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Initiative on Global Markets
Myron Scholes Global Market Forum
October 17, 2018

*I thank Jake Gosselin and Hanbin Yang for outstanding research assistance.
Overview

Focus on insurance coverage provisions

- Nothing on taxes*
- Nothing on “bending the cost curve” (ACOs, IPAB)

Three sections
1. Refresher on ACA’s insurance coverage provisions
2. Review of what happened
3. Issues, non-issues, and proposed solutions

*Except if you, like Roberts, consider the mandate a tax
1. Refresher on ACA’s insurance coverage provisions
   a. Expanded Medicaid
   b. Established individual market (Marketplaces)
   c. Individual and employer mandates
2. Review of what happened
3. Issues, non-issues, and proposed solutions
# Cheat Sheet: Federal Poverty Line

<table>
<thead>
<tr>
<th>Persons in Family/Household</th>
<th>100%</th>
<th>138%</th>
<th>250%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12,060</td>
<td>$16,643</td>
<td>$30,150</td>
<td>$48,240</td>
</tr>
<tr>
<td>2</td>
<td>$16,240</td>
<td>$22,411</td>
<td>$40,600</td>
<td>$64,960</td>
</tr>
<tr>
<td>3</td>
<td>$20,420</td>
<td>$28,180</td>
<td>$51,050</td>
<td>$81,680</td>
</tr>
<tr>
<td>4</td>
<td>$24,600</td>
<td>$33,948</td>
<td>$61,500</td>
<td>$98,400</td>
</tr>
</tbody>
</table>

FPL for continental USA in 2017 (applied to 2018 insurance coverage)
Pre-ACA Insurance Coverage

Health Insurance Coverage of the Nonelderly, 2011

- 55.8% Employer-Sponsored Coverage
- 18.0% Uninsured
- 20.5% Medicaid/Other Public
- 5.7% Private Non-Group
- 10% ≥400% FPL
- 39% 139-399% FPL (Subsidies)
- 51% <139% FPL (Medicaid)

266.4 Million Nonelderly
47.9 Million Uninsured

*Medicaid also includes other public programs: CHIP, other state programs, Medicare and military-related coverage. The federal poverty level for a family of four in 2011 was $22,350. Numbers may not add to 100 due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.
Median Medicaid/CHIP Eligibility Thresholds, January 2013

- Children: 235%
- Pregnant Women: 185%
- Working Parents: 61%
- Jobless Parents: 37%
- Childless Adults: 0%

Minimum Medicaid Eligibility under Health Reform - 138% FPL ($24,344 for a family of 3 in 2012)

SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.
Medicaid Expansion: Federal Gov’t Covers Cost

- Federal Medical Assistance Percentage (FMAP): States were historically guaranteed at least 1-to-1 match from federal government
  - Match rate higher for states with lower average personal income (topped out at 2.79-to-1 for Mississippi in 2015)
  - Enhanced match rates: Under ACA, federal government would pay 100% of additional costs during 2014-2016. Federal match would phase down to 90% in 2020, where it would stay.
  - Under the original law, states would have to expand Medicaid or risk losing all of their funding.

Marketplaces: Regulations

**Pricing**
- Guaranteed issue
- Modified community rating, limits price variation to geography, age (3:1 bands), and tobacco use (1.5:1 bands)

**Essential health benefits**
- Requires plans to cover certain “essential” health benefits

**3Rs**
- Risk adjustment (transfer across plans based on enrollee risk, permanent)
- Reinsurance (payments if enrollee cost exceeds threshold, 2014-2016)
- Risk corridors (limits upside and downside, 2014-2016).
Eligibility
• Income between 100% and 400% FPL
• No other (affordable) coverage:
  • Affordable defined as employee contribution < 9.56% household income
  • Citizen or legal resident

Premium Tax Credit

\[ PTC = \max\{\text{benchmark plan} - \% \text{ of income}, 0\} \]

where
• *benchmark plan* is second-lowest cost silver plan (70% AV)
• % of income increases from roughly 2 to 9.5% of income over FPL range

