the absence of NRP data for other components of employment tax, the estimates for both FICA and FUTA are projections based on applying the estimated compliance rates from the 1993 employment tax gap report to current reported taxes.

Estate Tax Underreporting Tax Gap

The estate tax underreporting tax gap estimate is a projection from the methodology used to estimate the prior TY 2006 estate tax underreporting tax gap. The TY 2006 estimate reflected the application of a prior methodology to new data adjusted for changes to the estate tax law[15]. Operational audit data were combined with a random sample of tax returns filed timely in Calendar Year 2004 in order to predict underreported tax on unaudited returns using an econometric model. The Processing Year 2004 estimate was converted to a TY 2004 estimate, based on a 2004 death year, by applying two adjustment factors: one for estates with a reported total gross estate valued less than $5 million, and one for estates with a reported total gross estate valued greater than $5 million. The estate tax underreporting tax gap estimate is estimated to be $1.0 billion and was projected based on the assumption of a constant compliance rate.

Underpayment Tax Gap

The gross underpayment tax gap is the amount of liability that is reported on timely filed returns, but is not paid on time. Underpayment tax gap estimates by type of tax are developed through a tabulation of IRS administrative data for a tax year that sums the amount of liability timely reported, but not timely paid. These tabulations are developed for individual income tax returns, corporation income tax returns, employment tax returns, excise tax returns, and estate and gift tax returns.

[14] The VRR is defined as the aggregate amount of tax reported on the returns, expressed as a percentage of the estimated total amount of tax that should have been reported (in this case, as determined by the auditors and projected to the rest of the population). The VRR differs from the VCR in that the VRR is an estimate of only the underreporting tax gap component. The VCR includes the nonfiling and underpayment tax gaps in the calculation.

[15] Erard, Brian. 1999. "Estate Tax Underreporting Gap Study: A Report Prepared for the Internal Revenue Service Economic Analysis and Modeling Group." Order number TIRNO-98-P-00406. Internal Revenue Service.

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Employers withhold and deposit individual income tax withheld from the pay of employees. The tax withheld and deposited is reported and reconciled on the employer's employment tax returns. For purposes of tax gap estimation an employer's failure to deposit or otherwise make timely payments of withheld income tax is included in the individual income tax gap and not the employment tax gap since the ultimate liability in this case is the employees' individual income tax liability.

The estimation methodology therefore includes two adjustments to the tabulations of administrative data. The first transfers tabulated amounts from employment tax to individual income tax. The amount of individual income tax withholding that an employer reports on time but did not deposit on time is tabulated as part of the analysis of the employment tax returns, but is included instead with the individual income tax underpayment tax gap.

The second accounts for situations in which an employer withholds income tax from employees, but does not report it on time (or pay it on time); that amount will not be included in the tabulations since they are based solely on timely filed employment tax returns. The reason why these amounts should be included in the underpayment tax gap is that they are ultimately payments of individual income tax, and we assume that the individual employee reported the tax liability and withholding on time, even though the employer did not report and did not pay it on time on the taxpayer's behalf.

This second adjustment is estimated as the amount associated with late employment tax returns filed by the date of the tabulation. If the amount associated with late returns filed after the tabulations were small, then these special tabulations presumably capture almost all the amount that could eventually be observed in tax records. Nonetheless, an unknown amount is presumably withheld from employees and never paid to the government by their employers; that is not estimated, even though it is by definition part of the individual income tax underpayment tax gap.

Finally, the self-employment tax underpayment tax gap is included with individual income tax underpayment gap in the underpayment tax gap tabulations since they are both reported on Form 1040. The self-employment tax portion was estimated from the total by assuming that the income and self-employment underpayment tax gaps are proportional to total individual income tax and self-employment tax liabilities.

Enforced and Other Late Payments

Some of the gross tax gap is collected through IRS enforcement efforts and some is paid late, i.e., after the payment due date without IRS intervention; for example, remitted when filing a return just before an extended filing deadline[16] or when filing an amended return. The general approach to estimating enforced and other late payments for a particular tax year is to track actual payments over time and then project these so that they include future payments that will eventually be made for that tax year. The details of the projection methods are described in detail in the forthcoming technical report.

Since the TY 2006 estimates were developed, new programs that tabulate enforced and late payments from IRS administrative data have been implemented. These tabulations distinguish payments made after the due date from those paid on time. The new tabulations show that previous assumptions about non-enforced late payments were somewhat too optimistic resulting in an estimate that was on the order of 25 percent higher than the current estimate. These new tabulations are used for all except the corporation income tax.

[16] The payment due date is generally the original due date of the return; extending the filing deadline does not extend the payment deadline.

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The corporation income tax estimates of enforced and other late payments are taken entirely from the tabulations of Total Enforcement Revenue Collected (TERC) from the Enforcement Revenue Information System. This is primarily because corporations often make timely estimated tax payments or realize other credits that are eventually applied to enforcement assessments related to a tax year that begins after the payment was made or the credit was realized. These payments cannot be identified in the standard tabulations of late payments used for the other types of tax because they are actually paid before the original due date; so they are enforced payments paid "on time." Using TERC assumes that corporations do not make any non-enforced late payments, which would not be captured by TERC.

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Texas, et al. v.

United States of America, et al.

USDC Northern District of Texas

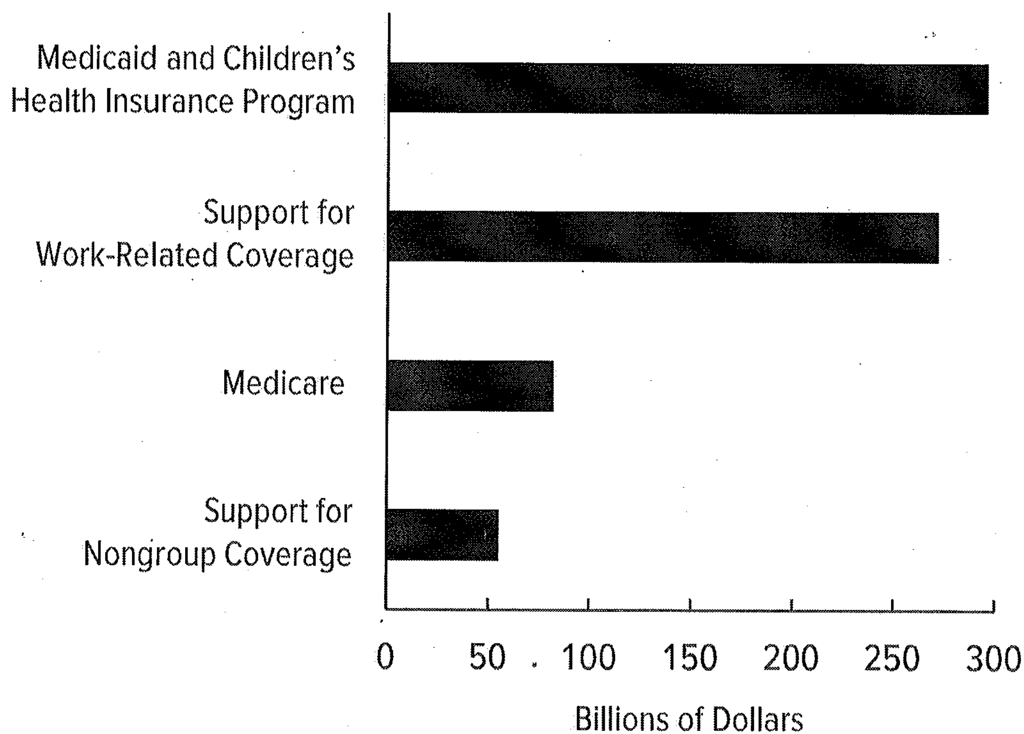
Case No. 4:18-cv-00167-O

Exhibit J

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

CBO

Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028



MAY 2018

At a Glance

The federal government subsidizes health insurance for most Americans through a variety of programs and tax provisions. This report updates CBO's baseline, providing estimates for the 2018–2028 period of the number of noninstitutionalized people under age 65 with health insurance and the federal costs associated with each kind of subsidy.

- In an average month in 2018, about 244 million of those people will have health insurance, and about 29 million will not. By 2028, about 243 million are projected to have health insurance and 35 million to lack it.
- Net federal subsidies for insured people in 2018 will total $685 billion. That amount is projected to reach $1.2 trillion in 2028. Medicaid and the Children's Health Insurance Program account for about 40 percent of that total, as do subsidies in the form of tax benefits for work-related insurance. Medicare accounts for about 10 percent, as do subsidies for coverage obtained through the marketplaces established by the Affordable Care Act or through the Basic Health Program.
- The market for nongroup health insurance (that is, insurance bought individually rather than through an employer) is expected to be stable in most areas of the country over the decade. Premiums for benchmark plans, which are the basis for determining subsidies in that market, are projected to increase by about 15 percent from 2018 to 2019 and by about 7 percent per year between 2019 and 2028.
- Since CBO's most recent report comparable to this one was published in September 2017, the projection of the number of people with subsidized coverage through the marketplaces in 2027 has fallen by 3 million, and the projection of the number of uninsured people in that year has risen by 5 million. Projected net federal subsidies for health insurance from 2018 to 2027 have fallen by 5 percent.

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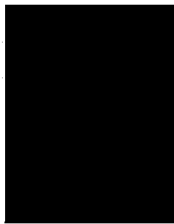

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Notes

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

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

Unless the report indicates otherwise, all years referred to in describing estimates of spending and revenues are federal fiscal years, which run from October 1 to September 30 and are designated by the calendar year in which they end.

Estimates of health insurance coverage reflect average monthly enrollment during a calendar year and include spouses and dependents covered under family policies. Those estimates are for the noninstitutionalized civilian population under age 65.

Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028

Summary

The federal government subsidizes health insurance for most Americans through a variety of programs and tax provisions. In 2018, net subsidies for noninstitutionalized people under age 65 will total $685 billion, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimate. That amount includes the cost of preferential tax treatment for work-related insurance coverage, the cost of Medicaid and Medicare coverage for people under age 65, and government payments for other kinds of health insurance coverage—such as plans purchased through the marketplaces established under the Affordable Care Act (ACA).

This report describes the basis for CBO's baseline projections of the federal costs for those subsidies under current law for the 2018–2028 period. Those projections of costs are built upon estimates of the number of people with health insurance of various kinds. During the coming year, CBO and JCT will use the projections presented here as the benchmark for assessing proposed legislation's effects on the subsidies.

How Many People Under Age 65 Are Projected to Have Health Insurance?

According to CBO and JCT's estimates, a monthly average of about 244 million noninstitutionalized civilians under age 65 will have health insurance in 2018. About two-thirds of the insured population under 65 will have coverage through an employer, and roughly a quarter will be enrolled in Medicaid or the Children's Health Insurance Program (CHIP). A smaller number will have nongroup coverage, coverage provided by Medicare, or coverage obtained from various other sources. For example, about 4 percent, or 9 million people, are projected to obtain coverage through the marketplaces.

On average throughout the year, about 29 million people—11 percent of all noninstitutionalized civilians younger than 65—will be uninsured in 2018, CBO and JCT estimate (see Figure 1).[1] Between 2018 and 2019, in the agencies' projections, the number of uninsured people rises by 3 million, mainly because the penalty associated with the individual mandate will be eliminated and premiums in the nongroup market will be higher.[2] The elimination of the penalty was enacted as part of Public Law 115-97 (originally called the Tax Cuts and Jobs Act and referred to as the 2017 tax act in this report).

From 2019 through 2028, the number of people with insurance coverage is projected to rise, from 241 million to 243 million, under current law. The number of uninsured people is also projected to grow, from 32 million to 35 million, increasing the share of the under-65 population without insurance to 13 percent.

How Large Are the Projected Federal Subsidies, Taxes, and Penalties Associated With Health Insurance?

The estimated $685 billion in net federal subsidies in 2018 for health insurance coverage for people under age 65 (reflecting the combined effects of subsidies and taxes and penalties) would equal 3.4 percent of gross domestic product (GDP) (see Figure 2). That amount is projected to rise at an average annual rate of about 6 percent between 2018 and 2028, reaching $1.2 trillion, or 3.9 percent of GDP, in 2028. The estimates of subsidies are intended to be in the middle of the distribution of potential outcomes but are uncertain.

For the 2019–2028 period, projected net subsidies amount to $9.3 trillion. Two types of costs account for most of that total:

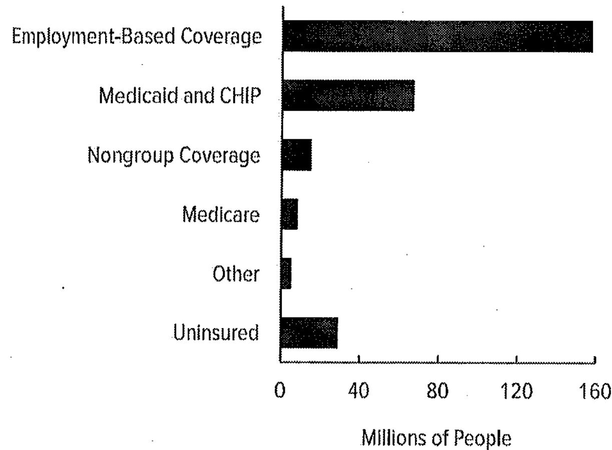
---

1. See Congressional Budget Office, *How CBO Defines and Estimates Health Insurance Coverage for People Under Age 65* (May 2018), www.cbo.gov/publication/53822.

2. The individual mandate is a provision of law that requires most U.S. citizens and noncitizens who lawfully reside in the country to have health insurance meeting specified standards and that imposes penalties on those without an exemption who do not comply.

Figure 1.

Health Insurance Coverage in 2018 for People Under Age 65



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

CHIP = Children's Health Insurance Program.

- Federal spending for people under age 65 with full Medicaid and CHIP benefits (excluding people who reside in a nursing home or another institution) is projected to amount to $4.0 trillion. That amount includes $842 billion for people made eligible for Medicaid by the ACA and $143 billion for CHIP enrollees.

- Federal subsidies for work-related coverage for people under age 65, which stem mainly from the exclusion of most premiums for such coverage from income and payroll taxes, are projected to amount to $3.7 trillion.

Other subsidy costs are smaller:

- Medicare benefits for noninstitutionalized beneficiaries under age 65 (net of their payments for premiums and other offsetting receipts) are projected to amount to $1.0 trillion. Such spending is primarily for people who are disabled.

- Subsidies for coverage obtained through the marketplaces or through the Basic Health Program are estimated to total about $0.8 trillion.

In the agencies' projections, the total cost of federal subsidies is offset to a small extent, $0.3 trillion, by taxes and penalties collected from health insurance providers, employers, and uninsured people.

How Stable Is the Nongroup Health Insurance Market Projected to Be?

The nongroup health insurance market is stable in most areas of the country over the next decade in CBO and JCT's projections—but that stability may be fragile in some places. In 2018, insurers are offering coverage in all areas, but about one-quarter of enrollees have access to only one insurer's plans. Stability would be threatened if more insurers exited markets with limited participation than entered them.

Although premiums have been increasing, most subsidized enrollees buying health insurance through the marketplaces are insulated from those increases. Out-of-pocket payments for premiums are based on a percentage of subsidized enrollees' income; the federal government pays the difference between that percentage and the premium for the benchmark plan used as the basis for determining subsidies. Those subsidies are anticipated to result in demand for insurance by enough people, including people with low health care expenditures, for the number of insurers in the marketplaces to be stable in most areas.

How Rapidly Are Premiums in the Nongroup Health Insurance Market Projected to Grow?

In 2018, the average premium for a benchmark plan—the gross amount not including any premium tax credits—is about 34 percent higher than it was in 2017. By CBO and JCT's estimates, in addition to rising health care costs per person, the increase was caused by three primary factors: First, insurers are no longer reimbursed for the costs of cost-sharing reductions (CSRs) through a direct payment; second, a larger percentage of the population lives in areas with only one insurer in the marketplace; and third, some insurers expected less enforcement of the individual mandate in 2018 (which would probably induce some healthier enrollees to leave the market).

CBO and JCT expect premiums for benchmark plans to increase by about 15 percent from 2018 to 2019, an increase that exceeds projected growth in overall spending for private health insurance. (That outcome includes the expected increase in nongroup premiums resulting from healthier people being less likely to obtain insurance after the elimination of the penalty related to the individual mandate.) The agencies expect premiums

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for benchmark plans to increase by an average of about 7 percent per year between 2019 and 2028.

Many people who enroll in coverage through the marketplaces receive federal subsidies in the form of premium tax credits, and the premiums they pay net of those tax credits are often substantially lower than the gross premiums. The net premiums those people face are projected to decline or to grow more slowly than the premiums in the nongroup market for people with higher income who are ineligible for subsidies.

How Do These Projections Compare With Previous Ones?

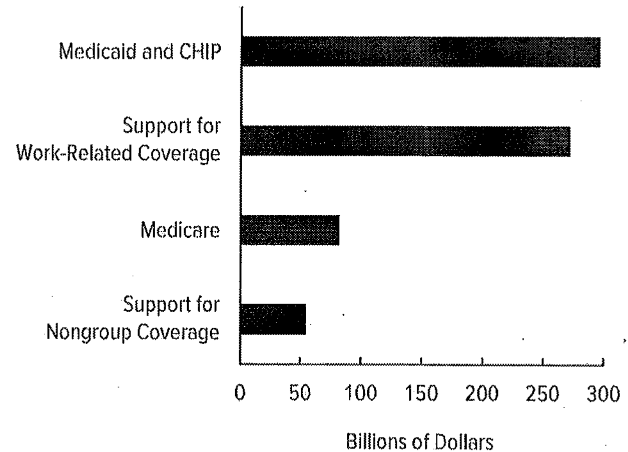
These projections update the preliminary projections of subsidies for insurance purchased through the marketplaces established under the ACA as well as revenues related to health insurance coverage for people under age 65 that were published in *The Budget and Economic Outlook* last month.[3] Compared with those preliminary estimates, federal spending for subsidizing health insurance marketplaces is now projected to be $4 billion lower in 2018 and $6 billion lower over the 2019–2028 period, and federal revenues associated with marketplace subsidies, work-related coverage, the excise tax on high-premium insurance plans, and penalties imposed on employers and uninsured people are projected to be $1 billion higher in 2018 and $24 billion higher over the 2019–2028 period, on net.

CBO's most recent report comparable to this one was published in September 2017.[4] For 2027 (the last year covered by that report and this one), CBO and JCT's projection of the number of people obtaining subsidized coverage through the marketplaces is now 3 million lower, and the projection of the number of uninsured people is now 5 million larger, than they were in that earlier report. The projection of net federal subsidies for health insurance from 2018 to 2027 is $481 billion (or 5 percent) lower. The largest contributors to that decrease are a $389 billion decline in projected subsidies for work-related coverage and a $202 billion decline in projected spending for Medicaid and CHIP.

Figure 2.

Health Insurance Subsidies in 2018 for People Under Age 65

Net federal subsidies for the year total $685 billion.



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

CHIP = Children's Health Insurance Program.

Projected Health Insurance Coverage

CBO broadly defines private health insurance coverage as a policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals. Such coverage is often referred to as comprehensive major medical coverage.

CBO and JCT project that, on average during 2018, 89 percent of the noninstitutionalized civilian population under age 65 will have health insurance, mostly from employment-based plans and Medicaid. Other major sources of coverage include CHIP, nongroup policies, and Medicare. Over the 2019–2028 period, a slightly smaller percentage of that population is projected to be insured. CBO and JCT's projections of insurance coverage are inherently uncertain and represent the agencies' central estimates.

Employment-Based Coverage

The most common source of health insurance for the noninstitutionalized civilian population under age 65 is a current or former employer—either one's own or a family member's. CBO and JCT estimate that in 2018, a monthly average of about 158 million people (or about

3. See Congressional Budget Office, *The Budget and Economic Outlook: 2018 to 2028* (April 2018), www.cbo.gov/publication/53651. The updated projections are incorporated in the adjustments to CBO's baseline budget projections that will be released later this week as part of the agency's analysis of the President's budget. See Congressional Budget Office, *An Analysis of the President's 2018 Budget* (forthcoming).

4. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027* (September 2017), www.cbo.gov/publication/53091.

Table 1.

Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Total Population Under Age 65	273	273	274	275	275	276	276	276	277	277	278
Employment-Based Coverage	158	159	159	157	156	155	154	154	154	154	154
Medicaid and CHIP[a]											
Made eligible for Medicaid by the ACA	12	12	12	12	13	13	13	14	14	14	14
Otherwise eligible for Medicaid	49	48	48	49	49	49	50	50	50	50	50
CHIP	6	6	6	6	6	6	6	6	6	6	6
Subtotal	67	66	66	67	68	69	69	70	70	70	70
Nongroup Coverage and the Basic Health Program											
Nongroup coverage purchased through marketplaces[b]											
Subsidized	8	7	7	7	7	7	7	7	6	6	6
Unsubsidized	2	2	2	2	2	2	2	2	2	2	2
Subtotal	9	9	9	9	9	9	9	9	9	8	8
Nongroup coverage purchased outside marketplaces	5	4	4	4	4	4	4	4	4	4	4
Total, nongroup coverage	15	12	12	12	13	13	13	13	12	12	12
Coverage through the Basic Health Program[c]	1	1	1	1	1	1	1	1	1	1	1
Medicare[d]	8	8	8	8	8	8	8	8	9	9	9
Other Coverage[e]	5	5	5	5	5	5	5	5	6	6	6
Uninsured[f]	29	32	34	35	35	35	35	35	35	35	35
Memorandum:											
Number of Insured People	244	241	241	240	240	241	241	241	242	242	243
Insured as a Percentage of the Population											
Including all U.S. residents	89	88	88	87	87	87	87	87	87	87	87
Excluding unauthorized immigrants	91	90	90	89	89	89	89	89	89	90	90

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

Estimates include noninstitutionalized civilian residents of the 50 states and the District of Columbia who are younger than 65. The components do not sum to the total population because some people report multiple sources of coverage. CBO and JCT estimate that in most years, 10 million people (or 4 percent of insured people) have multiple sources of coverage, such as employment-based coverage and Medicaid.

Estimates reflect average monthly enrollment over the course of a year and include spouses and dependents covered under family policies.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation.

a. Includes noninstitutionalized enrollees with full Medicaid benefits. Estimates are adjusted to account for people enrolled in more than one state.

b. Under the ACA, many people can purchase subsidized health insurance coverage through marketplaces, which are operated by the federal government, state governments, or partnerships between the federal and state governments.

c. The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.

d. Includes noninstitutionalized Medicare enrollees under age 65. Most Medicare-eligible people under age 65 qualify for Medicare because they participate in the Social Security Disability Insurance program.

e. Includes people with other kinds of insurance, such as student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.

f. Includes unauthorized immigrants, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid who do not enroll; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

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58 percent of the population under age 65) will have employment-based coverage (see Table 1 on page 4). That number is projected to decline to 154 million, or about 55 percent of the population under age 65, in 2028.

Roughly half of the projected reduction in employment-based coverage over the next decade is attributable to the elimination of the penalty associated with the individual mandate, which CBO and JCT estimate will lead to 2 million fewer people enrolling in employment-based coverage in most years after 2018. In addition, the agencies estimate that health insurance premiums that are rising faster than wages will exert downward pressure on enrollment in employment-based coverage. However, an increase in employment over the next two years resulting from changes in the government's fiscal policy is estimated to mitigate the negative effect of the growth in premiums in the near term.

Medicaid and CHIP

The next-largest source of coverage among people under age 65 is Medicaid. In 2018, CBO estimates, a monthly average of 61 million noninstitutionalized people will receive full Medicaid benefits.[5] By 2028, that number is projected to grow to 64 million people (14 million made eligible through the ACA's expansion of Medicaid coverage at states' option, and 50 million eligible otherwise). CBO estimates that 6 million people, mostly children but also some pregnant women, will be enrolled in CHIP in 2018, on average. Together, Medicaid and CHIP are projected to provide insurance coverage for one-quarter of the population under age 65 in 2028.

CBO's estimates of Medicaid enrollment over the next decade reflect the agency's expectation that, if current federal laws remained in place, additional states would expand eligibility for the program and that more people would enroll in the program in states that have already done so. Most of the increase in enrollment during that period would stem from additional states expanding eligibility for the program, CBO estimates. Under the ACA, states are permitted to expand eligibility for Medicaid to adults under age 65 whose income is no more than 138 percent of the federal poverty guidelines (also known as the federal poverty level, or FPL). The federal government pays a larger share of the costs for those people than it pays for those who are eligible otherwise. Currently, about 55 percent of people who meet the eligibility criteria established under the ACA live in states that expanded Medicaid. CBO anticipates that share would increase annually at a rate based on the historical pace of expansion since 2014. By 2028, about two-thirds of the people who meet the new eligibility criteria are projected to be in states that have expanded Medicaid coverage.

Nongroup Coverage and the Basic Health Program

Nongroup insurance covers a much smaller share of the population under age 65 than employment-based policies and Medicaid do. In 2018, a monthly average of about 15 million people under age 65 are expected to have such coverage, 9 million of whom will have purchased it through the marketplaces established under the ACA.[6] That number is a decline from 2017, when an estimated monthly average of 10 million people purchased nongroup coverage through the marketplaces. (Nongroup policies can be purchased either through the marketplaces—with or without government subsidies—or elsewhere.) An additional 1 million people are estimated to be participating in the Basic Health Program, which allows states to offer subsidized health coverage to certain low-income people outside the marketplaces.

Nongroup Coverage. Between 2018 and 2019, the number of people enrolled in health insurance through the nongroup market is projected to fall by 3 million, mainly because the penalty associated with the individual mandate will be eliminated and premiums faced by people who are ineligible for subsidies in the nongroup market will be higher. Enrollment in the nongroup market is then projected to remain between 12 million and 13 million in each year between 2019 and 2028. The

5. Some enrollees receive only partial benefits from Medicaid. They include Medicare enrollees who receive only assistance from Medicaid with out-of-pocket payments and premiums for Medicare, people who receive only family planning services, and unauthorized immigrants who receive only emergency services. Spending for enrollees who receive partial benefits is excluded from the estimates.

6. A total of 12 million people selected plans through the marketplaces by the close of the open-enrollment period established by the ACA. However, CBO and JCT estimate that the average monthly enrollment during the year will be lower than the total number of people who will have coverage at some point during the year because some people are covered for only part of the year: Those who experience a qualifying life event (such as a change in income or family size or the loss of employment-based insurance) are allowed to purchase coverage later in the year, and some people stop paying the premiums or leave their marketplace-based coverage as they become eligible for insurance through other sources.

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agencies estimate that between 6 million and 7 million of those people will receive subsidies.

The stability in estimated enrollment over the 2019–2028 period is the net result of offsetting effects. On the one hand, CBO and JCT expect the following factors to put downward pressure on enrollment between 2019 and 2028:

- Some additional people will forgo health insurance in years after 2019 as the reaction to the elimination of the individual mandate penalty reaches its full effect; and
- More states are expected to expand eligibility for Medicaid, reducing the number of people projected to obtain coverage through the marketplaces, because people who are eligible for Medicaid are not permitted to receive subsidies for marketplace coverage.

On the other hand, the agencies expect the following effects to increase nongroup enrollment between 2019 and 2028:

- More people will purchase subsidized coverage because they will be eligible for larger tax credits that cover a greater share of premiums for certain plans offered through the marketplaces. Those higher tax credits are based on the higher premiums brought about by the fact that insurers are no longer reimbursed for the costs of CSRs through a direct payment (see Box 1).
- More uninsured people will purchase short-term, limited-duration insurance (STLDI) offered in the nongroup market outside the marketplaces, reflecting a probability that a proposed regulation expanding such coverage takes effect (see Box 2 on page 10).

Stability in the Marketplaces. Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on the proportion of people who live in areas with participating insurers and on the likelihood that premiums will not rise in an unsustainable spiral. In the marketplaces, where premiums cannot be based on individual enrollees' health status, the market for insurance would be unstable if, for example, the people who wanted to buy coverage at any offered price would have average health care expenditures so high that offering the insurance would be unprofitable for insurers.

In CBO and JCT's projections, the marketplaces are stable in most areas in large part because most enrollees purchasing subsidized health insurance there are insulated from increases in premiums. The subsidies—combined with the rules requiring insurers to offer coverage for preexisting medical conditions, the relative ease of comparison shopping in the marketplaces, and the effects of other requirements—are anticipated to produce sufficient demand for nongroup insurance, including among people with low health care expenditures, to attract at least one insurer almost everywhere.

Moreover, data about insurers' profitability in 2017 provide some indication that the market is stable in most areas of the country.[7] Insurers' profitability, as measured by the share of premiums that goes toward their administrative costs and profits rather than paying for claims, increased in 2017, moving close to pre-ACA levels. That evidence suggests that the premium increases in 2017 were sufficient to account for the underlying health risk of the nongroup population.

Nevertheless, about 26 percent of the population lives in counties with only one insurer in the marketplace in 2018, up from 19 percent in 2017.[8] Several factors may have led insurers to withdraw from those markets, including low enrollment (both in the marketplaces and outside them) in part because of increases in premiums paid by people without subsidies; uncertainty about the enforcement of the individual mandate; and uncertainty about the federal policies affecting the nongroup market, including how preliminary regulations that would allow a wider range of insurance products to be sold might affect the nongroup market if they are finalized. Additional withdrawals are possible in 2019—in response to lower anticipated enrollment stemming from repeal of the penalty related to the individual mandate. Still, with steady demand for insurance in the marketplaces, CBO and JCT expect the number of insurers in

7. See Cynthia Cox, Ashley Semanskee, and Larry Levitt, *Individual Insurance Market Performance in 2017* (Kaiser Family Foundation, May 2018), http://tinyurl.com/yd3z5tm9.

8. Calculations based on data from Ashley Semanskee and others, *Insurer Participation on ACA Marketplaces, 2014–2018* (Kaiser Family Foundation, November 10, 2017), https://tinyurl.com/y75j4mn7.

the marketplaces to stabilize thereafter in most areas of the country.

Substantial uncertainty continues to exist about federal policies affecting the nongroup market and about the effects of eliminating the penalty related to the individual mandate. That uncertainty may affect insurers' decisions to participate in the nongroup market in future years, and such withdrawals could threaten market stability in some areas of the country.

Gross Premiums for Benchmark Plans in the Marketplaces. Premiums for benchmark silver plans in the marketplaces—which are key drivers of subsidy amounts—increased by an average of 34 percent from 2017 to 2018. That increase occurred for three main reasons:

- *CSRs.* CBO and JCT estimate that gross premiums for silver plans offered through the marketplaces are, on average, 10 percent higher in 2018 than they would have been without the announcement in October 2017 that the Administration would no longer reimburse insurers for the cost of CSRs through a direct payment without an appropriation for that purpose. Because insurers are required to provide lower cost-sharing for enrollees in silver plans purchased through the marketplaces even in the absence of a federal payment, most insurers increased gross premiums for those plans to cover the costs of CSRs. CBO and JCT estimate that the effects of the lack of a direct payment for CSRs will continue to phase in over the next few years, putting upward pressure on premiums for silver plans offered through the marketplaces.

- *Limited Competition.* The increase in the percentage of the population that lives in a county with only one insurer in the marketplace between 2017 and 2018 probably contributed to the growth in national average benchmark premiums in 2018, because areas where only one insurer offers coverage through the marketplace tend to have higher benchmark premiums than areas where multiple insurers compete against one another to offer coverage.

- *Uncertainty.* CBO and JCT also estimate that some of the increase in benchmark premiums from 2017 to 2018 was related to insurers' uncertainty about whether the individual mandate would be enforced. Such a reduction in enforcement would probably cause some healthier enrollees to leave the market.

The agencies expect insurers to raise premiums for benchmark plans offered through the marketplaces in 2019 by an average of roughly 15 percent over the premiums charged in 2018. Part of that increase is projected to occur because plans are expected to have a less healthy mix of enrollees after the penalty related to the individual mandate is no longer levied beginning on January 1, 2019. In total, CBO and JCT expect, premiums for nongroup health insurance will be about 10 percent higher in 2019 than they would have been if the individual mandate penalty remained in place and was enforced. The lack of a direct payment for CSRs and the rising costs of health care per person are also anticipated to contribute to the overall increase.

After a few years, average premiums for benchmark plans will rise largely with growth in health care spending per person, CBO and JCT expect.[9] As a result, average benchmark premiums in the marketplaces are projected to increase by an average of close to 10 percent per year over the 2019–2023 period and then by an average of roughly 5 percent per year over the 2024–2028 period, after the effects of the elimination of the individual mandate penalty and of the lack of a direct payment for CSRs are expected to be fully phased in. Overall, between 2018 and 2028, the average benchmark premium is projected to grow by an average of about 7 percent per year. Those growth rates are about 2 percentage points lower in real terms (after the effects of inflation are removed).

Gross Premiums by Tier and Age. In addition to the key role that gross premiums for benchmark silver plans play in determining subsidies, gross premiums for all tiers of plans—including bronze and gold, for example—reflect the amounts paid by people without subsidies. Gross premiums, which differ by age, geographic area, and smoking status, affect the number of people with different types of health insurance coverage.

Although premiums for benchmark silver plans increased by an average of 34 percent from 2017 to 2018, the premiums for the lowest-cost bronze and gold plans increased by 17 percent and 18 percent, respectively. Insurers' increasing silver plan premiums to cover the cost of CSRs contributed to that difference. Most

9. For discussion of how CBO and JCT project premiums, see Congressional Budget Office, *Private Health Insurance Premiums and Federal Policy* (February 2016), pp. 9–11, www.cbo.gov/publication/51130.

Box 1.

Cost-Sharing Reductions in the Congressional Budget Office's Spring 2018 Baseline

Background

The Affordable Care Act (ACA), in section 1402, requires insurers who participate in the marketplaces established under that act to offer cost-sharing reductions (CSRs) to eligible people. CSRs reduce deductibles and other out-of-pocket expenses like copayments.

To qualify for CSRs, people must generally purchase a silver plan through a marketplace and have income between 100 percent and 250 percent of the federal poverty guidelines (also known as the federal poverty level, or FPL).[1] The size of the subsidy varies with income. For example, in 2017, by the Congressional Budget Office's estimates, the average deductible for a single policyholder (for medical and drug expenses combined) with a silver plan varied according to income in the following way:

Income as a Percentage of the FPL	Approximate Deductible (Dollars)
Above 250 (Without CSRs)	3,600
Between 200 and 250	2,900
Between 150 and 200	800
Between 100 and 150	300

Before October 12, 2017, the federal government reimbursed insurers for the cost of CSRs through a direct payment. However, on that date, the Administration announced that, without an appropriation for that purpose, it would no longer make such payments to insurers. Because insurers are still required to offer CSRs and to bear their costs even without a direct payment from the government, most have covered those costs by explicitly increasing premiums for silver plans offered through the marketplaces for the 2018 plan year, and CBO expects all insurers to do so beginning in 2019.[2] (For the most part, insurers did not increase premiums for other plans to cover the cost of CSRs because the requirement for CSRs does not generally apply to those plans.)

Budgetary Treatment

CBO and the staff of the Joint Committee on Taxation (JCT) have long viewed the requirement that the federal government compensate insurers for CSRs as a form of entitlement authority. Section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985, which specifies rules for constructing CBO's baseline, requires that the agency assume full funding of entitlement authority.[3] On that basis, CBO included the CSR payments as direct spending (that is, spending that does not require appropriation action) in the agency's June 2017 baseline.

For the spring 2018 baseline, CBO and JCT project that the entitlement for subsidies for CSRs is being funded through higher premiums and larger premium tax credit subsidies instead of a direct payment. The projection reflects the way insurers are currently reimbursed for the cost of providing CSRs to eligible enrollees in light of the Administration's change in policy in October 2017.

1. In most marketplaces, people can choose among plans—such as bronze, silver, and gold—for which the portion of covered medical expenses paid by the insurer differs. The average percentage of covered expenses paid by the insurer is called the actuarial value of the plan. Silver plans differ from other plans because they must provide CSRs to eligible enrollees. For people at most income levels, the actuarial value of a silver plan is 70 percent. People who qualify for CSRs are eligible for silver plans with higher actuarial values: 73 percent for people with income between 200 percent and 250 percent of the FPL; 87 percent for people with income between 150 percent and 200 percent of the FPL; and 94 percent for people with income between 100 percent and 150 percent of the FPL. The actuarial values of bronze and gold plans are 60 percent and 80 percent, respectively.

   Individuals with income generally between 100 percent and 400 percent of the FPL are also eligible for tax credits to help cover a portion of their premiums. The size of those premium tax credits varies with income and premiums.

2. In 2018, in a few states, insurers did not explicitly increase premiums for silver plans in the marketplaces to account for CSRs because state regulators did not allow them to do so. Some insurers nevertheless raised premiums substantially for reasons that were not fully specified; in constructing its baseline, CBO attributed part of such increases to CSRs. Other insurers in those states did not raise premiums by much or at all, but, on the basis of information provided by those insurers, CBO projected that those premiums were sufficient to cover the cost of CSRs. Together, those situations involved fewer than 3 percent of subsidized enrollees in 2018, CBO estimates. For more information, see Sabrina Corlette, Kevin Lucia, and Maanasa Kona, *States Step Up to Protect Consumers in Wake of Cuts to ACA Cost-Sharing Reduction Payments* (The Commonwealth Fund, October 2017), https://tinyurl.com/y728ro2y.

3. 2 U.S.C. §907(b)(1) (2012). Entitlement authority is the authority for federal agencies to incur obligations to make payments to entities that meet the eligibility criteria set in law.

Continued

Box 1. Continued

Cost-Sharing Reductions in the Congressional Budget Office's Spring 2018 Baseline

That approach complies with section 257 of the Deficit Control Act because the CSR entitlement is assumed to be fully funded. CBO adopted that revised baseline treatment of the financing of CSRs after consulting with the House and Senate Budget Committees. On the basis of an analysis of insurers' rate filings, CBO and JCT estimate that gross premiums for silver plans offered through the marketplaces are, on average, about 10 percent higher in 2018 than they would have been if CSRs were funded through a direct payment. The agencies project that the amount will grow to roughly 20 percent by 2021.

