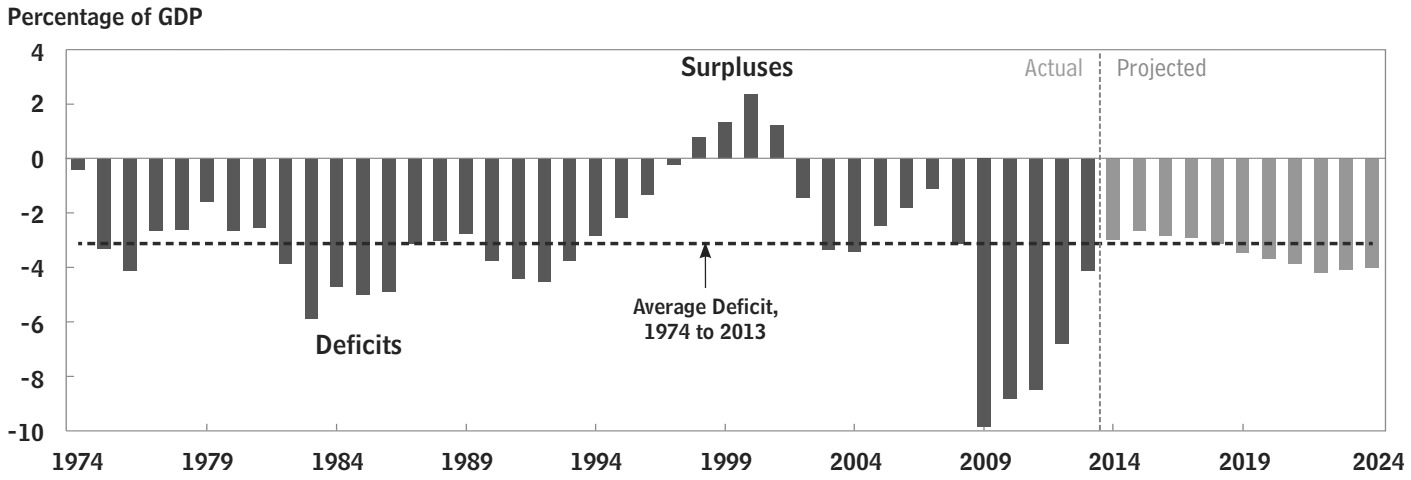
Exhibit 5

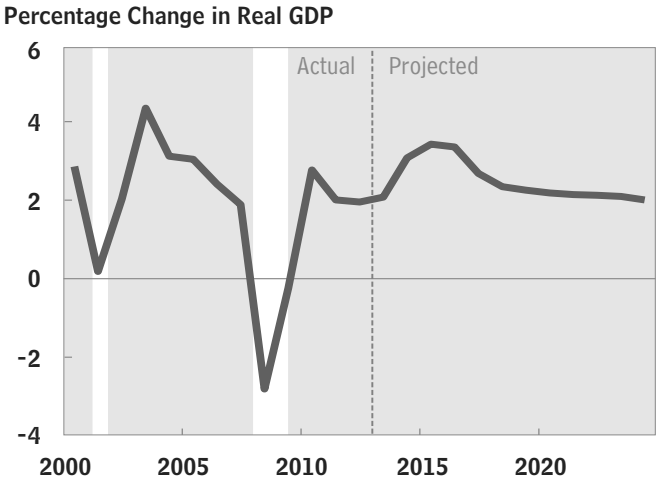
CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

CBO

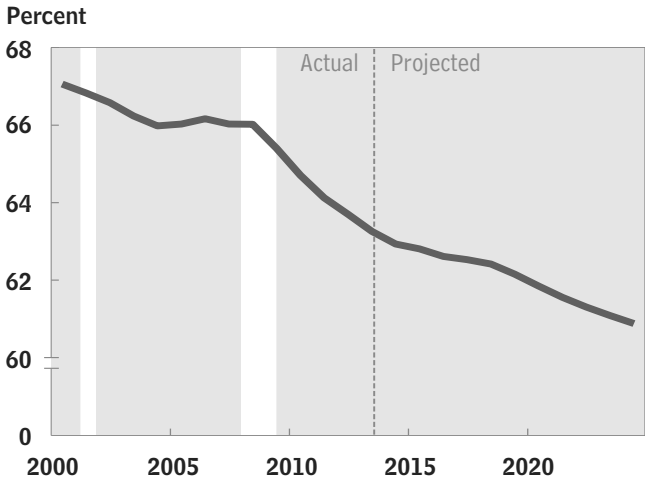
The Budget and Economic Outlook: 2014 to 2024



Total Deficits or Surpluses



Economic Growth



Labor Force Participation Rate

FEBRUARY 2014

APPENDIX

B

Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act

In preparing the February 2014 baseline budget projections, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have updated their estimates of the budgetary effects of the provisions of the Affordable Care Act (ACA) that relate to health insurance.[1] The new baseline estimates rely on analyses completed by the early part of December 2013 and account for administrative actions that were taken before then. The estimates, however, do not reflect CBO's updated economic projections, the most recent data on enrollment through insurance exchanges or the plans that have been offered through exchanges, and any federal administrative actions or decisions by states about expanding Medicaid coverage that have occurred since that time. Hence, these updates are both partial and preliminary.