1. Net-of-subsidy price for benchmark plan does *not* depend on list price
2. Full pass-through of incremental costs / savings for non-benchmark plans (intention was to not to distort intensive margin)
Net-of-Subsidy Premiums for Benchmark Plan in 2018

Cost-Sharing Reduction (CSR)

<table>
<thead>
<tr>
<th>Income (% Federal Poverty Level)</th>
<th>Actuarial Value of a silver plan</th>
<th>OOP Max for Individual/Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2017</td>
</tr>
<tr>
<td>Under 100%</td>
<td>70%</td>
<td>$7,150 / $14,300</td>
</tr>
<tr>
<td>100% - 150%</td>
<td>94%</td>
<td>$2,350 / $4,700</td>
</tr>
<tr>
<td>150% - 200%</td>
<td>87%</td>
<td>$2,350 / $4,700</td>
</tr>
<tr>
<td>200% - 250%</td>
<td>73%</td>
<td>$5,700 / $11,400</td>
</tr>
<tr>
<td>Over 250%</td>
<td>70%</td>
<td>$7,150 / $14,300</td>
</tr>
</tbody>
</table>

SOURCE: “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program,” Federal Register 81, no. 246 (December 22, 2016): 94058.
Individual Mandate

$max\{$695 \times \text{adult} + 347.5 \times \text{children}, \quad 2.5\% \text{ of income}$

up to a maximum $2,085 per year.

- Phased in over 2014-2016
- Lots of exemptions (financial hardship, religious objections, coverage caps of up to 3 months)
- With quasi-linear utility, mandate is equivalent to additional subsidy
- CBO coverage model scaled up mandate by 2x “moral suasion fudge factor”
Applies to employers with 50+ full-time employees (FTE) who offer coverage to less than 95% of FTE and dependent children

**Coverage requirement:** Penalty triggered if at least one FTE receives subsidy on Marketplace.
- Penalty $2,320 \times (\text{FTE} - 30)

**Affordability requirement:** Penalty triggered if FTE does not have affordable coverage (AV of 60% and employee contribution of less than 9.69% of income) and receives subsidy on Marketplace.
- Penalty $3,480 \times \text{(FTE receiving subsidy)}
- Penalty cannot be larger than that from not offering coverage

*For large firms, roughly $2K penalty for not providing affordable health insurance*
Outline

1. Refresher on ACA’s insurance coverage provisions
2. Review of what happened
   a. Medicaid
   b. Marketplaces
3. Issues, non-issues, and proposed solutions
Enhanced match rates: Under ACA, federal government would pay 100% of additional costs during 2014-2016. Federal match would phase down to 90% in 2020, where it would stay.

Under the original law, states would have to expand Medicaid or risk losing all of their funding.

In NFIB v. Sebelius, SCOTUS ruled the threat of losing all funding as unconstitutionally coercive, or “a gun to the head” as Roberts wrote in his majority opinion.

States could not expand Medicaid and not risk inframarginal funding.
Two-Thirds of States Expand Medicaid

Adopted (34 States including DC)
Considering Expansion (3 States)
Not Adopting At This Time (14 States)

Medicaid Enrollment

SOURCE: Quarterly Medicaid Enrollment and Expenditure Reports and Congressional Budget Office (CBO) Reports
Medicaid Enrollment

![Graph showing Medicaid Enrollment from 2010 to 2016 with projected and projected post SCOTUS lines.]

SOURCE: Quarterly Medicaid Enrollment and Expenditure Reports and Congressional Budget Office (CBO) Reports
Medicaid Enrollment

![Graph showing Medicaid enrollment trends from 2010 to 2016.](image)

- Projected
- Projected (post SCOTUS)
- VIII Group Enrollees
- VIII Group Newly Eligible Enrollees

SOURCE: Quarterly Medicaid Enrollment and Expenditure Reports and Congressional Budget Office (CBO) Reports
The System is down at the moment.
We're working to resolve the issue as soon as possible. Please try again later.