Effect on the Baseline

The size of premium tax credits is linked to the premiums for the second-lowest-cost silver plans offered through the marketplaces: Out-of-pocket payments for premiums for enrollees who are eligible for subsidies are based on a percentage of their income, and the government pays the difference through the premium tax credits. As a result, in CBO's projections, higher gross premiums for silver plans increase the amount of tax credits paid by the federal government, thereby covering insurers' costs for CSRs. Higher gross premiums for silver plans do not significantly affect the out-of-pocket payments that subsidized enrollees make for premiums for silver plans offered through the marketplaces because the structure of the premium tax credit largely insulates them from those increases.

For plans besides silver ones, insurers in most states have not increased gross premiums much, if at all, to cover the costs of CSRs. Because the premium tax credits are primarily based on the income of enrollees and not the nature of the plan they choose, enrollees could use those credits to cover a greater share of premiums for plans other than silver ones in those states. For example, more people are able to use their higher premium tax credits to obtain bronze plans, which cover a smaller share of benefits than silver plans, for free or for very low out-of-pocket payments for premiums. Also, some people with income between 200 percent and 400 percent of the FPL can purchase gold plans, which cover a greater share of benefits than do silver plans, with similar or lower premiums after tax credits. As a result of those changes, in most years, between 2 million and 3 million more people are estimated to purchase subsidized plans in the marketplaces than would have if the federal government had directly reimbursed insurers for the costs of CSRs.

Higher gross premiums for silver plans affect premiums for people who are not eligible for premium tax credits (most of whom have income above 400 percent of the FPL). However, many of those enrollees have options for purchasing other plans to avoid paying the premium increases resulting from the October 2017 policy change regarding the government's payments for CSRs. Just as insurers in most states have not appreciably increased premiums for plans other than silver ones to cover the costs of CSRs, insurers in many states have not increased the premiums of silver plans sold outside the marketplaces to cover the costs of CSRs either. Therefore, many people who are not eligible for subsidies are able to select a plan besides a silver one or a silver plan sold outside the marketplaces and avoid paying the premium increases stemming from the lack of a direct appropriation for CSRs.

Future Cost Estimates

In recent cost estimates for legislation that would appropriate funding for the payments to cover the costs of providing CSRs, CBO and JCT estimated that the appropriation would not affect direct spending or revenues because such payments were already incorporated in CBO's baseline projections.[4] After consulting with the budget committees about the baseline and about cost estimates relative to that baseline, CBO will continue that practice.

For legislation that would change the means of funding the CSR entitlement, CBO will estimate that enactment would not affect the federal deficit—because the obligations stemming from the entitlement can be fully satisfied through a direct payment or higher premiums and larger premium tax credit subsidies. However, if legislation was enacted that appropriated funds for direct payments for CSRs, the agency would update its baseline projections to incorporate those appropriations and to lower its projections of premium tax credits and other effects—because insurers would no longer increase gross premiums for silver plans offered through the marketplaces to cover the costs of providing CSRs.

4. See Congressional Budget Office, cost estimate for the Bipartisan Health Care Stabilization Act of 2018 (March 19, 2018), www.cbo.gov/publication/53666, and letter to the Honorable Lamar Alexander on the appropriation of cost-sharing reduction subsidies (March 19, 2018), www.cbo.gov/publication/53664.

Box 2.

Association Health Plans and Short-Term, Limited-Duration Insurance

The baseline presented in this report incorporates estimates from the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) of two recent regulations proposed by the Administration. The first regulation—published on January 5, 2018—would make it easier for business associations and other entities to offer health insurance through what are termed association health plans (AHPs) and multiple employer welfare associations, which are legal arrangements that allow business associations or unrelated employers to jointly offer health insurance and other fringe benefits to their members or employees. The second regulation—published on February 21, 2018—would expand the maximum policy length of short-term, limited-duration insurance (STLDI) plans from 3 months to 364 days. In accordance with CBO's standard practice for incorporating the effects of proposed rules, the baseline incorporates an assumption reflecting a 50 percent chance that the final issued rules will be the same as the proposed ones and a 50 percent chance that no new rules like the proposed ones will be issued.[1] The effects described here represent the agencies' estimates if the rules were implemented as proposed.

Estimated Effects of the Proposed Regulations

The agencies expect that the regulations would affect the small-group and nongroup insurance markets by allowing the sale of insurance products that do not comply with many current insurance regulations governing those markets. For example, insurers could offer plans that do not meet the minimum standards for benefits that insurers in the small-group and nongroup markets must provide, and insurers could also vary premiums on the basis of sex, occupation, and other personal characteristics. Both employers with healthier workforces and individuals who are relatively healthy and have income too high to qualify for premium tax credits for health insurance would find such plans appealing because the premiums would be lower than those for insurance products that comply with the current rules governing the small-group and nongroup markets.

By CBO and JCT's estimates, starting in 2023 (when the effects of both rules are estimated to be fully phased in), roughly 6 million additional people would enroll in either an AHP or STLDI plan as a result of the proposed rules, with about 4 million in AHPs and about 2 million in STLDI plans. (Of the 2 million additional enrollees in STLDI plans, fewer than 500,000 would purchase products not providing comprehensive financial protection against high-cost, low-probability medical events. CBO considers such people uninsured.)[2] The agencies estimate that the rules would decrease the number of uninsured people by roughly 1 million in 2023 and each year thereafter, with the majority of the previously uninsured enrolling in STLDI plans.

In 2023 and later years, about 90 percent of the 4 million people purchasing AHPs and 65 percent of the 2 million purchasing STLDI plans would have been insured in the absence of the proposed rules, CBO and JCT estimate. Because the people newly enrolled in AHPs or STLDI plans are projected to be healthier than those enrolled in small-group or nongroup plans that comply with the current regulations governing those markets, their departures would increase average premiums for those remaining in other small-group and nongroup plans. As a result, premiums are projected to be 2 percent to 3 percent higher in those markets in most years.

1. See Congressional Budget Office, letter to the Honorable John M. Spratt Jr. about how CBO reflects anticipated administrative actions in its baseline projections (May 2, 2007), www.cbo.gov/publication/18615. If final versions of the rules are promulgated, CBO and JCT will account for any changes from the regulations and will include estimates of the full effects of the final rules in subsequent cost estimates and in future baseline projections of health insurance coverage and federal subsidies for it.

2. In developing those estimates, CBO and JCT consulted with numerous policy and legal experts, industry associations, insurers, and state insurance regulators. On the basis of those conversations, the agencies expect that if the proposed STLDI regulation was finalized, a range of new STLDI insurance products would be sold. A small percentage of those plans would resemble current STLDI plans, which do not meet CBO's definition of health insurance coverage. In addition to those plans, insurers would, CBO expects, offer new types of short-term products resembling nongroup insurance products sold before the implementation of the Affordable Care Act. Those new products would probably limit benefits, be priced on the basis of individuals' health status, and impose lifetime and annual spending limits, and insurers could reject applicants on the basis of their health and any preexisting conditions. The majority of those plans would probably meet CBO's definition of private health insurance because they would still provide financial protection against high-cost, low-probability medical events.

Continued

Box 2. Continued

Association Health Plans and Short-Term, Limited-Duration Insurance

CBO and JCT estimate that the proposed rules would reduce the federal deficit by roughly $1 billion over the 2019–2028 period if implemented as proposed (and simultaneously, as assumed). On the basis of information obtained from stakeholders, CBO and JCT project that the rule on AHPs would primarily affect the small-group market and that the rule on STLDI plans would primarily affect the nongroup market. Over the 2019–2028 period, outlays for marketplace subsidies would increase on net by $2 billion, and revenues would increase by $3 billion. The net increase in marketplace subsidies reflects an increase in subsidies stemming from higher premiums, mostly offset by a reduction in the number of people receiving those subsidies.

Comparison With Other Estimates

CBO and JCT's assessment of the effects of the AHP and STLDI rules is in line with other published analyses, although comparing results is difficult because the policy scenarios evaluated are different. One outcome that is straightforward to compare is the effect of the rules on premiums for the small-group and nongroup plans that comply with the current regulations governing those markets. For that measure, CBO's estimate of a 2 percent to 3 percent increase in premiums accords with most other published estimates but is lower than the 6 percent increase estimated by the Chief Actuary for the Centers for Medicare & Medicaid Services (CMS).[3] Similarly, CBO's estimate of 4 million enrollees in AHPs is similar to other estimates.[4]

For the STLDI regulation, different analyses have reported very different measures, but most have reported the number of people leaving nongroup plans that comply with the current regulations governing that market. On that measure, CBO and JCT's estimate is significantly higher than the Administration's estimate contained in the proposed rule but lower than estimates in other published analyses.[5] Specifically, the Administration estimates in the proposed rule that fewer than 0.2 million people will leave the nongroup plans for STLDI plans, and other analyses show a range of 1.1 million to 2.2 million—compared with the agencies' estimate of almost 1 million departures in most years for both AHPs and STLDI plans (most of those for the latter).

3. For an analysis of how both rules would affect premiums for small-group and nongroup plans that comply with the regulations governing those markets, see Covered California, *Individual Markets Nationally Face High Premium Increases in Coming Years Absent Federal or State Action, With Wide Variation Among States* (March 8, 2018), Table 1, https://tinyurl.com/yb5bpc2y. For an analysis of how AHPs would affect premiums for nongroup plans, see Sabrina Corlette, Josh Hammerquist, and Pete Nakahata, "New Rules to Expand Association Health Plans," *The Actuary Magazine* (web exclusive, May 2018), https://tinyurl.com/yavdxagj. For CMS's analysis of the STLDI rule, see Centers for Medicare & Medicaid Services, "Estimated Impact of STLD Proposed Rule (2018)" (April 6, 2018), https://go.usa.gov/xQPpj.

4. For an analysis of expected enrollment in AHPs, see Dan Mendelson, Chris Sloan, and Chad Brooker, "Association Health Plans Projected to Enroll 3.2 Million Individuals," *Avalere* (press release, February 28, 2018), Table 2, https://tinyurl.com/yb6plqdh.

5. For the estimate in the proposed rule, see Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 7437, 7441 (proposed February 21, 2018), https://go.usa.gov/xQPY5. See also Centers for Medicare & Medicaid Services, "Estimated Impact of STLD Proposed Rule (2018)" (April 6, 2018), https://go.usa.gov/xQPpj. For a summary of other assessments, see Christopher Pope, "Evaluating Assessments of Short-Term Insurance Deregulation," *Health Affairs Blog* (blog entry, May 9, 2018) Exhibit 1, https://tinyurl.com/y9xbps6k. One of the assessments cited assumes that the individual mandate remains in place, so comparing its estimates with those of other assessments is difficult. The more comparable assessments are Michael Cohen, Michelle Anderson, and Ross Winkelman, "Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market" (prepared by Wakely Consulting Group for the Association for Community Affiliated Plans, 2018), Table 1, https://tinyurl.com/y7ccesj7; and Linda J. Blumberg, Matthew Buettgens, and Robin Wang, *Updated: The Potential Impact of Short-Term Limited Duration Policies on Insurance Coverage, Premiums, and Federal Spending* (Urban Institute, March 14, 2018), https://tinyurl.com/yc37zx3o.

insurers did not increase premiums for plans in other tiers to cover the cost of CSRs because the requirement to offer CSRs does not generally apply to those plans.

After 2018, growth in gross premiums is projected to be slightly slower for bronze than for silver plans mainly because premiums for silver plans are expected to absorb more of the costs for CSRs during the next few years. Such growth for gold plans is projected to be slower than for silver or bronze plans mainly because the fast growth in premiums for silver plans in the marketplaces is expected to cause some people to choose gold plans instead of silver plans and the health of those people is anticipated to reduce the average costs borne by gold plans. The fast premium growth of silver plans is projected to make those plans increasingly unattractive over time to people not eligible for subsidies. By the end of the coming decade, gross premiums for gold plans are projected to be lower than gross premiums for silver plans, and the gold plans will provide more generous benefits for people not eligible for CSRs.

Increases in gross premiums for a particular tier are the same across age groups in percentage terms, but gross premium amounts themselves differ substantially by age. For people without subsidies, premiums are estimated to be slightly less than three times higher for a 64-year-old than a 21-year-old, on average, after accounting for regulations in different states. For example, CBO and JCT estimate average premiums for a 21-year-old, a 45-year-old, and a 64-year-old who buy the lowest-cost gold plans through the marketplaces to be about $8,800, $12,600, and $25,700, respectively, in 2028 (see Figure 3). Those estimates represent a national average of premiums excluding any premium tax credits, reflecting the geographic distribution of people who have coverage through the marketplaces.

Net Premiums for People Eligible for Subsidies. Because many people who enroll in coverage through the marketplaces receive federal subsidies in the form of premium tax credits, the net premiums that enrollees pay are often substantially lower than the gross premiums discussed above. In 2017, the average gross premium for subsidized enrollees in all states that use the federally facilitated marketplace platform healthcare.gov was about $5,850, but the average net premium paid after subsidies was about $1,250 (see Figure 4). In 2018, gross premiums in those states grew substantially, to an average of about $7,650 for subsidized enrollees. Although people not receiving subsidies paid the gross amount, net premiums for subsidized people fell to an average of about $1,050 because average tax credits increased substantially.[10] Average tax credits increased because the average premium for a benchmark silver plan rose. Those tax credits can be used to buy a plan in any tier. Because the tax credits grew so much more than premiums for bronze and gold plans, enrollees receiving subsidies often saw a significant reduction in their net premiums for those plans from 2017 to 2018.

The net premiums faced by people eligible for subsidies in the nongroup market, whose income is less than 400 percent of the FPL, vary substantially by income as well as by tier and by age. However, the general trends over time for such people can be illustrated by the premiums for people with income at 225 percent of the FPL (see Figure 5).

For silver plans, growth in net premiums for people with that amount of income—and for many other people eligible for subsidies—is estimated to be about 5 percent per year between 2018 and 2028 in nominal terms and 3 percent in real terms. That growth is limited by several factors that apply equally across age groups. For example, net premiums are limited to be no more than a certain percentage of people's income.

For bronze and gold plans, growth in net premiums in CBO's projections is heavily influenced by premium tax credit amounts, which are linked to the second-lowest-cost silver plan in the marketplaces. Because the gross premiums for those silver plans rose so much in 2018, the net premiums for bronze and gold plans for people eligible for tax credits in 2017 fell substantially in percentage terms between 2017 and 2018 for people with income at 225 percent of the FPL and for many other people eligible for subsidies (if the 2017 net premiums were greater than zero). Between 2018 and 2028, the projected nominal growth in those premiums varies significantly by age and tier as well as income. However, after the effects of inflation are removed, net premiums for bronze and gold plans for many people eligible for subsidies are generally projected to decline over that period.

10. CBO's calculations are based on data on plans selected during the open-enrollment period for each year. See Centers for Medicare & Medicaid Services, "2017 Marketplace Open Enrollment Period Public Use Files," https://go.usa.gov/xQ5ba, and "2018 Marketplace Open Enrollment Period Public Use Files," https://go.usa.gov/xQ5bC.

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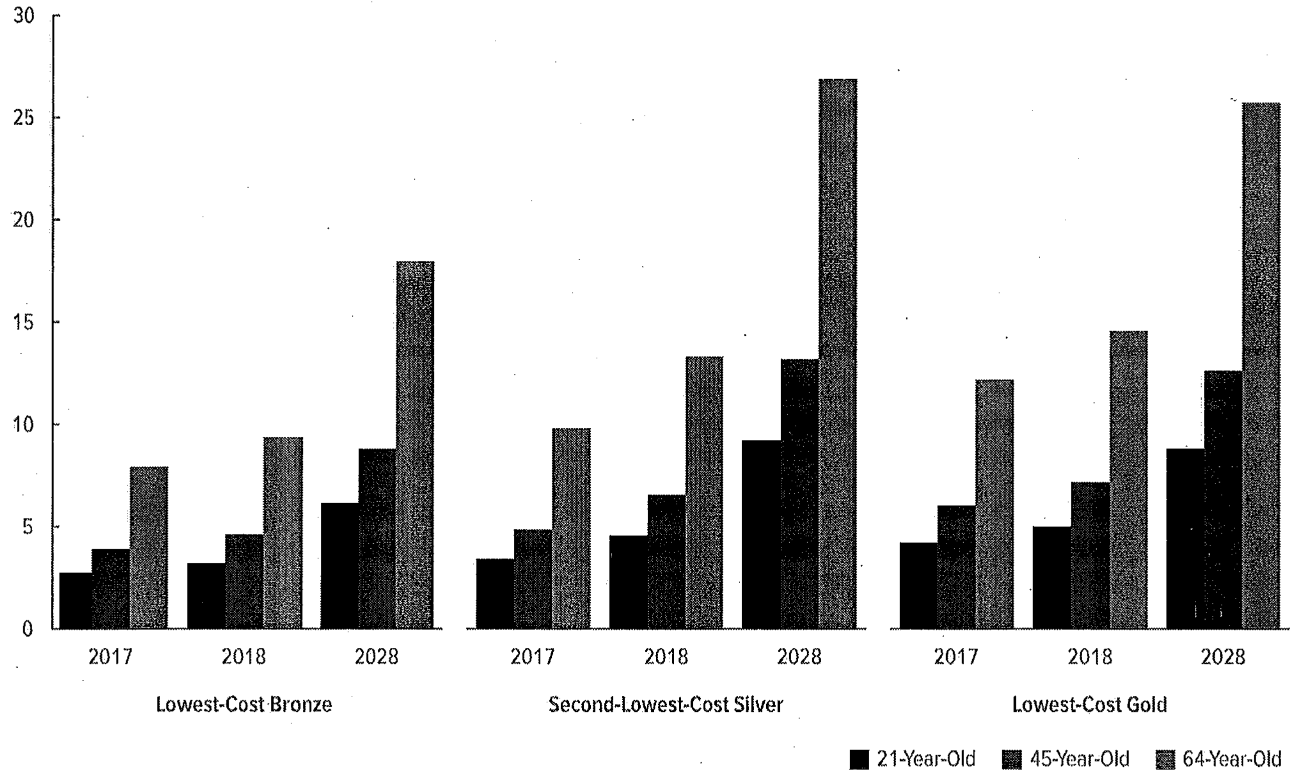
Figure 3.

Illustrative Examples, for Single Individuals, of Gross Premiums for Health Insurance Purchased Through the Marketplaces

Thousands of Dollars



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

Dollar amounts have been rounded to the nearest $50.

CBO and the staff of the Joint Committee on Taxation projected the average national gross premiums for a 21-year-old, a 45-year-old, and a 64-year-old in the nongroup health insurance market, taking into account the different age-rating methodology used in each state. The benchmark premium is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which a person resides. For bronze and gold plans, the premiums displayed in the figure are for the lowest-cost plan available in the marketplace in the area in which a person resides.

The actuarial value of a plan—the percentage of costs for covered services that the plan pays on average—differs by income. Bronze plans and gold plans have actuarial values of 60 percent and 80 percent, respectively. For people whose income is greater than 250 percent of the FPL, a silver plan has a standard 70 percent actuarial value.

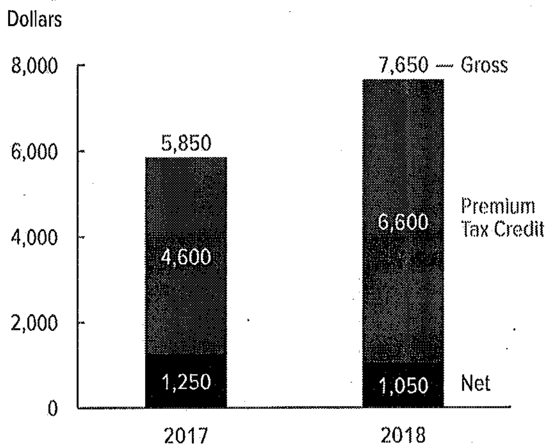
FPL = federal poverty level.

Basic Health Program. Under the ACA, states have the option to establish a Basic Health Program, which is primarily for people whose income is between 138 percent and 200 percent of the FPL. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would have been eligible through a marketplace. States can use those funds, in addition to funds from other sources, to offer health insurance that covers a broader set of benefits or requires smaller out-of-pocket payments than coverage in the marketplaces does.[11] So far, Minnesota and New York have created a Basic Health Program. In total, about 1 million people are projected to be enrolled in such a plan in each year from 2018 through 2028.

11. For more information about the Basic Health Program, see Centers for Medicare & Medicaid Services, "Basic Health Program" (accessed May 1, 2017), www.medicaid.gov/basic-health-program/index.html.

Figure 4.

Gross and Net Premiums for Subsidized Enrollees in States Using Healthcare.gov



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services.

Data are for enrollees receiving advanced payments of premium tax credits in states that use the federally facilitated marketplace platform healthcare.gov. The data are based on the plans selected during the open-enrollment period for each year.

Medicare and Other Coverage

Although Medicare is best known for providing coverage for people age 65 or older, it also covers some people who are under age 65. Many of those younger enrollees receive that coverage because they have qualified for benefits from the Social Security Disability Insurance program. (In general, people become eligible for Medicare two years after they qualify for disability insurance.) Between 8 million and 9 million people under age 65 are projected to be covered by Medicare in 2018 and in each year over the 2019–2028 period.

Other miscellaneous sources of coverage account for 5 million to 6 million people each year from 2018 to 2028. Those sources include student health plans, the Indian Health Service, and foreign sources.

Uninsured

An average of 29 million people under age 65 are projected to be uninsured in 2018. (In this report, CBO and JCT consider people uninsured if they are not covered by a plan or are not enrolled in a government program that provides financial protection from major medical risks.)

The number of uninsured people is projected to rise by 3 million in 2019, mainly because of the elimination of the penalty associated with the individual mandate and the higher premiums resulting from that change. That number rises by another 3 million over the following two years, on net, as more people adjust to the fact that they no longer face the mandate penalty. The effects of the penalty's elimination more than offset downward pressure on the number of uninsured people, which strengthens from 2019 to 2021. That pressure stems from higher premium tax credits caused by the lack of a direct appropriation for CSRs and from proposed regulations that would expand the use of association health plans (AHPs) and STLDI plans.

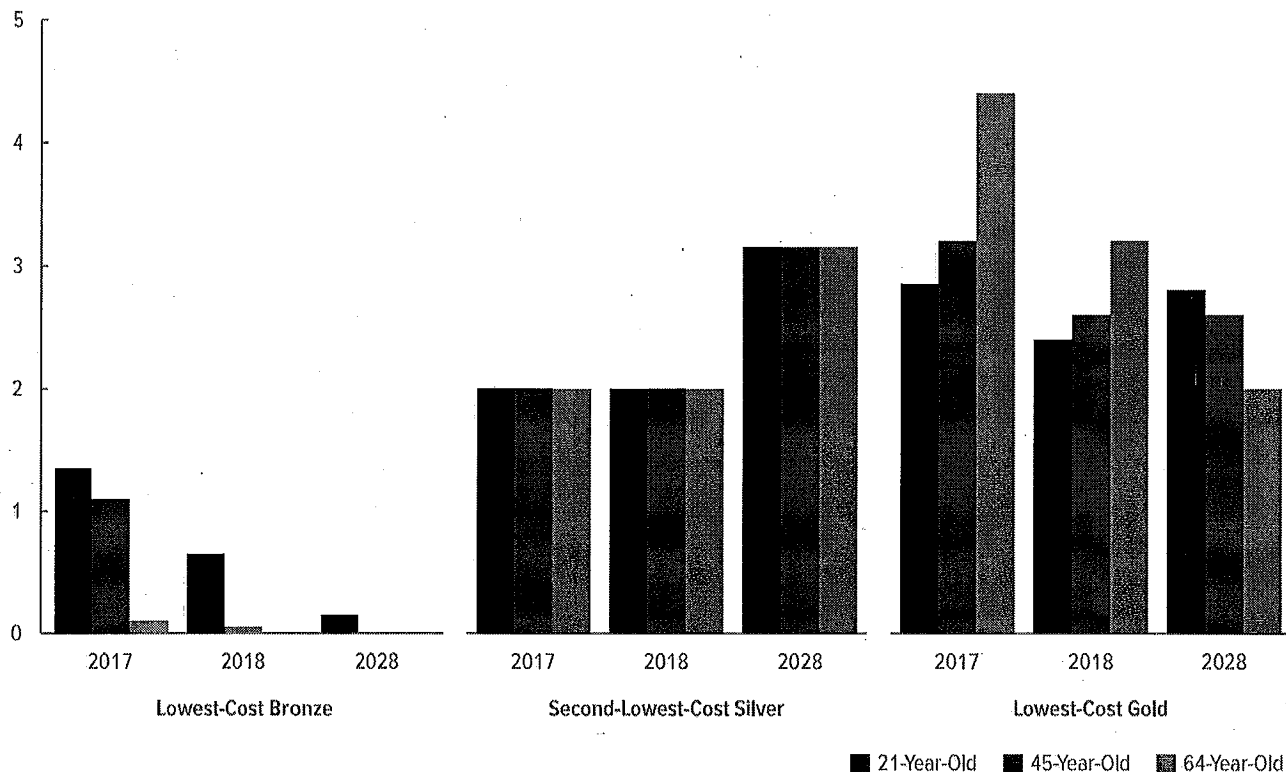
In most years over the next decade, and at the end of that period, about 13 percent of people under age 65 are projected to be uninsured, leaving about 35 million people uninsured in 2028.[12] In that year, according to CBO and JCT's estimates, about 20 percent of those uninsured people would be unauthorized immigrants and thus ineligible for subsidies through a marketplace or for most Medicaid benefits; about 10 percent would be ineligible for Medicaid because they live in a state that had not expanded coverage; about 20 percent would be eligible for Medicaid but would not enroll; and the remaining 50 percent would not purchase insurance to which they had access through an employer, through the marketplaces, or directly from insurers.

12. The sum of the estimates of the number of people enrolled in health insurance plans and the number of people who are uninsured exceeds CBO and JCT's estimate of the total population under age 65 by 10 million in most years, because some people will have multiple sources of coverage. A common example is people who report having both employment-based coverage and Medicaid. To arrive at the estimates given here, CBO and JCT did not assign a primary source of coverage to people who reported multiple sources; the resulting amounts align better with estimates of spending as well as with information about health insurance coverage from household surveys. (By contrast, when CBO and JCT have estimated changes in the sources of insurance coverage stemming from proposed legislation, the agencies have used only people's primary source of coverage to count them, an approach that has generally proved more useful for that purpose.)

Figure 5.

Illustrative Examples, for Single Individuals With Income at 225 Percent of the FPL, of Net Premiums for Health Insurance Purchased Through the Marketplaces

Thousands of Dollars



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

Dollar amounts have been rounded to the nearest $50.

CBO and the staff of the Joint Committee on Taxation projected the average national gross premiums for a 21-year-old, a 45-year-old, and a 64-year-old in the nongroup health insurance market, taking into account the different age-rating methodology used in each state. Net premiums equal gross premiums minus the projected premium tax credits for which a person is eligible. Premium tax credits are calculated as the difference between the benchmark premium and a specified percentage of income for a person with income at a given percentage of the FPL. That specified percentage generally grows over time. For the purpose of determining the premium tax credits, eligibility is based on the most recently published FPL as of the first day of the annual open-enrollment period for coverage for that year. The benchmark premium is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which a person resides. For bronze and gold plans, the premiums displayed in the figure are for the lowest-cost plan available in the marketplace in the area in which a person resides.

The actuarial value of a plan—the percentage of costs for covered services that the plan pays on average—differs by income. Bronze plans and gold plans have actuarial values of 60 percent and 80 percent, respectively. For people whose income is greater than 250 percent of the FPL, a silver plan has a standard 70 percent actuarial value. The cost-sharing amounts (out-of-pocket payments required under insurance policies) are reduced for covered people whose income is generally between 100 percent and 250 percent of the FPL. Those cost-sharing reductions generally have the effect of increasing the actuarial value of a typical silver plan from 70 percent 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.

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. A modified adjusted gross income at 225 percent of the FPL equaled $27,150 in 2017 and $27,300 in 2018; the amount is projected to be $34,550 in 2028.

FPL = federal poverty level.

Projected Subsidies for Health Insurance Coverage

The federal government encourages people to obtain health insurance by making it less expensive than it would be otherwise. For people under age 65, the government subsidizes health insurance coverage in four main ways:

- Giving tax benefits for work-related coverage,
- Providing roughly three-fifths of all funding for Medicaid (while requiring states to provide the remainder),
- Offering tax credits to eligible people who purchase coverage through the health insurance marketplaces, and
- Providing coverage through the Medicare program to people under age 65 who receive benefits from the Social Security Disability Insurance program or who meet certain other criteria.

The costs of those subsidies are partly offset by related taxes and penalties that the federal government collects. They include excise taxes on providers of health insurance and penalty payments from large employers that do not offer health insurance that meets certain standards.

If current laws did not change, the net federal subsidy for health insurance coverage for people under age 65—that is, the cost of all the subsidies minus the taxes and penalties—would be about $685 billion in 2018 and would total $9.3 trillion over the 2019–2028 period, CBO and JCT estimate (see Table 2). Those sums reflect projections by the agencies about choices that people would make about obtaining health insurance and are subject to considerable uncertainty.

Work-Related Coverage

Health insurance that people receive from employers is the most common source of subsidized coverage for people under age 65. Employers' payments for workers' health insurance coverage are a form of compensation, but unlike cash compensation, those payments are excluded from income and payroll taxes. In most cases, the amounts paid by workers themselves for their share of the cost of employment-based coverage are also excluded from income and payroll taxes. Another work-related subsidy is the income tax deduction for health insurance premiums that can be used by self-employed people, including sole proprietors and workers in partnerships (who may purchase insurance individually or as part of a group). In addition, some small employers that provide health insurance to their employees are eligible to receive a tax credit of up to 50 percent of the cost of that insurance.

JCT estimates that subsidies for work-related coverage for people under age 65 will total about $272 billion in 2018.[13] That amount is estimated to grow to $489 billion in 2028 and to total $3.7 trillion over the 2019–2028 period. The amount of the tax subsidy for work-related coverage is very large because the number of people with such coverage is large. (It is important to note that the estimated subsidies are not equal to the tax revenues that would be collected if those subsidies were eliminated, because in that event, many people would adjust their behavior to reduce the tax liability created by the change.)

Medicaid and CHIP

Outlays for all noninstitutionalized Medicaid and CHIP enrollees under age 65 who receive full benefits are estimated to amount to $296 billion in 2018. Over the 2019–2028 period, estimated outlays total $4 trillion: $842 billion (or 21 percent of the total) for people made eligible for Medicaid by the ACA and $3.2 trillion (or 79 percent) for people eligible for Medicaid or CHIP otherwise. Medicaid spending for the noninstitutionalized population under age 65 accounts for roughly 80 percent of total projected Medicaid spending for medical services over the 2019–2028 period.

Nongroup Coverage and the Basic Health Program

In 2018, subsidies for nongroup coverage obtained through the marketplaces, related spending and revenues (that is, premium tax credits, net spending and revenues related to risk adjustment and reinsurance, and grants to states), and payments for the Basic Health Program will total $55 billion, CBO and JCT estimate. Over the 2019–2028 period, such costs are projected to total $760 billion and to consist of the following main components:

13. That estimate excludes federal spending on medical benefits provided by the Department of Veterans Affairs and on the Defense Department's TRICARE program. For more information about those programs, see Congressional Budget Office, "Military and Veterans' Health Care," www.cbo.gov/topics/health-care/military-and-veterans-health-care.

- Outlays of $624 billion and a reduction in revenues of $79 billion for premium tax credits, totaling $703 billion (those tax credits cover a portion of eligible people's health insurance premiums and, because they are refundable, they can reduce individuals' tax liability below zero, resulting in outlays);
- Outlays of $57 billion for the Basic Health Program; and
- Outlays of $70 billion and revenues of roughly the same amount related to payments and collections for risk adjustment and reinsurance.

The third component of those subsidies is projected to have no net costs over time. The risk-adjustment and reinsurance programs were established under the ACA to stabilize premiums in the nongroup and small-group insurance markets by reducing the likelihood that particular insurers with a disproportionate share of less healthy enrollees would bear especially high costs.[14] The programs, which were implemented in 2014, make payments to insurers with less healthy enrollees; those payments are financed by collecting funds from insurers with healthier enrollees in the case of risk adjustment and by an assessment on a broad range of insurers in the case of reinsurance. The payments under the risk-adjustment and reinsurance programs are recorded in the budget as mandatory outlays, and the collections are recorded as revenues. In CBO's projections for the 2019–2028 period, risk-adjustment and reinsurance payments and collections total about $70 billion; almost all of that amount is for risk adjustment, as the last claims eligible for the reinsurance program are from plan year 2016. (Collections and payments ultimately offset each other exactly, but because of differences in the timing of collections and payments, slight discrepancies between the two will occur in any given period.)

Subsidies for insurance obtained through the marketplaces and outlays for the Basic Health Program depend on the number of people who purchase such coverage; the premiums for benchmark plans; and certain characteristics of enrollees, such as age, family size, and income. Combined, those subsidies and outlays for the Basic Health Program are projected to average $6,300 per subsidized enrollee in calendar year 2018 and to rise to about $12,440 in 2028.

Medicare

Net outlays for Medicare coverage for noninstitutionalized people under age 65 are projected to be $82 billion in 2018 and to total $1 trillion over the 2019–2028 period. That amount is about one-eighth of total projected net spending for the Medicare program.

Taxes and Penalties

Taxes and penalties related to health insurance coverage are expected to reduce the total amount of federal subsidies for such coverage by $21 billion in 2018. Under current law, those taxes and penalties would total $313 billion over the 2019–2028 period, CBO and JCT estimate—mostly from a tax on health insurance providers and from penalties imposed on some employers for not offering to their employees health insurance that meets specified standards.

Excise Tax on High-Premium Insurance Plans. An excise tax on certain high-cost employment-based coverage is scheduled to be imposed beginning in 2022. The tax was originally supposed to take effect in 2018, but lawmakers have delayed its implementation until 2022.[15] In CBO and JCT's projections, collections of that tax total $47 billion over the 2019–2028 period.

The excise tax is expected to cause some employers and workers to shift to health plans with lower premiums in order to entirely avoid paying the tax or to reduce their tax liability. Those shifts will generally increase income tax revenues, CBO and JCT estimate, because affected workers will receive less of their income in nontaxable health benefits and more in taxable wages. Including those increases in income tax revenues, JCT estimates receipts stemming from the imposition of the excise tax to total $168 billion over the coming decade.[16]

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14. The small-group insurance market is for health insurance generally purchased by or through employers with up to 50 employees; starting in 2016, states could expand the definition to include employers with up to 100 employees.

15. See section 101 of Div. P of the Consolidated Appropriations Act, 2016, P.L. 114-113, 129 Stat. 2242, 3037, and section 4002 of an act making further continuing appropriations for the fiscal year ending September 30, 2018, and for other purposes, P.L. 115-120, 132 Stat. 28, 29.

16. That amount is shown as a memorandum item in Table 2. If workers' wages were instead held constant, their total compensation would be reduced by the amount of the change in premiums. Their employers would have smaller deductions for compensation costs and hence more taxable income—and the resulting total revenues would be similar.

Table 2.

Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65

Billions of Dollars, by Fiscal Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	Total, 2019–2028
Work-Related Coverage												
Tax exclusion for employment-based coverage[a,b]	266	276	293	310	326	343	361	380	426	458	480	3,653
Income tax deduction for self-employment health insurance[c]	5	5	5	5	6	6	7	7	7	8	8	64
Small-employer tax credits[b]	1	1	1	1	1	1	1	1	1	1	1	8
Subtotal	272	282	299	316	332	350	368	387	434	466	489	3,725
Medicaid and CHIP[d]												
Made eligible for Medicaid by the ACA	59	62	63	68	74	80	87	93	99	105	111	842
Otherwise eligible for Medicaid	221	233	245	260	276	293	311	329	348	368	388	3,049
CHIP	16	16	14	13	13	13	14	14	15	15	16	143
Subtotal	296	310	323	340	363	386	411	436	462	488	514	4,034
Nongroup Coverage and the Basic Health Program												
Premium tax credit outlays	43	47	51	57	64	66	67	68	67	68	70	624
Premium tax credit revenue reductions	6	6	6	6	7	7	8	8	10	11	11	79
Subtotal, premium tax credits	49	53	57	63	71	73	74	75	76	78	81	703
Cost-sharing outlays	0	0	0	0	0	0	0	0	0	0	0	0
Outlays for the Basic Health Program	4	4	4	5	5	6	6	6	7	7	8	57
Collections for risk adjustment and reinsurance	-5	-5	-6	-6	-7	-7	-7	-8	-8	-8	-9	-71
Payments for risk adjustment and reinsurance	7	5	6	6	6	7	7	8	8	8	9	70
Marketplace grants to states	*	0	0	0	0	0	0	0	0	0	0	0
Subtotal	55	57	61	68	76	79	80	82	83	85	89	760
Medicare[e]	82	84	88	93	97	102	106	111	116	122	129	1,049
Taxes and Penalties Related to Coverage												
Gross collections of excise tax on high-premium insurance plans[f]	0	0	0	0	-1	-5	-5	-6	-8	-11	-12	-47
Penalty payments by uninsured people	-4	-3	0	0	0	0	0	0	0	0	0	-3
Net receipts from tax on health insurance providers[g]	-13	0	-14	-15	-16	-17	-18	-19	-20	-21	-22	-161
Gross collections of employer penalties[f]	-4	-8	-10	-11	-8	-9	-10	-10	-11	-12	-12	-101
Subtotal	-21	-11	-24	-26	-26	-31	-33	-35	-38	-43	-45	-313
Net Subsidies	**685**	**723**	**747**	**791**	**843**	**886**	**933**	**981**	**1,057**	**1,118**	**1,176**	**9,255**

Continued

Tax on Health Insurance Providers. Health insurers are subject to an excise tax (though legislation eliminated it for calendar year 2019). The law specifies the total amount of tax to be assessed, and that total is divided among insurers according to their share of total applicable premiums charged in the previous year. Some health insurers, such as firms operating self-insured plans and certain state government entities and tax-exempt providers, are fully or partly exempt from the tax.[17] Net revenues from the tax will be $13 billion in 2018 and under current law would increase to about $22 billion by 2028, for a total of $161 billion over the decade, CBO and JCT estimate.

17. A self-insured firm essentially acts as its own insurer and bears much of the financial risk of providing coverage to its workers.