CBO typically revises its baseline budget projections after the Administration releases its proposed budget for the coming year (in part because that release includes data on federal spending that has occurred during the previous year); CBO and JCT expect to incorporate into those revised baseline projections new information and additional data about the ACA that become available before that time. Although such revisions could be substantial, CBO and JCT cannot predict either their direction or their magnitude. Even at that point, however, information about the effects of the ACA in 2014 will be limited, and little more will be known about how the law will unfold over the next several years.

In the current, interim projections, CBO and JCT estimate that the ACA's coverage provisions will result in a net cost to the federal government of $41 billion in 2014 and $1,487 billion over the 2015–2024 period. Compared with last year's projections, which spanned the 2014–2023 period, the new estimate represents a downward revision of $9 billion in the net costs of those provisions over that 10-year period.[2] This appendix first describes the insurance coverage provisions of the ACA and provides more detail on CBO and JCT's current estimates of the budgetary effects of those provisions. That discussion is followed by an explanation of how and why those estimates differ from the estimates in CBO's May 2013 baseline.

The estimated net costs in 2014 stem almost entirely from spending for subsidies that will be provided through exchanges and from an increase in spending for Medicaid (see Table B-1). For the 2015–2024 period, the projected net costs consist of the following:

- Gross costs of $2,004 billion for Medicaid, the Children's Health Insurance Program (CHIP), subsidies and related spending for insurance obtained through exchanges, and tax credits for small employers; and
- Receipts of $517 billion from penalties on certain uninsured people and certain employers, an excise tax on high-premium insurance plans, and other budgetary effects—mostly increases in tax revenues.

1. 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.

2. For CBO and JCT's previous estimate of the budgetary effects of the insurance coverage provisions of the ACA, see Congressional Budget Office, "Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline" (supplemental material for *Updated Budget Projections: Fiscal Years 2013 to 2023*, May 2013), www.cbo.gov/publication/44190.

Table B-1.

Effects on the Deficit of the Insurance Coverage Provisions of the Affordable Care Act

(Billions of dollars, by fiscal year)

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total, 2015-2024
Exchange Subsidies and Related Spending[a]	20	47	85	104	118	123	129	137	143	151	159	1,197
Medicaid and CHIP Outlays[b]	19	41	62	70	76	80	83	87	92	98	103	792
Small-Employer Tax Credits[c]	1	2	1	1	1	1	1	2	2	2	2	15
Gross Cost of Coverage Provisions	40	90	148	175	195	205	214	226	237	250	263	2,004
Penalty Payments by Uninsured People	0	-2	-4	-5	-5	-5	-5	-6	-6	-6	-7	-52
Penalty Payments by Employers[c]	0	0	-11	-14	-15	-16	-17	-18	-19	-20	-21	-151
Excise Tax on High-Premium Insurance Plans[c]	0	0	0	0	-5	-9	-11	-14	-18	-22	-28	-108
Other Effects on Revenues and Outlays[d]	1	1	-6	-14	-20	-23	-24	-26	-28	-31	-34	-206
Net Cost of Coverage Provisions	**41**	**88**	**127**	**142**	**151**	**151**	**156**	**161**	**166**	**170**	**173**	**1,487**
Memorandum:												
Changes in Mandatory Spending	37	103	156	186	196	207	217	229	241	254	267	2,056
Changes in Revenues[e]	-4	15	29	44	45	55	61	68	75	84	94	570

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

Notes: These numbers exclude effects on the deficit of provisions of the Affordable Care Act that are not related to insurance coverage. They also exclude federal administrative costs subject to appropriation. (CBO has previously estimated that the Internal Revenue Service would need to spend between $5 billion and $10 billion over the 2010–2019 period to implement the Affordable Care Act and that the Department of Health and Human Services and other federal agencies would also need to spend $5 billion to $10 billion over that period.) In addition, the Affordable Care Act included explicit authorizations for spending on a variety of grant and other programs; that funding is also subject to future appropriation action.

Unless otherwise noted, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

CHIP = Children's Health Insurance Program.

a. Includes spending for exchange grants to states and net collections and payments for risk adjustment, reinsurance, and risk corridors.

b. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP over the 2015–2024 period will be about $70 billion higher because of the coverage provisions of the Affordable Care Act than it would be otherwise.

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

d. Consists mainly of the effects of changes in taxable compensation on revenues. CBO estimates that outlays for Social Security benefits will increase by about $8 billion over the 2015–2024 period and that the coverage provisions will have negligible effects on outlays for other federal programs.

e. Positive numbers indicate an increase in revenues, and negative numbers indicate a decrease in revenues.

Those estimates address only the insurance coverage provisions of the ACA; they do not constitute all of the act's budgetary effects. Many other provisions, on net, are projected to reduce budget deficits. Considering all of the coverage provisions and the other provisions together, CBO and JCT estimated in July 2012 (the most recent comprehensive estimates) that the total effect of the ACA would be to reduce federal deficits.[3]

The Insurance Coverage Provisions and Their Effects on People's Coverage

The key elements of the insurance coverage provisions of the ACA that are encompassed by the estimates discussed here include the following:

3. See Congressional Budget Office, letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act (July 24, 2012), www.cbo.gov/publication/43471.