Please include the reference ID below if you wish to contact us at 1-800-318-2596 for support.
Reference ID: 0.cd372f17.1380630458.1580ebf
Roughly 85% of enrollees receive subsidy. Fairly constant over time

Roughly 85% of enrollees receive subsidy. Fairly constant over time

Rise of Narrow Network Plans

- Broad: More than 70% of hospitals
- Narrow: Between 30% and 70% of hospitals
- Ultra-narrow: No more than 30% of hospitals

SOURCE: McKinsey & Company, “Hospital networks: Perspective from four years of the individual market exchanges”, May 2017
Withdrawal of Household Name Insurers

- Exits 31 states in 2016/2017 transition (remains partially in New York, Nevada, and Virginia)

- Exits entirely (13 States) in 2017/2018 transition

- Exits entirely (11 states) in 2017/2018 transition
Success of Plans with Experience in Medicaid Managed Care

- 0.6 million Marketplace enrollees in 2017
- Narrow networks (Southern CA plans exclude UCLA, Cedars-Sinai)
- Profitable (compared to large losses at many plans)

- 1.2 million Marketplace enrollees in 2017
- Low premium, high deductible, narrow network plans

Reductions in Plan Choice

CONSUMER CHOICE OF CARRIERS
% of consumers seeing a given number of carriers in their county

- 1 carrier
- 2 carriers
- 3-4 carriers
- 5+ carriers

2014: 7% 18% 42% 34%
2015: 2% 32% 57% 51%
2016: 2% 13% 34% 22%
2017: 19% 22% 37% 15%
2018: 26% 25% 34% 15%

1 Defined as the population eligible to purchase a qualified health plan (QHP).
2 Counting carriers that offer at least 1 silver plan at a parent company level.

SOURCE: McKinsey Center for US Health System Reform, McKinsey MPACT Model
Plan Choice in 2018

Number of Marketplace Insurers for 2018

- 1 insurer: 2 (24%)
- 2 insurers: 3 (16%)
- 3 or more insurers: 4 (37%)

Labor Market Effects

Employer Mandate

- 7/2013: Delayed from 2014 to 2015
- 2/2014: Raised threshold to 100+ FTE and eased coverage requirement to 70% in 2015 and 95% in 2016.

Share of part-time over total employed

1. Refresher on ACA’s insurance coverage provisions
2. Review of what happened
3. Issues, non-issues, and proposed solutions
   a. Issues and non-issues
   b. Proposed solutions
1. Refresher on ACA’s insurance coverage provisions
2. Review of what happened
3. Issues, non-issues, and proposed solutions
   a. Issues and non-issues
   b. Proposed solutions
Approval of the Affordable Care Act

Do you generally approve or disapprove of the 2010 Affordable Care Act, signed into law by President Obama that restructured the U.S. healthcare system?

% Approve  % Disapprove


GALLUP
Misplaced focus on list price*

- Recall that 85% of enrollees receive subsidy
- For these enrollees:
  - No effect on net-of-subsidy premium on benchmark plan
  - Ambiguous effect on premium of non-benchmark plan.
  - E.g., proportional premium increase (across all plans) will lower net-of-subsidy price of lowest cost silver plan and bronze plans, and raise net-subsidy price of higher cost silver and gold / platinum plans

Exceptions

- Death spiral of platinum plans (90% AV)
- Death spiral of broad network plans (see Shepard, 2016)

*Reminds me of media coverage of college tuition
Net-of-Subsidy Premiums Have Been Declining

A majority of subsidy-eligible consumers may see the net premium of the lowest-price silver plan in their county decline in 2018.

Change in Silver Net Premium for Subsidy-Eligible Consumers

<table>
<thead>
<tr>
<th>Year</th>
<th>Over 10% decrease</th>
<th>Within 10% decrease</th>
<th>No change</th>
<th>Within 10% increase</th>
<th>Over 10% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015-2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016-2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017-2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 This includes only subsidy-eligible consumers (those with incomes below 400% of the federal poverty level), among consumers defined as eligible to purchase a qualified health plan (QHP). In cases where states change their eligibility requirements (e.g., via Medicaid expansion) we use the most recent set of eligibility determinations for all years (such that we are always comparing what a consistent population would observe).