Table 2. Continued

Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65

Billions of Dollars, by Fiscal Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	Total, 2019–2028
Memorandum:												
Average Subsidy per Subsidized Marketplace or Basic Health Program Enrollee (Dollars)	6,300	7,210	8,010	9,330	9,970	10,200	10,740	11,050	11,440	11,940	12,440	n.a.
Collections of Excise Tax on High-Premium Insurance Plans, Including the Associated Effects on Revenues of Changes in Taxable Compensation	0	0	0	0	-8	-16	-20	-24	-28	-34	-39	-168

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

Positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

This table excludes outlays made by the federal government in its capacity as an employer.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation; n.a. = not applicable; * = between zero and $500 million.

a. Includes the effect on tax revenues of the exclusion of premiums for people under age 65 with employment-based insurance from federal income and payroll taxes and includes the effects on taxable wages of the excise tax on high-cost plans and penalty payments by employers. JCT made this projection; it differs from JCT's estimate of the tax expenditure for the exclusion of employer-paid health insurance because effects stemming from the exclusion for people over age 65 are excluded here and because the Federal Insurance Contributions Act tax exclusion for employer-paid health insurance is included here.

b. Includes increases in outlays and reductions in revenues.

c. JCT made this projection; it does not include effects stemming from the deduction for people over age 65.

d. For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits. Also, the federal government covers a larger share of costs for Medicaid enrollees whom the ACA made eligible for the program than for people otherwise eligible for Medicaid; the government therefore tracks those groups separately.

e. For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

f. The excise tax is scheduled to go into effect in 2022. Excludes the associated effects on revenues of changes in taxable compensation, which are included in the estimate of the tax exclusion for employment-based insurance. If those effects were included, net revenues stemming from the excise tax would total $168 billion over the 2019–2028 period, and revenues from penalty payments by employers would total $79 billion over that 10-year period.

g. Net receipts include effects of the excise tax on individual and corporate tax receipts. The tax is suspended in 2019.

Penalties on Employers. Some large employers that do not offer health insurance coverage that meets certain standards under the ACA will owe a penalty if they have any full-time employees who receive a subsidy through a health insurance marketplace.[18] The requirement generally applies to employers with at least 50 full-time-equivalent employees. In CBO and JCT's projections, payments of those penalties total $101 billion over the 2019–2028 period. However, the increased costs for employers that pay the penalties are projected to reduce other revenues by $22 billion, because employers would generally be expected to shift the costs of the penalties to workers by lowering taxable wages. Once that shift is taken into account, the net reduction in the deficit is $79 billion.

Uncertainty Surrounding the Estimates

The ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other parties will behave in the future are all difficult to predict, so the estimates in this report are uncertain. CBO and JCT have endeavored to develop budgetary estimates that are in the middle of the distribution of potential outcomes.

18. To meet the standards, the cost to employees for self-only coverage must not exceed a specified share of their income (which is 9.56 percent in 2018 and is scheduled to grow over time), and the plan must pay at least 60 percent of the cost of covered benefits.

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The actual distribution of health insurance coverage in future years could differ from the projections presented in this report for a variety of reasons. If national economic trends diverge from CBO's economic forecast, for example, that would alter the number of people offered insurance by their employers, as well as the number of people eligible for Medicaid or coverage through the marketplaces. Additionally, changes in laws or regulations would affect health insurance markets. For example, if proposed regulations take effect, AHPs and STLDI plans may have smaller or larger effects on enrollment and premiums in the small-group and nongroup insurance markets than projected in this report. Depending on how state insurance commissioners regulate those plans, those markets may expand, shrink, or, in some areas of the country, become unstable. Furthermore, such economic and regulatory factors may interact with one another in a variety of ways to bring about outcomes that differ from the projections presented here.

Many other factors will also affect federal subsidies for health care. One important factor is the extent to which the emergence and adoption of health care technology will raise or lower costs. New and less expensive medical procedures or treatments could prove effective in helping patients, which could lower costs. But other beneficial procedures and treatments might be more expensive. Other factors that could affect health care costs are changes in the structure of payment systems and innovations in the delivery of health care. Those changes could encourage providers to supply more cost-effective treatments and reduce costs per enrollee. Other changes could reach previously underserved populations and raise costs per enrollee.

Changes in the Estimates of Insurance Coverage and Subsidies Since September 2017

In CBO and JCT's current projections for the 2018–2027 period (the span covered by both last year's projections and the current ones), about 3 million more people are uninsured, on average, than the agencies estimated in September 2017. The agencies have decreased their estimate of the net federal subsidies associated with health insurance coverage for people under age 65 from $9.2 trillion to $8.8 trillion for that period (see Table 3).

Changes in the Estimates of Insurance Coverage

In most years of the 2018–2027 period, CBO and JCT have changed their projections in the following ways:

- The number of uninsured people is higher;
- Enrollment in subsidized and unsubsidized nongroup coverage is lower;
- Enrollment in Medicaid is lower; and
- Enrollment in employment-based coverage is higher.

Uninsured. In CBO and JCT's current projections, an average of 3 million more people are uninsured between 2018 and 2027 than the agencies estimated last September. However, the change in the number of uninsured people varies significantly over that 10-year period: In 2018, 1 million fewer people are projected to be uninsured, and in 2027, 5 million more people are projected to be uninsured.

Effects of Eliminating the Individual Mandate Penalty. The primary reason for the increase in the projected number of uninsured people in most years is the elimination of the penalty related to the individual mandate beginning in 2019. Without a penalty for not having insurance, fewer people are projected to enroll in health insurance because some people would have enrolled to avoid paying the penalty and because some people are expected to forgo insurance in response to the resulting higher premiums in the nongroup market.

The projections explained in this report incorporate revised methods for estimating the effects of eliminating the penalty. Using those updated methods, CBO and JCT estimate the reduction in health insurance coverage is about one-third smaller than the agencies previously estimated.[19]

The update was prompted by a reassessment of the decline in the number of uninsured people since 2012 and the reasons for it. CBO and JCT have long attributed only part of the decline to financial factors that reduced the cost of obtaining coverage or increased the cost of being uninsured: the expansion of publicly financed coverage by Medicaid, the availability of subsidies for insurance obtained through the marketplaces, and the financial effect of the individual mandate penalty. The agencies have attributed the remainder to nonfinancial factors that lowered barriers to obtaining

19. For information on the agencies' prior estimate, see Congressional Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (November 2017), www.cbo.gov/publication/53300.

coverage, including simplified procedures for participating in Medicaid, the existence of the marketplaces, outreach and advertising, and market rules having the effect of broadening coverage.[20] Other nonfinancial factors are related to the individual mandate, including people's tendency to comply with laws, widespread and growing expectations that most people should have coverage, and people's greater responsiveness to penalties than to subsidies.[21]

In CBO and JCT's current projections, compared with earlier ones:

- The total effect of all nonfinancial factors is smaller;
- The nonfinancial factors associated with the mandate explain a smaller share of the total effect of all nonfinancial factors; and
- The mandate has been in place for an additional year (five years in total), and people's expectations about whether one should have coverage are more established and, in CBO's current judgment, less sensitive to repealing the legal mandate.

Each of those revisions reduced the agencies' estimates of the effects of eliminating the mandate penalty, which include eliminating the effects of the financial penalty and almost all of the nonfinancial effects of the individual mandate.

Those revisions were based in part on CBO's analysis of data from the National Health Interview Survey (NHIS) to discern changes over time in the number of uninsured people. Whereas CBO and JCT previously relied more heavily on estimates from the Medical Expenditure Panel Survey—Household Component, the agencies now use the NHIS as their primary benchmark for information on the number of uninsured people because it is the earliest available source each year and provides more reliable estimates derived from a larger sample.[22] The revisions also took into account information from analysts at other organizations.[23]

Effects of Other Factors. Partially offsetting those changes to methods are some changes that would, all else being equal, tend to lower the estimated number of uninsured people:

- CBO and JCT have updated their projections of premiums in the nongroup market to account for how insurers and state insurance commissioners reacted to the lack of a direct appropriation for CSRs. As a result of that change in funding, about 2 million more people are estimated to purchase coverage through the nongroup market in most years than would have if the federal government had continued to directly reimburse insurers for the cost of CSRs; some of those people would otherwise have been uninsured.
- CBO and JCT have incorporated the effects of two proposed regulations that would expand AHPs and STLDI plans. In particular, following the usual procedures for incorporating the effects of proposed rules, the agencies have incorporated a 50 percent chance that the final issued rules will be the same as the proposed ones and a 50 percent chance that no new rules like the proposed ones will be issued. Accordingly, the number of uninsured people in the baseline is projected to be between 500,000 and 1 million lower in most years than it would otherwise have been.

20. Those market rules include prohibiting insurers from denying coverage or varying premiums because of an enrollee's health status, or limiting coverage because of preexisting medical conditions; they allow insurers to vary premiums only on the basis of age, tobacco use, and geographic location. In addition, the market rules require that nongroup plans cover certain categories of benefits defined as essential.

21. For additional information, see Alexandra Minicozzi, Unit Chief, Health Insurance Modeling Unit, Congressional Budget Office, *Modeling the Effect of the Individual Mandate on Health Insurance Coverage* (presentation to CBO's Panel of Health Advisers, Washington, D.C., September 15, 2017), www.cbo.gov/publication/53105.

22. For a discussion of the data that CBO and JCT use, see Congressional Budget Office, *How CBO Defines and Estimates Health Insurance Coverage for People Under Age 65* (May 2018), www.cbo.gov/publication/53822.

23. See Ashley Kirzinger and others, *Kaiser Health Tracking Poll—March 2018: Non-Group Enrollees* (April 3, 2018), https://tinyurl.com/y9osz5pm; John Hsu and others, "Eliminating the Individual Mandate Penalty in California: Harmful but Non-Fatal Changes in Enrollment and Premiums," *Health Affairs Blog* (blog entry, March 1, 2018), https://tinyurl.com/ybmbbob9; S&P Global Ratings, "U.S. Tax Reform: Repeal of the Health Insurance Mandate Will Save Less Than Expected, and Will Not Support the Current Insurance Market" (November 16, 2017); Paul Spitalnic, *Estimated Financial Effect of the "American Health Care Act of 2017"* (Centers for Medicare & Medicaid Services, Office of the Actuary, June 13, 2017), https://go.usa.gov/xQDfG; and Linda J. Blumberg, Matthew Buettgens, and John Holahan, *Implications of Partial Repeal of the ACA Through Reconciliation* (Urban Institute, December 2016), https://tinyurl.com/y6vkugs4.

Table 3.

Comparison of Current and Previous Projections of Health Insurance Coverage and Net Federal Subsidies for People Under Age 65

	2018			2018–2027		
	September 2017 Projection	Spring 2018 Projection[a]	Difference	September 2017 Projection	Spring 2018 Projection[a]	Difference
	Insurance Coverage During the Year[b] (Millions of people)			Average Insurance Coverage Over the Period[b] (Millions of people)		
Total Population	273	273	*	275	275	*
Employment-Based Coverage	157	158	1	153	156	3
Medicaid and CHIP[c]						
Made eligible for Medicaid by the ACA	13	12	*	15	13	-2
Otherwise eligible for Medicaid or CHIP	56	55	-1	55	55	*
Total	68	67	-1	70	68	-1
Nongroup Coverage and the Basic Health Program						
Subsidized nongroup	9	8	-2	10	7	-3
Unsubsidized nongroup	6	7	1	7	6	-2
Total	16	15	-1	18	13	-5
Coverage through the Basic Health Program[d]	1	1	*	1	1	*
Medicare[e]	8	8	*	9	8	*
Other Coverage[f]	5	5	*	5	5	*
Uninsured[g]	30	29	-1	31	34	3
	Effects on the Federal Deficit[h] (Billions of dollars)			Effects on the Cumulative Federal Deficit Over the Period[h] (Billions of dollars)		
Work-Related Coverage						
Tax exclusion for employment-based coverage[i,j]	297	266	-31	3,796	3,439	-357
Income tax deduction for self-employment health insurance[k]	7	5	-2	91	61	-30
Small-employer tax credits[j]	1	8	7	10	8	-2
Subtotal	306	279	-26	3,897	3,508	-389
Medicaid and CHIP[l]						
Made eligible for Medicaid by the ACA	76	59	-17	1,036	791	-245
Otherwise eligible for Medicaid or CHIP	238	237	-2	2,981	3,025	44
Subtotal	315	296	-19	4,017	3,815	-202
Nongroup Coverage and the Basic Health Program						
Premium tax credits	47	49	2	605	671	66
Cost-sharing outlays	9	0	-9	99	0	-99
Outlays for the Basic Health Program	5	4	-1	69	54	-15
Subtotal	62	55	-7	773	725	-48
Medicare[m]	81	82	2	1,011	1,003	-8
Taxes and Penalties Related to Coverage						
Gross collections of excise tax on high-premium insurance plans[n]	0	0	0	-29	-36	-7
Penalty payments by uninsured people	-4	-4	**	-51	-7	44
Net receipts from tax on health insurance providers[o]	-13	-13	0	-166	-152	13
Gross collections of employer penalties[n]	-12	-4	7	-207	-93	114
Subtotal	-28	-21	7	-453	-289	165
Net Subsidies[o]	**735**	**685**	**-50**	**9,245**	**8,764**	**-481**

Continued

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

Estimates of insurance coverage apply to calendar years, and estimates of the effect on the federal deficit apply to fiscal years.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation; * = between -500,000 and 500,000; ** = between zero and $500 million.

a. Estimates are from CBO's adjusted April 2018 baseline. The adjustment reflects updates to the preliminary projections (contained in *The Budget and Economic Outlook: 2018 to 2028*, released on April 9, 2018) for subsidies for insurance purchased through the marketplaces established under the ACA as well as for revenues related to health care.

b. Estimates include noninstitutionalized civilian residents of the 50 states and the District of Columbia who are younger than 65. The components do not sum to the total population because some people report multiple sources of coverage. CBO and JCT estimate that in most years, 10 million people (or 4 percent of insured people) have multiple sources of coverage, such as employment-based coverage and Medicaid. Estimates reflect average monthly enrollment over the course of a year and include spouses and dependents covered under family policies.

c. Includes noninstitutionalized enrollees with full Medicaid benefits. Estimates are adjusted to account for people enrolled in more than one state.

d. The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.

e. Includes noninstitutionalized Medicare enrollees under age 65. Most Medicare-eligible people under age 65 qualify for Medicare because they participate in the Social Security Disability Insurance program.

f. Includes people with other kinds of insurance, such as student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.

g. Includes unauthorized immigrants, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid who do not enroll; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

h. Positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

i. Includes the effect on tax revenues of the exclusion of premiums for people under age 65 with employment-based insurance from federal income and payroll taxes and includes the effects on taxable wages of the excise tax on high-cost plans and penalty payments by employers. JCT made this projection; it differs from JCT's estimate of the tax expenditure for the exclusion of employer-paid health insurance because effects stemming from the exclusion for people over age 65 are excluded here and because the Federal Insurance Contributions Act tax exclusion for employer-paid health insurance is included here.

j. Includes increases in outlays and reductions in revenues.

k. JCT made this projection; it does not include effects stemming from the deduction for people over age 65.

l. For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits. Also, the federal government covers a larger share of costs for Medicaid enrollees whom the ACA made eligible for the program than for people otherwise eligible for Medicaid; the government therefore tracks those groups separately.

m. For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

n. Excludes the associated effects on revenues of changes in taxable compensation, which are included in the estimate of the tax exclusion for employment-based insurance.

o. Net receipts include the effects of the excise tax on individual and corporate tax receipts. The tax is suspended in 2019.

- CBO and JCT have updated their estimates to include the recently enacted extension of funding for CHIP from 2018 to 2027. Because some people who will gain coverage through CHIP would otherwise have gone uninsured, its extension reduces projections of the number of uninsured people by fewer than 500,000 in each year.

Nongroup Coverage and the Basic Health Program. Average monthly enrollment in the nongroup market is now projected to be 1 million lower in 2018 and 5 million lower, on average, between 2018 and 2027 than estimated in September 2017. On average, over the 10-year period, subsidized enrollment is lower by 3 million people, and unsubsidized enrollment is lower by 2 million. Projections of enrollment in the Basic Health Program are not noticeably different.

The 2017 tax act's elimination of the individual mandate penalty accounts for most of the reduction in the projections of nongroup enrollment: Fewer people are expected to enroll in coverage through the nongroup market as a consequence. In addition, the extension of CHIP funding from 2018 through 2027 reduced estimates of enrollment in the nongroup market because some people

who will gain coverage through CHIP would otherwise have obtained nongroup coverage.

Those reductions in nongroup coverage are somewhat offset by the lack of direct federal funding for CSR payments. As discussed above, CBO and JCT estimate that funding CSRs through higher gross premiums and therefore higher premium tax credits will result in about 2 million more people purchasing coverage through the nongroup market in most years than would have if the federal government had continued to directly reimburse insurers for the cost of CSRs. In addition, CBO and JCT estimate that the proposed regulations that would expand STLDI plans would increase the number of people enrolled in nongroup coverage by fewer than 500,000 people. (That estimate reflects a 50 percent probability that the regulations will be finalized as proposed.)

Medicaid and CHIP. Relative to the September 2017 estimates, current estimates of enrollment in Medicaid and CHIP are 1 million lower for most years over the 2018–2027 period. The elimination of the individual mandate penalty was the largest factor reducing projected enrollment. In CBO's estimation, the penalty for not having insurance encouraged more people to enroll in Medicaid than would otherwise have been the case. For example, some people applied for coverage in the marketplaces as a result of the penalty and turned out to be eligible for Medicaid, and some Medicaid-eligible adults and children would have had to pay a penalty if they did not obtain insurance. As a result, when the penalty is eliminated, beginning in 2019, fewer people will enroll in Medicaid, CBO expects.

Partially offsetting that effect is additional estimated enrollment in CHIP stemming from the extension of funding for that program from 2018 through 2027.

Employment-Based Coverage. CBO and JCT increased last year's projections of enrollment in employment-based insurance coverage by 1 million people in 2018 and by an average of 3 million people between 2018 and 2027. Those net increases are the result of three main factors. First, the upward revision reflects an updated assessment of administrative data and data from household and employer surveys, which has led CBO and JCT to increase their estimate of the total number of people with employment-based coverage before 2018. Second, in its latest economic forecast, CBO projects that more people will be employed in most years over the coming decade than previously estimated, which boosts projected enrollment in employment-based coverage. Finally, partly on the basis of actual premiums for 2018, the agencies increased their projections of gross premiums for plans offered through the nongroup market, thereby increasing projected enrollment in employment-based coverage. (Because alternative sources of coverage would be more expensive, more employers are expected to offer insurance to their employees.)

Partially offsetting those factors increasing employment-based coverage is the elimination of the individual mandate penalty beginning in 2019. That factor has led CBO and JCT to lower their estimates of the number of people with employment-based coverage by 2 million in most years after 2018, relative to the September 2017 projections.

Changes in the Estimates of Subsidies, Penalties, and Taxes

In CBO and JCT's current projections, the net cost to the federal government of subsidizing health insurance coverage is $50 billion lower in 2018 and $481 billion (or about 5 percent) lower over the 2018–2027 period than it was in the agencies' September 2017 projections. Reduced estimates of the net cost of the tax exclusion for employment-based coverage and of Medicaid spending explain most of that decrease.

Tax Exclusion for Employment-Based Coverage. Estimates of the net cost of the tax exclusion for employment-based coverage are now $31 billion lower in 2018 and $357 billion lower over the 2018–2027 period. The cost of the exclusion depends on the number of people with employment-based coverage, the marginal tax rates of people enrolled in that coverage, and premiums for employment-based coverage. Although total enrollment in employment-based coverage is now projected to be higher than the September estimate, two other changes more than offset that effect: As a result of changes enacted in the 2017 tax act, marginal tax rates are estimated to be lower through 2025, and on the basis of new information available from the Internal Revenue Service about premiums in 2015, average premiums for employment-based coverage are, on net, estimated to be lower.

Medicaid and CHIP. CBO has reduced its projections of outlays for Medicaid and CHIP by $19 billion in 2018 and by $202 billion over the 2018–2027 period. Lower spending for Medicaid accounts for $280 billion of that net reduction, mostly because the elimination

of the individual mandate penalty is expected to lower enrollment in the program. In addition, the extension of funding for CHIP from 2018 through 2027 is estimated to generate savings for Medicaid because CBO had expected that, in the absence of extended funding for CHIP, states would switch some children who had been enrolled in CHIP to Medicaid.

CBO also has made technical revisions that have reduced its projections of Medicaid spending over the next decade. That reduction stems largely from lower-than-anticipated per capita costs in 2017 for people made eligible for Medicaid under the ACA and lower projections of cost growth for those enrollees.

As a result of the extension of funding for CHIP, CBO's current projection of outlays for the program over the 2018–2027 period is $78 billion higher than the September 2017 estimate.

Subsidies for Nongroup Coverage and the Basic Health Program. CBO and JCT's estimates of the net cost of subsidies for coverage through the marketplaces, along with estimates of related spending and revenues, are now $7 billion lower for 2018 and $48 billion lower for the 2018–2027 period. That net reduction results from the agencies' lower projections of subsidized enrollment through the marketplaces, partly offset by an increase in the estimated per-person cost of that coverage. The elimination of the individual mandate penalty accounts for most of the reduction in nongroup enrollment.

The estimated per-person cost of subsidized nongroup coverage is higher in the current projections for two main reasons. The lack of direct funding for CSRs increased average gross premiums for benchmark plans, which results in higher average subsidies. In addition, the elimination of the individual mandate penalty is expected to result in a less healthy mix of enrollees, thereby increasing projected average gross premiums and, therefore, subsidies.

Penalties and Taxes Related to Coverage. CBO and JCT have lowered their estimates of collections of penalty payments by individuals who do not purchase health insurance coverage meeting the ACA's standards by less than $500,000 in 2018 and by $44 billion over the 2018–2027 period. That reduction stems almost entirely from the 2017 tax act and its elimination of the penalty associated with the individual mandate beginning in 2019. As a result, CBO and JCT expect that no such penalties will be collected from people who are uninsured in 2019 or later years.

In addition, CBO and JCT have reduced their estimate of collections of penalty payments from employers that do not offer coverage meeting the ACA's standards by $7 billion in 2018 and by $114 billion over the 2018–2027 period as a result of new data from the Treasury Department showing less reported penalty liability than previously projected.

Comparisons of CBO and JCT's Projections With Actual Coverage and Subsidies

In order to improve CBO and JCT's baseline projections, the agencies compare their projections of health insurance coverage and federal subsidies for people under age 65 with actual enrollment and costs reported by the Administration, state governments, and surveys whenever possible. This report compares projections for 2017 published in March 2016 and September 2017 with actual amounts for 2017 (see Table 4).

Nongroup Coverage and the Basic Health Program

CBO and JCT's March 2016 projection of subsidies for nongroup coverage obtained through the marketplaces, related spending and revenues, and payments for the Basic Health Program accounted for the largest estimating error for 2017. The agency estimated that those subsidies would total $55 billion in 2017—about $11 billion, or about 25 percent, more than the actual amount reported by the Administration for 2017.

CBO and JCT overestimated costs to the federal government because they overestimated the number of people who would enroll through the marketplaces, and receive subsidies, in 2017. In March 2016, CBO and JCT estimated that 12 million people would enroll in subsidized coverage through the marketplaces—about 4 million, or 50 percent, more than the actual number. At the time, CBO and JCT expected enrollment to grow from 2016 to 2017 as more people gained experience with the marketplaces and more employers responded to the availability of subsidies by declining to offer insurance to their employees. However, enrollment through the marketplaces changed little in 2017. As a result, in their September 2017 projections, CBO and JCT significantly reduced their estimates of enrollment through the marketplaces in 2017 and later years.

The effect on subsidies of overestimating enrollment in the March 2016 projection was partially offset by

Table 4.

Selected Estimates of Health Insurance Coverage and Net Federal Subsidies for People Under Age 65 in CBO's March 2016 and September 2017 Projections Compared With Actual Coverage and Subsidies in 2017

	March 2016 Baseline	September 2017 Projection	Actual	Difference, March 2016–Actual	Difference, September 2017–Actual
	Selected Categories of Health Insurance Coverage for People Under Age 65 (Millions of people, calendar year 2017)				
Nongroup Coverage Purchased Through the Health Insurance Marketplaces[a]					
Subsidized	12	8	8	4	*
Unsubsidized	3	2	2	1	*
Total	15	10	10	5	*
Basic Health Program[b]	1	1	1	*	*
Uninsured[c]	26	28	28	-2	*
	Selected Categories of Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65 (Billions of dollars, fiscal year 2017)				
Medicaid and CHIP[d]					
Medicaid[e]	279	280	276	3	5
CHIP	13	16	16	-3	-1
Total	292	296	292	-1	4
Nongroup Coverage and the Basic Health Program					
Premium tax credits[f]	43	34	35	8	-1
Cost-sharing outlays[f]	9	7	6	3	1
Outlays for the Basic Health Program[f]	4	5	4	-1	**
Collections for risk adjustment and reinsurance[g]	-11	-9	-10	-1	1
Payments for risk adjustment and reinsurance[g]	10	9	9	2	**
Total	55	45	45	11	1

Continued

underestimating the average costs per subsidized enrollee.[24] In March 2016, CBO and JCT's estimate of average costs per subsidized marketplace or Basic Health Program enrollee was too low—by about 10 percent. Using information from the beginning of 2017, CBO and JCT increased their estimates of average costs in that year and later years in their September 2017 projection. All told, the agencies' September 2017 projection of subsidies for nongroup coverage obtained through the marketplaces, related spending and revenues, and Basic Health Program payments for 2017 turned out to be $1 billion higher than the actual amount for that fiscal year.[25]

Other Subsidies and Revenues

For all other categories of subsidies, taxes, and penalties related to coverage for people under age 65 for which actual information for 2017 is available, CBO and JCT's March 2016 and September 2017 projections for 2017 differed by less than 5 percent from the actual amounts. For example, CBO estimated in March 2016 that outlays for noninstitutionalized Medicaid and CHIP enrollees under age 65 who receive full benefits would be $292 billion and in September 2017, $296 billion. Actual spending in 2017 was $292 billion.

24. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2016* (March 2016), www.cbo.gov/publication/51385.

25. For calendar year 2017, the overestimate of total spending that could be calculated by multiplying CBO's September 2017 projection of enrollment by its projection of average costs is substantially larger than the overestimate for total spending in fiscal year 2017 mostly because the Administration stopped the payment of CSRs in October 2017 and those payments had been projected to continue in CBO's baseline.

Table 4. Continued

Selected Estimates of Health Insurance Coverage and Net Federal Subsidies for People Under Age 65 in CBO's March 2016 and September 2017 Projections Compared With Actual Coverage and Subsidies in 2017

	March 2016 Baseline	September 2017 Projection	Actual	Difference, March 2016–Actual	Difference, September 2017–Actual
	Selected Categories of Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65 (Billions of dollars, fiscal year 2017)				
Medicare[d,h]	81	80	82	-1	-2
Penalty Payments by Uninsured People[i]	-3	-3	-3	**	**
Memorandum:					
Average Subsidy per Subsidized Marketplace or Basic Health Program Enrollee (Dollars, calendar year 2017)[j]	4,550	5,550	5,010	-460	540

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation; and additional sources listed below.

Comparisons are shown only for categories of health insurance and net federal subsidies associated with people under age 65 for which actual values are publicly available for at least part of 2017.

CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation; * = between -500,000 and 500,000; ** = between -$500 million and $500 million.

a. Actual value based on data published by the Centers for Medicare & Medicaid Services. See Centers for Medicare & Medicaid Services, "2017 Effectuated Enrollment Snapshot" (accessed April 25, 2018), https://go.usa.gov/xR7j7 (PDF, 489 KB) and "First Half of 2017 Average Effectuated Enrollment Report" (accessed April 25, 2018), https://go.usa.gov/xQmaM.

b. Actual value based on information published by the state governments of Minnesota and New York, which are the only states that have used the program. See Randall Chun, MinnesotaCare (Minnesota House of Representatives, House Research Department, updated December 2017) www.house.leg.state.mn.us/hrd/pubs/mncare.pdf (104 KB); and New York State Department of Health, "2017 Open Enrollment Report," https://go.usa.gov/xQm9U.

c. Actual value reflects the number of uninsured people reported by the National Health Interview Survey adjusted downward to exclude people with Indian Health Service coverage, which CBO and JCT consider to be health insurance coverage. See Robin A. Cohen, Emily P. Zammitti, and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2017* (National Center for Health Statistics, May 2018), https://go.usa.gov/xQmKM (PDF, 530 KB).

d. See Department of the Treasury, "Final Monthly Treasury Statement of Receipts and Outlays of the United States Government for Fiscal Year 2017 Through September 30, 2017, and Other Periods" (October 2017), https://go.usa.gov/xQmsd.

e. Actual value reported by the Department of the Treasury adjusted to reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits.

f. Office of Management and Budget, *Budget of the U.S. Government: Appendix*, "Detailed Budget Estimates by Agency: Department of the Treasury" (February 2018), p. 956, https://go.usa.gov/xR7Dc.

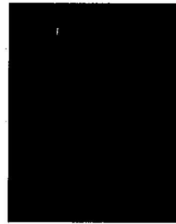
g. Office of Management and Budget, *Budget of the U.S. Government: Appendix*, "Detailed Budget Estimates by Agency: Department of Health and Human Services" (February 2018), pp. 449–450, https://go.usa.gov/xR7Dc.

h. Actual value reported by the Department of the Treasury adjusted to reflect benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

i. Actual value based on preliminary data from the Internal Revenue Service. See Internal Revenue Service, "SOI Tax Stats—Individual Income Tax Returns," Preliminary Data, Statistical Tables, Table 1—Individual Income Tax Returns: Selected Income and Tax Items (accessed April 19, 2018), https://go.usa.gov/xQm9k.

j. Estimates of actual costs per person are the ratios of costs to subsidized enrollment through the health insurance marketplaces or the Basic Health Program in a calendar year.

CBO



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About This Document

Each year, the Congressional Budget Office issues a series of publications describing its projections of the federal budget. This report provides background information that helps explain some of the projections in the most recent of those publications and also provides updated estimates. In keeping with CBO's mandate to provide objective, impartial analysis, this report makes no recommendations.

Kate Fritzsche and Kevin McNellis prepared the report with contributions from Sarah Masi. Susan Yeh Beyer, Alice Burns, Philippa Haven, Ben Hopkins, Sean Lyons, Eamon Molloy, Romain Parsad, Allison Percy, Ezra Porter, Lisa Ramirez-Branum, Robert Stewart, Chris Zogby, and the staff of the Joint Committee on Taxation contributed to the analysis. Jessica Banthin, Chad Chirico, Theresa Gullo, Leo Lex, Alexandra Minicozzi, and David Weaver provided guidance and helpful comments.

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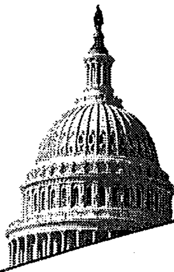
Keith Hall
Director
May 2018

Texas, et al. v.
United States of America, et al.

USDC Northern District of Texas
Case No. 4:18-cv-00167-O

Exhibit K



AUGUST 2017

The Effects of Terminating Payments for Cost-Sharing Reductions

Summary

The Affordable Care Act (ACA) requires insurers to offer plans with reduced deductibles, copayments, and other means of cost sharing to some of the people who purchase plans through the marketplaces established by that legislation. The size of those reductions depends on those people's income. In turn, insurers receive federal payments arranged by the Secretary of Health and Human Services to cover the costs they incur because of that requirement.

At the request of the House Democratic Leader and the House Democratic Whip, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have estimated the effects of terminating those payments for cost-sharing reductions (CSRs). In particular, the agencies analyzed what would happen under this policy: By the end of this month, it is known that CSR payments will continue through December 2017 but not thereafter.

Effects on Market Stability and Premiums

CBO and JCT expect that insurers in some states would withdraw from or not enter the nongroup market because of substantial uncertainty about the effects of the policy on average health care costs for people purchasing plans. In the agencies' estimation, under the policy, about 5 percent of people live in areas that would have no insurers in the nongroup market in 2018. By 2020, though, insurers would have observed the operation of markets in many areas under the policy and CBO and JCT expect that more insurers would participate, so people in almost all areas would be able to buy nongroup insurance (as is projected to be the case throughout the next decade under CBO's baseline projection).[1]

Because they would still be required to bear the costs of CSRs even without payments from the government, participating insurers would raise premiums of "silver" plans to cover the costs. In order to qualify for CSRs, most enrollees must purchase a silver plan through the nongroup insurance marketplace in their area, generally have income between 100 percent and 250 percent of the federal poverty level (FPL), receive premium tax credits toward the silver plan, and not be eligible for other types of coverage, such as employment-based coverage or Medicaid. According to CBO and JCT's projections, for single policyholders, gross premiums (that is, before premium tax credits are accounted for) for silver plans offered through the marketplaces would, on average, rise by about 20 percent in 2018 relative to the amount in CBO's March 2016 baseline and rise slightly more in later years. Such premiums for other plans would rise a few percent during the next two years, on average, above the increases already projected in the baseline in response to uncertainty among states and insurers about how to respond under the policy. In later years, the agencies anticipate, premiums for other plans would not generally rise above baseline projections because CSRs are not available for those plans.

When premiums for silver plans increased under the policy, tax credit amounts per person for purchasing insurance in the nongroup market would increase because the credits are directly linked to those premiums. According to CBO and JCT's projections, many people eligible for the credits with income between 100 percent and 200 percent of the FPL—who, under the baseline, receive most of the cost-sharing reductions paid—would use their increased tax credits to purchase the same silver plans with low cost sharing that they would purchase

1. Under the policy analyzed, because of the timing, insurers would know about the termination of the CSR payments before having to finalize premiums for next year. But if the timing was different, if CSR payments were stopped after premiums were finalized or were already being charged, CBO and JCT expect that additional insurers would exit the marketplaces in 2018 to reduce their financial losses.

under the baseline, and they would pay net premiums (with the tax credits factored in) that were similar to what they would pay if the CSR payments were continued. Alternatively, they could buy insurance that covered less of their health care expenses, and in many of those cases, the tax credits would cover the premiums entirely. Because CBO and JCT anticipate that most insurance commissioners would eventually permit insurers to substantially increase the gross premiums for silver plans in the marketplaces and not to do so for other plans, almost all people at other income levels would then buy other plans. (Under the baseline, some of those people would buy silver plans, and some would buy other plans.)

Effects on the Federal Budget and Health Insurance Coverage

Implementing the policy would increase the federal deficit, on net, by $194 billion from 2017 through 2026, CBO and JCT estimate. Total federal subsidies for health insurance in the nongroup market—in particular, the sum of the premium tax credits and the CSR payments—would increase for two reasons: The average amount of subsidy per person would be greater, and more people would receive subsidies in most years.

Because the tax credits would increase when premiums for silver plans rose, the agencies estimate that the average subsidy per person receiving premium tax credits to purchase nongroup health insurance would increase. Increases in those tax credits for people with income between 100 percent and 200 percent of the FPL would roughly offset the reductions in CSR payments. However, increases in premium tax credits for those with income between 200 percent and 400 percent of the FPL would substantially exceed the small reductions in CSR payments for this group.

By CBO and JCT's estimates, the number of people receiving subsidies for nongroup health insurance would increase under the policy in most years. In particular, because tax credits would increase and gross premiums for plans other than silver plans in the marketplaces would not change substantially, many people with income between 200 percent and 400 percent of the FPL would, compared with outcomes under the baseline, be able to pay lower net premiums for insurance that pays for the same share (or an even greater share) of covered benefits. As a result, more people would purchase plans in the marketplaces than would have otherwise and fewer people would purchase employment-based health insurance—reducing the number of uninsured people, on net, in most years. (Under the policy, demand for employment-based insurance among some employees would be weaker because insurance in the marketplaces would be more attractive, and the agencies expect fewer employers would offer health insurance to their workers in most years.)

During the next two years, the increase in subsidies stemming from those two reasons would be partially offset by lower spending in areas where no insurers participated in the marketplaces in response to the policy, CBO and JCT estimate. In those years, the number of uninsured people would be slightly higher or about the same as under the baseline.

Overall Effects

As a result of the increase in total subsidies under the policy, CBO and JCT project these outcomes, compared with what would occur if the CSR payments were continued:

- The fraction of people living in areas with no insurers offering nongroup plans would be greater during the next two years and about the same starting in 2020;
- Gross premiums for silver plans offered through the marketplaces would be 20 percent higher in 2018 and 25 percent higher by 2020—boosting the amount of premium tax credits according to the statutory formula;
- Most people would pay net premiums (after accounting for premium tax credits) for nongroup insurance throughout the next decade that were similar to or less than what they would pay otherwise—although the share of people facing slight increases would be higher during the next two years;
- Federal deficits would increase by $6 billion in 2018, $21 billion in 2020, and $26 billion in 2026; and
- The number of people uninsured would be slightly higher in 2018 but slightly lower starting in 2020.

Those effects are uncertain and would depend on how the policy was implemented.

For this analysis, the agencies have measured the budgetary effects relative to CBO's March 2016 baseline to

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produce estimates most comparable to those published earlier this year for legislation related to the budget reconciliation process for 2017. In an analysis using a preliminary version of updated projections of spending to subsidize health insurance purchased through the marketplaces that will be published soon, CBO and JCT find most of the results to be similar to those discussed here.[2] The main exception is this: Premiums under the policy would rise by a smaller amount in 2018—as the updated projections incorporate some increase in premiums next year as a result of current uncertainty about future CSR payments. Specifically, the agencies now expect that some insurers will assume that CSR payments will not be made in full during 2018 (as some insurers have indicated in preliminary filings), will incorporate the associated costs into their premiums for that year, and will, if CSR payments continue to be made, make adjustments in 2019 to account for them. Those expectations will be reflected in the updated projections but were not included in the March 2016 baseline.

How Key Elements of the Current System Work

In most marketplaces, people can choose among plans—such as bronze, silver, and gold—for which the average percentage of the total cost of covered medical expenses paid by the insurer (that is, the actuarial value of the plan) differs. The share of medical expenses that is not paid by the insurer is paid by enrollees in the form of deductibles and other cost sharing.