- Many individuals and families will be able to purchase subsidized insurance through exchanges operated either by the federal government or by a state government,
- States are permitted to significantly expand eligibility for Medicaid but may decline to do so,
- Most legal residents of the United States must either obtain health insurance or pay a penalty tax for not doing so,
- Certain employers that decline to offer minimum health insurance coverage to their employees will be assessed penalties,
- A federal excise tax will be imposed on some health insurance plans with high premiums, and
- Insurers may not deny coverage to people on the basis of their health status or charge enrollees in poor health higher insurance premiums.

The ACA also made other changes to rules governing health insurance coverage that are not listed here.

CBO and JCT estimate that the insurance coverage provisions of the ACA will markedly increase the number of nonelderly people who have health insurance—by about 13 million in 2014, 20 million in 2015, and 25 million in each of the subsequent years through 2024 (see Table B-2). Still, according to estimates by CBO and JCT, about 31 million nonelderly residents of the United States are likely to be without health insurance in 2024, roughly one out of every nine such residents. Of that group, about 30 percent are expected to be unauthorized immigrants and thus ineligible for most Medicaid benefits and for the exchange subsidies; about 20 percent will be eligible for Medicaid but will choose not to enroll; about 5 percent will be ineligible for Medicaid because they live in a state that has chosen not to expand coverage; and about 45 percent will not purchase insurance even though they have access through an employer, an exchange, or directly from an insurer.

Enrollment in and Subsidies for Coverage Through Exchanges

Subsidies and related spending for insurance obtained through exchanges constitute the largest share of the costs of the coverage provisions of the ACA. CBO and JCT project that, under current law, 6 million people in 2014 will receive insurance coverage through the new exchanges. Over time, more people are expected to respond to the new coverage options, so enrollment is projected to increase sharply in 2015 and 2016. Starting in 2017, between 24 million and 25 million people are expected to obtain coverage each year through exchanges, and roughly 80 percent of those enrollees are expected to receive subsidies for purchasing that insurance.

CBO and JCT estimate that, under current law, exchange subsidies and related spending will total $20 billion in 2014. Over the 2015–2024 period, such spending is projected to total $1.2 trillion, as follows:

- Outlays of $899 billion and a reduction in revenues of $137 billion for premium assistance tax credits, which cover a portion of eligible individuals' and families' health insurance premiums, summing to $1,036 billion (see Table B-3);[4]
- Outlays of $167 billion for cost-sharing subsidies (which reduce out-of-pocket payments for low-income enrollees);
- Outlays of $2 billion for grants to states for operating exchanges; and
- Outlays of $208 billion and revenues of $215 billion related to payments and collections for risk adjustment, reinsurance, and risk corridors—summing to net receipts of $8 billion.

Although the government's net cash flow associated with the risk adjustment, reinsurance, and risk corridor programs is estimated to be small, those programs play a significant role in the new insurance system. All three programs, which take effect in 2014, reduce the likelihood that particular health insurers will bear especially high costs to cover the expenses of a disproportionate share of less healthy enrollees. Thus, those programs encourage insurers to offer coverage under the new

4. The subsidies for health insurance premiums are structured as refundable tax credits; the portions of such credits that exceed taxpayers' other income tax liabilities are classified as outlays in the federal budget, and the portions that reduce tax payments appear in the budget as reductions in revenues.

Table B-2.

Effects of the Affordable Care Act on Health Insurance Coverage

(Millions of nonelderly people, by calendar year)

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Insurance Coverage Under Prior Law[a]											
Medicaid and CHIP	34	34	33	33	33	33	34	34	34	34	35
Employment-based coverage	157	159	161	164	165	166	167	167	168	169	169
Nongroup and other coverage[b]	25	26	26	27	27	27	27	28	28	28	28
Uninsured[c]	57	57	56	56	55	55	56	56	56	56	57
Total	274	276	277	279	281	282	284	285	286	288	289
Change in Insurance Coverage Under the ACA											
Insurance exchanges	6	13	22	24	25	25	24	25	24	24	24
Medicaid and CHIP	8	12	12	12	12	12	13	13	13	13	13
Employment-based coverage[d]	*	-2	-6	-6	-7	-7	-7	-7	-7	-7	-7
Nongroup and other coverage[b]	-2	-3	-4	-5	-5	-5	-5	-5	-5	-5	-5
Uninsured[c]	-13	-20	-25	-25	-25	-25	-25	-25	-25	-25	-25
Uninsured Under the ACA											
Number of uninsured nonelderly people[c]	45	37	31	30	30	30	30	31	31	31	31
Insured as a percentage of the nonelderly population											
Including all U.S. residents	84	86	89	89	89	89	89	89	89	89	89
Excluding unauthorized immigrants	86	89	91	92	92	92	92	92	92	92	92
Memorandum:											
Exchange Enrollees and Subsidies											
Number with unaffordable offer from employer[e]	*	*	*	1	1	1	1	1	1	1	1
Number of unsubsidized exchange enrollees[f]	1	2	4	4	5	5	5	5	5	5	5
Average exchange subsidy per subsidized enrollee (Dollars)	4,700	5,330	5,350	5,590	5,990	6,240	6,720	7,060	7,460	7,900	8,370

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

Notes: Figures for the nonelderly population include residents of the 50 states and the District of Columbia who are younger than 65.