2 On October 12, 2017, the Trump administration announced that it would not make cost-sharing reduction (CSR) payments to carriers. Most states instructed carriers to account for the loss of CSR funding in the 2018 plan year. However, the approaches vary -- for example, many states required carriers to load additional premium increases onto silver tier plans, while others asked insurers to spread additional premium increases across all metal tiers. Thus, there is variation in premium trends across states and metal tiers.

SOURCE: McKinsey Center for US Health System Reform, McKinsey MPACT Model
Enrollment Has Not Plummeted

Insurer Exits Are Concerning

Number of Marketplace Insurers for 2018

<table>
<thead>
<tr>
<th>1 insurer</th>
<th>2 insurers</th>
<th>3 insurers</th>
<th>4 or more insurers</th>
</tr>
</thead>
<tbody>
<tr>
<td>23% of enrollees</td>
<td>24%</td>
<td>16%</td>
<td>37%</td>
</tr>
</tbody>
</table>

How bad is it?

• In 2018, 23% of enrollees (and 52% of counties) had one insurer
• Primarily a rural market issue

Markets seem to have stabilized

• Early data from 2019 suggest small expansion in plan offerings and small reduction in list prices
• However, not clear whether there will be entry in single-plan rural markets

SOURCES:
http://www.modernhealthcare.com/article/20180709/NEWS/180709925
Mandate less financially important than subsidies
• At 250% FPL, family of 4 receives $7,975 subsidy for buying insurance; only faces $2,085 penalty for not having coverage

Few pay the penalty
• In 2015, 12 million tax filers claimed an exemption, and 6.7 million tax filers paid the penalty

Lots of confusion
• 40% did not know mandate was repealed, 21% thought repeal took effect immediately

Likely a small effect but nobody knows
1. Refresher on ACA’s insurance coverage provisions
2. Review of what happened
3. Issues, non-issues, and proposed solutions
   a. Issues and non-issues
   b. Proposed solutions
Re-Insurance

- Alaska, Maine, Minnesota, New Jersey, Oregon, Wisconsin have used Section 1332 Waivers to set up re-insurance schemes

- Typically cover fraction of claims (e.g., 80%) above some level (e.g., $50K), with the details varying by state

- Not cheap: Alaska spent $55 million for 17K individuals; would cost $38 billion per year to scale up nationally

- Regressive: Does not affect net-of-subsidy premiums for <400% FPL; transfer to higher income enrollees

SOURCES:
Short-Term Plans

• Until recently short-term plans limited to 3 months, with limits on renewability

• New Trump Administration rule allows people to stay on short-term plans for 364 days, with renewals for up to 3 years
  • However, many states have more restrictive limits

• Medically underwritten, no coverage for pre-existing conditions, no minimum essential benefits (e.g., no maternity coverage).
  • Lower premiums ($124 per month vs. $400 for ACA plan)

• Concern about cream-skimming from ACA exchanges
  • Probably won’t be disastrous but certainly won’t help

SOURCES:
Americans Now Evenly Split on Support for Government-Run Health System

Which of the following approaches for providing healthcare in the United States would you prefer — [ROTATED: replacing the current healthcare system with a new government-run healthcare system, (or) maintaining the current system based mostly on private health insurance]?

- % Government-run system
- % System based on private insurance

<table>
<thead>
<tr>
<th>Year</th>
<th>Government-run system (%)</th>
<th>System based on private insurance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>61</td>
<td>34</td>
</tr>
<tr>
<td>2011</td>
<td>56</td>
<td>39</td>
</tr>
<tr>
<td>2012</td>
<td>61</td>
<td>34</td>
</tr>
<tr>
<td>2013</td>
<td>61</td>
<td>35</td>
</tr>
<tr>
<td>2014</td>
<td>61</td>
<td>35</td>
</tr>
<tr>
<td>2015</td>
<td>53</td>
<td>43</td>
</tr>
<tr>
<td>2016</td>
<td>48</td>
<td>47</td>
</tr>
<tr>
<td>2017</td>
<td>47</td>
<td>47</td>
</tr>
</tbody>
</table>

GALLUP
Democrats have introduced a flurry of proposals
KFF buckets these proposals into 4 groups
1. Medicare-For-All: single national health insurance program
2. Public plan available on ACA marketplaces
3. Medicare buy-in for older individuals
4. Medicaid buy-in that states can offer to individuals through ACA marketplace