Silver plans differ from other plans because they must provide CSRs to eligible enrollees: The actuarial value depends on the policyholder's income as a percentage of the FPL.[3] Insurers are required to offer such plans to participate in the marketplaces. For people at most income levels, the actuarial value for a silver plan is 70 percent; the average deductible for a single policyholder, for medical and drug expenses combined, is about $3,600 in 2017. People with income between 100 percent and 250 percent of the FPL, however, are generally eligible for silver plans with higher actuarial values (and with lower deductibles), as follows:

- For people with income between 100 percent and 150 percent of the FPL, 94 percent (with an average deductible of about $300);
- For people with income between 150 percent and 200 percent of the FPL, 87 percent (with an average deductible of about $800); and
- For people with income between 200 percent and 250 percent of the FPL, 73 percent (with an average deductible of about $2,900).

Insurance companies can cover those higher shares of health care costs at current premium rates because they receive CSR payments from the federal government based on the number of enrollees they have in each eligibility category. To pay such shares of the cost of benefits in the absence of CSR payments, insurers would raise premiums.

The premium tax credits also reduce the amount that certain low-income people pay for health care in the nongroup market. The eligibility for such tax credits and the method for calculating the credit amounts in the nongroup market would be unchanged under the policy. The size of the premium tax credits depends on household income and on the premiums for a benchmark plan—the second-lowest-cost silver plan—in an enrollee's geographic area. An enrollee eligible for the tax credits pays a certain maximum percentage of his or her income toward the premiums for that benchmark plan, and the credits cover the amount by which the premiums for the benchmark plan exceed that percentage of income.

When the premiums for the benchmark plan go up, the amount of the tax credits goes up, and the amount of the premiums paid by an enrollee who is eligible for the credits is generally unchanged. Hence, an enrollee eligible for the premium tax credits is insulated from variations in premiums in different geographic locations and is also largely insulated from increases in the premiums for the benchmark plan. If a person chooses a plan with premiums higher than those for the benchmark plan, then he or she pays the difference as an additional amount toward the premiums, providing some incentive to choose lower-priced insurance. Similarly, if the person

2. Those updated estimates will be used to adjust the current set of baseline projections of such spending, which were published in June 2017. See Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2017 to 2027* (June 2017), www.cbo.gov/publication/52801.

3. In addition, certain Native Americans are eligible for plans with no deductibles or other cost sharing; the eligibility rules for those plans differ.

chooses a plan with premiums lower than the benchmark plan's, then he or she pays a lower cost.

In addition, the federal requirement that health insurers maintain a minimum medical loss ratio, which is equivalent to capping the share of premiums that may go toward insurers' administrative costs and profits, would be unchanged under the policy analyzed here. That requirement, combined with the competitive pressure to attract enrollees to lower-priced insurance in markets with more than one insurer, would eventually constrain increases in premiums for silver plans—even though the sums paid by subsidized enrollees in the marketplaces would largely be determined by their income, and the increases would primarily be borne by the federal government in the form of larger premium tax credits.

Effects on Market Stability

Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on the proportion of people living in areas with participating insurers and on the likelihood of premiums' not rising in an unsustainable spiral. The market for insurance purchased individually with premiums not based on one's health status would be unstable if, for example, the people who wanted to buy coverage at any offered price would have average health care expenditures so high that offering the insurance would be unprofitable.

Although premiums have been rising, subsidized enrollees purchasing health insurance coverage in the nongroup market are insulated from increases in premiums when they purchase a plan with premiums at or below those for the benchmark plan because the net premiums they pay are based on a percentage of their income. The subsidies to purchase coverage, combined with the requirement that most people obtain health insurance coverage (also known as the individual mandate), are anticipated to cause sufficient demand for insurance by enough people, including people with low health care expenditures, for the market to be stable in most areas as the ACA is currently being implemented. Under the baseline, fewer than one-half of one percent of people live in areas of the country that are projected to have no participation by insurers in the nongroup market. Several factors may affect insurers' decisions to not participate—including lack of profitability and substantial uncertainty about enforcement of the individual mandate and about future payments for CSRs.

CBO and JCT anticipate that, under this policy, the nongroup insurance market would also continue to be stable in most areas of the country. Subsidies to purchase insurance combined with the individual mandate would maintain sufficient demand for insurance by people with low health care expenditures. Substantial uncertainty about how consumers might respond to the significant increases in premiums following the termination of CSR payments would lead some insurers to withdraw from or not enter the nongroup market in some states, but the agencies anticipate that the situation would be temporary. Under the policy, CBO and JCT estimate, about 5 percent of people live in areas of the country in which insurers would not participate in the nongroup market in 2018, but insurers would participate in nearly all areas by 2020. (If the timing of the policy was different, its effects in 2018 would be different.)

Effects on Gross Premiums Charged by Insurers

Under this policy, average premiums for the second-lowest-cost silver plan offered through the marketplaces for single policyholders would be about 20 percent higher in 2018 than the premiums projected in CBO's March 2016 baseline, mainly because gross premiums alone, rather than premiums in combination with CSR payments, would have to cover the insurer's share of enrollees' health care costs. In 2020 and subsequent years, by CBO and JCT's estimates, the premiums for such benchmark plans would be about 25 percent higher than under the baseline.

Those increases would occur, CBO and JCT expect, because most state insurance commissioners would eventually allow insurers to compensate for the termination of CSR payments by raising premiums substantially for silver plans offered through the marketplaces. The agencies anticipate that insurers would propose to raise premiums for those plans because they are the plans required to bear—through cost-sharing reductions—the costs of having actuarial values of 87 percent or 94 percent for people with income between 100 percent and 200 percent of the FPL who enroll. Many insurance commissioners would favor that increase, CBO and JCT expect, because it would result in larger increases in premium tax credits for people in their states and, thus, lower net premiums paid by enrollees than alternatives that insurers might propose. Very few people at other income levels (facing the same gross premiums but for coverage with an actuarial value of 73 percent or lower)

would then enroll in silver plans in the marketplaces under the policy. Instead, they would purchase other plans, the agencies project.

The gross premiums for bronze plans with actuarial values around 60 percent and gold plans with actuarial values around 80 percent would change much less as a result of the policy, CBO and JCT anticipate, although some increases would occur during the next two years because of insurers' uncertainty about the policy's effects. The agencies expect that most state insurance commissioners would not allow insurers to significantly raise premiums for bronze and gold plans under the policy, especially after a year or two of experience, as those plans are not accompanied with cost-sharing reductions. Allowing premium increases for bronze and gold plans because of increases in costs for silver plans would distort prices in the market, because the increases would not correspond to changes in costs for those plans and would result in lower premium tax credits than if the increases were concentrated among silver plans.

However, for some bronze plans in the marketplaces, CBO and JCT project that gross premiums would modestly increase: those with an actuarial value that insurers would increase (within the allowable range) in an attempt to attract people who would have bought silver plans under the baseline but would not under the policy because of the large premium increases for them.

For gold plans in the marketplaces, the agencies project that gross premiums would be modestly lower under the policy because those plans would attract a larger share of healthier people who, under the baseline, would have bought silver plans. Under the baseline, gold plans tend to attract less healthy people who expect to have high health care expenditures, whereas silver plans attract healthier people as well.[4]

Effects on Net Premiums Paid by Enrollees

CBO and JCT anticipate that many people with income between 100 percent and 200 percent of the FPL purchasing insurance through the marketplaces would enroll in a silver plan with net premiums, after accounting for premium tax credits, that were similar under this policy and under the baseline. Some people in that income range would purchase bronze or gold plans for which the tax credits would cover the premiums entirely; however, in doing so, they would not be eligible for CSRs.

In general, CBO and JCT expect that most purchasers in the nongroup market with income between 200 percent and 400 percent of the FPL could pay net premiums equal to or less than those under the baseline for insurance with an actuarial value the same as (or even greater than) under the baseline. The main reason that purchasers could pay less or obtain a higher actuarial value is that the higher premiums for silver plans would boost the premium tax credit amounts.[5]

For purchasers in the nongroup market with income above 400 percent of the FPL, net and gross premiums would be the same because they are not eligible for premium tax credits. Under the policy, they could pay about the same premiums for bronze or silver plans (by purchasing outside the marketplaces) as under the baseline and lower premiums for gold plans (because of the health of enrollees in the plans), CBO and JCT project.

Effects for People With Income Between 100 Percent and 200 Percent of the FPL

To assess the potential effects of the policy change, CBO and JCT constructed a set of examples to illustrate average amounts for gross premiums, premium tax credits, and net premiums (after accounting for the tax credits) in 2026. The agencies project, for instance, that people with income at 125 percent of the FPL, regardless of age, would pay a net premium of $500 in 2026 to purchase a silver plan—the plan with the highest actuarial value for them—under the policy and $450 under the baseline (see Table 1, at the end of this document).[6] People

4. Federal risk-adjustment payments—which are made under the baseline and would be under the policy as well—aim to compensate insurers whose plans cover less healthy people, but the payments can address the risk only imperfectly. As a result, CBO and JCT anticipate that the greater share of healthy enrollees in gold plans under the policy would contribute to the modest reduction in premiums for those plans even though risk-adjustment payments would be made.

5. For related projections in California's market, see Wesley Yin and Richard Domurat, *Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding* (commissioned by Covered California, January 26, 2017), http://tinyurl.com/yb86m89v.

6. Those estimates of net premiums are determined by CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026, which differs under the policy and under the baseline. That projection takes into account the difference in the probability, as estimated under the policy and

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with income at 175 percent of the FPL, the agencies estimate, would pay a net premium of $1,850 under the policy and $1,700 under the baseline for a silver plan. Although gross premiums would be higher because of the termination of CSR payments under the policy, net premiums would be determined as a percentage of people's income, and larger premium tax credits would make up most of the difference.

Under the policy, because of the larger premium tax credits (reflecting the higher costs of silver plans), some people in this income range would pay no net premiums for a plan with a higher actuarial value than one they could have purchased with no net premiums under the baseline. For example, under the policy, a 64-year-old with income at 125 percent of the FPL could purchase a gold plan and pay no net premiums but, under the baseline, could obtain only a bronze plan with no net premiums.

Effects for People With Income Between 200 Percent and 400 Percent of the FPL

Under the policy, CBO and JCT anticipate, people with income between 200 percent and 400 percent of the FPL would continue to have access to the same silver plans that they are projected to purchase under the baseline—with net premiums being similar in 2026. For those people, silver plans would have an actuarial value between bronze and gold plans. In the marketplaces, the gross premiums for silver plans would be higher than under the baseline, but premium tax credits for many people in that income range would be larger (see Table 2, at the end of this document). Outside the marketplaces, where such tax credits could not be used, CBO and JCT expect that silver plans would be offered with gross premiums about the same as those charged under the baseline because insurers would design slightly different products for sale there and could therefore price them differently than the plans sold in the marketplaces. Plans outside the marketplaces could be attractive to younger people whose premiums were not a large enough percentage of their income to qualify them for tax credits.

However, CBO and JCT project that, under the policy, people with income between 200 percent and 400 percent of the FPL who are eligible for premium tax credits would mostly use those larger amounts to purchase bronze or gold plans rather than silver plans—eventually boosting enrollment in the marketplaces. Bronze plans would have a lower actuarial value and lower premiums than silver or gold plans, offering potential enrollees a trade-off. But gold plans would have a higher actuarial value than silver plans available to people in this income range and, for many of those people, lower net premiums—such that very few of them would choose a silver plan.

For instance, in the agencies' set of illustrative examples for 2026 under the policy, a 40-year-old with income at 225 percent of the FPL could pay a net premium of $1,150 for a bronze plan or $3,050 for a gold plan. (A silver plan would be available with a net premium of $3,350—more than the cost for a gold plan with a higher actuarial value.) Under the baseline, that person could pay $2,050 for a bronze plan, $3,050 for a silver plan, or $4,900 for a gold plan. Thus, under the policy, that person would have lower net premiums for a plan of equal or higher actuarial value.

Gold plans would attract a larger share of enrollees under the policy—mostly people with income between 200 percent and 400 percent of the FPL who would have purchased a silver plan under the baseline. In addition to the larger premium tax credits under the policy, lower gross premiums would eventually contribute to higher enrollment. Under the policy, gross premiums for gold plans would eventually be lower than those for silver plans because, the agencies expect, silver plans would almost exclusively insure people with income between 100 percent and 200 percent of the FPL and (with CSRs) provide actuarial values of 87 percent or 94 percent—significantly higher than the actuarial value of around 80 percent for gold plans. Gross premiums for gold plans under the policy would be modestly lower than under the baseline because, in CBO and JCT's estimation, enrollees would be healthier and therefore have lower health care expenditures.

Enrollees' ages would make a bigger difference in their net premiums for those at the higher end of this income range. A 21-year-old with income at 375 percent of the FPL, for instance, could pay the same net premium in 2026 for a bronze plan ($4,300) or a silver plan ($5,100)

in CBO's March 2016 baseline, that the specified percentages of income would be increased. Such an increase would apply if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceeded 0.504 percent of gross domestic product in the preceding year. CBO projects that the probability of reaching that percentage would be greater under the policy than it is under the baseline.

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under the policy (by purchasing outside the marketplace) as under the baseline, and $350 less for a gold plan.[7] A 64-year-old with that income would see more attractive options. Such a person could pay a net premium of $6,800 for a gold plan under the policy, compared with $6,750 for a silver plan under the baseline. For a bronze plan, that person could pay $2,300 under the policy, compared with $4,350 under the baseline. Older people's much larger premium tax credits under the policy explain the difference.

Effects for People With Income Above 400 Percent of the FPL

For people with income above 400 percent of the FPL, silver plans offered through the marketplaces would be less attractive than other plans. Because those people are not eligible for premium tax credits, however, the increase in their purchases of gold plans would be proportionately smaller than the increase for people with income between 200 percent and 400 percent of the FPL—and the increase in their purchases of plans outside the marketplaces, proportionately larger. In the agencies' set of illustrative examples, a 40-year-old with income at 450 percent of the FPL, for instance, could pay the same net premium in 2026 for a bronze plan or a silver plan under the policy (by purchasing outside the marketplace) as under the baseline, and $450 less for a gold plan.

Effects on the Federal Budget

CBO and JCT estimate that, on net, adopting this policy would increase the federal deficit by a total of $194 billion over the 2017–2026 period. That change would result from a $201 billion increase in outlays and a $7 billion increase in revenues (see Table 3, at the end of this document).

The total increase in the deficit that would result under the policy includes the following amounts:

- Costs of $247 billion from net increases in marketplace subsidies (an increase of $365 billion for premium tax credits offset by a reduction in CSR payments of $118 billion) stemming from increases in the average subsidy per person for people receiving the ACA's tax credits for premium assistance to purchase nongroup health insurance and in the number of people receiving those subsidies in most years and
- A net increase of $7 billion in federal outlays for Medicaid because of higher enrollment resulting from a reduction in the number of employers offering health insurance to their workers in most years.

Those increases in the deficit would be partially offset by:

- Savings of $47 billion, mostly associated with shifts in the mix of taxable and nontaxable compensation—resulting in more taxable income—from a net decrease in most years in the number of people estimated to enroll in employment-based health insurance coverage, and
- A net increase of $11 billion in revenues resulting from an increase in most years in the number of employers subject to penalties for not offering health insurance.

Effects on Health Insurance Coverage

According to CBO and JCT's estimates, the number of people uninsured under this policy would be about 1 million higher than under the baseline in 2018 but about 1 million lower in each year starting in 2020 (see Table 4, at the end of this document). In 2018, under the policy, the largest effect on coverage would derive from the drop in the number of insurers participating in the nongroup market.

By 2020, the effect on coverage would stem primarily from the increases in premium tax credits, which would make purchasing nongroup insurance more attractive for some people. As a result, a larger number of people would purchase insurance through the marketplaces, and a smaller number of people would purchase employment-based health insurance.

7. CBO and JCT expect that, under the policy, gross premiums for bronze and silver plans offered outside the marketplaces would be about the same as under the baseline and lower than those for plans offered through the marketplaces in most areas. For bronze plans, the agencies anticipate, some insurers would raise the actuarial value of plans offered through the marketplaces to 65 percent (the maximum currently allowed) to try to attract enrollees who might have purchased silver plans if the premiums were lower. Bronze plans offered outside the marketplaces with an actuarial value of 60 percent would have lower premiums. For silver plans, premiums would be lower for ones offered outside the marketplaces because plans offered through the marketplaces would have premiums covering the costs of people eligible for higher actuarial values (of 87 percent and 94 percent).

Uncertainty Surrounding the Estimates

CBO and JCT have endeavored to develop budgetary estimates that are in the middle of the distribution of potential outcomes. Such estimates are inherently imprecise because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by this policy are all difficult to predict.

Under this policy, the responses by states and insurers in the short term are particularly uncertain. For example, under the policy, total federal subsidies would be smaller and the number of uninsured people would be larger if more people lived in areas with no insurers in the marketplaces than the agencies project, and vice versa. Also, the increases in premium tax credits could be larger than CBO and JCT project if states allowed very large increases in premiums in 2018 to ensure that they had at least one insurer in an area. But the increases in tax credits could be smaller than projected if more people than the agencies expect lived in states requiring insurers to spread premium increases in 2018 across bronze, silver, and gold plans in the marketplaces as well as outside them, rather than focusing the increases on silver plans in the marketplaces.

Additional Issues Depending on How the Policy Was Implemented

CBO and JCT analyzed the effects of eliminating the Administration's authority to make CSR payments. For their analysis, the agencies assumed that hypothetical legislation with that end would be enacted by August 31, 2017, and that CSR payments would not be made after December 31, 2017. If the Administration, either of its own volition or in response to a court order, announced by August 31, 2017, that it would not make CSR payments after December 31, 2017, the agencies expect that the results would be similar to those discussed here. If the policy was implemented differently, various additional issues would arise.

Timing

If the announcement date and the effective date for the policy differed from what CBO and JCT used in this analysis, then the effects of the policy would differ. For example, if CSR payments were terminated after insurers had finalized or had begun charging premiums not incorporating such a change, insurers would suffer significant financial losses. To reduce those losses, some insurers would exit the marketplaces in the middle of the year. Some of those marketplaces would have no insurers remaining—reducing federal costs but increasing the number of people who were uninsured. Also, subsequent lawsuits might result in outlays by the federal government. If the effective date for terminating CSR payments was the beginning of 2019 instead of 2018, the effects in 2018 would be much smaller.

Certainty

Implementation of the policy through legislation, as opposed to executive or judicial action, would provide greater certainty about how the ACA would be carried out in the short term. Executive or judicial action could very well be challenged in lawsuits that would take some time to resolve—potentially extending the number of years insurers might not participate in the marketplaces.

CBO's Baseline

In CBO and JCT's initial cost estimate for the ACA and in subsequent baseline projections, the agencies have recorded the CSR payments as direct spending (that is, spending that does not require appropriation action)—a conclusion reached because the cost-sharing subsidies were viewed as a form of entitlement authority. The statute that specifies construction of the baseline requires that CBO assume full funding of entitlement authority.[8]

In 2014, the government began making payments for cost-sharing subsidies, and the House of Representatives subsequently brought a lawsuit challenging the department's authority to make such payments. On May 12, 2016, the District Court for the District of Columbia held that the government did not have the authority to make payments for cost-sharing subsidies but allowed it to continue making payments pending appeal. On February 22, 2017, at the request of the House of Representatives and the Administration, the U.S. Court of Appeals for the District of Columbia Circuit agreed to hold the appeal in abeyance while the Congress and the Administration seek a resolution, presumably through legislation. On August 1, 2017, that court allowed 17 states and the District of Columbia to intervene in the case, so future actions in the case will now involve those parties in addition to the House of Representatives and the Administration.

8. See section 257(b)(1) of the Balanced Budget and Emergency Deficit Control Act of 1985; 2 U.S.C. §907(b)(1).

CBO has not made any changes to its baseline projections in response to that court case because the case is on appeal and the Administration has continued to make the payments for cost-sharing subsidies. CBO typically updates its baseline budget projections at specific times each year to reflect legislative action, economic changes, and other developments. During the course of a year, however, events occur (usually, the enactment of legislation, actions by the courts, or decisions by executive branch agencies) that are different from those anticipated in developing the baseline projections. If new information indicates that an action or event that would affect CBO's baseline has happened or definitely will happen, CBO incorporates that information in its next regular update of its baseline. In addition, CBO immediately takes that information into account in assessing what will happen under current law when it analyzes the effects of legislation being considered by the Congress, even if the agency has not published new baseline projections.

If the Administration stopped making CSR payments because of executive or judicial action, CBO's typical procedures for updating its baseline would not necessarily apply because of the conflict between that action and the statutory requirements for constructing the baseline. Specifically, because the CSR payments are considered an entitlement, projections incorporating that action would differ from ones reflecting the statutory requirement that CBO assume full funding of entitlement authority. Hence, CBO would consult with the Budget Committees to decide whether and how to reflect the action in the agency's baseline and cost estimates. If the policy was implemented through legislation, no such conflict would arise, and its effects would be reflected in the baseline and cost estimates immediately.

Methodology

This policy's effects would depend in part on how individuals responded to changes in the prices, after subsidies, they had to pay for nongroup insurance and on their underlying desire for such insurance. Effects would also stem from how businesses responded to changes in those prices for nongroup insurance and in the attractiveness of other aspects of nongroup alternatives to employment-based insurance.

To capture those complex interactions, CBO uses a microsimulation model to estimate how rates of coverage and sources of insurance would change as a result of alterations in eligibility and subsidies for—and thus the net cost of—various insurance options. Based on survey data, that model incorporates a wide range of information about a representative sample of individuals and families, including their income, employment, health status, and health insurance coverage. The model also incorporates information from the research literature about the responsiveness of individuals and employers to price changes and the responsiveness of individuals to changes in eligibility for public coverage. CBO regularly updates the model so that it incorporates information from the most recent administrative data on insurance coverage and premiums. CBO and JCT use that model—in combination with models to project tax revenues, models of spending and actions by states, projections of trends in early retirees' health insurance coverage, and other available information—to inform their estimates of the numbers of people with certain types of coverage and the associated federal budgetary costs.[9]

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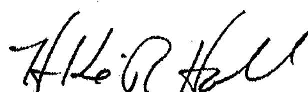


Keith Hall
Director
August 2017

9. For additional information, see Congressional Budget Office, "Methods for Analyzing Health Insurance Coverage" (accessed August 14, 2017), www.cbo.gov/topics/health-care/methods-analyzing-health-insurance-coverage.

Table 1. Illustrative Examples, for Single Individuals With Income Under 200 Percent of the FPL, of Subsidies for Nongroup Health Insurance in 2026 Under CBO's Baseline and Under a Policy Eliminating CSR Payments

Dollars

	Bronze Plan				Gold Plan				Silver Plan			
	Premium[a] -	Premium Tax Credit[b] =	Net Premium Paid	Actuarial Value of Plan (Percent)[c]	Premium[a] -	Premium Tax Credit[b] =	Net Premium Paid	Actuarial Value of Plan (Percent)[c]	Premium[a] -	Premium Tax Credit[b] =	Net Premium Paid	Actuarial Value of Plan After Cost-Sharing Subsidies (Percent)[c]
Single Individual With Annual Income of $18,900 (125 percent of FPL) and Not Eligible for Medicaid[d]												
Under the Baseline												
21 years old	4,300	4,300	0		*6,550*	*4,650*	*1,900*		5,100	4,650	450	
40 years old	5,500	5,500	0	60	*8,350*	*6,050*	*2,300*	80	6,500	6,050	450	94
64 years old	12,900	12,900	0		*19,650*	*14,850*	*4,800*		15,300	14,850	450	
Under the Policy, in the Marketplaces												
21 years old	4,700	4,700	0		6,200	5,900	300		6,400	5,900	500	
40 years old	6,000	6,000	0	65	7,900	7,700	200	80	8,200	7,700	500	94
64 years old	*14,100*	*14,100*	*0*		18,600	18,600	0		19,200	18,700	500	
Single Individual With Annual Income of $26,500 (175 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	3,400	900		*6,550*	*3,400*	*3,150*		5,100	3,400	1,700	
40 years old	5,500	4,800	700	60	*8,350*	*4,800*	*3,550*	80	6,500	4,800	1,700	87
64 years old	12,900	12,900	0		*19,650*	*13,600*	*6,050*		15,300	13,600	1,700	
Under the Policy, in the Marketplaces												
21 years old	4,700	4,550	150		6,200	4,550	1,650		6,400	4,550	1,850	
40 years old	6,000	6,000	0	65	7,900	6,350	1,550	80	8,200	6,350	1,850	87
64 years old	14,100	14,100	0		18,600	17,350	1,250		19,200	17,350	1,850	

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

All dollar figures have been rounded to the nearest $50. Amounts in light italic type show premiums for plans that very few people would buy because either more comprehensive coverage would be available at the same or a lower cost or equivalent coverage would be available at a lower cost.

CSR = cost-sharing reduction; FPL = federal poverty level.

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 the baseline and under a policy in which CSR payments to insurers are eliminated. 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, under which 64-year-olds can be charged premiums that are three times as much as those for 21-year-olds. CBO projects that, under both the baseline and the policy, most states will use the default 3-to-1 age-rating curve.

b. 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. That specified percentage grows over time. 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. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 takes into account the difference in the probability, as estimated in CBO's March 2016 baseline and under the policy eliminating CSR payments, that the specified percentages of income would be increased. Such an increase would apply if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceeded 0.504 percent of gross domestic product in the preceding year. CBO projects that the probability of reaching that percentage would be higher under the policy than it is under the baseline.

c. The actuarial value of a plan is the percentage of costs for covered services that the plan pays on average. The federal government's CSR payments to insurers 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 subsidy amounts in this example would range from $1,600 for a 21-year-old with income at 125 percent of the FPL to $4,750 for a 64-year-old at the same income level and 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, CSRs generally 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.

If CSR payments were eliminated, insurers would still have to provide plans with reduced cost-sharing to qualified individuals at the specified income levels. CBO projects that state insurance commissioners would most likely direct insurers to incorporate the amounts into the premiums only for silver plans because doing so would best take advantage of increases in premium tax credits. CBO anticipates that in most states, bronze plans available in the marketplaces would have an actuarial value of 65 percent, and gold plans, 80 percent. Silver plans would have an actuarial value of 70 percent for those not eligible for CSRs and 73 percent, 87 percent, or 94 percent for those eligible. Outside the marketplaces, plans would be available at actuarial values of 60 percent, 70 percent, and 80 percent, CBO anticipates.

The premiums for plans reflect not only the difference in the percentage of costs paid but also the effects of induced demand, as people in plans with a higher actuarial value tend to consume more health services, and risk selection, as people with higher expected health care costs are more likely to buy plans with higher actuarial values. A risk-adjustment program under the Affordable Care Act mitigates but does not fully eliminate the effect of risk selection.

d. 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 $18,900 will equal 125 percent of the FPL and an income of $26,500 will equal 175 percent of the FPL.

Table 2. Illustrative Examples, for Single Individuals With Income Over 200 Percent of the FPL, of Subsidies for Nongroup Health Insurance in 2026 Under CBO's Baseline and Under a Policy Eliminating CSR Payments

Dollars

	Bronze Plan				Silver Plan				Gold Plan			
	Premium[a] -	Premium Tax Credit[b] =	Net Premium Paid	Actuarial Value of Plan (Percent)[c]	Premium[a] -	Premium Tax Credit[b] =	Net Premium Paid	Actuarial Value of Plan After Cost-Sharing Subsidies (Percent)[c]	Premium[a] -	Premium Tax Credit[b] =	Net Premium Paid	Actuarial Value of Plan (Percent)[c]
Single Individual With Annual Income of $34,100 (225 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	2,050	2,250		5,100	2,050	3,050		6,550	2,050	4,500	
40 years old	5,500	3,450	2,050	60	6,500	3,450	3,050	73	8,350	3,450	4,900	80
64 years old	12,900	12,250	650		15,300	12,250	3,050		19,650	12,250	7,400	
Under the Policy, In the Marketplaces												
21 years old	4,700	3,050	1,650		6,400	3,050	3,350		6,200	3,050	3,150	
40 years old	6,000	4,850	1,150	65	8,200	4,850	3,350	73	7,900	4,850	3,050	80
64 years old	14,100	14,100	0		19,200	15,850	3,350		18,600	15,850	2,750	
Under the Policy, Outside the Marketplaces												
21 years old	4,300	0	4,300		5,100	0	5,100		6,200	0	6,200	
40 years old	5,500	0	5,500	60	6,500	0	6,500	73	7,900	0	7,900	80
64 years old	12,900	0	12,900		15,300	0	15,300		18,600	0	18,600	
Single Individual With Annual Income of $56,800 (375 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	0	4,300		5,100	0	5,100		6,550	0	6,550	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	8,350	0	8,350	80
64 years old	12,900	8,550	4,350		15,300	8,550	6,750		19,650	8,550	11,100	
Under the Policy, In the Marketplaces												
21 years old	4,700	0	4,700		6,400	0	6,400		6,200	0	6,200	
40 years old	6,000	800	5,200	65	8,200	800	7,400	70	7,900	800	7,100	80
64 years old	14,100	11,800	2,300		19,200	11,800	7,400		18,600	11,800	6,800	
Under the Policy, Outside the Marketplaces												
21 years old	4,300	0	4,300		5,100	0	5,100		6,200	0	6,200	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	7,900	0	7,900	80
64 years old	12,900	0	12,900		15,300	0	15,300		18,600	0	18,600	
Single Individual With Annual Income of $68,200 (450 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	0	4,300		5,100	0	5,100		6,550	0	6,550	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	8,350	0	8,350	80
64 years old	12,900	0	12,900		15,300	0	15,300		19,650	0	19,650	
Under the Policy, In the Marketplaces												
21 years old	4,700	0	4,700		6,400	0	6,400		6,200	0	6,200	
40 years old	6,000	0	6,000	65	8,200	0	8,200	70	7,900	0	7,900	80
64 years old	14,100	0	14,100		19,200	0	19,200		18,600	0	18,600	
Under the Policy, Outside the Marketplaces												
21 years old	4,300	0	4,300		5,100	0	5,100		6,200	0	6,200	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	7,900	0	7,900	80
64 years old	12,900	0	12,900		15,300	0	15,300		18,600	0	18,600	

Continued

Table 2 continued.

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

All dollar figures have been rounded to the nearest $50. Amounts in light italic type show premiums for plans that very few people would buy because either more comprehensive coverage would be available at the same or a lower cost or equivalent coverage would be available at a lower cost.

CSR = cost-sharing reduction; FPL = federal poverty level.

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 the baseline and under a policy in which CSR payments to insurers are eliminated. 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, under which 64-year-olds can be charged premiums that are three times as much as those for 21-year-olds. CBO projects that, under both the baseline and the policy, most states will use the default 3-to-1 age-rating curve.

b. 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. That specified percentage grows over time. 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. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 takes into account the difference in the probability, as estimated in CBO's March 2016 baseline and under the policy eliminating CSR payments, that the specified percentages of income would be increased. Such an increase would apply if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceeded 0.504 percent of gross domestic product in the preceding year. CBO projects that the probability of reaching that percentage would be higher under the policy than it is under the baseline.

c. The actuarial value of a plan is the percentage of costs for covered services that the plan pays on average. The federal government's CSR payments to insurers 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 subsidy amounts in this example would range from $150 for a 21-year-old with income at 225 percent of the FPL to $450 for a 64-year-old at the same income level. Under current law, CSRs generally 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.

If CSR payments were eliminated, insurers would still have to provide plans with reduced cost-sharing to qualified individuals at the specified income levels. CBO projects that state insurance commissioners would most likely direct insurers to incorporate the amounts into the premiums only for silver plans because doing so would best take advantage of increases in premium tax credits. CBO anticipates that in most states, bronze plans available in the marketplaces would have an actuarial value of 65 percent, and gold plans, 80 percent. Silver plans would have an actuarial value of 70 percent for those not eligible for CSRs and 73 percent, 87 percent, or 94 percent for those eligible. Outside the marketplaces, plans would be available at actuarial values of 60 percent, 70 percent, and 80 percent, CBO anticipates.

The premiums for plans reflect not only the difference in the percentage of costs paid but also the effects of induced demand, as people in plans with a higher actuarial value tend to consume more health services, and risk selection, as people with higher expected health care costs are more likely to buy plans with higher actuarial values. A risk-adjustment program under the Affordable Care Act mitigates but does not fully eliminate the effect of risk selection.

Because plans and premiums available in and outside the marketplaces would differ more under the policy than they do under current law, individuals would have a greater incentive to compare options in both markets.

d. 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 $34,100 would equal 225 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.

Table 3. Estimate of the Net Budgetary Effects of Terminating Payments for Cost-Sharing Reductions

Billions of Dollars, by Fiscal Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2026
Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	0	6	13	22	28	32	35	36	37	37	247
Medicaid	0	-1	-1	*	1	1	1	2	2	2	7
Change in Small-Employer Tax Credits[b,c]	0	*	*	*	*	*	*	*	*	*	*
Change in Penalty Payments by Employers[c]	0	0	*	*	-1	-1	-2	-2	-2	-3	-11
Change in Penalty Payments by Uninsured People	0	0	*	*	*	*	*	*	*	*	*
Medicare[d]	0	0	*	*	*	*	*	*	*	*	-2
Other Effects on Revenues and Outlays[e]	0	1	1	-1	-4	-7	-8	-9	-10	-10	-47
Total Effect on the Deficit	**0**	**6**	**14**	**21**	**24**	**25**	**26**	**26**	**26**	**26**	**194**
Memorandum:											
Total Changes in Direct Spending	0	4	9	17	23	26	30	31	31	31	201
Total Changes in Revenues[f]	0	-3	-5	-4	-1	2	3	5	5	5	7
Details of Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues											
Premium tax credits											
Effects on outlays	0	13	22	29	35	38	41	43	44	44	309
Effects on revenues	0	2	4	5	6	7	8	8	8	8	56
Subtotal	0	15	25	35	41	45	49	51	52	52	365
Cost-sharing outlays	0	-8	-12	-13	-13	-13	-14	-14	-15	-16	-118
Outlays for the Basic Health Program	0	*	*	*	*	*	*	*	*	*	*
Collections for risk adjustment	0	0	-1	-1	-1	-1	-1	-1	-1	-1	-6
Payments for risk adjustment	0	0	1	1	1	1	1	1	1	1	6
Total	0	6	13	22	28	32	35	36	37	37	247

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

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. Budget authority would be equal to the outlays shown.

Except as noted, positive numbers indicate an increase in the deficit, and 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 includes 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 that changes in taxable compensation would have on revenues.

d. Effects arise mostly from changes in payments to hospitals that treat a disproportionate share of uninsured or low-income patients.

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

f. Positive numbers indicate an increase in revenues; negative numbers indicate a decrease in revenues.

Table 4. Effects of Terminating Payments for Cost-Sharing Reductions 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 Policy										
Medicaid[a]	0	*	*	*	*	*	*	*	*	*
Nongroup coverage, including marketplaces	0	-1	*	2	3	3	4	4	3	3
Employment-based coverage	0	1	*	-1	-2	-3	-3	-3	-3	-3
Other coverage[b]	0	*	*	*	*	*	*	*	*	*
Uninsured	0	1	*	-1	-1	-1	-1	-1	-1	-1
Uninsured Under the Policy	26	27	27	27	26	27	27	27	27	27
Percentage of the Population Under Age 65 With Insurance Under the Policy										
Including all U.S. residents	90	90	90	90	90	90	90	90	90	90
Excluding unauthorized immigrants	93	92	93	93	93	93	93	93	93	93

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 staff of 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.

Numbers may not add up to totals because of rounding.

* = between -500,000 and 500,000.

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.

00317

Texas, et al. v.
United States of America, et al.

USDC Northern District of Texas
Case No. 4:18-cv-00167-O

Exhibit L

HEALTH INSURANCE EXCHANGES 2018 OPEN ENROLLMENT PERIOD FINAL REPORT

Date	2018-04-03
Title	HEALTH INSURANCE EXCHANGES 2018 OPEN ENROLLMENT PERIOD FINAL REPORT
Contact	press@cms.hhs.gov

HEALTH INSURANCE EXCHANGES 2018 OPEN ENROLLMENT PERIOD FINAL REPORT

This report summarizes enrollment activity in the individual Exchanges[1] during the Open Enrollment Period for the 2018 plan year (2018 OEP) for all 50 states and the District of Columbia. Approximately 11.8 million[2] consumers selected or were automatically re-enrolled[3] in Exchange plans during the 2018 OEP. An accompanying public use file (PUF) includes detailed state-level data on plan selections and demographic characteristics of consumers.[4] The methodology for this report and detailed metric definitions are included with the public use file.

The 2018 OEP Final Report includes data for the 39 states that use the HealthCare.gov eligibility and enrollment platform, as well as for the 12 State-Based Exchanges (SBEs) that use their own eligibility and enrollment platforms.[5] Demographic and plan information for consumers with a plan selection provided by all 50 states plus DC include: age, metal level, and whether the consumer had advance payments of the premium tax credit (APTC) or cost sharing reductions (CSR).

For the 39 states that use the HealthCare.gov platform, additional data are available, including gender, rural location, self-reported race and ethnicity, household income as a percent of the federal poverty level (FPL), and the average premiums among consumers with and without APTC. Data files with information on plan selections at the county and zip code levels are also available for HealthCare.gov states.

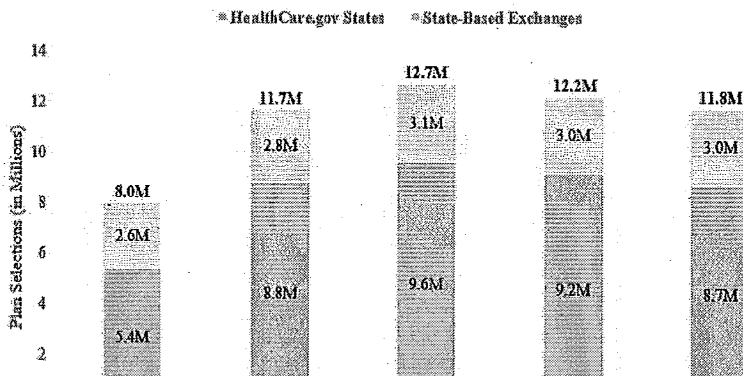
Key findings from this report include:

- Approximately 11.8 million consumers selected or were automatically re-enrolled in an Exchange plan in the 50 states, plus DC.
- Twenty-seven percent of consumers with a plan selection were classified as new consumers.
- Sixty-three percent of consumers selected silver plans; 29 percent of consumers selected bronze plans and 7 percent of consumers selected gold.
- Among consumers using HealthCare.gov, the average premium before application of the tax credit was $621 during the 2018 OEP and $476 during the 2017 OEP.