CHIP = Children's Health Insurance Program; ACA = Affordable Care Act; * = between -500,000 and 500,000.

a. Figures reflect average enrollment over the course of a year and include spouses and dependents covered under family policies; people reporting multiple sources of coverage are assigned a primary source. To illustrate the effects of the Affordable Care Act, which is part of current law, changes in coverage are compared with coverage projections in the absence of that legislation, or "prior law."

b. The effects are almost entirely for nongroup coverage; "other" includes Medicare.

c. The number of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.

d. The change in employment-based coverage is the net result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by workers and their families. For example, in 2019, an estimated 11 million people who would have had an offer of employment-based coverage under prior law will lose their offer under current law, and an estimated 3 million people who would have enrolled in employment-based coverage will still have such an offer but will choose to no longer enroll in that coverage. Those decreases in employment-based coverage will be partially offset by an estimated 7 million people who will newly enroll in employment-based coverage under the Affordable Care Act.

e. Workers who would have to pay more than a specified share of their income (9.5 percent in 2014) for employment-based coverage could receive subsidies through an exchange.

f. Excludes coverage purchased directly from insurers outside of an exchange.

Table B-3.

Enrollment in, and Budgetary Effects of, Health Insurance Exchanges

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total, 2015-2024
						Exchange Enrollment						
						(Millions of nonelderly people, by calendar year)[a]						
Individually Purchased Coverage												
Subsidized	5	11	19	20	20	20	20	20	19	19	19	n.a.
Unsubsidized[b]	1	2	4	4	5	5	5	5	5	5	5	n.a.
Total	**6**	**13**	**22**	**24**	**25**	**25**	**24**	**25**	**24**	**24**	**24**	**n.a.**
Employment-Based Coverage Purchased Through Exchanges[b]	2	2	3	4	4	4	4	4	4	4	4	n.a.
						Budgetary Effects						
						(Billions of dollars, by fiscal year)						
Changes in Mandatory Spending												
Premium credit outlays	13	33	63	79	88	92	97	103	109	115	121	899
Cost-sharing subsidies	3	8	13	15	16	17	17	18	19	21	22	167
Exchange grants to states	2	1	*	*	0	0	0	0	0	0	0	2
Payments for risk adjustment, reinsurance, and risk corridors	0	20	19	23	17	19	21	21	22	23	23	208
Total	**18**	**62**	**95**	**118**	**121**	**127**	**135**	**143**	**150**	**158**	**166**	**1,275**
Changes in Revenues												
Premium credit revenues	-2	-6	-11	-13	-14	-15	-15	-15	-15	-16	-16	-137
Collections for risk adjustment, reinsurance, and risk corridors	0	21	21	27	17	19	21	21	22	23	23	215
Total	**-2**	**14**	**10**	**14**	**3**	**4**	**6**	**6**	**7**	**7**	**7**	**78**
Net Increase in the Deficit From Exchange Subsidies and Related Spending	20	47	85	104	118	123	129	137	143	151	159	1,197
Memorandum:												
Total Exchange Subsidies (Billions of dollars, by calendar year)	25	57	100	112	121	124	132	139	145	153	162	1,244
Average Exchange Subsidy per Subsidized Enrollee (Dollars)	4,700	5,330	5,350	5,590	5,990	6,240	6,720	7,060	7,460	7,900	8,370	n.a.

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

Note: n.a. = not applicable; * = between zero and $500 million.

a. Figures reflect average enrollment over the course of a year and include spouses and dependents covered under family policies. Figures for the nonelderly population include residents of the 50 states and the District of Columbia who are younger than 65.

b. Excludes coverage purchased directly from insurers outside of an exchange.

federal rules and curtail their incentives to avoid accepting high-cost enrollees. Although those programs apply to different segments of the insurance market, all serve to spread risk either among the insurers or between the insurers and the federal government, as follows:

- Risk adjustment is a permanent program that transfers resources from health insurance plans that attract a relatively small proportion of high-risk enrollees (people with serious chronic conditions, for example) to plans that attract a relatively large proportion of such people. Payments will be made to insurance companies in the individual and small-group markets

to the extent that those companies attract some enrollees who are not as healthy as some others and therefore would be expected to have higher medical claims. Similarly, risk adjustment collections are paid by companies whose plans attract a disproportionate share of healthier enrollees in those same markets. The risk adjustment system is facilitated by the federal government, but, by law, essentially entails transfers between insurance companies with no net budgetary effect. Risk adjustment payments and collections apply to plans sold within or outside of exchanges but not to plans that do not comply with the market and benefit standards established by the ACA. Under the ACA, the risk adjustment process will be a permanent feature of the health insurance system.

- The reinsurance program applies to insurance issued in the first three years, 2014 through 2016, to facilitate a stable individual insurance market during the transition to the new insurance system under the ACA. (Although risk adjustment can help compensate plans that enroll high-risk individuals, that process generally cannot fully compensate plans for unusually high claims if the individual market as a whole enrolls more high-risk individuals than insurers anticipated.) Reinsurance payments will be made by the federal government to all plans that operate in the individual insurance market (within or outside of exchanges, excluding plans that do not comply with the ACA's market and benefit standards) whose enrollees incur particularly high costs for medical claims—that is, costs above a specified threshold and up to a certain maximum. To cover those costs, the government will collect a per-enrollee assessment ($63 in 2014) from most private insurance plans, including self-insured plans and plans that are offered in the large-group market.[5] As in the case of the risk adjustment process, the payments to and from the government are specified to be equal and so will have no net budgetary effect over the course of the program.