SOURCES: “Medicare-for-All and Public Plan Buy-In Proposals: Overview and Key Issues”
Proposal considered by CBO

- HHS administers public health insurance plan offered through exchanges
- Premiums are set to cover costs
- Provider payments set at Medicare+0% for hospitals Medicare+5% for physicians
  - Medicare pays roughly 60% of ESI rates; likely have smaller advantage vs. narrow network plans
- Note: Adverse selection into public plan would be (partially) offset by risk adjustment

CBO (November 2013)

- Reduces premiums 7-8%
- Increases coverage by 2 million (seems big)
- Public plan market share estimated at 35%
- Reduces exchange subsidies by $39B over 2016-2023 (both through direct and indirect “competitive” effects)

Concluding Thought

• Marketplace is a right-of-center approach to expanding coverage
  • Idea came out of Heritage Foundation, ACA was modeled on RomneyCare

• Building well-functioning health insurance markets is hard; requires lots of tinkering to get right

• For ACA Marketplaces to thrive, need both parties to be committed to success

• Interesting to see if Republicans change course; already some evidence of this on pre-existing conditions

• If they don’t, a government-run alternative is increasingly likely
Backup slides
<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Medical deductible</th>
<th>Medical OOP max</th>
<th>Inpatient facility coinsurance</th>
<th>Inpatient facility copay</th>
<th>Inpatient physician coinsurance</th>
<th>Inpatient physician copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>70% AV individual</td>
<td>$ 4,033</td>
<td>$ 6,863</td>
<td>31%</td>
<td>$ 654</td>
<td>29%</td>
<td>$ 398</td>
</tr>
<tr>
<td>70% AV family of 4</td>
<td>$ 8,292</td>
<td>$ 13,725</td>
<td>31%</td>
<td>$ 654</td>
<td>29%</td>
<td>$ 398</td>
</tr>
<tr>
<td>87% AV individual</td>
<td>$ 764</td>
<td>$ 2,022</td>
<td>24%</td>
<td>$ 279</td>
<td>21%</td>
<td>$ 317</td>
</tr>
<tr>
<td>87% AV family of 4</td>
<td>$ 1,557</td>
<td>$ 4,045</td>
<td>24%</td>
<td>$ 279</td>
<td>21%</td>
<td>$ 317</td>
</tr>
</tbody>
</table>

Coinsurance and copay are conditional on being positive. Most plans have either coinsurance or copay.

### Clawback Limits

#### Table 3: Repayment Amounts under Current Law by Income Level for 2018

<table>
<thead>
<tr>
<th>Income (% Federal Poverty Level)</th>
<th>Maximum repayment amount for a single individual</th>
<th>Maximum repayment amount for couples and families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 200% FPL</td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td>200% - less than 300% FPL</td>
<td>$775</td>
<td>$1,550</td>
</tr>
<tr>
<td>300% - less than 400% FPL</td>
<td>$1,300</td>
<td>$2,600</td>
</tr>
<tr>
<td>400% FPL or greater</td>
<td>Full Amount</td>
<td>Full Amount</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FPL</th>
<th>Income for single ($)</th>
<th>Income for family of 4 ($)</th>
<th>Premium Cap</th>
<th>Monthly premium for single ($)</th>
<th>Monthly premium for family of 4 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>12,060</td>
<td>24,600</td>
<td>2.01%</td>
<td>20.20</td>
<td>41.21</td>
</tr>
<tr>
<td>133%</td>
<td>16,040</td>
<td>32,718</td>
<td>2.01%</td>
<td>26.87</td>
<td>54.80</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3.02%</td>
<td>40.37</td>
<td>82.34</td>
</tr>
<tr>
<td>150%</td>
<td>18,090</td>
<td>36,900</td>
<td>4.03%</td>
<td>60.75</td>
<td>123.92</td>
</tr>
<tr>
<td>200%</td>
<td>24,120</td>
<td>49,200</td>
<td>6.34%</td>
<td>127.43</td>
<td>259.94</td>
</tr>
<tr>
<td>250%</td>
<td>30,150</td>
<td>61,500</td>
<td>8.10%</td>
<td>203.51</td>
<td>415.13</td>
</tr>
<tr>
<td>300%</td>
<td>36,180</td>
<td>73,800</td>
<td>9.56%</td>
<td>288.23</td>
<td>587.94</td>
</tr>
<tr>
<td>400%</td>
<td>48,240</td>
<td>98,400</td>
<td>9.56%</td>
<td>384.31</td>
<td>783.92</td>
</tr>
</tbody>
</table>