Consumers Selecting Plans through the Exchanges: 50 States, plus DC

Approximately 11.8 million consumers selected or were automatically re-enrolled in an Exchange plan during the 2018 OEP. This includes approximately 8.7 million consumers in the 39 states using the HealthCare.gov platform and approximately 3.0 million consumers in SBEs (see Figure 1).[6]

Figure 1: Plan Selections during the 2014 – 2018 Open Enrollment Periods[7]



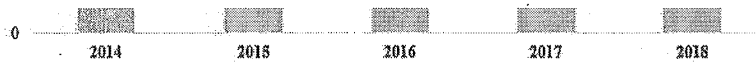


Table 1 summarizes the types of consumers who enrolled during the 2018 OEP for all 50 states plus DC. Twenty-seven percent of consumers with a plan selection were new to the Exchanges and 47 percent of consumers actively returned to select a 2018 plan on the Exchanges.

Table 1: Summary of 2018 OEP Plan Selections by Enrollment Type

	Number[8]	% of Total
2018 New Consumers	3,223,034	27
Returning Consumers Re-enrolling in 2018 Coverage		
Active Re-enrolles	5,467,967	47
Automatic Re-enrollees	2,865,774	24
Unknown Re-enrollment type	193,407	2
Total 2018 Plan Selection	11,750,175	100

Table 2 summarizes selected demographic and plan characteristics for consumers during the 2018 OEP; additional information is contained in the accompanying public use file. Nine percent of all Exchange consumers were younger than 18 years old. Nationally, 83 percent of consumers had their premiums reduced by APTC.

Table 2: Demographic and Plan Characteristics of Consumers with 2018 OEP Plan Selections

Age	**Number[9]**	**% of Total[10]**
0 to 17	1,003,825	9
18 to 34	3,073,716	26
35 to 54	4,231,303	36
55+	3,359,538	29
Metal Level		
Catastrophic	98,389	1
Bronze	3,358,078	29
Silver	7,353,570	63
Gold	833,026	7
Platinum	110,893	1
Financial Assistance [11]		
With APTC	9,776,104	83
With CSR	6,302,193	54

Consumers Selecting Plans through the HealthCare.gov Platform

Additional information is available for the 8.7 million consumers in states that use HealthCare.gov. Table 3 shows selected demographic and plan characteristics among consumers who selected plans during the 2018 OEP. Fifty-four percent of HealthCare.gov consumers were female and 18 percent of consumers resided in a rural location. Seventy percent of consumers reported household incomes between 100% and 250% FPL.[12]

Table 3: Demographic and Plan Characteristics of Consumers with 2018 OEP Plan Selections on HealthCare.gov

Gender	**Number**	**% of Total[13]**
Female	4,763,670	54
Male	3,979,972	46
Location		
Rural	1,573,716	18
Non-rural	7,169,926	82
Race		
Asian	629,935	7
African-American	598,440	7
White	4,309,822	49
Other Race[14]	364,366	4
Unknown	2,841,079	32
Ethnicity		
Hispanic/Latino	1,033,699	12
Not Hispanic/Latino	5,428,184	62
Unknown	2,281,759	26

Household Income		
100% - 250% FPL	6,142,502	70
251% - 400% FPL	1,614,363	18
Other Household Income[15]	986,777	11

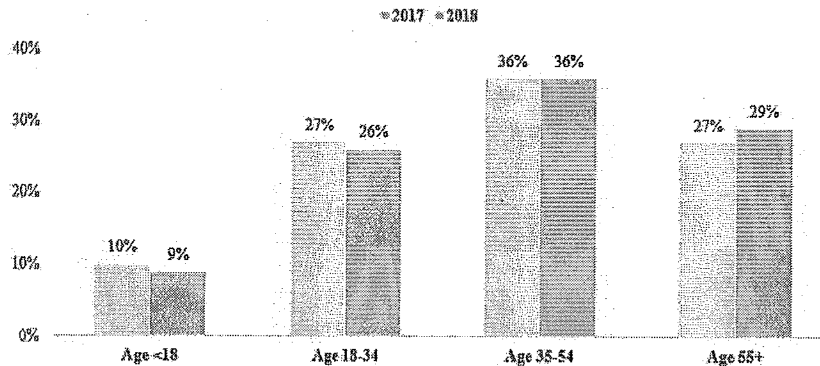
Table 4 contains information on premiums for consumers in states that used HealthCare.gov in 2018. The average premium before application of the tax credit was $621 during the 2018 OEP and $476 during the 2017 OEP. Eighty-five percent of consumers who selected or were automatically re-enrolled in a 2018 plan through HealthCare.gov had APTC. Among consumers with APTC in 2018, the average tax credit covered about 86 percent of the total premium, resulting in an average premium after APTC of $89 per month.

Table 4: Average Premium and Average Net Premium after APTC for Consumers with a 2018 OEP Plan Selection on HealthCare.gov

	Number	Average Premium	Average APTC	Average Premium after APTC
All Consumers	8,746,642	$621	$468	$153
Consumers w/ APTC	7,447,615	$639	$550	$89
Consumers w/o APTC	1,295,027	$522	NA	NA

In the 2018 OEP, nine percent of consumers were younger than 18 years old compared to 10 percent in 2017 (see Figure 2). Twenty-six percent of consumers were between 18 and 34 years old in 2018 compared to 27 percent in 2017. Twenty-nine percent of 2018 OEP consumers were 55 years or older, while 27 percent of 2017 OEP consumers were 55 years or older.

Figure 2: Proportion of Open Enrollment HealthCare.gov Consumers, by Age



The state-level PUF can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html

[1] This report includes Qualified Health Plan (QHP) selections made on the individual Exchange; the state-level and county-level public use files also includes data on dental plan selections.

[2] In addition to the total plan selections in this report there were 829,197 individuals in New York and Minnesota who signed up for coverage through a BHP. States have the option of establishing BHPs to provide health coverage for low-income residents who might otherwise be eligible for Exchange coverage.

[3] As in prior years, consumers with coverage at the end of 2017 who did not make an active selection were generally automatically re-enrolled for 2018. When consumers had 2018 Exchange plans available to them from their 2017 issuer, they were automatically re-enrolled into the same plan as 2017 or a different plan from the same issuer; depending on the Exchange, they could also be automatically re-enrolled into a suggested alternate plan from a different issuer.

[4] The state-level PUF can be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html. For the 39 states that use the HealthCare.gov eligibility and enrollment platform, public use files with information on plan selections at the county and zip code levels are also available.

[5] Data for SBEs that use their own eligibility and enrollment platforms are retrieved from the respective states' information systems and have not been validated by CMS, thus metric calculations for these states may vary. The 12 SBEs that use their own eligibility and enrollment platforms are California, Colorado, Connecticut, the District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington.

[6] Figures for HealthCare.gov states and SBEs do not sum to 11.8 million due to rounding, see the state-level PUF for more information.

[7] The data for the 2014 OEP was from 10/1/2013 to 4/19/2014; the 2015 OEP was from 11/15/2014 to 2/22/2015; the 2016 OEP was from 11/1/2015 to 2/1/2016 (1/31/2016 for some states); the 2017 OEP was from 11/1/2016 to 1/31/2017; for HealthCare.gov states the 2018 OEP was from 11/1/2017 to 12/15/2017 with data reported through 12/23/2017 (data through dates vary for SBEs; see the PUF methodology for detailed information). Plan selections by Exchange platform for each OEP reflects the status of the state's Exchange platform at the time of that OEP. Caution should be used when comparing plan selections across OEPs since some states have transitioned platforms between years, and state expansion of Medicaid may affect enrollment figures from year to year. Additionally, the rate at which issuers submitted plan cancellations may have varied from year to year and caution should be used in interpreting these data as they do not reflect plan effectuations.

[8] Enrollment type does not sum to the total due to administrative errors in processing a limited number of plan cancellations/terminations in Vermont. Please refer to the state-level PUF for more information.

[9] Some SBEs were unable to verify enrollee age and metal level characteristics, therefore those figures do not sum to 11,750,175; more information is available in the PUF definitions.

[10] The figures reported reflect data as a percent of the total (11,750,175), therefore totals may not sum to 100%.

[11] Financial assistance metrics were updated April 27, 2018 to reflect changes submitted by Washington, please see the state-level PUF for more information.

[12] For a family of four in 2018, a household income between 100% and 250% FPL generally corresponds to an annual household income of between $24,600 and $61,500.

[13] Totals may not sum to 100% due to rounding.

[14] Other Race includes multiracial, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander.

[15] Other household income includes plan selections for which consumers were not requesting financial assistance, incomes below 100% FPL, incomes above 400% FPL, and unknown income. Please see the public use file for more information.

[16] Note that these findings may not be generalizable to the entire population of consumers who selected an ACA compliant plan without APTC, as many consumers in this population purchase plans off the Exchange; premiums in this document aren't representative of individual plans off the Exchange.

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Texas, et al. v.
United States of America, et al.

USDC Northern District of Texas
Case No. 4:18-cv-00167-O

Exhibit M

Statement before the House Committee on Ways and Means
Subcommittee on Oversight

Examining the Effectiveness of the Individual Mandate under the Affordable Care Act

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Resident Fellow in Health Policy Studies

January 24, 2017

The American Enterprise Institute (AEI) is a nonpartisan, nonprofit, 501(c)(3) educational organization and does not take institutional positions on any issues. The views expressed in this testimony are those of the author.

Thank you Chairman Buchanan, Subcommittee Ranking Member Lewis, and Members of the Subcommittee for the opportunity to testify today to examine the effectiveness of the individual mandate under the Affordable Care Act (ACA).

I am testifying today as a health policy researcher and a resident fellow at the American Enterprise Institute (AEI). I also will draw upon previous experience as a senior health economist at the Joint Economic Committee and health policy researcher at several other Washington-based research organizations.

My testimony will outline the rationales and motivations behind use of the individual mandate within the ACA and then examine its disappointing record in trying to achieve its goals. I will summarize the inherent political, economic, and legal limits in attempting to implement and enforce a strong mandate, as well as the potential dangers and drawbacks in doing so. Finally, I will suggest that we need to distinguish the actual effects of the mandate from those due to other health policy changes, either in increasing insurance coverage or limiting its costs. I will conclude by outlining a variety of alternative policy remedies that could be pursued if the individual mandate is either weakened further or repealed.

The shaky case for the individual mandate is based on mistaken premises, faulty economic analysis, short-sighted politics, and flawed health policy. Opponents have found the mandate to be administratively challenging, politically unsustainable, economically unnecessary, beyond the proper role of government, and constitutionally questionable.

Arguments in favor of the individual mandate usually present it as a necessary, though far less popular, means to more laudable ends such as universal coverage, better access to health care for persons with preexisting health conditions, and lower health care costs for those already insured. However, the relationship between the mandate and the problems it purportedly could

solve always has been tenuous and contradictory at best. It turns out that the type of mandate that the U.S. political economy and health care system is likely to deliver in practice is very different and more complicated than what might be assumed under best-case theories.

Rearranging Increased Coverage Costs

One of the strongest driving forces behind officeholders resorting to the individual mandate is the desire to substitute "off-budget" mandated private funds in place of more visible taxes that they would otherwise find hard to impose to meet their insurance coverage goals and finance additional health care spending. Making the full costs of mandatory coverage more transparent reduces popular support for the latter. The hope instead is that an individual mandate can obscure the full sticker-price shock to taxpayers because mandated private spending is not officially treated as part of the federal budget. Instead, employers and insurers are enlisted as surrogate "tax collectors" through less transparent and politically accountable means.

Not surprisingly an individual mandate has the least support from those it is purported to help: people who currently do not enroll in public coverage or employer-sponsored insurance or who do not already purchase individual-market coverage. After all, coercing some people to do what they otherwise would not is the very point of a legal mandate. However, trying to force them to buy insurance they cannot afford or pay more for such coverage than it actually appears to be worth to them remains politically difficult.

Hence, an individual mandate often promises, but never manages, to pay for itself. In order to get lower-income individuals to comply with a mandate to purchase more insurance than they can afford, or want, to purchase, substantial taxpayer subsidies are used to fill some of the affordability gap. Insurance mandates create a perpetual conflict between their escalating costs, limited public and private resources to pay for them, and the false guarantees of richer coverage

ahead. The imbalances may be financed through various combinations of higher taxes, reduced benefits, higher premiums, lower take-home pay, fewer economic opportunities, and less insurance coverage for everyone else. Doing so also reduces portions of any projected increases in new premium "revenue" expected by insurers and health care providers from expanded coverage. Eventually, some of those less-visible costs are reimposed on the initially more "fortunate" newly insured.

Weak Enforcement

In their comprehensive review of the likely efficacy of mandates for health insurance, Glied, Hartz, and Giorgi (2007) concluded that predicting a target population's response to a mandate is, at best, an inexact science. Performance of mandates varies greatly with such important factors as the affordability of costs of compliance, the size of penalties, and the probability that penalties will be imposed in a timely manner. Glied, Hartz, and Giorgi also noted that even the best mandate is unlikely to affect the behavior of those who are transient (in terms of place of residence or employment status) and have few assets.

Some modelers of the coverage take-up effects of an individual mandate appear to assume reflexively that its commands will be obeyed faithfully, enforced consistently, and executed with nearly flawless precision. Actual enforcement practice under the ACA provides more of a muffled bark and toothless bite.

One early indication was that the mandate did not even begin to apply until January 1, 2014, even though the law was enacted in March 2010. Although the mandate penalties were supposed to be enforced by the Internal Revenue Service and collected through taxpayers' annual income tax returns, the agency is not allowed to use many of its standard enforcement tools to ensure payment of those taxes. The law provides that anyone who fails to pay in a timely

manner any penalty imposed by the mandate "shall not be subject to any criminal prosecution or penalty" and that the secretary of the Treasury shall not "file notice of lien" or "levy" on any property of a taxpayer by reason of such failure.[1]

The penalties for failing to comply with the mandate also are rather modest in proportion to the likely average premium cost of required coverage.[ii] The predictable result was that millions of individuals calculated that it is much less expensive to pay the penalty than to purchase mandatory insurance. The law's guaranteed-issue incentives for potential purchasers, coupled with loose enforcement of eligibility for special enrollment periods between annual open season windows, encouraged individuals to enroll "just in time" when sick and "go bare" when healthy (and pay less in penalties than in total premiums), further ensuring limited and erratic mandate compliance.

Moreover, the ACA provisions for exemptions from the individual mandate -- involving illegal immigrants, foreign nationals, religious prohibitions, and most importantly "unaffordability"[iii] all reveal how various political and economic factors limit the enforceable scope of any theoretically universal mandate. Once the individual mandate was first put into effect for the 2014 plan year, other permissive exemptions were added, for such excuses as recent death of a close family member, facing evictions, and having medical expenses that could not be paid in the last 24 months that resulted in substantial debt. In addition, reliance on the federal income tax system and the IRS as primary enforcers of the mandate fails to reach millions of Americans who are not required to (or do not) file a federal income tax return. The penalty is pro-rated for people who are uninsured for a portion of the year and waived for people who have a period without insurance of less than three months.

Ironically, even the strongest version of an individual mandate to purchase health

insurance would be too weak to guarantee what should be its ultimate objective – improvements in people's health. Requiring that someone have health insurance is not the same as ensuring they actually receive all of the effective health care services they may need in a timely manner and comply with their physicians' advice, let alone that we all take many other steps beyond even the delivery of covered medical services that might do more to improve their current and future health. To do that, one might need to mandate not just the purchase of health insurance but also delivery of the actual "treatment"! Yet somehow the image of a mandate that all preventive and therapeutic "treatment" be received at the right time and right place (or even the right physical point of entry?) with no questions asked or informed consent required suggests more vividly the limits of government coercion in achieving health goals.

Weak Compliance

Projections for compliance versus penalty payment under the individual mandate by the Congressional Budget Office (CBO) have tended to overestimate the degree of compliance, but in a choppy manner. For example, using 2016 as a baseline year, CBO first projected in April 2010 that the ACA's individual mandate would help produce more coverage of the uninsured and collect only $4.2 billion in mandate penalties from 3.9 million individuals, even while leaving 13-14 million Americans exempt from its reach. In 2012, CBO revised those numbers to project a higher amount of $6.9 billion in mandate penalties from about 5.9 million individuals. In 2014, CBO lowered those estimates to $4.2 billion, to be collected from about 3.9 million individuals. In 2016, the CBO estimates dipped slightly again, to $3 billion collected from a monthly average of 3 million individuals. CBO's reported estimates regarding the number of exempted individuals for the years 2014-2016 are not reported in a consistent manner, particularly in distinguishing between individuals who did not have to report on compliance

because they were exempt from filing federal income taxes and others who were exempt from the individual mandate for other reasons.

These varying estimates somewhat reflect changes in underlying assumptions, reporting methods, and ACA implementation policy, but they also suggest their inexact nature and limited degrees of predictive accuracy. In practice, the IRS has reported noticeably higher numbers of individual mandate penalty payers (7.5 million in 2014, 6.5 million in 2015), despite lower amounts of actual revenue collected ($1.5 billion in 2014, $1.7 billion in 2015). The IRS also reports that about 12 million individuals in 2014 and 12.7 million individuals in 2015 were exempted from the mandate. (The 2015 estimates are preliminary and likely to grow somewhat higher, based on past trends).

Still the Most Unpopular Part of the ACA

The individual mandate issues touches expose nerves and offends core principles in ways that other elements of the modern regulatory state do not. Many Americans remain troubled by the idea of Congress imposing a legal mandate on citizens to purchase a private (but highly regulated) product, regardless of their wishes. They worry that implementing an individual mandate inevitably generates more and more rules regarding exactly what it requires, how it is carried out, and who pays for it. Hence, the individual mandate has consistently remained the most intensely unpopular provision of the new health law since it first took shape. For example, the November Kaiser Health Tracking Poll conducted shortly after the November elections found that only 35 percent of all Americans held favorable views about the individual mandate.[iv]

Concerns that an individual mandate violates basic principles of economic freedom, personal choice, and limited government under the U.S. Constitution have persisted years after the Supreme Court's narrowly divided decision in *NFIB v. Sebelius* to uphold the ACA mandate

as a constitutionally valid exercise of the congressional power to tax, rather than as a regulatory penalty under the power of Congress to regulate interstate commerce.[v] It appears that the individual mandate remains politically unpopular whether it is viewed as a limited regulatory penalty to spur more purchasing of required health insurance or a modest tax to help finance subsidies to do so.

Reciprocal Floors and Ceilings Limit the Individual Mandate

The ACA's individual mandate was primarily designed to help fill in the gaps between what the law's advocates could deliver politically in larger taxpayer subsidies for expanded health insurance coverage and the higher costs of coverage produced by more aggressive regulation of health insurance. It essentially aimed to require less-cost, low-risk individuals not only to obtain or retain federally-mandated minimum essential coverage, but also to pay more for it, in order to cross-subsidize lower premiums for other high-risk and/or low-income individuals. However, the individual mandate continues to face significant political limits on how large the mandate's penalties can be, how aggressively they can be enforced, and how much compliance the mandate will produce. Hence, the mandate's best future for continued survival involves operating much more as a gentle "suggestion" or nudge (with modest penalties and weak enforcement) rather than a more polarizing "command."

In short, the space separating the floor and ceiling for the individual mandate is narrow. If the individual mandate ever begins the reach the point in practice at which it threatens to become more binding and effective, political feedback and pressure to pull back will intensify.

Impact on Insurance Coverage Expansion?

It's a fact that health insurance coverage has increased significantly since the ACA was enacted into law and implemented. The causal factors are more complex and contestable.

CBO has tended to be on the high side of claims that the ACA would rapidly and substantially increase coverage in the new law's exchanges (later renamed "Marketplaces") for individual coverage. It also has repeatedly overestimated the role of the individual mandate in delivering such gains. CBO's original projections assumed far more stability in the exchanges by now, and much larger enrollment in them (about 21-22 million people, rather than a little more than half that number). Rather than reexamine the flawed foundations of its previous assumptions, CBO appears to have recently doubled down on them in projecting that a partial repeal of the ACA (similar to one passed by Congress but vetoed in January 2016), without additional provisions to replace it, would increase the number of uninsured by 18 million in 2018, 27 million in 2020, and 32 million in 2026.

The CBO estimates are flawed in overstating its baseline assumptions for future growth in the ACA's version of individual market coverage, exaggerating the response rate of those subject to the individual mandate before and after its possible repeal, misestimating Medicaid coverage effects, and setting unrealistic parameters for future health policy changes.[vi]

To be fair, the ACA in practice has evolved through numerous iterations of interrelated moving parts, unforeseen modifications in policies and practices, and changes in economic assumptions. However, it's still accurate to conclude that the most significant force behind the size and shape of insurance coverage gains has been large taxpayer subsidies, particularly through the expanded Medicaid program. Indeed, even the most recent estimate by one of the ACA's past architects, Jonathan Gruber, concluded that overall coverage rates in 2014 did not respond to either the mandate's penalties or exemptions for lacking coverage. Gruber and his co-authors did find that Medicaid accounted for 63 percent of the coverage gains in 2014 that their methods could identify, and that the fairly modest effects of the law's premium subsidies for

ACA exchange coverage accounted for the rest.[vii]

This type of analysis is consistent with other findings that enrollment rates for ACA exchanges are sensitive to one's income and premium tax credit subsidy level,[viii] and that enrollment by younger and healthier risks – the primary targets of the individual mandate -- has failed to reach expected levels.[ix]

Future Unknowns

Given that the practical consequences of the individual mandate in increasing insurance market coverage appear to be minimal, at best, what accounts for other sources of support or opposition to it? One well-worn hope is that the individual mandate can help to strengthen and lock in the effects of other ACA health insurance regulations for minimum essential health benefits, qualified health plans, adjusted community rating, and guaranteed issue, in part by reducing their most visible on-budget costs. The ultimate aim on the regulatory side would be to make the purchase of any other alternative health care arrangements all but impossible.

Opponents of the individual mandate want to short-circuit any future evolution of a stronger mandate that requires compliance with potentially more sweeping regulations not yet implemented, or even proposed. Hence, a large portion of the ongoing debate over the individual mandate is as much about what it might become later than what it is currently.

Alternatives

Focus on the individual mandate in the ACA's drafting, implementation, and post-enactment debate has tended to obscure and preempt consideration of other policy alternatives. They include:

- Extension of HIPAA-like protection against health status risk-rating to individuals who maintain "continuous" qualified insurance coverage while switching between individual market health plans or between group-market and individual-market plans,
- Imposing penalties in the form of higher insurance premium surcharges for each time that an individual fails to obtain or maintain minimum qualified coverage during annual open enrollment periods. This would operate somewhat like the delayed enrollment penalty for coverage in Medicare Part B or Medicare Part D.[x]
- Tightening eligibility and enforcement further for "special enrollment" periods between annual open seasons in ACA exchanges
- Default enrollment in minimum qualified coverage costing no more than the value of applicable federal taxpayer subsidies for insurance, provided that sufficient notice and simple mechanisms to "opt out" are ensured,
- Providing even more generous, but also more transparent, taxpayer subsidies for obtaining and maintaining qualified insurance coverage in the individual market. This would emulate part of the success of employer-sponsored insurance and federal employee health benefits program coverage, albeit at an even-higher per-enrollee budgetary cost.
- Enabling and incentivizing insurers to offer coverage that is less expensive and more attractive to potential uninsured customers.

Of course, the last option --- though closest to market-based, competitive, patient-centered health insurance -- is likely to be considered only as a last resort if and when the other policy options fail!

[i] Patient Protection and Affordable Care Act, 2010, section 1501(g)(2)[(A) and (B)(i-ii)]).

[ii] The penalty is the greater of a flat-dollar amount or a percentage of the violator's income. After the penalty amounts were phased in over three years (ending in 2016), the flat-dollar version equaled $695 per individual, and the percentage-of-income version equaled 2.5 percent of income. The total family penalty for the flat-dollar version is capped at 300% of the amount per individual. The total monthly penalty for a taxpayer and his or her dependents for the percentage-of-income version cannot be more than the cost of the national average premium for bronze-level health plans (60 percent actuarial value) offered through health insurance exchanges (for the relevant family size). The latter penalty amount can be multiplied by the number of individuals in a family subject to a penalty, up to a maximum of five individuals. The flat dollar penalty amount is indexed to increase at the rate of inflation in years after 2016.

[iii] Unaffordability in the ACA statute is defined as when one's required health premium costs would be greater than, 8 percent of household income, beginning in 2014. This unaffordability measure has been subsequently indexed upward to 8.13 percent for 2016.

[iv] Ashley Kirzinger, Elise Sugarman, and Mollyann Brodie, Kaiser Health Tracking Poll: November 2016, Kaiser Family Foundation, December 1, 2016, Figure 11, http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-november-2016/. See also Dennis Thompson, "6 Years Later, Obamacare Still Divides America: Poll," *HealthDay,* May 5, 2016, (Table 3 notes a Harris Poll finding that 64 percent of U.S. adults would like to repeal the ACA's individual mandate), http://www.theharrispoll.com/politics/Obamacare-Still-Divides-America.html.

[v] See Thomas A. Lambert, "How the Supreme Court Doomed the ACA to Failure," *Regulation*, Winter 2012-2013, https://object.cato.org/sites/cato.org/files/serials/files/regulation/2013/1/v35n4-5.pdf, asserting that Chief Justice Roberts' majority opinion also means that the penalty for failure to carry health insurance can count as a tax for constitutional purposes, and remain a valid exercise of congressional power, but only if it is kept so small as to be largely ineffective.

[vi] See, e.g., Brian Blasé, "Learning from CBO's History of Incorrect ObamaCare Projections," *The Apothecary*, January 2, 2017, http://www.forbes.com/sites/theapothecary/2017-01-02/learning-from-cbos-history-of-incorrect-obamacare-projections/print/; Avik Roy, "Four Critical Problems with the CBO's Latest Obamacare Repeal Estimates, The Apothecary, January 17, 2017, http://www.forbes.com/sites/theapothecary/2017/01/17/four-critical-problems-with-the-cbos-latest-obamacare-repeal-estimates/#1292a6b77862.

[vii] Molly Frean, Jonathan Gruber, and Benjamin D. Sommers, "Disentangling the ACA's Coverage Effects – Lessons for Policymakers," *New England Journal of Medicine*, 375, no. 17 (2016): 1605-1607. See also Molly Frean, Jonathan Gruber, and Benjamin D. Sommers, "Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act," National Bureau of Economic Research Working Paper no. 22213, April 2016 (finding that "the mandate penalty had a negligible impact on coverage").

[viii] Caroline F. Pearson, "Exchanges Struggle to Enroll Consumers as Income Increases," Avalere, March 25, 2015, http://avalere.com/expertise/managed-care/insights/exchanges-struggle-to-enroll-consumers-as-income-increases.

[ix] Brian Blasé, "ObamaCare's Failure and Moving Health Care Policy in a New Direction," *The Apothecary*, December 15, 2016, http://www.forbes.com/sites/theapothecary/2016/12/15/obamcares-failure-and-moving-health-care-policy-in-a-new-direction/print/

[x] The penalty would not necessarily be cumulative over one's remaining lifetime if one "requalifies" again by obtaining and maintaining such coverage in several subsequent, consecutive years.

Texas, et al. v.
United States of America, et al.

USDC Northern District of Texas
Case No. 4:18-cv-00167-O

Exhibit N

Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey

Tricia Brooks, Karina Wagnerman,

Samantha Artiga (https://www.kff.org/person/samantha-artiga/), and

Elizabeth Cornachione (https://www.kff.org/person/elizabeth-cornachione/)

Published: Mar 21, 2018

EXECUTIVE SUMMARY

Key Takeaways

This 16th annual 50-state survey provides data on Medicaid and the Children's Health Insurance Program (CHIP) eligibility, enrollment, renewal and cost sharing policies as of January 2018. It shows:

- Medicaid and CHIP provide a robust base of coverage for low-income children. All but two states cover children with incomes up to at least 200% of the federal poverty leve (FPL, $41,560 per year for a family of three in 2018), including 19 states that cover children with incomes at or above 300% FPL. The ten-year extension of federal funding for CHIP approved by Congress provides states stable funding to maintain children's coverage and continues protections for children's coverage moving forward.
- There have been major gains in Medicaid eligibility for parents and other adults undei the Affordable Care Act (ACA) Medicaid expansion, but eligibility remains limited in the 19 states that have not implemented the expansion. Among non-expansion states, the median eligibility level for parents is 43% FPL ($8,935 for a family of three in 2018) and other adults generally are ineligible. Alabama and Texas have the lowest parent eligibility limits at 18% FPL or $3,740 per year for a family of three. Additional states may expand Medicaid for adults in the coming year, which would reduce the number of poor uninsured adults who fall into the coverage gap. States moving forward with expansion may seek waivers to add requirements or restrictions for adults as a condition of expanding.
- Through significant investments of time and resources, most states have transformed their Medicaid and CHIP enrollment and renewal processes to provide a modernized, streamlined experience as outlined in the ACA. With these processes, a growing number of states are processing real-time eligibility determinations and automated renewals through electronic data matches with trusted data sources. Looking ahead, waivers and other proposed changes for adults, including premiums and cost sharing, work requirements, and lockout periods, require complex documentation and costly administrative processes that run counter to the simplified enrollment and renewal processes states have implemented under the ACA.

This 16th annual 50-state survey provides data on Medicaid and the Children's Health Insurance Program (CHIP) eligibility, enrollment, renewal and cost sharing policies as of January 2018. It takes stock of how the programs have evolved as the fifth year of implementation of the Affordable Care Act (ACA) begins, discusses policy changes made during 2017, and looks ahead to issues that may affect state policies moving forward. It is based on a survey of state Medicaid and CHIP officials conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families. State data are available in Appendix Tables 1-20.

Eligibility

Medicaid and CHIP eligibility for children and pregnant women has remained robust under the ACA. Reflecting expansions prior to the ACA, all but two states cover children with incomes up to at least 200% FPL ($41,560 per year for a family of three in 2018) through Medicaid and CHIP (Figure 1), and 34 states cover pregnant women up to at least 200% FPL. Eligibility levels for children and pregnant women did not change significantly under the ACA. The ACA protected children's eligibility under its maintenance of effort (MOE) provision, which requires states to maintain eligibility levels for children that are at least as high as those in place when the ACA was enacted in 2010. The recent ten-year extension of CHIP continues the MOE. Under this legislation, the MOE will only apply to children in families with incomes at or below 300% FPL (305% FPL after the five percentage point of income disregard) after October 1, 2019, although states can maintai current higher eligibility levels and receive federal matching funds.

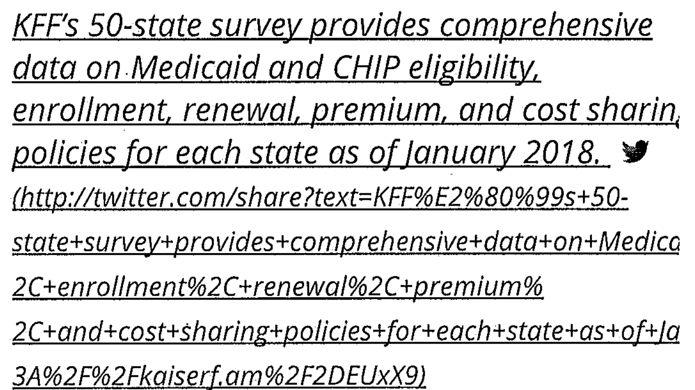
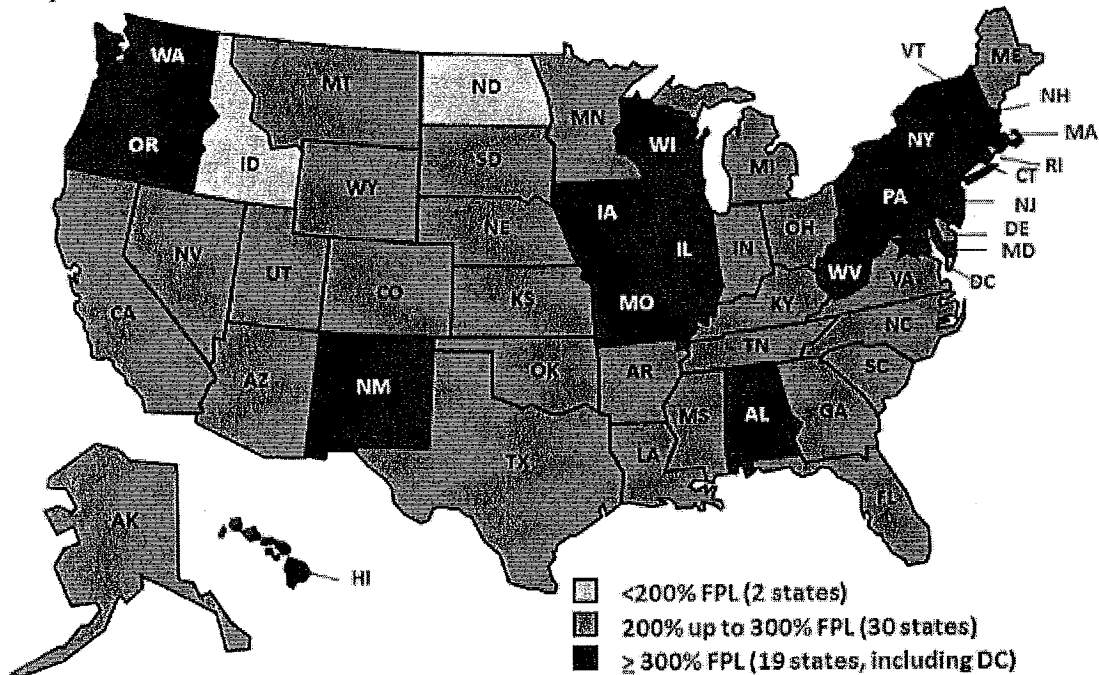

KFF's 50-state survey provides comprehensive data on Medicaid and CHIP eligibility, enrollment, renewal, premium, and cost sharin policies for each state as of January 2018.
(http://twitter.com/share?text=KFF%E2%80%99s+50-state+survey+provides+comprehensive+data+on+Medica 2C+enrollment%2C+renewal%2C+premium% 2C+and+cost+sharing+policies+for+each+state+as+of+Ja 3A%2F%2Fkaiserf.am%2F2DEUxX9)

Figure 1

Income Eligibility Levels for Children in Medicaid/CHIP, January 2018



NOTE: Eligibility levels are based on 2018 federal poverty levels (FPLs) for a family of three. In 2018, the FPL was $20,780 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

Figure 1: Income Eligibility Levels for Children in Medicaid/CHIP, January 2018

Over time, states have continued to take up options to expand coverage to targete groups that primarily focus on children and pregnant women. These include options like expanding access to coverage for lawfully residing immigrant children and pregnant women without a five-year waiting period and covering dependents of state employees ir CHIP. Many of these options were available to states before the ACA, but states have continued to take up these options since implementing the ACA to increase access to and minimize gaps in coverage.

As of January 2018, 32 states have implemented the Medicaid expansion, which significantly increased eligibility for parents and other adults. Under the ACA, the median eligibility level for parents across states increased from 61% FPL ($11,913 per yea for a family of three) in 2013 to 138% FPL ($28,676 per year for a family of three) in 2018 (Figure 2). The median eligibility level for other adults increased from 0% FPL ($0 per year for an individual) to 138% FPL ($16,753 per year for an individual) between 2013 and 201 since adults without dependent children were not eligible for Medicaid under federal rule prior to the ACA.

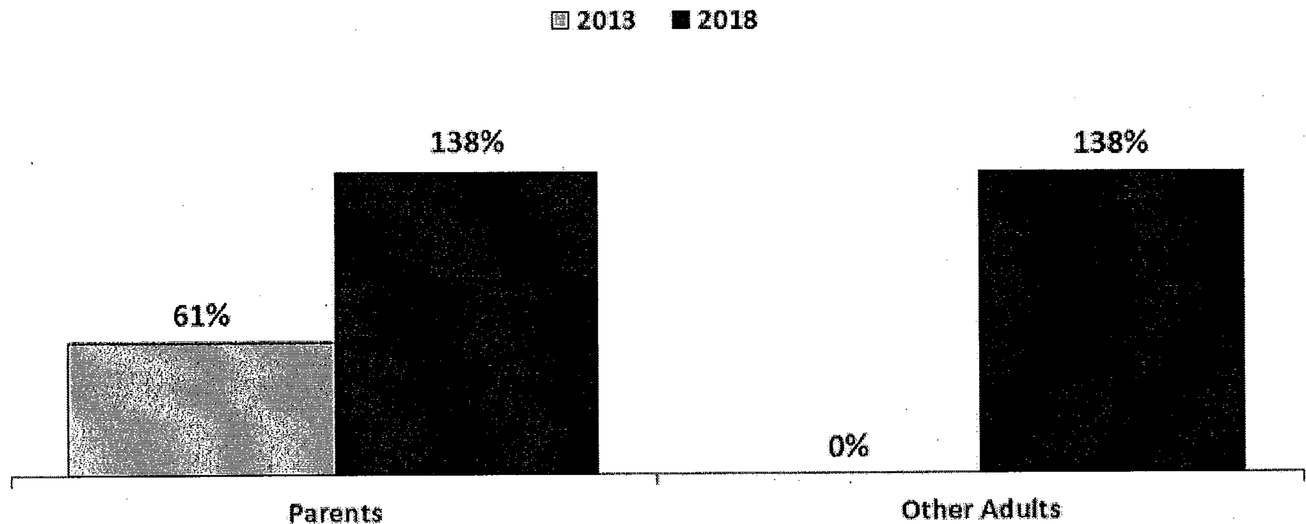
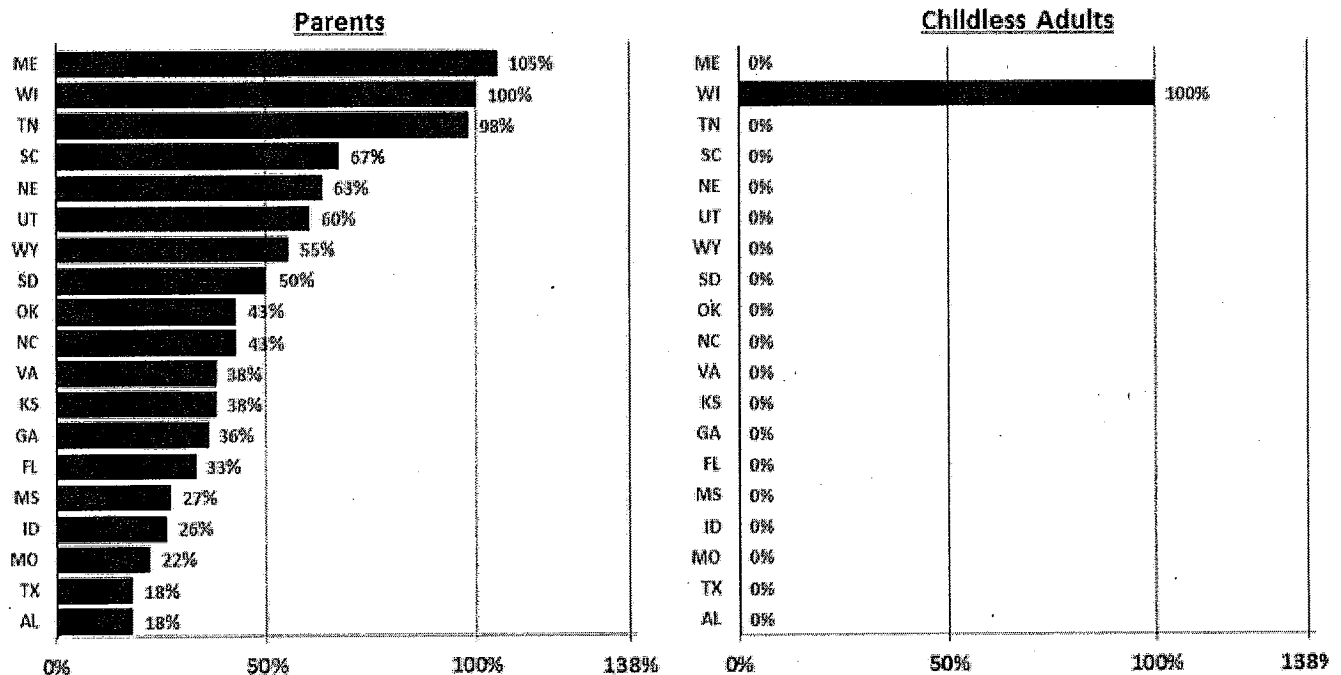


Figure 2: Median Medicaid Eligibility Levels for Adults as a Percent of the Federal Poverty Level, 2013 and 2018

In the 19 states that have not implemented the Medicaid expansion, eligibility for parents and other adults is very limited. In 17 of these states, parent eligibility is limited to less than the poverty level, including 11 states that limit parent eligibility to less than half of poverty, which is just over $10,000 per year for a family of three (Figure 3). Other adults remain ineligible for Medicaid regardless of their income in all of these states, except Wisconsin. In these states, 2.4 million poor adults fall into a coverage gap because they earn too much to qualify for Medicaid but not enough to receive subsidies for Marketplace coverage, which become available at 100% FPL.[1]
(https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2018-findings-from-a-50-state-survey/view/footnotes/#footnote-252557-1)

Figure 3

Medicaid Income Eligibility Limits for Adults in States that Have Not Implemented the Medicaid Expansion, January 2018



NOTES: Eligibility levels are based on 2018 federal poverty levels (FPLs) and are calculated based on a family of three for parents and an individual for childless adults. In 2018, the FPL was $20,780 for a family of three and $12,140 for an individual. Thresholds include the standard five percentage point of FPL disregard. OK and UT provide more limited coverage to some childless adults under Section 1115 waiver authority
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

Figure 3: Medicaid Income Eligibility Limits for Adults in States that Have Not Implemented the Medicaid Expansion, January 2018

Eligibility remained largely stable during 2017, with a few states making changes. During 2017, Maine adopted the Medicaid expansion through a ballot initiative, but it has not yet been implemented. In addition, Utah increased parent eligibility from 45% FPL to 60% FPL and obtained a waiver that expanded coverage to a limited number of adults without dependent children with incomes below 5% FPL who have behavioral health needs. In contrast, at the direction of the state legislature, Connecticut reduced parent eligibility from 150% FPL to the Medicaid expansion limit of 138% FPL. Outside of these changes, a few states adopted targeted options to expand coverage, while others discontinued use of certain coverage options.

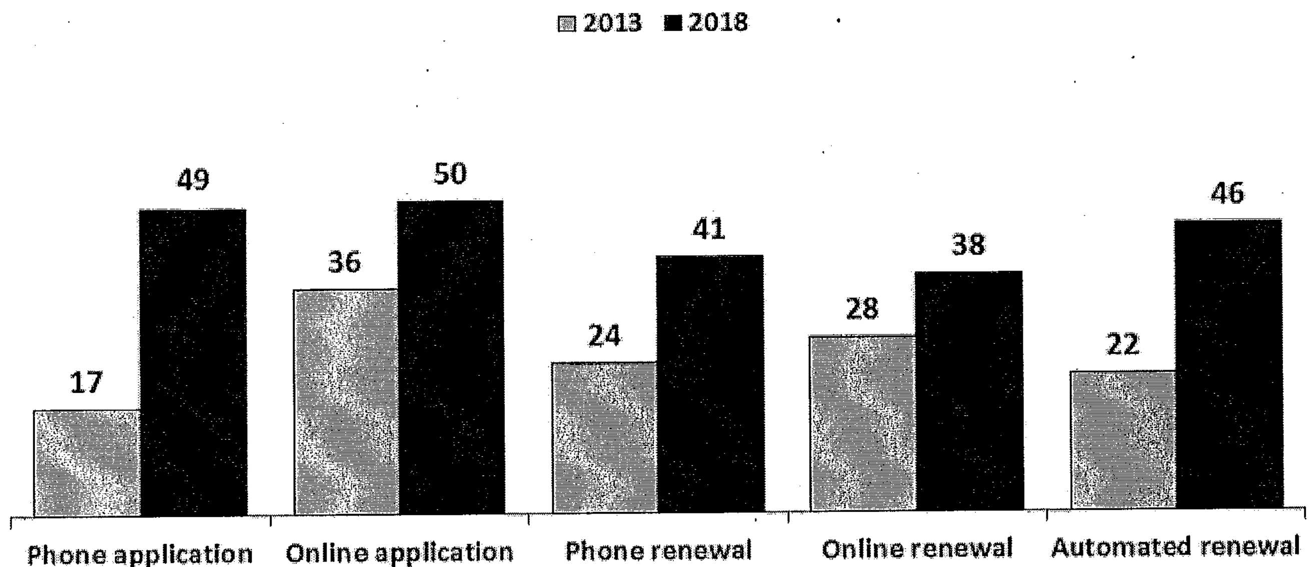
Enrollment and Renewal

Under the ACA, most states have transformed their Medicaid and CHIP enrollment and renewal processes to provide a modernized, streamlined experience as outline in the ACA. In addition to expanding Medicaid to low-income adults, the ACA established

electronic data-driven, streamlined enrollment and renewal processes for Medicaid and CHIP across all states. The ACA also provided enhanced federal funding to support states in replacing or upgrading their antiquated eligibility systems to implement these new processes. Before the ACA, individuals could not apply for Medicaid by phone or online in many states and typically had to provide documentation like pay stubs and wait weeks fo an eligibility determination. Further, they often had to repeat these steps at renewal. Through major investments of time and resources, most states have largely realized the streamlined processes established by the ACA. As of January 2018, individuals can apply for and renew Medicaid online or by phone in nearly every state (Figure 4). In 40 states, individuals can receive a real-time eligibility determination within 24 hours without havin to submit pay stubs or documentation when the state can electronically verify information. Nearly all states also are using electronic data matches to renew coverage without the individual having to submit paperwork.

Figure 4

Number of States with Selected Enrollment and Renewal Processes, 2013 and 2018



SOURCE: Based on results of a national survey conducted by the Kaiser Family Foundation and the Georgetown Center for Children and Families, 2013 and 2018.

Figure 4: Number of States with Selected Enrollment and Renewal Processes, 2013 and 2018

In 2017, some states continued to advance enrollment and renewal processes, but states also focused attention and resources on other priorities. Some states continued to implement simplifications and enhancements to their processes and systems. Several additional states implemented real-time determinations or automated renewals and a few states continued progress to reintegrate Medicaid eligibility determinations for seniors and people with disabilities and non-health programs into their upgraded systems. Many other changes were incremental, such as expanding features of online applications and accounts and increasing the share of applications that receive real-time determinations. This leveling off of continued advancement in part reflects that states have largely achieved improved processes now that they are five years into implementation. However, other policy proposals over the past year, including proposals to repeal the ACA, change the financing and structure of Medicaid, and an extended gap in federal funding for CHIP, may have shifted attention away from the focus on improvements to enrollment and renewal processes.

Premiums and Cost Sharing

Premiums and cost sharing remain limited for most Medicaid enrollees. Consistent with previous years, premiums and cost sharing are more prevalent in CHIP, which covers families with incomes above Medicaid eligibility limits. Premiums and cost sharing for most Medicaid enrollees remain limited, reflecting federal requirements designed to ensure enrollees do not face financial barriers to coverage and care. However, through recent waivers, several states have implemented higher premiums than otherwise allowed under federal rules, with some including lockout periods for non-payment of premiums.

Looking Ahead

Coverage for children and pregnant women will likely remain strong, bolstered by a ten-year extension in federal funding for CHIP. After a four-month lapse in funding, Congress extended federal funding for CHIP for ten years, providing states stable funding to maintain children's coverage. The legislation also extended the MOE provision that requires states to maintain Medicaid and CHIP eligibility levels for children through 2027. After October 1, 2019, the MOE will only apply to children in families with income at or below 300% FPL (305% FPL after accounting for the five percentage point of income disregard) although states may keep current eligibility at a higher level and receive federal CHIP matching funds. The legislation continues the 23 percentage point enhanced federal match rate for CHIP established by the ACA through 2019, but phases down the match rate to the regular CHIP rate in 2021.

There could be continued gains in eligibility for adults if additional states adopt the Medicaid expansion, but some may add new requirements or restrictions for adults as a condition of expanding coverage. As noted, Maine adopted the Medicaid

expansion through a ballot initiative in 2017, although it has not yet been implemented. Additional states may move forward with the expansion over the coming year, which would reduce the number of poor uninsured adults that currently fall into the coverage gap in non-expansion states. States moving forward with expansion may seek waivers to add requirements or restrictions for adults as a condition of expanding.

Proposals to make significant changes to Medicaid's structure and financing are likely to continue to be debated. While efforts to cap and limit Medicaid financing stalled in 2017, proposals to restructure Medicaid and reduce federal spending are likely to reemerge. The President's FY2019 budget proposes reductions to Medicaid and some Congressional leaders continue to express interest in reducing spending on entitlement programs, including Medicaid and Medicare. Changes to the financing and structure of Medicaid would have significant implications for the coverage gains achieved for children and adults to date. Moreover, uncertainty around the future of the program could limit state interest in continuing efforts to expand coverage and improve enrollment and renewal processes.

Waivers and other proposed changes require complex documentation and costly administrative processes for adults that run counter to simplified enrollment and renewal processes states have implemented under the ACA. Recently approved and proposed Section 1115 waivers (https://www.kff.org/medicaid/issue-brief/which-states-have-approved-and-pending-section-1115-medicaid-waivers/) include new restrictions and requirements for adults such as work requirements, premiums, cost sharing, time limits on coverage, drug screening and testing requirements, asset tests, more frequent redeterminations, waivers of reasonable promptness and retroactive eligibility, and lockout periods. In addition, the President's FY2019 budget proposes to allow states once again to require individuals to meet an asset test and to provide documentation to verify citizenship and immigration status before receipt of Medicaid, although states already must verify citizenship and immigration status under current law. Research and previous state experience shows that such changes would likely create barriers for eligible individuals to obtain and maintain coverage and access needed care. They also will be complex and costly for states to implement.

Table 3
State Adoption of Optional Medicaid and CHIP Coverage for Children, January 2018

State	Coverage for Dependents of State Employees in CHIP[1, 2] (Total = 36)	Lawfully-Residing Immigrants Covered without 5-Year Wait[3] Medicaid	CHIP[2] (Total = 36)	Provides Medicaid Coverage to Former Foster Youth up to Age 26 from Other States[4]
Total	**18**	**33**	**22**	**12**
Alabama	Y			
Alaska	N/A (M-CHIP)		N/A (M-CHIP)	
Arizona				
Arkansas[5]	Y	Y	Y	
California[6]	N/A (M-CHIP)	Y	N/A (M-CHIP)	Y
Colorado	Y	Y	Y	
Connecticut	Y	Y	Y	
Delaware[7]		Y	Y	Y
District of Columbia[6]	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Florida	Y	Y	Y	
Georgia	Y			Y
Hawaii	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Idaho				
Illinois[6]		Y	Y	
Indiana				
Iowa[8]		Y	Y	
Kansas	Y			
Kentucky	Y	Y	Y	Y
Louisiana[9]				
Maine[10]	Y	Y	Y	
Maryland	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Massachusetts[6]		Y	Y	Y
Michigan	N/A (M-CHIP)		N/A (M-CHIP)	Y
Minnesota	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Mississippi	Y			
Missouri				
Montana[9]	Y	Y	Y	
Nebraska	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Nevada	Y			
New Hampshire	N/A (M-CHIP)		N/A (M-CHIP)	
New Jersey		Y	Y	
New Mexico	N/A (M-CHIP)	Y	N/A (M-CHIP)	Y
New York[6,. 9]		Y	Y	
North Carolina	Y	Y	Y	
North Dakota				
Ohio	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Oklahoma	N/A (M-CHIP)		N/A (M-CHIP)	
Oregon[6]		Y	Y	
Pennsylvania[11]	Y	Y	Y	Y
Rhode Island	N/A (M-CHIP)	Y	N/A (M-CHIP)	
South Carolina[12]	N/A (M-CHIP)	Y	N/A (M-CHIP)	
South Dakota				Y
Tennessee	Y			
Texas	Y	Y	Y	
Utah		Y	Y	Y
Vermont	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Virginia	Y	Y	Y	Y
Washington[6]		Y	Y	
West Virginia	Y	Y	Y	
Wisconsin		Y	Y	Y
Wyoming				

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

00346

Table 12
Presumptive Eligibility in Medicaid and CHIP, January 2018[1]

State	Children		Pregnant Women		Parents	Adults[2] (Total = 33)	Family Planning Expansion[2] (Total = 29)	Former Foster Youth
	Medicaid	CHIP[2] (Total =36)	Medicaid	CHIP[2] (Total = 5)				
Total	**20**	**11**	**30**	**3**	**9**	**6**	**6**	**10**
Alabama				N/A		N/A		
Alaska		N/A (M-CHIP)		N/A			N/A	
Arizona				N/A			N/A	
Arkansas				N/A			N/A	
California	Y	N/A (M-CHIP)	Y	N/A				Y
Colorado	Y	Y	Y	Y			N/A	
Connecticut	Y	Y	Y	N/A			Y	Y
Delaware				N/A			N/A	
District of Columbia		N/A (M-CHIP)	Y	N/A			N/A	
Florida			Y	N/A		N/A		
Georgia			Y	N/A		N/A		
Hawaii		N/A (M-CHIP)		N/A			N/A	
Idaho	Y	Y	Y	N/A	Y	N/A	N/A	Y
Illinois	Y	Y	Y	N/A			N/A	
Indiana	Y	Y	Y	N/A	Y	Y	Y	Y
Iowa	Y	Y	Y	N/A	Y			Y
Kansas[3]	Y	Y	Y	N/A		N/A	N/A	
Kentucky			Y	N/A				
Louisiana				N/A				
Maine			Y	N/A		N/A		
Maryland		N/A (M-CHIP)		N/A				
Massachusetts				N/A			N/A	
Michigan	Y	N/A (M-CHIP)	Y	N/A			N/A	Y
Minnesota		N/A (M-CHIP)		N/A			Y	
Mississippi				N/A		N/A		
Missouri	Y	Y	Y	Y		N/A		
Montana	Y	Y	Y	N/A	Y	Y		Y
Nebraska		N/A (M-CHIP)	Y	N/A		N/A	N/A	
Nevada				N/A			N/A	
New Hampshire	Y	N/A (M-CHIP)	Y	N/A	Y	Y	Y	
New Jersey	Y	Y	Y	Y	Y	Y	N/A	
New Mexico[4]	Y	N/A (M-CHIP)	Y	N/A				
New York	Y	Y	Y	N/A			Y	
North Carolina			Y	N/A		N/A		
North Dakota				N/A			N/A	
Ohio	Y	N/A (M-CHIP)	Y	N/A	Y	Y	N/A	Y
Oklahoma		N/A (M-CHIP)		N/A		N/A		
Oregon				N/A				
Pennsylvania			Y	N/A				
Rhode Island		N/A (M-CHIP)						
South Carolina		N/A (M-CHIP)		N/A		N/A		
South Dakota				N/A		N/A	N/A	
Tennessee[5]	Y		Y	N/A		N/A	N/A	
Texas			Y	N/A		N/A	N/A	
Utah			Y	N/A		N/A	N/A	
Vermont		N/A (M-CHIP)		N/A				
Virginia						N/A		
Washington				N/A				
West Virginia	Y		Y	N/A	Y	Y	N/A	Y
Wisconsin	Y		Y	N/A			Y	
Wyoming	Y		Y	N/A	Y	N/A		Y

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

00347

Texas, et al. v.
United States of America, et al.

USDC Northern District of Texas
Case No. 4:18-cv-00167-O

Exhibit O

(/)

Community First Choice

Services

- Buy-in for Adults (/services/health/medicaid-chip/programs/medicaid-buy-adults)
- CHIP (/services/health/medicaid-chip/programs/chip)
- Children's Medicaid (https://yourtexasbenefits.hhsc.texas.gov/programs/health/child/childrens-medicaid)
- Community First Choice (/services/health/medicaid-chip/programs/community-first-choice)
- Dual Eligible Project (MMP) (/services/health/medicaid-chip/programs/dual-eligible-project-mmp)
- Managed Care Report Cards (CHIP, STAR, STAR+PLUS) (/services/health/medicaid-chip/programs/managed-care-report-cards)
- Medicaid for Adults (/services/health/medicaid-chip/programs/medicaid-adults)
- Medicaid for Breast and Cervical Cancer Program (/services/health/medicaid-chip/programs/medicaid-breast-cervical-cancer-program-managed-care-expansion)
- Medical and Dental Plans (/services/health/medicaid-chip/programs/medical-dental-plans)
- Mental Health and Substance Use Disorder Parity (/services/health/medicaid-chip/programs/mental-health-substance-use-disorder-parity)
- MyChildrensMedicaid.org (https://www.mychildrensmedicaid.org/)
- Pregnant Women (https://yourtexasbenefits.hhsc.texas.gov/programs/health/women/pregnant)
- STAR (/services/health/medicaid-chip/programs/star-medicaid-managed-care-program)
- STAR Health (http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-star.asp)
- STAR Kids (/services/health/medicaid-chip/programs/star-kids)
- STAR+PLUS (/services/health/medicaid-chip/programs/starplus)
- Your Texas Benefits Medicaid ID Card (/services/health/medicaid-chip/programs/your-texas-benefits-medicaid-id-card)
- Wellness Program (/services/health/medicaid-chip/programs/texas-medicaid-chip-wellness-program)

- Provider Information (/services/health/medicaid-chip/provider-information)

- Medicare (/services/health/medicare)
- Palliative Care (/services/health/palliative-care)
- Prevention (/services/health/prevention)
- Women & Children (/services/health/women-children)

- Mental Health & Substance Use (/services/mental-health-substance-use)
- Questions About Your Benefits (/services/questions-about-your-benefits)
- Safety (/services/safety)
- Service Coordination (/services/service-coordination)

Senate Bill 7 from the 2013 Texas Legislature requires the Health and Human Services Commission (HHSC) to put in place a cost-effective option for attendant and habilitation services for people with disabilities who have STAR+PLUS Medicaid coverage.

A federal option, called Community First Choice, allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities. This option provides states with a 6 percent increase in federal matching funds for Medicaid for these services.

Who can get Community First Choice services?

To be eligible for Community First Choice services an individual must:

- Be eligible for Medicaid.
- Need help with activities of daily living, such as dressing, bathing and eating.
- Need an institutional level of care.

Community First Choice Services

Community First Choice Services include:

- Help with activities of daily living and health-related tasks through hands-on assistance, supervision or cueing.
- Services to help the individual learn how to care for themselves.
- Backup systems or ways to ensure continuity of services and supports.
- Training on how to select, manage and dismiss attendants.

Texas began the Community First Choice program on June 1, 2015. This means:

- Individuals on a 1915(c) waiver interest list who meet eligibility and coverage requirements may be eligible to get Community First Choice services.

- Individuals already getting services through a 1915(c) waiver will continue to get those services as they do today from their existing providers.

Read more information on selecting a provider for Community First Choice services (PDF) (https://hhs.texas.gov/sites/default/files//documents/services/health/medicaid-chip/programs/community-first-choice/cfc-flyer.pdf)

Provider Resources

- Community First Choice Provider Training (PDF) (https://hhs.texas.gov/sites/default/files//documents/services/health/medicaid-chip/programs/community-first-choice/cfc-provider-training.pdf)
- Community First Choice FAQs (PDF) (https://hhs.texas.gov/sites/default/files//documents/services/health/medicaid-chip/programs/community-first-choice/cfc-faqs.pdf)
- Community First Choice Summary Tool (PDF) (https://hhs.texas.gov/sites/default/files//documents/services/health/medicaid-chip/programs/community-first-choice/cfc-summary.pdf)

Provider Training

Training Archive: Community First Choice, January 2015 (offsite link) (https://attendee.gotowebinar.com/recording/4776263482028915969)

Contracting with Medicaid Managed Care Organizations to Deliver Community First Choice Services

Community First Choice (CFC) is a program that enables Texas Medicaid to provide the most cost effective approach to basic attendant and habilitation service delivery. The services available in CFC are:

- Personal assistance services
- Habilitation services
- Emergency response services
- Support management

STAR+PLUS and STAR Health Medicaid managed care organizations (MCOs) are required to extend a contract to the significant traditional providers (STPs) that provide services in the Community Living Assistance and Support Services (CLASS), Home and Community-based Services (HCS), Texas Home Living (TxHmL), and the Deaf Blind with Multiple Disabilities

(DBMD) waiver programs. For the purposes of CFC, STPs are those active providers who had expenditures (paid claims) for services delivered in the waiver programs from September 1, 2013 through February 6, 2015.

The MCOs listed below are in the process of extending contracts to all that have been identified as STPs. The MCOs contracts with STP providers must align with the Health and Human Services (HHS) waiver contract areas. Therefore, STP providers contracted with an MCO will only be able to provide services in the counties that are reflected in their HHS contracts. If you are a waiver provider listed above and you have not been contacted by an MCO in your service area, use the numbers listed below to call the plans:

Amerigroup	1-713-218-5100 Extension 55446
Molina	1-866-449-6849
Cigna HealthSpring	1-877-653-0331
United Healthcare	1-888-787-4107
Superior	1-866-615-9399 Extension 22534

If you are a provider that currently has a contract with one of the MCOs listed and you want to provide CFC services, call the plan to discuss whether you'll need a contract amendment to deliver those services.

Website

Accessibility (/policies-practices-privacy)

Copyright/Disclaimer (/policies-practices-privacy#copyright)

Email Encryption (/about-hhs/find-us/email-encryption)

File Viewing (/file-viewing-information)

Links (/policies-practices-privacy#links)

Site Privacy and Security (/policies-practices-privacy#security)

Report Website Problems (mailto:webmaster@hhsc.state.tx.us?subject=Problem with HHS website)

About HHS

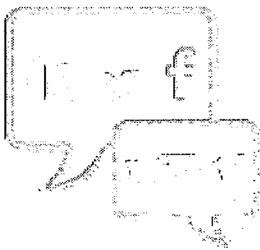
Compact with Texans (/about-hhs/your-rights/compact-texans)
Ethics Policy (/policies-practices-privacy#ethics)
Find Us (/about-hhs/find-us)
How to Get Help (https://yourtexasbenefits.hhsc.texas.gov/)
Jobs at HHS (/about-hhs/jobs-hhs)
Notice of Privacy Practices (/health-human-services-agencies-notice-privacy-practices)
Report Fraud, Waste and Abuse (https://oig.hhsc.texas.gov/report-fraud)
Your Texas Benefits (https://yourtexasbenefits.com/ssp/SSPHome/ssphome.jsp)

State of Texas

Statewide Search (https://www.tsl.texas.gov/trail/index.html)
Texas.gov (https://www.texas.gov/)
Texas Homeland Security (http://gov.texas.gov/hsgd)
Texas Veteran's Portal (http://veterans.portal.texas.gov/)

HHS Social Media

Keep up with what's new at HHS.
Visit our social media directory.



(/about-hhs/communications-events/social-media)

Texas, et al. v.
United States of America, et al.

USDC Northern District of Texas
Case No. 4:18-cv-00167-O

Exhibit P

Report on the Cost-Effectiveness of Community First Choice in STAR+PLUS

As Required By
Senate Bill 7, 83rd Texas Legislature, Regular Session, 2013

Health and Human Services Commission
February 2017

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List of Acronyms 7

Appendix A: Community First Choice Potential Savings in State General Revenue A-1

1. Executive Summary

Senate Bill (S.B.) 7, 83rd Legislature, Regular Session, 2013, directed the Health and Human Services Commission (HHSC) to implement the most cost-effective option for the delivery of basic attendant and habilitation services to individuals with disabilities, including intellectual and developmental disabilities (IDD), and maximize federal funding. In June 2015, HHSC implemented Community First Choice (CFC), a Medicaid state plan benefit providing community-based long-term services and supports (LTSS) to Medicaid-eligible individuals who meet an institutional level of care as an alternative to services in an institutional setting. Unlike home and community-based waivers, CFC is an entitlement, and anyone who is eligible and needs the service may receive it. CFC services earn the state an additional six percent federal match, on top of the existing Federal Medical Assistance Percentage (FMAP) for state plan services.

CFC benefits available in Texas include personal assistance services (PAS), habilitation services, emergency response services, and support management. Prior to implementation of CFC, habilitation and habilitation-like services were only available in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID) and 1915(c) IDD waiver programs. Most IDD waivers have lengthy interest lists.

As required by S.B. 7, in June 2016, HHSC submitted a report to the Legislature titled, *Report on Implementation of Basic Attendant Care and Habilitation for Individuals with Intellectual and Developmental Disabilities in STAR+PLUS.*[1] This report focused on implementation of CFC for individuals enrolled in managed care programs, such as the STAR+PLUS program and the STAR Health program for children in state conservatorship. In addition, the report outlined CFC services in the traditional fee-for-service system, including individuals enrolled in 1915(c) waiver programs. This report may be referenced for additional information about the implementation of CFC.

S.B. 7 also directed HHSC to report on the cost-effectiveness of delivering basic attendant and habilitation services to individuals with disabilities, including IDD, enrolled in the STAR+PLUS Medicaid managed care program. To be cost-effective, delivery of CFC services must cost less than the outcomes associated with not providing the services. Although HHSC continues to monitor cost and outcomes data, comprehensive information related to outcomes is not currently available due to CFC services being implemented so recently. As a result, this report focuses on available data describing the cost-effectiveness of providing CFC to individuals in home and community-based services programs (including IDD waiver programs and the STAR+PLUS Home and Community-Based Services (HCBS) program), who had access to similar services prior to CFC implementation. This report also provides estimates of cost-effectiveness for the provision of CFC services to individuals with IDD enrolled in STAR+PLUS who are not enrolled in an IDD waiver or the STAR+PLUS HCBS program. Prior to the implementation of CFC, these individuals did not have access to community-based LTSS because they were on interest lists for IDD waiver programs.

[1] Report on Implementation of Basic Attendant Care and Habilitation for Individuals with Intellectual and Developmental Disabilities in STAR+PLUS can be accessed at: https://hhs.texas.gov/sites/hhs/files//sb7-community-first-choice-implementation.pdf

00359

2. Introduction

The Centers for Medicare & Medicaid Services permits states to offer programs to "waive" certain requirements and provide services in an individual's home or other community-based setting instead of an institutional setting. Prior to the implementation of CFC, adults without access to waiver programs and those with needs exceeding the basic state plan PAS benefit had limited options for obtaining LTSS to help them remain in the community and prevent admission to an institution. Although the Legislature has historically funded additional slots in waiver programs, interest in these programs continues to outpace available slots and individuals may experience significant time on a waiver program interest list.

If a state opts to provide CFC, federal regulations require the provision of certain services under §1915(k) of the Social Security Act, including:

- Assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks
- Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks
- Backup systems or mechanisms to ensure continuity of services and supports
- Voluntary training on how to select, manage, and dismiss attendants

In Texas, the four required services described above are offered and called: CFC PAS, habilitation, emergency response services, and support management. CFC regulations allow for other optional services. CFC services must be provided in a home or community-based setting and a through person-centered planning framework. The state also made assurances around other criteria, such as quality and provider networks.

In June 2016, HHSC submitted a report to the Legislature describing the implementation of CFC. This report is an addendum to the June report and provides additional information required by S.B. 7 regarding the cost-effectiveness of CFC. At this time, a true estimate of cost-effectiveness is not available. Calculating the actual cost-effectiveness of implementing CFC in STAR+PLUS requires not only information about costs, but information about outcomes. Measurable outcomes of CFC include increased independence, integration into the greater community, employment, and improved health and wellness. Though measures of these outcomes are in place, there are currently limited data because the services were implemented so recently. HHSC continues to collect and evaluate measures of the cost-effectiveness of CFC. In the absence of comprehensive outcomes data, this report focuses instead on estimating the cost-effectiveness of providing CFC to existing community-based LTSS populations by comparing the costs of the services delivered prior to CFC to those after CFC. To estimate CFC cost-effectiveness for the IDD population not previously receiving community-based LTSS, this report discusses the costs and outcomes of CFC service delivery as compared to the alternative of receiving services in an institutional setting.

00360

3. Cost-Effectiveness of Serving Existing Populations

Changes in 1915(c) Waiver Services

Individuals in waiver programs serving people with disabilities historically had access to services similar to those delivered through CFC such as PAS, habilitation, and personal care services (PCS).

PAS is a benefit offered in Texas Medicaid to assist individuals with ADLs like bathing, dressing and eating, as well as IADLs. IADLs are those activities which support ADLs, such as grocery shopping and light housework. PAS is available through CFC for individuals requiring the level of care provided by a nursing facility, ICF/IID, or a freestanding psychiatric facility (also called an institution for mental disease) for those under 21 or over 65 years old.

Habilitation, another CFC service, helps individuals acquire, maintain, and enhance their ability to perform ADLs and IADLs. Prior to the implementation of CFC, all 1915(c) IDD waiver programs included either habilitation or a habilitation-like service that may have also included attendant-like services. Individuals enrolled in the Community Living Assistance and Support Services (CLASS) and Deaf-Blind with Multiple Disabilities (DBMD) waivers received habilitation services through their waiver programs. On June 1, 2015, habilitation in CLASS and residential habilitation in DBMD were replaced by CFC PAS and habilitation (PAS/HAB) on all individual plans of care (IPCs).

Individuals enrolled in the Home and Community-based Services (HCS) waiver program received a service called supported home living, which provided habilitation. Individuals enrolled in the Texas Home Living (TxHmL) waiver program accessed a habilitation service called community supports through their waiver. Following implementation of CFC, supported home living and community supports were replaced by CFC PAS/HAB on all IPCs. Subsequent to these changes, expenditures in TxHmL grew rapidly, which the Department of Aging and Disability Services (DADS) responded to with a series of actions, including implementing a new assessment, clarifying provider qualifications, and not releasing new waiver slots for the program starting in September 2015.[2]

Children and young adults enrolled in the Medically Dependent Children Program (MDCP) and Youth Empowerment Services (YES) 1915(c) waiver programs may have received PCS, similar to PAS, which assists individuals with ADLs and IADLs. PCS is a service available to children and young adults through the state plan; it is not a part of services received through their waiver programs. However, to be eligible for these waivers, MDCP and YES recipients require the level of care provided in an institution. As a result of meeting an institutional level of care, these children and young adults are eligible to receive services through CFC rather than PCS (which is matched at the standard FMAP).

[2] On September 1, 2016, administration of the 1915(c) waiver programs, including TxHmL, transitioned from DADS to HHSC.

00361

Cost-Effectiveness of CFC in Place of 1915(c) Waiver Services

Implementation of CFC has significantly increased the cost of serving individuals in TxHmL, as services once accessed in this program (e.g., community supports) were replaced by CFC services (CFC PAS/HAB). In state fiscal year 2016, the average monthly cost to serve each person in TxHmL exceeded appropriated costs by $780.57 per month, which equated to an annual expenditure of $56.1 million all funds, or $19.7 million general revenue funds.

However, even with cost growth in TxHmL, HHSC considers CFC to be cost-effective overall for individuals enrolled in the 1915(c) waiver programs. CFC services receive an additional six percent federal match over the existing FMAP for state plan services. The implementation of CFC reduced the general revenue expenditures for the other 1915(c) waivers by $16 million in general revenue funds. As a result, the implementation of CFC enabled HHSC to provide an additional $56.1 million of services for a net general revenue cost of $3.7 million. CFC enhanced the state's ability to provide community-based services, which are more cost-effective than institutional care, at a lower cost to the state general revenue fund.

Changes in 1115 Waiver Services

Prior to the implementation of CFC, individuals in STAR+PLUS accessed PAS through either the state plan or through the STAR+PLUS HCBS program (also called STAR+PLUS Waiver). Those receiving services through the STAR+PLUS HCBS program also had access to emergency response services through the waiver. STAR+PLUS and STAR+PLUS HCBS are operated under the authority of an 1115 waiver. Eligibility for STAR+PLUS HCBS requires, among other criteria, need for a level of care provided by a nursing facility. Eligibility for PAS through the state plan is based on functional need for the service.

The delivery of CFC to individuals in STAR+PLUS who meet a nursing facility level of care is complicated by federal provisions relating to delivering home and community-based services under the authority of §1115 of the Social Security Act. Individuals who receive Supplemental Security Income (SSI) or SSI-related Medicaid automatically meet the first eligibility criteria for CFC, which is Medicaid eligibility. As a result of federal provisions, only individuals with SSI or SSI-Related Medicaid in STAR+PLUS HCBS are eligible to receive PAS and emergency response services through CFC. This population is approximately 68 percent of those in STAR+PLUS HCBS. Individuals in STAR+PLUS HCBS who are above the SSI income limit are not eligible for CFC.

Cost-Effectiveness of CFC in Place of STAR+PLUS HCBS Services

Beginning June 1, 2015, as individuals in STAR+PLUS HCBS were reassessed for their annual individual service plan development, all PAS and emergency response services for CFC-eligible individuals were authorized through CFC rather than STAR+PLUS HCBS. In managed care, HHSC draws federal matching funds on the amount of capitation paid to a managed care organization (MCO), rather than for each dollar spent on a service. The component of the capitation rate dedicated to PAS and emergency response through CFC receives an additional six percent match. As a result, the additional six percent match for the component of the capitation for services delivered through CFC and previously provided at the standard FMAP, with no variation in outcomes to date, implies CFC is cost-effective for individuals with SSI or SSI-related Medicaid in STAR+PLUS HCBS. Appendix A describes the potential savings to state general revenue funds of offering CFC in STAR+PLUS.

In addition to needing the level of care provided by a nursing facility, to be eligible for STAR+PLUS HCBS an individual must require the services provided by STAR+PLUS HCBS that are not available through another resource. If an individual's needs can be met by state plan services, they are not eligible for STAR+PLUS HCBS. Following the implementation of CFC and the subsequent broadening of state plan services, some individuals' needs could be met through the state plan, representing a cost savings for HHSC. The capitation paid to MCOs for individuals in STAR+PLUS HCBS is a higher rate than for individuals requiring only state plan LTSS. If an individual who received PAS and emergency response services through STAR+PLUS HCBS can now receive those services through CFC, not only does the state draw an additional six percent match for those services, but the state also pays the MCO a lower capitation rate for delivering the same services. This implies CFC is cost-effective for this population as well.

4. Cost-Effectiveness of Serving Individuals on Interest Lists

Texas maintains lists of individuals who are interested in receiving waiver services on a first-come, first-served basis. One population benefiting from the implementation of CFC are Medicaid-eligible individuals who, because of their need for habilitation services, are on interest lists for waiver programs offering habilitation. Texas does not determine whether an individual is eligible for a waiver program until a slot in the waiver is available. As of October 2016, the number of individuals on interest lists for CLASS, DBMD, HCS, TxHmL, and MDCP totaled more than 218,000[3]. Those on a waiver interest list who are eligible for Medicaid can be assessed to determine if they are eligible for CFC services.

To date, the number of individuals on an interest list assessed for CFC is lower than HHSC's initial estimates. There are a number of reasons individuals may be resistant to a CFC assessment. As noted in the June 2016 report, HHSC is working with state and community partners to ensure individuals eligible for CFC know and understand that receipt of CFC services does not affect their ability to remain in a waiver program or jeopardize their slot on an interest list. Targeted outreach to Medicaid-eligible individuals on an interest list continues in Medicaid managed care.

CFC may be a cost-effective alternative to providing services in an institution for those individuals on an interest list. For example, the Medicaid payment rate for a single day for individuals in a small ICF/IID with the lowest level of need was $144.25 in state fiscal year 2016, and the cost for care in a state-operated ICF/IID (state supported living center) was nearly $650 per individual per day. An individual in STAR+PLUS could receive 10 hours of CFC habilitation in their own home or family home for less than $130, if the MCO paid the proxy rate set by HHSC.

This comparison does not include estimates of the savings related to accessing informal supports available in the community. Individuals in their own home, family home, or other community setting often have informal supports to help them maintain their independence. These informal supports can include family, other caregivers, and access to services like assistance with housing-related expenses, congregate meals, and social activities provided through local non-

[3] This number includes duplicate counts as individuals may be on multiple interest lists.

profits and faith-based organizations. Many individuals in STAR+PLUS access these additional services, with Medicaid services like CFC, to help them remain in the community.

5. Conclusion

Calculating the actual cost-effectiveness of implementing CFC in STAR+PLUS requires not only information about costs, but also information about outcomes. Some outcomes for CFC cannot currently be measured, such as increased independence, integration into the greater community, employment, and improved health and wellness. However, CFC can contribute to the cost-effectiveness of providing services to some populations by increasing the FMAP for CFC-like services. Drawing an additional six percent federal match for existing services may help offset some of the costs of providing CFC to individuals who have not previously accessed community-based LTSS. In addition, CFC can offer a cost-effective alternative for individuals who previously accessed a waiver slot but only needed PAS, habilitation, or emergency response services, which were unavailable outside of a waiver program until implementation of CFC. As a result of the availability of these services through CFC, individuals may not need to access a more expensive waiver slot. At this time, the only way to estimate the cost-effectiveness of providing CFC to individuals on an interest list is a comparison of the cost of providing institutional services to the same population. HHSC is mindful of the need to ensure Medicaid services are cost-effective and continues to evaluate CFC costs and outcomes.

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List of Acronyms

Acronym	Full Name
ADL	Activity of daily living
CFC	Community First Choice
CLASS	Community Living Assistance and Support Services
DBMD	Deaf-Blind with Multiple Disabilities
FMAP	Federal Medical Assistance Percentage
HCS	Home and Community-based Services
IADL	Instrumental activity of daily living
ICF/IID	Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition
IDD	Intellectual and developmental disabilities
IPC	Individual plan of care
LTSS	Long-term services and supports
MCO	Managed care organization
MDCP	Medically Dependent Children Program
PCS	Personal care services
PAS	Personal assistance services
PAS/HAB	Personal assistance services and habilitation
SSI	Supplemental Security Income
STAR+PLUS HCBS	STAR+ PLUS Home and Community-Based Services
TxHmL	Texas Home Living
YES	Youth Empowerment Services

00365

Appendix A: Community First Choice Potential Savings in State General Revenue

This appendix provides a summary and explanation of the potential savings in state general revenue as a result of CFC services, which receive an additional six percent federal match. In managed care models like STAR+PLUS, Texas receives federal matching funds for the capitation paid to a MCO. The tables and explanation below describe how the additional matching funds are applied to the part of the capitation Texas pays MCOs for CFC-like and CFC services, respectively.

The amount of capitation HHSC pays to STAR+PLUS MCOs varies by geography and other factors. Based on the total amount of capitation paid, the portion of the capitation that accounts for CFC-like services, and preliminary counts of the STAR+PLUS population, HHSC estimates approximately $100.00 per STAR+PLUS member per month on services similar to those available through CFC in state fiscal year 2016. Shown below in Table 1, the additional six percent match accounts for approximately $35 million more federal dollars. With no apparent difference in outcomes to date, this implies CFC is cost-effective for individuals in STAR+PLUS HCBS.

Table 1. Cost-Effectiveness of CFC Services in STAR+PLUS HCBS for SFY 2016

Funding Stream	Prior to CFC	With CFC
General Revenue	$247 M	$212 M
Federal Funds	$330 M	$365 M
All Funds	**$577 M**	**$577 M**

Note: Figures are estimated based on preliminary caseload data and only includes the component of the capitation rate for existing CFC-like services.

Based on the total amount of capitation paid for STAR+PLUS members not in a waiver program, the component of the capitation that accounts for CFC services, and preliminary counts of the STAR+PLUS population, HHSC estimates paying STAR+PLUS MCOs approximately $50.00 per member per month for CFC in state fiscal year 2016. Shown below in Table 2, overall the state spent approximately $98 million for CFC in STAR+PLUS, including the additional six percent match.

Table 2. Total Capitation Paid for CFC Services in STAR+PLUS for SFY 2016

Funding Stream	CFC Component
General Revenue	$98 M
Federal Funds	$168 M
All Funds	**$265 M**

Note: Figures are estimated based on preliminary caseload data and only includes the component of the capitation rate for CFC services.

Although Table 2 shows a cost to the state for providing CFC, it does not take into account cost-avoidance should individuals on an interest list access more costly, institutional services. For example, for overall community-based LTSS including CFC, HHSC paid STAR+PLUS MCOs approximately[4] $340 per member per month in state fiscal year 2016. For the enhanced services in STAR+PLUS HCBS for the same period of time, HHSC paid STAR+PLUS MCOs approximately $1,730 per member per month. Both community-based LTSS and STAR+PLUS HCBS are less expensive to the state than institutional care, which amounts to approximately $3,820 per member in a nursing facility per month.

[4] Note: Estimates of capitation paid in state fiscal year 2016 are based on preliminary caseload data and are blended to include all services. HHSC cannot estimate per member per month for other institutional levels of care, as only nursing facility rates are currently available.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ,

Plaintiffs,

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,

Defendants.

CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON,

Intervenors-Defendants.

Civil Action No. 4:18-cv-00167-O

DECLARATION OF JUDY MOHR PETERSON, IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Judy Mohr Peterson, declare:

1) I serve as the Medicaid Director for the State of Hawaii. I have been in this role since July 2015. Prior to that, I served as the Medicaid Director for the Oregon Health Authority in the State of Oregon (2009-June 2015).

2) Med-QUEST, Department of Human Services, is the single state Medicaid Agency for the State of Hawaii and implements Hawaii's Medicaid program. I am the administrator of the Med-QUEST Division.

3) This declaration is submitted in support of the Intervenor-States' Opposition to Plaintiffs' Motion for Preliminary Injunction.

4) **Granting a preliminary injunction would result in significant costs and injuries to the State Medicaid Agency and to state residents.** Based on my knowledge and experience, dismantling the Affordable Care Act would result in a loss of benefits and services and federal investments to support Med-QUEST and the 360,000 beneficiaries served. In addition, it would cause severe harm to the state of Hawaii, to its residents, and to its economy. Hawaii would experience harm and increased costs from the dismantling of the state's administrative structure and apparatus, created in compliance with, and to work in conjunction with, the Affordable Care Act (ACA) in the following ways:

- Hawaii's current eligibility system, KOLEA, is programmed to determine Medicaid eligibility using ACA prescribed eligibility determination methodologies. Changing the eligibility determination methodologies would require extensive computer operating system modifications at an estimated cost of $4,000,000.00 ($3,000,000 federal funds; $1,000,000 state funds) ;
- Notices regarding changes to eligibility would have to be developed and sent out to affected individuals. Approximately $1,000,000.00 (750,000.00 federal funds; $250,000.00 state funds) would be needed for the development of new notices and approximately $350,000 ($174,000.00 federal funds; $175,000.00 state funds) would be needed for the production and mailing costs;
- The State of Hawaii would incur an estimated $250,000 ($125,000.00 federal

funds; $125,000.00 state funds) in costs related to training staff on new policies and procedures;

- A change in eligibility determination methodologies would cause major interruption and delays in determination of eligibility benefits for applicants and eligibility redetermination of beneficiaries (approximately 305,000 individuals);

5) **Hawaii could lose billions of dollars provided through the Affordable Care Act**

- Specifically, Hawaii has received $2.1 billion via the Medicaid expansion.
- The Public Health and Prevention Fund provides approximately $8 million annually to Hawaii, which the state uses to manage and administer data systems like the Behavioral Risk Factor Surveillance System and Hawaii's Surveillance and Disease Outbreak Management System. The funding is also used to recognize disease trends, incidence, and impact, and to develop preventive and response measures as needed. Health care services to those with HIV or Zika are also affected.

6) **Thousands of Hawaii residents could lose access to affordable coverage**

- Overall the number of individuals with insurance has increased. In Hawaii, the rate of uninsured was 5% in 2016, the most recent figure available. The ACA expanded coverage through two key mechanisms: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance Exchanges for those individuals with moderate incomes.
- Medicaid is an important source of healthcare insurance coverage and has resulted in coverage gains and reduction in the uninsured rate, both among the low-income population and within other vulnerable populations. As a result of Medicaid

expansion in Hawaii, 117,000 people have coverage -- approximately one-third of our total of 360,000 on Medicaid -- and the state has experienced a reduction in the uninsured rate. This 117,000 figure includes individuals who became eligible for Medicaid under Hawaii's early (pre-2013) expansion as well as the 33,000 who became eligible under the further expansion implemented in October 2013. Without the ACA, all of these people would lose coverage. About 30% of the expansion group suffers from mental illness, 4% of them with severe mental illness; 1 in 4 have diabetes; 30% have asthma while 1 in 8 has chronic obstructive disease; and over one third struggle with some sort of substance use issue. Lack of health insurance would likely lead to an exacerbation of the health conditions, negatively impacting their health. On average, Hawaii spends about $510 monthly for each Medicaid expansion person or about $6,120 annually. We receive enhanced federal match for this population.

- Using alternate eligibility determination methodologies would result in many beneficiaries losing eligibility which in turn would cause loss of revenue for providers and health plans, and reduced federal matching dollars;
- An injunction of the ACA would impact all of the non aged, blind, or disabled groups, affecting approximately 80% of the total Medicaid population of Hawaii, which currently stands at 362,464 beneficiaries (as of March, 2018);
- Hawaii's low-income population would lose coverage if or until CMS approves an 1115 waiver amendment to cover the low-income population. However, Hawaii would have to demonstrate that coverage of this population would be "budget neutral", in other words, that it would not cost more to the federal government than not covering them. A budget neutrality test would be extremely difficult to pass

making it more likely that the entire ACA adult expansion population would lose their eligibility if they did not qualify for any other program. Even if Hawaii were able to reinstate this population by way of an 1115 waiver, Hawaii would lose the enhanced match for that population.

- The Exchange is an important reform made by the ACA. In Hawaii in 2017, 16,711 people were covered on the Marketplace, with 13,728 eligible for APTC subsidies.

7) **The loss of programs that were expanded under the ACA would lead to a decrease in opportunities to access home and community based services.**

- Medicaid Money Follows the Person Demonstration: in 2015 Hawaii received over $2 million under this program. It has helped move 584 people living in institutions into home or community based settings.

8) All of the foregoing injuries would occur if the Plaintiffs' motion for preliminary injunction were granted.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on June 05, 2018, in Honolulu, Hawaii.

Judy Mohr Peterson
Administrator, Med-QUEST Division
Department of Human Services
State of Hawaii

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ,

Plaintiffs,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,

Defendants.

CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON,

Intervenors-Defendants.

Civil Action No. 4:18-cv-00167-O

DECLARATION OF CLAUDIA SCHLOSBERG IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Claudia Schlosberg, declare:

1. This declaration is submitted in support of the Intervenors-Defendants' Opposition to the Motion to Intervene. Based on my knowledge and experience, dismantling the Affordable Care Act would cause severe harm to the District of Columbia, to its residents and to its economy. In addition to loss of benefits and services and federal investments to support the District of Columbia's healthcare system, dismantling or suspending implementation of the Affordable Care Act would cause severe harm to the District of Columbia, to its residents and to its economy. The District of Columbia would experience harm and increased costs from the dismantling of the District's administrative structure and apparatus, created in compliance with, and to work in conjunction with, the Affordable Care Act.

2. I am the Senior Deputy and State Medicaid Director for the Department of Health Care Finance (DHCF) for Washington, D.C. I am responsible for the effective management of the Medicaid, CHIP and Alliance Health Insurance Programs. Together, these programs provide DHCF health insurance coverage to over 270,000 low income residents of the District of Columbia. I currently oversee policy development, eligibility, fee-for-service and managed care service delivery, program operations, program integrity, long-term care and implementation of health care reform and innovation. Previously, I served as DHCF's Director of the Health Care Policy and Research Administration. I have been employed at DHCF since August 2011 and have over 30 years of experience in health care policy, program administration and regulatory and legislative affairs pertaining to publicly-financed health care programs.

3. DHCF is the single state agency for the administration of Medicaid in the District of Columbia (the District). DHCF is accountable to the United States Centers for Medicare and

Medicaid Services (CMS), the federal agency responsible for administration and oversight of the Medicaid program under Titles IXX and XXI of the Social Security Act, as amended by the Patient Protection and Affordable Care Act (the ACA) and accompanying regulations. Under the Affordable Care Act, the District has made significant gains with regard to healthcare funding, Medicaid coverage, access to care, and the quality of health care services delivered, as highlighted below:

4. **The Affordable Care Act directs significant funding to the District of Columbia:**

- Specifically, the District of Columbia has received $2.05 billion in federal reimbursement for Medicaid expansion; $53 million in grants provided under the Public Health and Prevention Fund from 2010 to 2016[1]; $4.2 million in grants and funding from the Center for Medicare and Medicaid Innovation; and $6.8 million in federal Medicaid reimbursement to provide Health Home services authorized under Section 2703 of the ACA.

5. **The Affordable Care Act increased access to affordable coverage.**

- The ACA expanded coverage through two key mechanism: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance exchanges for those individuals with moderate incomes.
- From 2010 to 2016, the District's overall uninsured rate fell 44%, from 7.8% to 4%, and the uninsured rate for the lowest-income individuals (0-199 percent of the federal poverty level (FPL) covered under the District's Medicaid expansion program fell 42 percent, from 13.5 percent to 7.8 percent. This increase in coverage has directly resulted from the ACA's new affordable coverage options and the Medicaid expansion, combined with new support for outreach from assisters and one-stop streamlined enrollment through the Health Benefits Exchange portal, DC Healthlink, all funded and directed under the ACA.

[1] *Prevention and Public Health Fund Detailed Information - Trust for America's Health* (Trust for America's Health, August 2017) http://healthyamericans.org/report/134/.

- Medicaid is an important source of healthcare insurance coverage and has resulted in significant coverage gains and reduction in the uninsured rate, both among the low-income population and within other vulnerable populations. Nearly 60 percent of the 321,518 individuals served by the District Health Benefits Exchange from when the Exchange opened in October 2013 through April 2017 were Medicaid beneficiaries. In FY 2017, the District Medicaid program provided coverage to approximately 40 percent of all District residents. Total average monthly Medicaid enrollment has grown 54 percent since the District expanded Medicaid, from nearly 170,000 in 2010 to 262,250 in 2017 and most of these coverage gains have been from the Medicaid expansion eligibility group. The District's generous levels of coverage for children under Medicaid and a CHIP-funded Medicaid expansion have also contributed to strong coverage rates overall. The District's rate of insurance coverage for children (97%) and its participation rate in public coverage programs (98.6%) are among the highest in the nation. In FY 2017, 93,184 childless Medicaid expansion adults and 89,491 children were enrolled in the District's Medicaid program, with each group comprising one-third of total Medicaid enrollment.
- The ACA has led to increased access to affordable care in the District as well as improved financial security for individuals who previously experienced trouble paying medical bills. According to the Commonwealth Fund, from 2013 to 2016, there was approximately a 20 percent decrease in the number adults in the District who went without care due to cost and a similar decrease in the number of individuals with high out-of-pocket medical spending.[2] From 2013 to 2016, there was a 40 percent decrease in the number of at risk adults who were without a routine doctor visit in the past two years.

6. **The ACA has had a positive economic benefit for the District.**

- The District has realized budget savings and revenue gains under the ACA.

[2] Susan Hayes, et al., *What's at Stake: States' Progress on Health Coverage and Access to Care, 2013–2016* (The Commonwealth Fund, Dec. 2017) http://www.commonwealthfund.org/publications/issue-briefs/2017/dec/states-progress-health-coverage-and-access.

- As an estimate of the substantial economic gains the District has experienced from coverage expansions and other provisions of the ACA, the Economic Policy Institute estimated that the District would lose between an estimated $100 and $146 million in federal health care spending per year in the event of ACA repeal.[3]
- The District also gained financially by having the federal government fund programs that were previously locally funded. Before the ACA was enacted, the District operated the DC Healthcare Alliance Program (Alliance), a 100 percent locally-funded program designed to provide medical assistance to low-income District residents ineligible for Medicaid or Medicare. With the Medicaid expansion to childless adults in 2010, the District was able to transition over 30,000 individuals who previously received coverage under the Alliance program to the new Medicaid expansion, thereby shifting the financial burden for coverage for these individuals from local to federal funds, which were covered at 100% federal medical assistance percentage in the first few years. In 2014 and 2015, the District saved approximately $82 million in averted local spending as a result of receiving federal matching funds for these individuals who previously were enrolled in the District's Alliance program.[4]
- By covering previously uninsured and underinsured individuals, the District's Medicaid expansion also enabled the District to save in spending for locally-funded behavioral health service programs that previously provided services to most of the more than 93,000 individuals now covered under the childless adult expansion.
- District hospital uncompensated care costs declined by 60% from $250,000 in 2010 to $100,000 in 2015 as the District's Medicaid expansion and ACA coverage expansion was implemented.[5]

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[3] Josh Bivens, *Repealing the Affordable Care Act Would Cost Jobs in Every State* (Economic Policy Institute, (Jan. 31, 2017) https://www.epi.org/files/pdf/120447.pdf.

[4] Deborah Bachrach, et al., *States Expanding Medicaid See Significant Budget Savings and Revenue Gains,* (RWJF State Health Reform Assistance Network, March 2016), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

[5] *Uncompensated Care Summary*, 2010-2015, DC Department of Health, State Health Planning Development Administration, https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/Uncompensated_care_updated_10_11_

(continued…)

- Researchers have estimated that the District has also experienced strong job and economic growth as a result of the ACA and could risk losing an estimated 1,400 jobs in year one and over 6,000 jobs over the next eight years if the ACA or its Medicaid expansion is repealed.[6]

7. **The ACA expanded Medicaid programs to provide States with increased opportunities to increase access to home and community based services.**

- The ACA extended and expanded the Money Follows the Person (MFP) demonstration program. The District's MFP rebalancing demonstration project is a pathway to independent living for individuals who have physical disabilities, and with intellectual and developmental disabilities. MFP functions through the District's two home and community-based (HCBS) waiver programs operated by DHCF and the District's Department on Disability Services. The federal grant program provides support to the District in order to shift Medicaid spending on long-term care away from a facility based system to one that offers services and supports in HCBS by allowing individuals receiving to choose where to receive their services. The District has received a cumulative award of $18.5 million under the demonstration program attributable to the ACA, from 2012 until the first quarter of FY 2018.
- In addition to covering HCBS costs for these individuals at an enhanced federal match rate for up to 365 days after discharge, the MFP grant provided important support to build the District's capacity to provide transition coordination, housing identification, and intensive case management services for people moving from facility-based care to the community. From its inception in 2008 to 2014, MFP has transitioned an average of 29 beneficiaries per year from facilities to HCBS. From 2015 to 2017, MFP transitioned approximately 38 beneficiaries per year. In 2017, MFP funding helped transition 38 beneficiaries to the community and another 40 beneficiaries received HCBS and support services funded through the demonstration.

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[6] Bivens, *supra* note 3.

8. **The ACA has allowed the District to test and implement reforms to healthcare delivery systems that support State policy priorities of increasing efficiency and quality of care.**

Under CMMI State Innovation Model (SIM) Round Two, DHCF spent over $720,000 of a Design Award to develop a State Health Innovation Plan (SHIP). The SHIP set forth the District's plan to: reform care delivery by implementing an integrated system capable of delivery value-based care; reform reimbursement by designing a payment structure that aligns provider reimbursement with improvement in health outcomes; and improve population health through integration of community linkages and care redesign. As the District works toward realization of the goals set forth in the SHIP DHCF has implemented several programs and initiatives. A few of these initiatives are set forth below.

- **Health Homes**

On January 1, 2016, DHCF, in coordination with the District Department of Behavioral Health, launched My DC Health Home, a new Health Home benefit (authorized under Section 2703 of the ACA) for Medicaid beneficiaries with serious and persistent mental health care needs. The health home provider coordinates a person's full array of health and social service needs—including primary and hospital health services; mental health care, substance abuse care and long-term care services and supports. My DC Health Home currently provides services to over 1,700 District Medicaid beneficiaries. The goal of the program is to serve unmet need in this vulnerable population an in the process reduce avoidable health care costs, specifically preventable hospital admissions, readmissions, and avoidable emergency room visits for the individuals with serious and persistent mental illnesses enrolled My DC Health Home.

On July 1, 2017, DHCF launched My Health GPS, a second Health Home program for Medicaid beneficiaries with multiple chronic conditions. Under this initiative, interdisciplinary teams embedded in the primary care setting serve as the central point for

integrating and coordinating the full array of eligible beneficiaries' primary, acute, behavioral health, and long-term services and supports to improve health outcomes and reduce avoidable and preventable hospital admissions and ER visits. My Health GPS currently serves over 3,500 District Medicaid beneficiaries.

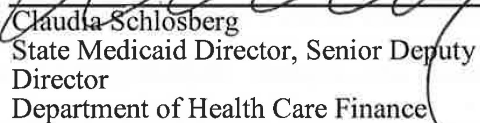
- **Payment Reform Initiatives**

DHCF has also implemented a number of payment reforms for providers in an effort to move incrementally toward the goal of value-based purchasing. Payment reform initiatives include: a pay-for-performance program for Federally-Qualified Health Centers; a quality improvement incentive program for nursing facilities; and two quality improvement incentive programs for My Health GPS providers.

9. All of the foregoing benefits of the Affordable Care Act would be removed if the Plaintiffs' preliminary injunction were granted.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on June 6, 2018, in Washington, District of Columbia.



Claudia Schlosberg
State Medicaid Director, Senior Deputy Director
Department of Health Care Finance

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenors-Defendants.	

DECLARATION OF RYAN SMITH IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Ryan Smith, declare:

1. I am 28 years old and a resident of Chicago, Illinois. I am currently employed as a legal assistant and will be attending law school in fall 2018.
2. In the summer of 2013 my physician diagnosed me with two separate mental illnesses: generalized anxiety disorder and panic disorder. I made the decision to go on a daily medication to manage my mental illness. At the time, my employer provided health insurance that made the cost of my medications affordable. Prior to medication, I was experiencing daily panic attacks. They were debilitating in that they lasted for hours, left me unable to sleep at night, and interfered with my normal work routine. The medication I was prescribed, Sertraline, helped prevent my panic attacks. I went from having one to two every day to having none at all.
3. In the fall of 2014, I lost my job and with it, my health benefits. Fortunately, my then-home of Michigan had established a healthcare exchange, and I was able to purchase health insurance on the exchange that was affordable, thanks in part to subsidies provided by the ACA. This helped keep the cost of my medication and doctor's visits at an affordable level. Without insurance, my prescriptions would have cost hundreds of dollars a month, which I could not afford while I was unemployed.
4. If I had not been able to afford my medication, searching for a job would have been exceptionally difficult, and my unemployment would have been prolonged. With my medication, and the affordable insurance I had through the healthcare exchange, I was able to actively search for employment. Access to mental healthcare is as critical as access to physical healthcare, and without the Affordable Care Act, my experience with unemployment might have been substantially worse.

5. Even though I am no longer covered through a plan purchased through the marketplace, I continue to utilize mental health services, and the protections offered under the Affordable Care Act remain critical. I know that whatever plan I enroll in will include mental health services as an essential health benefit, that mental health treatments will be in parity with other kinds of health services, and I will never be discriminated against for a pre-existing condition.

6. I support the Intervenor-Defendants' defense of the ACA. Elimination of the ACA would hurt me and my family.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on June 1, 2018, in Chicago, Illinois.

Ryan Smith

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

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TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, Plaintiffs, \TES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenors-Defendants.	

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DECLARATION OF DR. KARA ODOM WALKER IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

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1. **I, Dr. Kara Odom Walker, declare:**

- I am the Secretary of the Delaware Department of Health and Social Services (DHSS). I have served as the Secretary of the DHSS since February 6, 2017. Prior to my present post, I served as the Deputy Chief Science Officer at the Patient-Centered Outcomes Research Institute (PCORI) in Washington D.C. from August 2012 to January 2017. Furthermore, as a family physician with health services and community-based participatory research training, I previously was an assistant clinical professor in family and community medicine at the University of California, San Francisco, where I developed measurement instruments to better understand integrated care in health systems for diverse populations from July 2010 to July 2012.
- I graduated with honors from the University of Delaware with a BS in chemical engineering. Thereafter I received my MD from Jefferson Medical College and MPH from Johns Hopkins University. I completed postgraduate training at University of California, San Francisco, and served as a Robert Wood Johnson Clinical Scholar at the University of California, Los Angeles, where I conducted research on the impact of hospital closure on underserved, minority populations.
- As an advocate for health equity and minority and underserved populations, I was recognized for leadership by the Harvard Business School's program for leadership development, the American Medical Association, and the National Medical Association. I served as past national president of the Student National Medical Association and past postgraduate physician trustee of the National Medical Association.

2. As one of the largest agencies in state government, DHSS has 11 divisions, employs more than 4,000 people and in one way or another affects almost every citizen in our great state. Our divisions provide services in the areas of public health, social services,

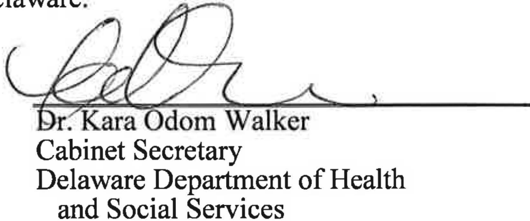
1 substance abuse and mental health, child support, developmental disabilities, long-term
2 care, visual impairment, aging and adults with physical disabilities, state service
3 centers, management services, financial coaching, and Medicaid and medical assistance.
4 The Department includes three long-term care facilities and the state's only public
5 psychiatric hospital, the Delaware Psychiatric Center.
6
7 3. This declaration is submitted in support of the Intervenor-States' Opposition to the
8 Application for Preliminary Injunction. Based on my knowledge and experience,
9 dismantling the Affordable Care Act would cause severe harm to the State of Delaware,
10 to its residents and to its economy. In addition to loss of benefits and services and federal
11 investments to support Delaware's healthcare system, dismantling or suspending
12 implementation of the Affordable Care Act would cause severe harm to the State of
13 Delaware, to its residents and to its economy. Delaware would experience harm and
14
15 increased costs from the dismantling of the state's administrative structure and apparatus,
16 created in compliance with, and to work in conjunction with, the Affordable Care Act.
17
18 4. **The Affordable Care Act directs billions of dollars directly to Delaware.**
19 - Delaware has received $800 million via Medicaid expansion alone.
20 5. **The Affordable Care Act (ACA) increased access to affordable coverage.**
21 Overall the number of individuals with insurance has increased. In Delaware, the
22 percentage of population which was uninsured fell from 9.1% in 2013 to 5.7% in
23 2016. This translates into the number of people without coverage falling from 83,000
24 in 2013 to 53,000 in 2016.
25 - The ACA expanded coverage through two key mechanisms: Medicaid expansion for
26 those individuals with the lowest incomes, and federal health subsidies to purchase
27 coverage in new health insurance Exchanges for those individuals with moderate
28 incomes.

- Medicaid is an important source of healthcare insurance coverage and has resulted in significant coverage gains and reduction in the uninsured rate, both among the low-income population and within other vulnerable populations. As a result of Medicaid expansion Delaware has been able to provide coverage to 11,000 new enrollees and maintain coverage for 50,000 adults from an earlier expansion with enhanced federal financial support, and the state has experienced a large reduction in the uninsured rate.

6. **The ACA has positive economic benefits on states.**
   - Studies have shown that states expanding Medicaid under the ACA have realized budget savings, revenue gains, and overall economic growth.
   - In Delaware, $500 million has been saved as a result of Medicaid expansion.
7. **The ACA has allowed States to test and implement reforms to healthcare delivery systems that support State policy priorities of increasing efficiency and quality of care.**
   - Delaware received Center for Medicare and Medicaid Innovation (CMMI) grants totaling $35 million over four years (2015-2018).
8. All of the foregoing benefits of the Affordable Care Act would be removed if the Plaintiffs' motion for preliminary injunction were granted.

I declare that the foregoing is true and correct based on information and belief.

Executed on June 6, 2018, in New Castle, Delaware.



Dr. Kara Odom Walker
Cabinet Secretary
Delaware Department of Health
and Social Services

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ,

Plaintiffs,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,

Defendants.

CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON,

Intervenors-Defendants.

Civil Action No. 4:18-cv-00167-O

DECLARATION OF SHERRY WHITE IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Sherry White, declare:

1. I am 46 years old and a resident of Corning, New York.

2. My husband and I are self-employed small business owners, and we have had to purchase our own insurance for the last 15 years.

3. Prior to the Affordable Care Act, our family of four purchased a plan through the private market at $800 per month. While our family is fortunate to be relatively healthy, we found ourselves needing our insurance for several small things over the years and each time, we found that our plan did not provide the coverage we needed. For example, I required physical therapy after I tore a tendon in my wrist and my husband needed a CPAP machine to treat sleep apnea. I learned that our plan did not cover both my physical therapy and his CPAP machine and we were forced to pay out of pocket if we wanted care.

4. We found ourselves paying for a plan that did not cover what we needed and cost more than our mortgage. And at one point, we were forced to choose between paying for the premiums and putting groceries on the table. We chose to drop our coverage.

5. Because of the Affordable Care Act, we were able to purchase a plan through the NY State of Health state marketplace that is more robust than our previous coverage and, after the tax credit subsidy is taken into account, half of the price. Because of the provision allowing children to stay on their parents' plan, we have been able to cover our young adult daughters until they are able to secure coverage of their own.

6. It is impossible to overstate the importance of the essential health benefits for our family. Between us, we have been able to receive coverage for preventive services, prescription drugs, medical equipment, and a hospitalization. Thankfully, we no longer have to worry about our plan turning down care the way our last one did.

7. Having stable, comprehensive coverage has helped us avoid a catastrophe that would have required us to close our business. While on this plan, I experienced a kidney stone and was forced to go to the hospital; the lithotripsy and overnight hospital stay cost us over $10,000. If our insurance did not have meaningful coverage for hospitalizations and limits to our out of pocket costs, it would have been

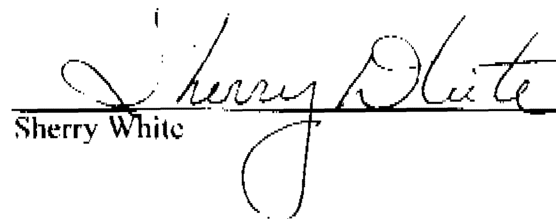
catastrophic. There is no way we could have afforded to pay that out of pocket. As small business owners, when we are injured or sick, we close the doors and lose all sources of income.

8. The Affordable Care Act has given our family the coverage and security of knowing that if we get sick, we will not go bankrupt as a result.

9. I support the Intervenor-Defendants' defense of the ACA. Elimination of the ACA would hurt me and my family.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on June1,2018 in Corning, N.Y.



Sherry White

SA2018100536

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA,

Plaintiffs,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,

Defendants,

and,

CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA, and WASHINGTON,

Intervenor-Defendants.

Civ. Action No. 18-cv-00167-O

DECLARATION OF WALKER WILSON IN SUPPORT OF INTERVENOR-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Walker Wilson, declare:

1. I am the Assistant Secretary of Policy at the North Carolina Department of Health and Human Services. I was previously the Director of the Health Policy Office at Blue Cross Blue Shield North Carolina where I led the team analyzing federal regulations under the Affordable Care Act.

2. The NC Department of Health and Human Services manages the delivery of health- and human-related services for all North Carolinians, especially our most vulnerable citizens – children, elderly, disabled and low-income families. The Department is divided into 30 divisions and offices. NCDHHS divisions and offices fall under four broad service areas – health, human services, administrative, and support functions.

3. This declaration is submitted in support of the Intervenor-States' Opposition to the application for a preliminary injunction. Based on my knowledge and experience, and in addition to the loss of benefits and services and federal investments to support North Carolina's health care system, dismantling or suspending implementation of the Affordable Care Act would cause severe harm to the state of North Carolina, to its residents, and to its economy. North Carolina would experience harm and increased costs from the dismantling of the state's administrative structure and apparatus, created in compliance with, and to work in conjunction with, the Affordable Care Act.

1. The Affordable Care Act directs billions of dollars directly to North Carolina.

- Specifically, North Carolina has received $32,538,454 through the Public Health and Prevention Fund.

2. The Affordable Care Act (ACA) increased access to affordable coverage.

- In North Carolina, 8,919,000 people have health insurance of some form and the rate of uninsured is 10.4 percent.

- The Exchange is an important reform made by the ACA. In North Carolina, 519,803 total consumers selected an exchange plan during 2018 Open Enrollment.

3. The ACA resulted in better quality and more accessible, affordable health care for consumers.

- The ACA created robust consumer protections to help ensure individuals can access the health care system.
    - 2,266,000 North Carolinians with private health insurance gained preventive service coverage with no cost-sharing,
    - The health care law expanded mental health and substance use disorder benefits and federal parity protections for 1,897,489 North Carolinians.
    - 3,091,000 people in North Carolina, including 1,186,000 women and 804,000 children, are free from worrying about lifetime limits on coverage.
    - As many as 4,099,922 non-elderly North Carolinians have some type of pre-existing health condition, including 539,092 children. Today, health insurers can no longer deny coverage to anyone because of a pre-existing condition, like asthma or diabetes, under the health care law.
- Through 2014 in North Carolina, people with Medicare have saved nearly $471,772,959 on prescription drugs because of the Affordable Care Act. In 2014 alone, 174,517 individuals in North Carolina saved over $153,325,756, or an average of $879 per beneficiary.
- In addition, the ACA created additional consumer protections and rights such as:
    - Delivery system reforms to improve quality, including incentives to:
        - reduce hospital-acquired conditions and readmissions;
        - adopt electronic medical records;

- coordinate care; and
- prioritize quality over quantity of care.

- Allowing the creation of Accountable Care Organizations with incentives for achieving quality benchmarks focused on the prevention and mitigation of chronic disease.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on June 6, 2018, in Raleigh, North Carolina.

Walker A. Wilson

Walker Wilson
Assistant Secretary for Policy
NC Department of Health and Human Services

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ,

Plaintiffs,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,

Defendants.

CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON,

Intervenors-Defendants.

Civil Action No. 4:18-cv-00167-O

DECLARATION OF DR. HOWARD A. ZUCKER IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, Howard A. Zucker, declare:

1. I am the Commissioner of the New York State Department of Health (DOH). I make

this declaration in my capacity as the Commissioner after consultation with DOH program staff directing the initiatives detailed below. This declaration is submitted in support of the Intervenor-States' Opposition to Plaintiffs' Motion for Preliminary Injunction. Based on my knowledge and experience, dismantling or suspending implementation of the Affordable Care Act would cause severe harm to the State of New York, its residents, and its economy. In addition to losing federal benefits, services and investments that support New York's healthcare system, New York would experience harm and increased costs from the dismantling of the state's administrative structure and apparatus, created in compliance with, and to work in conjunction with, the Affordable Care Act. An estimated 3 million New Yorkers currently enrolled in Medicaid, the Basic Health Program or a Qualified Health Plan with federal tax subsidies will lose their health insurance coverage if the Affordable Care Act is suspended. In addition, the state would incur enormous costs to undo years of work to implement the provisions of the ACA. Electronic eligibility systems which are built to determine eligibility based on a Modified Adjusted Gross Income (MAGI) standard as required by the ACA, would need to be entirely rebuilt or significantly modified to adjudicate eligibility using a series of complicated eligibility categories and associated income deductions. Eligibility for millions of consumers would need to be redetermined based on revised rules. Notices would need to be issued to each household notifying them of the change in eligibility and offering them due process through submission of an appeal. Given the millions of New Yorkers that would be impacted by such a suspension, customer service call center volume would reach unprecedented levels and appeals of eligibility changes, in particular, the loss of coverage or financial subsidies would cause the number of appeals to increase commensurately. All tallied, the estimated cost to the state would reach nearly $900 million including an estimated $330 million for information systems modifications

plus an estimated $570 million for customer service to handle consumer calls and appeals which is a manually intensive process.

2. DOH's mission is to protect, improve and promote the health, productivity and wellbeing of all New Yorkers. DOH administers several programs that receive funding through the Affordable Care Act (ACA) in order to achieve this mission.

3. As described below, the ACA has significantly increased New York State's ability to provide access to affordable comprehensive health insurance coverage and health care services to state residents. Rolling back the ACA's provisions puts the health of millions of New Yorkers at risk.

4. **The Affordable Care Act provides billions of dollars directly to New York to improve the health of its residents.**

- Funding available through the ACA has allowed New York to improve the health of its residents. New York has received more than $17 billion in federal revenue to expand affordable health coverage in the appropriate setting for New Yorkers, including: $12.9 billion in federal revenue as a result of state adoption of the Medicaid expansion provisions of the ACA; $3.5 billion in federal funding to support the Basic Health Program option of the ACA making health care coverage more affordable for lower income New Yorkers; $26.9 million in funding through the Public Health and Prevention Fund; $618 million in funding to support the Balancing Incentive Program; $100 million in continuing grants from the Center for Medicare and Medicaid Innovation for transforming primary care practices to advanced patient centered care; and nearly $185 million in funding to support the Money Follows the Person (MFP) program.

5. **The Affordable Care Act increased residents' access to affordable coverage.**

- The ACA expanded health coverage for New Yorkers through three key mechanisms: (1) the Medicaid expansion for those individuals with the lowest incomes; (2) the Basic Health Program (BHP), known as the "Essential Plan" in New York, for individuals with income slightly higher than Medicaid levels and lawfully present immigrants ineligible for Medicaid; and (3) federal subsidies to lower the cost of coverage for individuals with moderate incomes.
- Since implementing the ACA, New York has seen significant coverage gains. Since 2013, nearly 1 million people have gained coverage, and the rate of uninsured in New York has declined from 10 to below 5 percent, its lowest level ever. Coverage gains were seen among:
    - Young adults ages 19 to 25, whose uninsured rate fell from 17 percent to 8 percent;
    - African American/Black New Yorkers, whose uninsured rate fell from 12 percent to 7 percent;
    - Asian New Yorkers, whose uninsured rate fell from 14 percent to 8 percent;
    - Hispanic/Latino New Yorkers, whose uninsured rate fell from 20 percent to 12 percent;
    - New Yorkers who are full-time employees, whose uninsured rate fell from 12 percent to 7 percent; and
    - New Yorkers with household incomes under 200 percent of FPL, whose uninsured rate fell from 16 percent to 10 percent.

- Medicaid is an important source of healthcare insurance coverage for low income residents and the most vulnerable citizens. Prior to the ACA, New York had been a leader in making access to health care accessible to low-income residents through Medicaid expansion permitted under Section 1115 federal waivers. Nonetheless, an estimated one million people who were eligible for Medicaid remained uninsured, placing financial burden on the health care system when these individuals presented for services sicker and had no health plan to pay providers, often hospitals.
- As a result of implementing the ACA's Medicaid expansion, 301,721 New Yorkers became newly eligible for health care coverage. An additional 1,148,587 New Yorkers are covered by Medicaid with the state receiving an enhanced federal Medical Assistance Percentage (FMAP) under the provisions of the ACA.
- New York has also provided its residents with coverage under the Basic Health Program, a program created by the ACA, and available to states to opt into through submission of a "blueprint" to HHS. As of January 31, 2018, BHP provides 738,851 lower income New Yorkers with health coverage at a lower monthly premium cost, no annual deductible and lower copayments for services as compared to a silver tier Qualified Health Plan (QHP) with cost sharing reductions. In late 2015, modeling by The Urban Institute found that Essential Plan, as compared to a QHP, reduces both premium and out-of-pocket costs for these individuals by over $1,100 a year.
- Prior to implementing the ACA, New York's individual insurance market was often described as being in a "death spiral." With individual monthly premiums

of well over $1,000 a month, only the wealthiest individuals and/or people with high medical service utilization were likely to purchase coverage. Enrollment in the state's individual insurance markets had dropped to about 17,000.

- Since the 2014 implementation of the ACA, New York's individual insurance market has grown by 2000 percent to over 365,000. With this extraordinary increase in membership, individual market premiums have fallen by over 50 percent as compared to premiums in 2013, making coverage more accessible for New Yorkers.
- In addition to this dramatic reduction in premiums, the ACA allows nearly 150,000 New Yorkers to receive federal tax credits to further reduce the cost of coverage and cost sharing reductions to help reduce out of pocket costs such as deductibles, coinsurance and copayments. In 2018, New Yorkers are expected to receive over $531 million in tax credits, bringing the cumulative benefit of the ACA tax credits received by New Yorkers to over $2.7 billion since 2014.
- In 2016, 348,566 Medicare beneficiaries in New York received discounts on the Medicare Part D prescription drug coverage gap, known as the "donut hole," totaling more than $2.1 billion. On average, the beneficiary discount was $1,320.

6. **The ACA has positive economic benefits on states.**

- Given that health care comprises 18 percent of the national gross domestic product, the federal assistance states receive through the Affordable Care Act has a significant effect on the economy. A Commonwealth Fund analysis estimated that the repeal of the Medicaid expansion and premium tax credits could lead to the loss of 2.6 million jobs nationwide and $1.5 trillion gross state products over

five years. According to the report, in New York the repeal of the Medicaid expansion and tax credits would result in 131,000 jobs lost, $154 billion in lost business output, and $90 in lost gross state product.

- Since implementation of the ACA, the number of uninsured has been reduced significantly, and New York hospitals have reported a dramatic decrease in self-pay hospital utilization as patients have gained a usual source of payment. New York State Institutional Cost Reports show a 23 percent reduction in self-pay hospital emergency room visits, a 40 percent reduction in self-pay inpatient services and a 17 percent reduction in self-pay outpatient visits. Having a usual source of payment for patients reduces the risk of uncompensated care costs.

7. **The ACA expanded programs in Medicaid to provide States with increased opportunities to increase access to home and community based services.**

- Funding available to states through the ACA has allowed New York to increase opportunities for residents to access home and community based services through several programs. In January 2007, the federal Centers of Medicare and Medicaid Services (CMS) approved New York's application to participate in the Money Follows the Person Rebalancing Demonstration Program (MFP). The MFP Demonstration, authorized under the Deficit Reduction Act and extended by the Affordable Care Act, involves transitioning eligible individuals from long-term institutions like nursing facilities and intermediate care facilities into qualified community-based settings.

- The MFP has helped New York State to rebalance the Medicaid long-term care systems by assisting people who want to leave institutional settings to receive services in their communities of choice.
- Initiatives like MFP have contributed to the rebalancing of New York State's long-term health care system, increasing the amount of Medicaid spending on Home and Community Based Services in New York State by 56.68% from 2008 through calendar year 2016. MFP provides enhanced federal match of home and community based services provided to former residents of institutional settings who successfully transition to community living. These additional federal dollars support rebalancing efforts in long term care systems in New York. New York State MFP has utilized between $15-$20 million dollars for each of the last three years to provide assistance to individuals in nursing homes and intermediate care facilities to facilitate their transition to living.
- Community First Choice Option (CFCO) is an enhanced personal care benefit established under the Affordable Care Act. States were authorized to amend their state plan to cover enhanced personal attendant services and supports to address activities of daily living (ADL), instrumental activities of daily living (IADL) and health-related needs through hands-on assistance, supervision and/or cueing. Other services and supports required under CFCO include assistance with skill acquisition, maintenance or enhancement to facilitate an individual meeting his or her own ADL, IADL or health-related needs. Also, voluntary training to provide individuals with the skills to hire, train and dismiss personal attendants is required. Optional CFCO services and supports include social transportation,

home and vehicle modifications and assistance with moving expenses for those transitioning to community based care from institutional settings. CFCO services are intended to be primarily self-directed either by the person receiving the services and supports or through a designated representative. States who opt to implement a CFCO state plan benefit are eligible for an additional 6% FMAP.

- The Balancing Incentive Program (BIP) was authorized in the Affordable Care Act in 2010. It provides grants to states that agree to develop and implement three structural reforms believed to facilitate rebalancing of Medicaid expenditures toward community-based rather than institutional long-term services and supports (LTSS). Grants are earned through enhanced FMAP based on each state's spending on certain HCBS LTSS spending during the BIP period between the grant approval and September 30, 2015. While earnings ceased during the initial BIP period, states were granted additional time to meet the requirements and spend the funds generated during the BIP period. The final BIP period ended September 30, 2017.
- New York was one of 18 states that elected to participate in the BIP program. The program's overarching goal was to increase the percentage of state Medicaid expenditures on community-based long-term services and supports over 50% prior to the end of the BIP period. New York exceeded this goal early on and now spends nearly 65% of its Medicaid LTSS expenditures in community-based settings. From 2014 through 2017, more than 57,000 individuals were served through BIP.

8. **The ACA has allowed States to test and implement reforms to healthcare delivery systems that support State policy priorities of increasing efficiency and quality of care.**

- The ACA created the Center for Medicare and Medicaid Innovation (CMMI) which established the State Innovation Models (SIM) initiative to encourage state payment and delivery reforms. New York is a SIM award state. With this $100 million award, DOH has implemented a primary care transformation initiative to meet the goals of having improved access to high quality, cost-effective health care for 80% of New York residents, improving the health of our population. With this initiative, over 2,500 practices will receive transformation assistance to increase practice capability for access to appointments, patient-centric coordinated care using health information to improve quality and outcomes.
- New York State has two facilities participating in Accountable Health Communities, a program that focuses on addressing the gap between clinical care and community services addressing health-related social needs or social determinants of health. Data from this program will inform models for addressing social determinants in communities, essential to increasing access to primary care and reducing unnecessary hospital utilization.

9. **The ACA created a dedicated funding stream to improve the nation's public health system.**

- The Prevention and Public Health Fund was established under Section 4002 of the ACA. Also known as the Prevention Fund or PPHF, it is the nation's first

mandatory funding stream dedicated to improving our nation's public health system.

- PPHF funds that have been allocated to the Centers for Disease Control and Prevention (CDC) have enhanced state capacity to provide immunizations against infectious diseases; increase detection and prevention efforts related to infectious disease threats including pandemic influenza; have supported the Preventive Health & Health Services Block Grant that addresses unique public health issues on state levels including prevention of lead poisoning, fall prevention, rape crisis and sexual violence prevention, tobacco use prevention, hunger prevention, and enhanced water quality; and has supported state funding through the Epidemiology and Laboratory Capacity (ELC) and Emerging Infections Program (EIP) grants that have built capability critical during recent outbreaks including those related to multi-state foodborne illness, influenza, and fungal meningitis, and provides a foundation for the antibiotic resistance and healthcare associated infections programs that is estimated to avert billions of dollars in healthcare spending.
- New York State currently receives funding from the PPHF to conduct chronic disease prevention programs addressing diabetes, obesity, cardiovascular disease tobacco use, and arthritis. Chronic diseases are among the leading causes of death and disability in New York State. They account for approximately 60% of all deaths in the state and affect the quality of life for millions of New Yorkers. However, chronic diseases are also among the most preventable, if there is adequate support for effective prevention programs and policies.

- In addition to addressing chronic diseases, without continued PPHF funding, grants that support communicable disease prevention, detection, and control would be severely impacted. Current grant funding through the CDC supports communicable disease surveillance and outbreak control in communities, healthcare settings (hospitals and nursing homes), tuberculosis prevention and control, and combating vaccine preventable diseases. CDC funds New York annually through the Emerging Infections Program grant, the Epidemiology and Laboratory Capacity grant, the Immunization and Vaccines for Children Cooperative Agreement funding, and Preventive Health & Health Services Block grant. A portion of the PPHF funding is directed to increase and improve the critical public health work conducted at the local level which extends the reach and impact of the state capacity.

10. **The ACA resulted in better quality and more accessible, affordable healthcare for consumers.**

- Compared to individuals in states that have chosen not to implement key coverage mechanisms in the ACA, individuals who live in states that are implementing the law have improved access to care. According to a recent Commonwealth Fund Survey[1]:
    - Nationally, in 2012 the share of individuals who reported they could not access needed care due to cost was 43 percent. This share dropped to 34

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[1] The Commonwealth Fund, Issue Brief, March 2017, *Insurance Coverage, Access to Care, and Medical Debt Since the ACA: A Look at California, Florida, New York and Texas* http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/mar/1935_gunja_coverage_access_four_largest_states_ib.pdf.

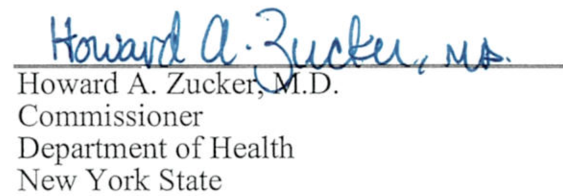
percent in 2016 nationally, and in New York the percentage dropped to 29 percent in 2016. In comparable large states like Florida and Texas, the share of individuals who reported they could not access needed care in 2016 was far higher: 41 percent and 45 percent, respectively.

- Nationally, in 2012 the share of individuals who reported having trouble paying their medical bills was 41 percent. This share dropped to 37 percent in 2016, and in New York, the number dropped to 28 percent. In comparison, the share of individuals reporting having trouble paying medical bills was 41 percent and 44 percent in Florida and Texas, respectively.

11. New York will lose all of these benefits under the Affordable Care Act if the Plaintiffs prevail on their Motion for Preliminary Injunction.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on June 6, 2018, in New York City, New York.



Howard A. Zucker, M.D.
Commissioner
Department of Health
New York State

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	No. 4:18-cv-00167-O
CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenors-Defendants.	

DECLARATION OF PATRICK M. ALLEN IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

1 I, Patrick M. Allen, declare:

2 1. I am the Director of the Oregon Health Authority. For several years I was the
3 Director of the Oregon Department of Consumer and Business Services. In both roles, I have
4 overseen Oregon's health insurance market and exchange. The details below were provided to
5 me by agency personnel who are responsible for collecting and analyzing the described data,
6 upon whom I regularly rely in performing my duties.

7 2. This declaration is submitted in support of the Intervenor-States' Opposition to
8 application for a preliminary injunction. Based on my knowledge and experience, dismantling
9 the Affordable Care Act would cause severe harm to the state of Oregon, to its residents and to its
10 economy. In addition to loss of benefits and services and federal investments to support state's
11 healthcare system, dismantling or suspending implementation of the Affordable Care Act would
12 cause severe harm to the state of Oregon, to its residents and to its economy. As explained in
13 detail below, Oregon would experience harm and increased costs from the dismantling of the
14 state's administrative structure and apparatus, created in compliance with, and to work in
15 conjunction with, the Affordable Care Act should the injunction be granted.

16 3. The Oregon Health Authority is at the forefront of lowering and containing costs,
17 improving quality and increasing access to health care in order to improve the lifelong health of
18 Oregonians. OHA is overseen by the nine-member citizen Oregon Health Policy Board working
19 towards comprehensive health reform in our state.

20 4. **The Affordable Care Act directs billions of dollars directly to Oregon.**

21 - Specifically, Oregon has received $10.4 billion via Medicaid expansion; $4.1
22 billion through the Community First Choice Option; of which approximately $359 million was
23 from enhanced federal match; $38.9 million through the Public Health and Prevention Fund; and
24 $41.5 million in grants from the Center for Medicare and Medicaid Innovation. Oregon also
25 expects to receive an additional $54,482,113 in federal pass-through funding in 2018 through the
26 state's approved Section 1332 State Innovation Wavier.

27

28

5. **The Affordable Care Act (ACA) increased access to affordable coverage.**

- Overall the number of individuals with insurance has increased. In Oregon, in 2017, 3,747,500 people had health insurance coverage (93.8%). In 2013 before ACA, 3,236,200 people in Oregon had health insurance coverage (85.5%). Approximately 500,000 people gained health coverage in Oregon between 2013 and 2017. The rate of uninsured in the state is now 6.2%. This is a decrease from 2013 when 14.5% of Oregonians were uninsured.
- The ACA expanded coverage through two key mechanism: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance exchanges for those individuals with moderate incomes.
- Medicaid is an important source of healthcare insurance coverage and has resulted in significant coverage gains and reduction in the uninsured rate, both among the low-income population and within other vulnerable populations.
- As a result of the Medicaid expansion, there were 520,432 persons on the Oregon Health Plan for one or more months in 2017, and the state has experienced a large reduction in the uninsured rate.
- The Exchange is an important reform made by the ACA. As of January 1, 2018, 107,925 Oregonians were enrolled in federally subsidized exchange coverage as a result of the law.

6. **The ACA has positive economic benefits on states.**

- Studies have shown that states expanding Medicaid under the ACA have realized budget savings, revenue gains, and overall economic growth.
- Statewide uncompensated care fell by $652.3 million from its high in 2013 of $1.29 billion, of down 51 percentage points, to its current level of $633.1 million as of 2017.

- Following implementation of the ACA, Oregon added 23,300 health care jobs. On average, the state's rate of job growth has outpaced rates of job gains in states that did not expand Medicaid coverage.
- In addition, Oregon has added approximately 20,000 home care workers and personal support worker jobs since the passage of ACA to provide in-home long term services and supports. These positions are paid above minimum wage and have access to benefits like health care coverage and paid time off.

7. **The ACA expanded programs in Medicaid to provide States with increased opportunities to increase access to home and community based services.**

- The Community First Choice Option (CFCO) removed enrollment caps and crisis-based eligibility criteria for children to receive Home and Community Based Services (HCBS). Many families with children with intellectual and developmental disabilities are now receiving needed supports without having to reach crisis. Since implementation of CFCO (July 1, 2013 – June 30, 2017) the number of children receiving services has increased by over 500%.
- Since implementation of CFCO (July 1, 2013 – June 30, 2017), the number of older adults and people with disabilities served through the program increased by 36%.
- Availability of in-home services and supports helps prevent individuals from moving to residential services or other more restrictive settings.
- CFCO has provided a robust set of tools such as environmental modifications and assistive technology that allow individuals to remain independent in their own homes.

8. **The ACA has allowed States to test and implement reforms to healthcare delivery systems that support State policy priorities of increasing efficiency and quality of care.**

- The State Innovation Model (SIM) grant supported the acceleration of health transformation in Oregon and fueled the spread of the coordinated care model from the Medicaid population to other payers and populations. Oregon's CMS waiver allows us

to implement the coordinated care model with the Medicaid population, while SIM funding allows the work to go further, faster and touch more Oregonians. SIM also provided funding for a comprehensive evaluation to help other states learn what key steps and tools work to transform the delivery system and achieve the triple aim: better health, better car, and lower costs. Areas of SIM funded work included:

- o Patient-Centered Primary Care Home (PCPCH) program. Evaluation results confirm the success of the PCPCH program, the foundation of the efforts of Oregon's health system transformation. Key evaluation findings include:
  - ▪ Clinics participating in the program cut health care costs by 4.2 percent, or approximately $41 per person per quarter. Effects increased significantly the longer clinics were designated as a PCPCH, generally doubling from the first to third year of recognition.
  - ▪ Saved an estimated $240 million over its first three years (from 2012-2014).
  - ▪ For every $1 increase in primary care spending under the program, there was $13 in savings in downstream costs.
  - ▪ PCPCH clinics have accomplished significant transformation, resulting in greater effectiveness and efficiency, within primary care and the larger health care system.
- o Health information technology (HIT) and Health Information Exchange (HIE)
- o OHA Transformation Center
- o Tobacco Cessation
- o Colorectal Cancer Screenings
- o Primary Care Payment Reform
- o Value Based Payments
- o Behavioral Health Integration

- Project ECHO
- Oral Health Integration
- Population Health
- Regional Health Equity Coalitions
- Health Equity Leadership
- Health Care Interpreter Learning Collaborative
- Long Term Care
- Medicare-Medicaid Dual Eligibility
- Early Learning
- Health Evidence Review Commission
- SIM Self-Evaluation

9. **The ACA resulted in better quality and more accessible, affordable healthcare for consumers.**

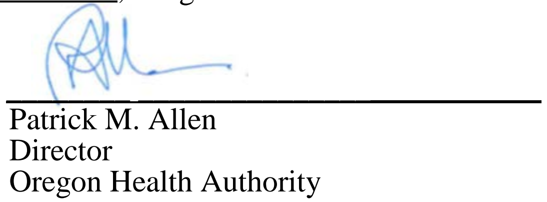
- The ACA created robust consumer protections to help ensure individuals can access the healthcare system.
- In 2017, 3,747,500 people in Oregon had health insurance coverage (93.8%). In 2013 before ACA, 3,236,200 people in Oregon had health insurance coverage (85.5%). Approximately 500,000 people gained health coverage in Oregon between 2013 and 2017.
- The ACA has led to improved access to care. In 2017, 93.4% of Oregonians reported having a usual place of care, a 7.2 percentage point increase since 2013. For Oregonians enrolled in the state's Medicaid program, that rate is even higher, 95.2 in 2017 reported having a usual place of care.
- The ACA has led to improved financial security for 694,000 individuals who previously experienced trouble paying medical bills. In 2017, 8.4% of Oregonians (335,000 people) had trouble paying medical bills, down from 28.4% of Oregonians (1,029,000) in 2013. This represents a 20 percentage point decrease in Oregonians who had trouble paying medical bills.

- In addition, the ACA created additional consumer protections and rights such as:
- In 2017, 68.0% of Oregonians had dental coverage (2,715,200 people), compared to only 64.2% in 2013. This represents an increase 3.8 percentage points or 560,600 Oregonians gaining access to dental coverage since implementation of the ACA.
- In 2017, 16.7% of Oregonians went to the ER in the past 12 months, compared to 22.5% of Oregonians in 2013. This represents a decrease of 5.8 percentage points or 560,600 Oregonians gaining access to dental coverage since implementation of the ACA.

10. All of the foregoing benefits of the Affordable Care Act would be removed if the Plaintiffs' motion for preliminary injunction were granted.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on June 6, 2018 in Salem, Oregon.



Patrick M. Allen
Director
Oregon Health Authority

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF TEXAS

FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, MISSISSIPPI, by and through Governor Phil Bryant, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, and WEST VIRGINIA, Plaintiffs, **v.** **UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,** Defendants, and,	Civ. Action No. 18-cv-00167-O **DECLARATION OF ZACHARY W. SHERMAN IN SUPPORT OF INTERVENOR-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION**

CALIFORNIA, et al. Intervenor-Defendants.

I, Zachary W. Sherman, declare:

1. I am the Director of HealthSource RI, Rhode Island's state-based health insurance exchange. I have been Director for over two years, and have served in multiple capacities at HealthSource RI since shortly after the Affordable Care Act passed in 2010.
2. HealthSource RI was created in 2011 and has been operational since 2013, connecting Rhode Islanders with affordable plans and participating in many aspects of federal health reform.
3. Based on my knowledge and experience, dismantling the Affordable Care Act would cause significant harm to the state of Rhode Island, its residents and its economy. The withdrawal of the federal investments that have been made under this law to stabilize, strengthen and improve our state's health care system would be devastating. Beyond that, our residents would lose critical benefits and services they have come to rely upon and that have helped our state in reducing its rate of uninsured to the lowest in history. Dismantling the ACA and the technical infrastructure that has been developed to implement it in Rhode Island would come at a substantial cost to Rhode Islanders. In addition to launching a state-based marketplace under the ACA, Rhode Island was able to make significant technological improvements, modernizing the way providers, consumers and payers interface with many state and federal programs. Disentangling these advancements would cost many millions of dollars. Furthermore, the administrative and operational costs associated with transitioning our residents off ACA programs would be significant. The work that would be required to re-engineer program eligibility policies, system and business process rules, regulations, notices, and to conduct the subsequent outreach and administration of appeals alone would require considerable technological and operational

support. This would likely cost the state millions of additional unbudgeted dollars. Moreover, it would be exponentially more costly for the state to maintain its existing health coverage gains and the level of benefits and services Rhode Islanders currently have access to under the ACA. The impact of losing the foregoing funding and subsequent progress made in Rhode Island would have resounding and damaging effects in this state for years to come.

4. The Affordable Care Act increased access to affordable coverage.

- Overall, the number of individuals with insurance in Rhode Island has increased. According to the Rhode Island Health Insurance Survey (HIS), a comprehensive phone-based household survey, in Rhode Island, 999,145 people have coverage, bringing the rate of uninsured in this state down to just 4.2%. This marks a significant improvement from 2012, when the rate of uninsured was 11%, and is representative of 73,000 more Rhode Islanders obtaining coverage. One out of every ten Rhode Islanders have health insurance through the ACA.
- The ACA expanded coverage through two key mechanism: Medicaid expansion for those individuals with the lowest incomes, and federal subsidies to purchase coverage in new health insurance Exchanges for those individuals with moderate incomes.
- Medicaid is an important source of healthcare insurance coverage and has resulted in significant coverage gains and a reduction in the uninsured rate, both among the low-income population and among other vulnerable populations. As a result of Medicaid expansion in Rhode Island, as of February 2018, 77,846 people have coverage.
- The Exchange is an important reform enacted by the ACA. In Rhode Island, 25,159 people enrolled in coverage with federal affordability subsidies during this most recent Open Enrollment Period. In other words, 82% of all enrollees in commercial plans through the Exchange are receiving federal assistance towards the purchase of their health coverage.

1 **5. The ACA expanded programs in Medicaid to provide States with increased**
2 **opportunities to increase access to home and community based services.**

- Through the Medicaid Money Follows the Person Demonstration, Rhode Island receives federal financial assistance to move elderly nursing home residents out of nursing homes and back into their own homes or into the homes of their loved ones. This grant has allowed the state to expand the program to assist individuals in managing their care outside of a nursing home. Over the grant period, the state has seen a shift in Long Term Services and Supports spending for the state. The percent of the state Medicaid expenditures for home and community based services increased over the period of the grant, with a corresponding decline in the percent of expenditures for institutional care.

6. The ACA resulted in better quality and more accessible, affordable healthcare for consumers.

- The ACA created robust consumer protections to help ensure individuals can access the healthcare system.
    - As of April 2017, 88,827 Rhode Islanders were enrolled in ACA compliant Individual and Small Group market plans sold by a Rhode Island carrier. It is because of the ACA that these enrollees have access to coverage for dependents through a parents' plan until the dependent turns twenty-six, access to certain mandated preventive services including access to birth control, cancer screenings, and immunizations for children, and access to essential health benefits such as substance use disorder treatment and maternity and newborn care.
- The ACA has led to improved access to care. For example, in 2016, 4.8% of those surveyed through the HIS in RI said they'd skipped or took less of a medication in order to make it last longer as compared to 6.1% in 2012. In that same time period,

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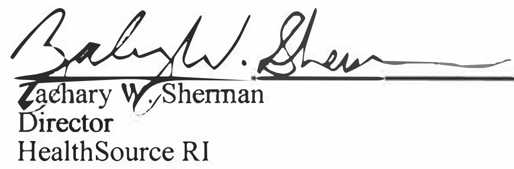
the percentage of respondents in the same survey who said that they did not get a prescription filled because they could not afford it dropped from 5.5% to 4.5%.

- The ACA has led to improved financial security. For example, in 2016, results from the HIS showed that 19.1% of respondents said they had experienced trouble paying medical bills at some time during the past year, down from 24.1% in 2012.
- The ACA also created important additional consumer protections and rights such as:
  - A prohibition on higher premiums for those with pre-existing conditions;
  - A prohibition on annual and lifetime limits for covered benefits and discrimination in benefit design;
  - Guaranteed issue and renewability of health coverage; and
  - Transparency of plan benefits, providers, and drug coverage.

7. All of the foregoing benefits of the Affordable Care Act would be removed if the Plaintiffs' motion for preliminary injunction were granted.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on June 6, 2018 in East Providence, RI.



Zachary W. Sherman
Director
HealthSource RI

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON, Intervenors-Defendants.	

DECLARATION OF JOHN JAY SHANNON IN SUPPORT OF INTERVENORS-DEFENDANTS' OPPOSITION TO APPLICATION FOR PRELIMINARY INJUNCTION

I, John Jay Shannon, declare:

1. This declaration is submitted in support of the Intervenors-Defendants' Opposition to the Application for Preliminary Injunction. Based on my knowledge and experience, dismantling the Affordable Care Act would cause harm to the State of Illinois, to its residents and to its economy. In addition to loss of benefits and services and federal investments to support Illinois' healthcare system, including Cook County Health & Hospitals System, dismantling or suspending implementation of the Affordable Care Act would cause severe harm to the State of Illinois, to its residents and to its economy. Illinois would experience harm and increased costs from the dismantling of the state's administrative structure and apparatus, created in compliance with, and to work in conjunction with, the Affordable Care Act.

2. I am a board certified physician and the Chief Executive Officer of the Cook County Health & Hospitals System (CCHHS).

3. CCHHS is one of the largest public health care systems in the United States, providing a range of health care services regardless of a patient's ability to pay. CCHHS serves approximately 300,000 unique patients annually through more than 1 million outpatient visits and more than 20,000 inpatient hospitals admissions.

4. CCHHS is comprised of two hospitals (John H. Stroger, Jr. Hospital and Provident Hospital), a robust network of more than a dozen community health centers, the Ruth M. Rothstein CORE Center, the Cook County Department of Public Health, Cermak Health Services, which provides health care to individuals at the Cook County Jail and the Juvenile Temporary Detention Center, and CountyCare, a Medicaid managed care health plan.

5. The enactment of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, (collectively the "Affordable Care Act") has had a positive effect on CCHHS' ability to serve the residents of Cook County. In particular, the Affordable Care Act offered states the option to expand eligibility for their state Medicaid plan to individuals with incomes at or below 133% of the federal poverty level with heightened matching of federal funds. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). Illinois enacted a law to expand the eligibility for its state Medicaid

plan to individuals aged 19 or older but younger than 65 with incomes at or below 133% of the federal poverty level. 305 ILCS 5/5-2(18). These newly eligible individuals are often known as "ACA adults." The expansion of Medicaid to ACA adults in Illinois created access to coverage for many existing CCHHS patients who were previously uninsured.

6. The CountyCare Medicaid managed care health plan launched in 2012 as a demonstration project through a federal Centers for Medicare and Medicaid Services (CMS) 1115 Waiver granted to the state of Illinois to early-enroll eligible low-income Cook County ACA adults into a Medicaid managed care program. In 2014, CountyCare was awarded a contract with the Illinois Department of Healthcare and Family Services to operate as a Managed Care Community Network health plan to provide coverage for Cook County Medicaid eligible beneficiaries. CountyCare was also awarded a contract from the State of Illinois' Department of Healthcare and Family Services to provide services under its Medicaid Managed Care Program beginning January 1, 2018. As part of that program, encouraged by the Affordable Care Act, CountyCare receives a capitated per-member per-month payment from the State of Illinois to pay for services rendered to Illinois Medicaid recipients in its network. CountyCare provides coverage to more than 320,000 members, of which 54,000 are ACA adults who are only eligible for Medicaid because Illinois expanded eligibility pursuant to the Affordable Care Act. In FY2015, CountyCare spent approximately $300 million on claims for ACA adults. Many of CountyCare's members are long-standing CCHHS patients who have previously received care regardless of their ability to pay. Without coverage through Illinois' Medicaid expansion, many of these individuals would be uninsured and may require crucial medical care from CCHHS without being able to provide insurance or other coverage. Unfortunately, many of these patients may decline to seek necessary medical care if they were to lose their Medicaid coverage.

7. The Medicaid expansion has reduced the number of CCHHS patients who receive services without insurance or other coverage. In FY 2012, 63% of CCHHS' patients were uninsured. By FY 2017, the percentage of patients without insurance or other coverage had dropped to 39%. This decrease is largely attributed to the number of ACA adults who were

newly eligible for Medicaid because of Illinois' Medicaid expansion pursuant to the Affordable Care Act.

8. The decrease in the number of patients who are uninsured has had a noticeable effect on CCHHS' costs for uncompensated care. In FY 2013, CCHHS provided $585.8 million in uncompensated care. Newly eligible ACA adults were entitled to enroll in Medicaid beginning January 1, 2014. 305 ILCS 5/5-2(18). As a result, the amount of uncompensated care that CCHHS provided in FY 2014 dropped to $313.6 million. Although that number has increased in recent years, CCHHS' costs for uncompensated care have stayed below the costs prior to Illinois' Medicaid expansion. This drop in uncompensated care costs has enabled CCHHS to improve services and care for Illinois patients and engage in a multi-year strategy to address behavioral health services pursuant to a pending Medicaid Section 1115 Waiver Proposal submitted by the State of Illinois. As a result of ACA funding, CCHHS has also reduced the amount of local tax dollars that are required to support its operations from $481 million in 2009 to $103.5 million in FY2018.

9. Pursuant to Illinois law, if federal matching funds to Illinois for the Medicaid expansion population falls below 90%, coverage for persons eligible for Medicaid through the Medicaid expansion shall cease no later than the end of the third month following the reduction of federal funding below 90%. 305 ILCS 5/5-2(18).

10. If persons enrolled in Medicaid through the Medicaid expansion lose coverage, Illinois hospitals, including CCHHS and other public hospitals in Illinois, will experience an increase in uncompensated care that they must provide to their communities. CCHHS estimates that it could lose $100-200 million in reimbursements from CountyCare and $100-250 million in reimbursements from other Medicaid managed care organizations for services provided if ACA adults lose their Medicaid coverage. CCHHS is also likely to experience a migration of patients from other systems without insurance or other coverage because of CCHHS' policy to provide care to all patients regardless of their ability to pay. CCHHS estimates that it could experience at least $100 million annually in increased uncompensated care costs, with a potential additional

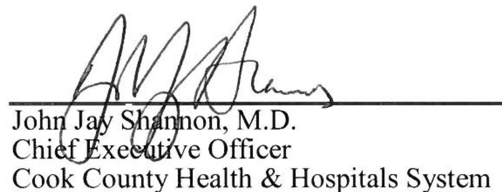
$500 million in additional expenses, if the Affordable Care Act and the Medicaid expansion were repealed.

11. Should the ACA be enjoined from operation, CCHHS and other public hospitals will face increased costs from uncompensated care and will suffer additional strains on their ability to deliver high-quality healthcare services to our patients.

12. All of the foregoing benefits of the Affordable Care Act would be removed if the Plaintiffs' motion for preliminary injunction were granted.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on June 6, 2018, in Chicago, Illinois.



John Jay Shannon, M.D.
Chief Executive Officer
Cook County Health & Hospitals System

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY and JOHN NANTZ,

Plaintiffs,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE,

Defendants.

CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA and WASHINGTON,

Intervenors-Defendants.

Civil Action No. 4:18-cv-00167-O

DECLARATION OF KRISTI M. BOHN

DECLARATION OF KRISTI M. BOHN, CHIEF HEALTH ACTUARY FOR THE MINNESOTA DEPARTMENT OF COMMERCE IN OPPOSITION OF MOTION FOR PRELIMINARY INJUNCTION

I, KRISTI M. BOHN, declare:

1. I am the Chief Health Actuary for the Minnesota Department of Commerce. I have been working in the actuarial field for 23 years and my credentials are as follows: Fellow of the Society of Actuaries, a Member of the Academy of Actuaries, and an Enrolled Actuary of the Joint Board under ERISA. I have been working as the Chief Health Actuary at Commerce for over four years, and as such, am familiar with the facts and circumstances surrounding the Affordable Care Act (ACA) and its affect in the state of Minnesota.

2. In this affidavit, I refer to the action taken by Congress in the Tax Cuts and Jobs Act of 2017 as a *reduction* of the Individual Shared Responsibility Payment (SRP), rather than an elimination of the individual mandate. The applicable language of the SRP penalty was never removed from federal law, but rather the parameters were reset by the Tax Cuts and Jobs Act of 2017, effective January 1, 2019.

3. Minnesota's individual market covered over 300,000 people in 2015. I estimate that today, this market covers somewhere between 150,000 and 155,000 people. The primary cause of the individual market's decrease in enrollment is due to premium rate increases. As a counter-balance, more individuals qualified and received federal premium tax credit subsidies through Minnesota's state-based Health Insurance Exchange, MNsure, which resulted in relatively stable individual market enrollment in Minnesota in recent years.

4. The elimination of the ACA would severely disrupt the ability to access and purchase health insurance coverage for between 150,000 to 300,000 people in Minnesota's individual market. Minnesota Statutes Chapters 62A, 62L, 62K, 62Q and 62V were comprehensively revised to conform with the ACA. However, without the federal premium tax credits, health insurance will be unaffordable for the vast majority of Minnesotans, resulting in lack of access to health care.

    4.1 I estimate that over 30,000 Minnesotans will not be able to secure commercial health insurance due to the repeal of the ACA and the ability of insurance companies discriminate against individuals with pre-existing conditions. Minnesota's high risk pool had reached over 26,000 in 2013, and enrollees with high-cost cases increased significantly in 2014 and 2015. This number would be higher if it included the Medicaid expansion and MinnesotaCare populations.

4.2 Many more Minnesotans would be uninsured. According to the 2017 Minnesota Health Access Survey,[1] Minnesota's uninsured rate was estimated to be 6.3 percent in 2017. In 2013, the uninsured rate was an estimated 8.2 percent, and had been estimated at 9.0 percent in 2009 and 2011.

5. Minnesota, like Alaska, Oregon, Wisconsin, Oklahoma and Maine, took significant action to address affordability while maintaining the goal of offering comprehensive coverage. Without the ACA, it is likely that Minnesota would experience direct financial harm. Minnesota's Section 1332 waiver implies that the federal government will provide $150 to $200 million to the state for Minnesota's state-based reinsurance program. To date, Minnesota has dedicated $271 million per year to reduce insurance premiums in the individual market for plan years 2018 and 2019.

6. In Minnesota, people who would otherwise have to buy insurance in the private market with incomes between 133% and 200% of poverty who do not have access to employer-based coverage, are enrolled in Minnesota's Basic Health Program (MinnesotaCare). This program was established under Section 1331 of the ACA. This program would also be lost if the federal government is enjoined from enforcing the ACA. Basic Health Programs receive from the federal government 95% of what the enrollees would have otherwise received in premium and cost-sharing subsidies in the individual market from the federal government. Minnesota uses these funds to purchase group coverage from health plans, and at a lower price point for consumers. Based on information from the Minnesota Department of Human Services there are approximately 82,000 people enrolled in this program, and Minnesota received approximately $548 million in federal funding in calendar year 2017. Calendar year 2018 funding is uncertain because of the HHS decision to discontinue a portion of the funding related to the CSRs.

7. Minnesota's provider community would experience financial harm caused by increased uncompensated care. I do not have data to estimate this impact, though it is an important concern given that the federal government significantly decreased Disproportionate Share Hospital (DSH) payments due to the ACA. Some affected providers are county hospitals. It is also important to note because it is unique to Minnesota: Minnesota had provided coverage for adults without children since the 1970s, at 100% state cost. As a result, Minnesota's Medicaid DSH allotment is disproportionately low, compared to other states that used the Medicaid DSH funding to pay for deep-end, hospital care for those adults who were uninsured in those states.

[1] http://www.shadac.org/publications/minnesotas-changing-health-insurance-landscape-results-2017-minnesota-health-access

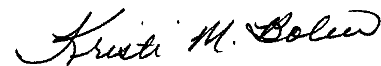
8. The elimination of the ACA would also affect the health of Minnesotans and the State of Minnesota's public health costs. While this is not readily quantifiable, it is important to remember that for most people, access to health insurance and public health programs such as Medicaid, like the BHP, provides their access to health care. It is also important to consider that individual market premium escalation is due to people with health care conditions now having the ability to access the care they need.

9. The ACA provided the authority for Medicaid to cover adults without minor children who are not disabled. Prior to the ACA, these individuals received some coverage through various state-funded programs. There are currently 212,000 people enrolled in the expansion population. Their income is less than 133% of the poverty level, which means that private insurance is out of range. According to the Minnesota Department of Human Services Minnesota receives approximately $1.7 billion annually in federal funding to support this Medicaid expansion.

10. Loss of coverage for people in the Medicaid expansion and MinnesotaCare will increase the rate of uninsurance in Minnesota. It will increase the amount of uncompensated care for providers. The lack of coverage through the public programs, combined with the inability to buy coverage in the private market, means that many people will delay necessary preventive care, will receive delayed treatment for their medical conditions, or no treatment at all.

11. Finally, it is important to note that there were many items in the ACA that are not connected to federal subsidies and taxes. For example, most health plans in commercial markets and Medicaid must now offer coverage to children until age 26 (including foster children), often without regard to the child's disability, residence, tax status or marital status. Most health plans no longer can apply pre-existing conditions, lifetime and annual limits. These have been important changes that have significantly affected the finances of consumers and state budgets.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge and investigation of fact provided to me by other state agencies. Executed on June 7, 2018, in St. Paul, Minnesota.



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Certificate of Service

On June 7, 2018 I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all counsel and/or *pro se* parties of record electronically or by another manner authorized by Federal Rule of Civil Procedure 5 (b)(2).

s/ M. Schoenhardt