- The risk corridor program also will reduce the risks faced by insurers during the first few years of the new system. Risk corridor payments are made by the government to individual and small-group plans sold in exchanges whose actual costs for medical claims exceed their expected costs by certain percentages. (Those percentages are the "corridors.") At the same time, risk corridor collections are paid to the government by those individual and small-group plans whose actual costs for medical claims fall short of their expected costs by certain percentages. Risk corridor calculations are based on insurers' costs after accounting for risk adjustment and reinsurance payments and collections. Risk corridors also apply to certain plans sold outside an exchange if the plans are the same as (or substantially the same as) plans sold by the same carrier within an exchange. The risk corridor program is temporary, applying only to insurance issued from 2014 through 2016. In contrast to the risk adjustment and reinsurance programs, payments and collections under the risk corridor program will not necessarily equal one another: If insurers' costs exceed their expectations, on average, the risk corridor program will impose costs on the federal budget; if, however, insurers' costs fall below their expectations, on average, the risk corridor program will generate savings for the federal budget.

For all three programs, payments will be recorded in the budget as outlays and collections will be recorded as revenues. CBO projects that risk adjustment payments and collections will each total $179 billion over the 2015–2024 period and that reinsurance payments and collections will each total $20 billion over that same 10-year period; thus the flows from those programs will have no net budgetary effect.[6] CBO now projects that, over the 2015–2024 period, risk corridor payments from the federal government to health insurers will total $8 billion and the corresponding collections from insurers will amount to $16 billion, yielding net savings for the federal government of $8 billion. The analysis underlying those latter figures is described below in the section on changes from the previous estimate.

5. According to a recent proposed regulation, the Department of Health and Human Services plans to exempt self-insured, self-administered plans from reinsurance assessments in 2015 and 2016.

6. Collections and payments for the risk adjustment, reinsurance, and risk corridor programs will occur after the close of a benefit year. Therefore, collections and payments for insurance provided in 2014 will occur in 2015, and so forth. Under the reinsurance program, an additional $5 billion will be collected from health insurance plans and deposited into the general fund of the U.S. Treasury. That amount is the same as that appropriated for the Early Retiree Reinsurance Program (which was in operation before 2014) and is not included here as part of the budgetary effects of the ACA's insurance coverage provisions.

Enrollment in and Costs for Medicaid and CHIP

CBO and JCT project that the number of people enrolled in Medicaid and CHIP will be substantially higher—by 8 million in 2014 and by 12 million to 13 million people every year between 2015 and 2024—than would have been the case in the absence of the ACA (see Table B-2 on page 108). The increase anticipated after 2014 reflects the expectation that more people in states that have already expanded Medicaid will enroll in the program and that more states will expand eligibility for Medicaid (although those increases will be partially offset by fewer people enrolling in CHIP starting in 2016—funding projected for that program in CBO's baseline is reduced in that year).[7]

CBO and JCT estimate that the added costs to the federal government for Medicaid and CHIP attributable to the ACA will be $19 billion in 2014 and will grow to $70 billion in 2017. For the 2015–2024 period, they are projected to total $792 billion (see Table B-1 on page 106).

Tax Credits for Small Employers

Under the ACA, certain small employers are eligible to receive tax credits to reduce the cost of providing health insurance to their employees. CBO and JCT project that those tax credits will total $15 billion over the 2015–2024 period.

Penalty Payments and Excise Taxes

Certain employers of more than 50 full-time-equivalent workers will be assessed penalties by the federal government if they decide not to offer health insurance coverage that meets an affordability standard under the ACA. CBO and JCT estimate that payments of those penalties will total $151 billion over the 2015–2024 period. Some people who do not obtain health insurance coverage also will face penalties. CBO and JCT estimate that those payments will total $52 billion over the 10-year period. In addition, the excise tax on high-premium insurance plans is projected to boost federal revenues by $108 billion over the 2015–2024 period.[8]

Other Effects on Revenues and Outlays

CBO and JCT project that, as a result of the ACA, between 6 million and 7 million fewer people will have employment-based insurance coverage each year from 2016 through 2024 than would be the case in the absence of the ACA. That change is the net result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by workers and their families. For example, in 2019, an estimated 11 million people who would have had an offer of employment-based coverage in the absence of the ACA will lose their offer under current law, and about 3 million people who would have enrolled in employment-based coverage will still have such an offer but will choose not to enroll in that coverage. Those decreases in employment-based coverage will be partially offset by an estimated 7 million people who will newly enroll in employment-based coverage under the ACA.

Because of the net reduction in employment-based coverage, the share of people's compensation that takes the form of nontaxable benefits (such as health insurance premiums) will be smaller—and the share that takes the form of taxable wages will be larger—than would otherwise be the case. That shift will boost net federal receipts. Partially offsetting the federal savings will be an estimated $8 billion increase in Social Security benefits that will arise from the higher wages paid to workers. All told, CBO and JCT project, those changes will reduce federal budget deficits by $206 billion over the 2015–2024 period.

Changes From the Previous Estimates of the Effects of the Insurance Coverage Provisions of the ACA

CBO and JCT's current, interim projections of the effects of the insurance coverage provisions of the ACA reflect administrative actions and certain other information available through early December 2013. The current projections do not differ substantially from the previous

7. Annual spending for CHIP is projected to reach $15 billion in 2015—the year in which the program is scheduled to expire. Under the rules governing baseline projections for expiring programs, CBO projects funding for CHIP after 2015 at an annualized amount of about $6 billion. (For more details about the CHIP baseline, see Chapter 3.)

8. That estimated increase in federal revenues over the 2015–2024 period consists of about $31 billion in excise tax receipts and about $77 billion in higher net revenues from the associated effects of changes in employees' taxable compensation.

ones, which were released in May 2013.[9] In all, the revisions incorporated in the current baseline decrease by $9 billion the projected cost of the ACA's insurance coverage provisions over the 2014–2023 period (the period covered by the previous baseline), from $1,363 billion to $1,354 billion (see Table B-4): $2 billion of that amount is a net decrease in outlays and $7 billion is a net increase in revenues. Nearly all of the change is for the 2014–2017 period.

Relative to the May 2013 projections, CBO and JCT now estimate that, in 2014, about 1 million fewer people will obtain coverage through exchanges, about 1 million fewer people will enroll in Medicaid and CHIP as a result of the ACA, and about 1 million more people will be uninsured. Those changes primarily reflect the significant technical problems that have been encountered in the initial phases of implementing the ACA. Also, estimated premiums for 2014 have been reduced on the basis of a preliminary analysis of premiums for plans offered through exchanges. The limited information available in early December regarding enrollment and premiums for insurance coverage in exchanges in 2014 does not provide a sound basis for changing estimates of enrollment or premiums for future years; however, CBO and JCT are monitoring such information and may make more substantial changes in their estimates for 2014 and later years for subsequent baseline projections.

Several factors explain the various changes in the budgetary flows stemming from the ACA's coverage provisions, including lower estimates for enrollment and exchange premiums, new estimates for the effects of risk corridors, and the effects of recent administrative actions:

- Taken together, the downward revisions to the estimates of enrollment and premiums reduced the cost projected for the ACA's insurance coverage provisions—including spending for Medicaid, CHIP, and exchange subsidies as well as effects on taxable compensation—by roughly $11 billion, on net, for fiscal years 2014 and 2015.
- CBO and JCT also incorporated into the updated baseline projections some new estimates of payments and collections for the risk corridor program, which had previously been projected to have no net budgetary effect; collections are now projected to exceed payments by $8 billion for the 2015–2017 period.
- The updated estimates include the budgetary effects of two administrative actions, which added, on net, $12 billion to projected deficits for the 2014–2016 period.

Those three sets of changes, together with a shift of roughly $1 billion in spending from "exchange subsidies and related spending" to other parts of the budget, account for the $9 billion reduction in the estimated net cost of the coverage provisions over the 2014–2023 period.[10]

Lower Enrollment in the Exchanges, Medicaid, and CHIP

In light of technical problems that impeded many people's enrollment in exchanges in the first months of the open enrollment period, CBO and JCT have reduced their estimate of enrollment for the current year from 7 million to 6 million people. Between October and late December 2013, about 2 million people selected a health insurance plan through an exchange.[11] That figure is significantly below the total that CBO and JCT estimate will enroll in 2014. However, the open enrollment period

9. For CBO and JCT's previous estimate of the budgetary effects of the insurance coverage provisions of the ACA, see Congressional Budget Office, "Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline" (supplemental material for *Updated Budget Projections: Fiscal Years 2013 to 2023*, May 2013), www.cbo.gov/publication/44190. For a discussion of previous updates to CBO's estimates, see Congressional Budget Office, "CBO's Estimate of the Net Budgetary Impact of the Affordable Care Act's Health Insurance Provisions Has Not Changed Much Over Time," *CBO Blog* (May 14, 2013), www.cbo.gov/publication/44176.

10. CBO's May 2013 estimate of the budgetary effects of the insurance coverage provisions of the ACA included an estimated $1 billion in spending for high-risk pools, premium-review activities, and loans to consumer-operated and -oriented plans for the 2014–2023 period. A similar amount is included elsewhere in CBO's February 2014 baseline projections.

11. See Department of Health and Human Services, *Health Insurance Marketplace: January Enrollment Report* (January 2014), http://go.usa.gov/BccV (PDF, 3392 KB). More recent reports indicate that the number of enrollees has risen since December 2013.

Table B-4.

Comparison of CBO's Current and Previous Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act

	May 2013 Baseline	February 2014 Baseline	Difference
	Change in Insurance Coverage Under the ACA in 2014 (Millions of nonelderly people, by calendar year)[a]		
Insurance Exchanges	7	6	-1
Medicaid and CHIP	9	8	-1
Employment-Based Coverage[b]	*	*	*
Nongroup and Other Coverage[c]	-2	-2	*
Uninsured[d]	-14	-13	1
	Effects on the Cumulative Federal Deficit, 2014 to 2023[e] (Billions of dollars)		
Exchange Subsidies and Related Spending[f]	1,075	1,058	-16
Medicaid and CHIP Outlays	710	708	-2
Small-Employer Tax Credits[g]	14	14	**
Gross Cost of Coverage Provisions	1,798	1,780	-18
Penalty Payments by Uninsured People	-45	-45	**
Penalty Payments by Employers[g]	-140	-130	10
Excise Tax on High-Premium Insurance Plans[g]	-80	-80	0
Other Effects on Revenues and Outlays[h]	-171	-171	-1
Net Cost of Coverage Provisions	**1,363**	**1,354**	**-9**
Memorandum:			
Net Collections and Payments for Risk Adjustment, Reinsurance, and Risk Corridors[i]	0	-8	-8

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

Note: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; * = between -500,000 and 500,000; ** = between -$500 million and $500 million.

a. Figures for the nonelderly population include residents of the 50 states and the District of Columbia who are younger than 65.

b. The change in employment-based coverage is the net result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by workers and their families.

c. The effects are almost entirely for nongroup coverage; "other" includes Medicare.

d. The number of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.

e. Positive numbers indicate an increase in the deficit; negative numbers indicate a decrease in the deficit. They also exclude effects on the deficit of other provisions of the Affordable Care Act that are not related to insurance coverage. They also exclude federal administrative costs subject to appropriation.

f. Includes spending for exchange grants to states and net collections and payments for risk adjustment, reinsurance, and risk corridors (see Memorandum). CBO's May 2013 baseline also included an estimated $1 billion in spending for high-risk pools, premium review activities, and loans to consumer-operated and -oriented plans over the 2014–2023 period. A similar total is included elsewhere in CBO's February 2014 baseline.

g. These effects on the deficit include the associated effects of changes in taxable compensation on revenues.

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

i. These effects are included in "Exchange Subsidies and Related Spending."

lasts through March, and CBO and JCT anticipate that, similar to initial enrollment patterns for other new health care programs, the number of people who sign up will increase sharply toward the end of the period. In particular, people who choose to enroll primarily to avoid a penalty for being uninsured may wait until the end of the open enrollment period to choose a plan. Thus, it is possible that the number of enrollees will reach the 7 million originally projected for 2014, just as it is possible that the number will fall short of the current estimate of 6 million. In any event, CBO and JCT estimate that enrollment in exchanges will rise sharply in the next few years—reaching 22 million by 2016—as people become more familiar with the new insurance options and subsidies.

CBO and JCT expect that lower projected enrollment in 2014 and lower estimated premiums for that year (discussed below) will reduce the subsidies that are provided through exchanges by $10 billion for fiscal years 2014 and 2015 relative to the previous estimates. That reduction is partly offset by other small factors that add, on net, $3 billion to projected subsidies. In addition, CBO and JCT now estimate that the risk corridor program will have net receipts of $8 billion over the 2015–2017 period, compared with the previous estimate of no net budgetary effect (a revision that also is discussed below). All together, including the change in the definition of related spending discussed earlier, those revisions led to a net $16 billion reduction in the projection for exchange subsidies and related spending over the 2014–2023 period compared with the estimate published in May 2013 (see Table B-4 on page 113).

CBO also has reduced, from 9 million to 8 million, its estimate of the number of people who will enroll in Medicaid and CHIP in 2014 as a result of the ACA. That reduction reflects the greater-than-expected technical problems in implementing the ACA; for example, the exchanges operated by the federal government have struggled to transfer application information to state agencies for people who might be eligible for Medicaid or CHIP. Additional Medicaid and CHIP enrollment to date is lower than the 8 million currently projected by CBO and JCT. However, because people can enroll in either program at any time during the year and because CBO and JCT expect that many people who apply for subsidies through the exchanges by the end of March 2014 will discover that they are eligible for Medicaid or CHIP, the agencies expect enrollment in those two programs to continue to rise throughout 2014. Nevertheless, as a result of lower projected enrollment in 2014, CBO and JCT now anticipate that outlays for Medicaid and CHIP will be $2 billion less in fiscal years 2014 and 2015 than the agencies projected in May 2013.

Lower Premiums for Policies Purchased Through Exchanges

CBO and JCT lowered their estimate of average premiums for insurance coverage through exchanges in 2014 by about 15 percent on the basis of a preliminary analysis of plans offered through exchanges. Because the information about premiums and enrollment is still limited, however, CBO and JCT have not adjusted their projections of premiums for years after 2014. As more information becomes available, CBO and JCT will undertake additional analyses of observed premiums and of factors that affect premiums or change the attractiveness of insurance plans offered through exchanges compared with plans available from other sources. Those factors include the intensity of management of health care services, the payments to providers for those services, the breadth of provider networks, and the characteristics and expected health care costs of people who enroll through exchanges. Future revisions to CBO and JCT's projections of premiums and of other characteristics of plans offered through exchanges could affect estimates of exchange enrollment and subsidies. (The previous section discusses the combined budgetary effects of reducing projections for premiums and enrollment in 2014.)

New Estimates for the Risk Corridor Program

CBO now projects that, over the 2015–2017 period, risk corridor payments from the federal government to health insurers will total $8 billion and that the corresponding collections from insurers will amount to $16 billion, yielding net savings for the federal government of $8 billion. By contrast, in its baseline projections published in May 2013, the agency estimated that payments and collections for risk corridors would roughly offset one another. The current projection reflects the net effect of two changes. First, a revised assessment of how the risk corridor program is likely to operate increased the amount estimated for collections and reduced the amount estimated for payments, thereby generating net savings of about $8.5 billion. Second, an analysis of the effect that a recent administrative action will have on risk corridor payments reduced the amount estimated for collections and increased the amount estimated for

payments, thereby reducing the projection of net savings by less than $1 billion.

Whether insurers pay into or receive payments from the risk corridor system for 2014 will depend on how their actual health care claims compare with their expected claims, as reflected in the premium bids they submitted to exchanges in mid-2013 and after accounting for payments and collections for risk adjustment and reinsurance. To inform its projections, CBO analyzed recent data from the Medicare drug benefit (Part D), which established competitive marketplaces for coverage that are analogous to the ACA's insurance exchanges, and included similar provisions for risk adjustment, reinsurance, and risk corridors. Under Part D's risk corridors, collections from insurers have exceeded payments to insurers, yielding net collections that have averaged about $1 billion per year—between 2 percent and 3 percent of total covered costs for drugs under Part D. In CBO's judgment, that experience suggests that plans' premium bids in the ACA's exchanges will probably exceed their costs by a few percent. Despite the technical problems that have impeded enrollment in exchanges—and the resulting reduction in CBO and JCT's projection of enrollment for 2014—CBO expects that premium bids will still exceed costs and, as a result, collections from insurers for the risk corridor program will exceed payments.

The net savings of $8.5 billion from this program that CBO would have projected in the absence of the recent administrative action exceeds average net receipts under Part D for a few reasons, including the greater amount of expenses encompassed by the ACA's risk corridor system and the smaller percentages (narrower corridors) used in the ACA's system that minimize potential gains and losses alike for insurers in the first few years. However, the government has only limited experience with this type of program, and there are many uncertainties about how the market for health insurance will function under the ACA and how various outcomes would affect the government's costs or savings for the risk corridor program. In its estimate, CBO aims to be in the middle of the distribution of possible outcomes.

Administrative Actions

Under the ACA, certain large employers that do not offer health insurance coverage that meets the affordability standard set in that law will be subject to penalties. In addition, insurers and certain other health coverage providers (primarily employers that self-insure) will be required to report the names of those receiving coverage, and certain large employers will be required to report the health insurance coverage offered to their full-time employees. In July 2013, the Administration announced a delay of one year in the penalties for certain large employers that do not provide affordable coverage and in certain reporting requirements for insurers and employers. As a result of those changes, CBO and JCT reduced by $10 billion their estimate of revenues arising from penalties to be paid by employers in 2015 (because penalties assessed for 2014 would have been collected in 2015). Other effects from the one-year delay in penalties as well as small effects from certain final rules announced by the summer of 2013 added another $2 billion, on net, to estimated costs.[12]

In November 2013, the Administration announced that state insurance commissioners could give health insurers the option of allowing individuals and small businesses to re-enroll in coverage that did not comply with certain market and benefit rules, such as the prohibition against adjusting premiums based on health status, that were scheduled to take effect in January 2014. CBO and JCT estimate that, as a result, roughly 1½ million people in the individual and small-group markets will renew policies in 2014 that are not compliant with those rules. In addition, because subscribers may renew such coverage between January and October of 2014, CBO and JCT estimate that half a million people will continue to be enrolled in noncompliant policies in 2015.

CBO and JCT estimate that the November announcement will reduce spending for exchange subsidies only slightly, for two reasons. First, in 2014, exchanges are new and many people may not yet be aware of their eligibility for subsidies and therefore would not have signed up for the subsidies even in the absence of the announcement. Second, most people who are eligible for and enroll in subsidized coverage through an exchange will face lower costs for that coverage than for unsubsidized coverage in a noncompliant plan. Most of the people who renew enrollment in noncompliant plans will probably be those who would have bought an unsubsidized ACA-compliant plan either within or outside of exchanges or who would

12. See Congressional Budget Office, letter to the Honorable Paul Ryan concerning an analysis of the Administration's announced delay of certain requirements under the Affordable Care Act (July 30, 2013), www.cbo.gov/publication/44465.

have enrolled in an ACA-compliant plan through their small employer. They will probably pay lower premiums for noncompliant plans, on average, than they would have paid otherwise; as a result, some of those people will generate a small amount of additional tax revenue. Specifically, those who are self-employed will deduct a smaller amount from their taxable income for health insurance premiums, and those who receive insurance through the small-group market will receive a greater share of their compensation in the form of taxable wages and salaries rather than nontaxable benefits.

However, the small budgetary savings attributable to that announcement will be more than offset, in CBO and JCT's judgment, by changes the Administration is planning for the risk corridor program that are intended to help mitigate losses that insurers might incur as a result of the November announcement.[13] People who renew noncompliant policies are expected to be generally healthier than people who enroll in ACA-compliant plans, thereby leading to slightly higher medical claims per enrollee among ACA-compliant plans. Because the Administration's action was taken after insurers had set their premiums for 2014, insurers could not change their current premiums to reflect that increase in expected medical claims; some of those added costs will be borne by the government under the risk corridor program. Hence, the November announcement and the Administration's proposed changes to the risk corridor program led CBO to reduce its projection of net receipts under that program by a little less than $1 billion.

13. The Administration also announced changes to the reinsurance program; however, those changes did not affect CBO's projection of reinsurance payments because CBO had previously projected that all collections under that program would be spent.