Research on Labor Market Effects

• Based on CPS data, Moriya, Selden, and Simon (2016) and Mathur, Slovov, and Strain (2016) found no effects of ACA on part-time work.

• Kaestner et al. (NBER Working Paper 2015) found no effects on usual hours of work and probability of full-time work for a sample of 22-64 year olds with a high school degree or less.

• Levy, Buchmueller, and Nikpay (2015) found no evidence to suggest either an increase in part-time work or an increased probability of retirement among those 55-64 years of age in states that expanded Medicaid versus those that did not.

• However, Even and Macpherson (2016) found significant increase in involuntary part-time employment using data 1994-2015 CPS data on non-elderly workers without a college degree.
Mandate Repeal: Nobody Knows

**Few pay the penalty**
- In 2015, 12 million tax filers claimed an exemption, and 6.7 million tax filers paid the penalty

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family of 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>250% FPL</td>
<td>$30,150</td>
<td>$61,500</td>
</tr>
<tr>
<td>Average list premium*</td>
<td>$4,328</td>
<td>$12,957</td>
</tr>
<tr>
<td>Net of subsidy premium</td>
<td>$2,442</td>
<td>$4,982</td>
</tr>
<tr>
<td>Mandate penalty</td>
<td>$754</td>
<td>$2,085</td>
</tr>
<tr>
<td>Net of mandate &quot;price&quot; increase with 33% mandate payment rate**</td>
<td>11.3%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Net of mandate &quot;price&quot; increase with 33% mandate payment rate, 2X MSFF***</td>
<td>25.6%</td>
<td>38.2%</td>
</tr>
</tbody>
</table>

**NOTES:**
*Average premiums are benchmark plan in 2017. Individual is 40-year-old non-smoker and family is 40-year-old non-smoking couple with 2 children.
**Net of mandate “price” is net of subsidy premium – mandate penalty
***Moral suasion fudge factor

**SOURCES:**
### Table 2.

**Effects of Repealing the Individual Mandate on Health Insurance Coverage for People Under Age 65**

**Table 2.**

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
<th>2026</th>
<th>2027</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Change in Coverage Under the Policy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid(^a)</td>
<td>0</td>
<td>-1</td>
<td>-2</td>
<td>-4</td>
<td>-4</td>
<td>-4</td>
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<td>Other coverage(^b)</td>
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<td>*</td>
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<td>*</td>
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**Sources:** Congressional Budget Office; staff of the Joint Committee on Taxation.

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**SOURCE:** [https://www.cbo.gov/publication/52142](https://www.cbo.gov/publication/52142)
# Mandate Repeal: Budgetary Effects

## Table 1

### Estimate of the Net Budgetary Effects of Repealing the Individual Mandate

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
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<th>2025</th>
<th>2026</th>
<th>2027</th>
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<tbody>
<tr>
<td><strong>Total, 2018–2027</strong></td>
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<td>Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues*&lt;sup&gt;a,b&lt;/sup&gt;</td>
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<td>Other Effects on Revenues and Outlays&lt;sup&gt;e&lt;/sup&gt;</td>
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<td>4</td>
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</tbody>
</table>

* Source: https://www.cbo.gov/publication/52142
Insurer Exits and Bare Counties

SOURCE: Harold Pollack and Todd Schuble
Cost-Sharing Reduction Payments

- Insurers are required to offer CSR to consumers with incomes up to 250% FPL
- Obama Administration reimbursed insurers despite unclear legal authority
- House sued Obama Administration to stop payments (appeal pending)
- 10/12/2017: Trump Administration halts CSR payments
- Currently multiple lawsuits challenging the legality of Trump Administration decision

SOURCES: