CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 19, 2017

H.R. 1628
Obamacare Repeal Reconciliation Act of 2017

An Amendment in the Nature of a Substitute [LYN17479]
as Posted on the Website of the Senate Committee on the Budget on July 19, 2017

SUMMARY

The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have completed an estimate of the direct spending and revenue effects of the Obamacare Repeal Reconciliation Act of 2017, an amendment in the nature of a substitute to H.R. 1628, which would repeal many provisions of the Affordable Care Act (ACA). According to the agencies' analysis, enacting the legislation would decrease deficits by $473 billion over the 2017-2026 period (see Figure 1).

CBO and JCT estimate that enacting the legislation would affect insurance coverage and premiums primarily in these ways:

- The number of people who are uninsured would increase by 17 million in 2018, compared with the number under current law. That number would increase to 27 million in 2020, after the elimination of the ACA's expansion of eligibility for Medicaid and the elimination of subsidies for insurance purchased through the marketplaces established by the ACA, and then to 32 million in 2026.

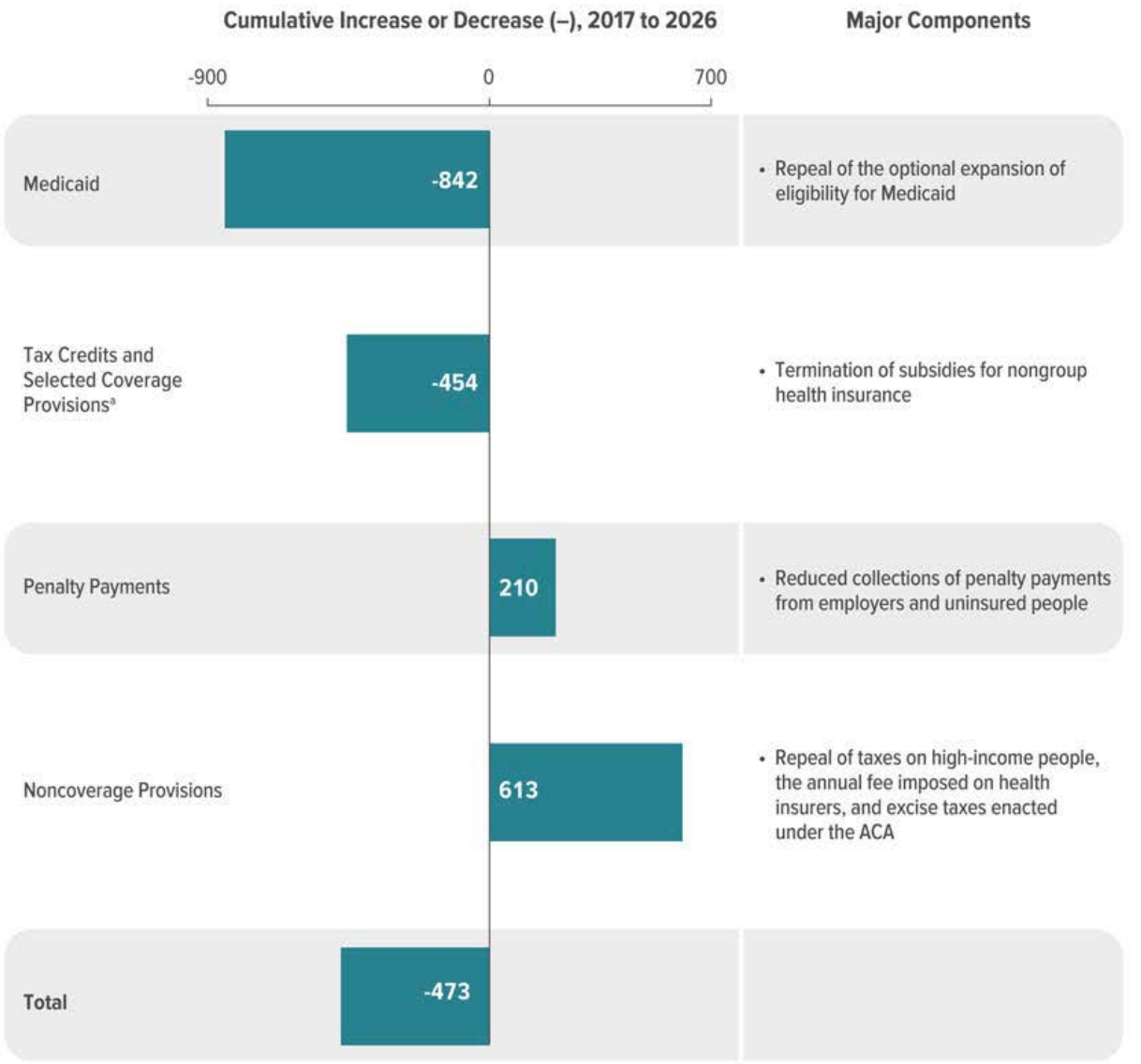
- Average premiums in the nongroup market (for individual policies purchased through the marketplaces or directly from insurers) would increase by roughly 25 percent—relative to projections under current law—in 2018. The increase would reach about 50 percent in 2020, and premiums would about double by 2026.

In CBO and JCT's estimation, under this legislation, about half of the nation's population would live in areas having no insurer participating in the nongroup market in 2020 because of downward pressure on enrollment and upward pressure on premiums. That share would continue to increase, extending to about three-quarters of the population by 2026.

Figure 1.

Net Effects of the Obamacare Repeal Reconciliation Act of 2017 on the Budget Deficit

Billions of Dollars



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

These estimates are for the Obamacare Repeal Reconciliation Act of 2017, a Senate amendment in the nature of a substitute to H.R. 1628.

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

ACA = Affordable Care Act.

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

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

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

CBO and JCT have reviewed the legislation and determined that it would impose no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO and JCT have determined that the legislation would impose private-sector mandates as defined in UMRA. On the basis of information from JCT, CBO estimates that the aggregate cost of the mandates would exceed the annual threshold established in UMRA for private-sector mandates ($156 million in 2017, adjusted annually for inflation).

MAJOR PROVISIONS OF THE LEGISLATION

The largest budgetary effects of enacting the legislation would stem from:

- Repealing the optional expansion of eligibility for Medicaid established in the ACA, beginning in 2020;

- Repealing subsidies for health insurance coverage obtained through the marketplaces beginning in 2020 and, prior to that year, eliminating the limitation on the amount people would have to repay if the premium tax credit they received during the year exceeded the allowed amount based on their actual income;

- Beginning upon enactment, eliminating penalties associated with the requirements that most people obtain health insurance coverage (also known as the individual mandate) and that large employers offer their employees health insurance coverage that meets specified standards (also known as the employer mandate), while keeping those requirements in place; and

- Repealing many of the provisions of the ACA that increase federal tax revenues (apart from the effect of the provisions related to insurance coverage) and delaying the federal excise tax imposed on some health insurance plans with high premiums so that it would take effect in 2026.

Upon enactment, other parts of the legislation that affect the budget would:

- Repeal reductions to state allotments for Medicaid payments to hospitals that treat a disproportionate share of uninsured or low-income patients;

- Increase the amount of funding authorized for and appropriated to the Community Health Center Fund and for grants to states to address substance abuse; and

- Prohibit federal funds from being made available, for one year, to certain entities that provide abortions.[1]

In addition, in later years, the legislation would do the following:

- Eliminate the Prevention and Public Health Fund, beginning in 2019, and

- Terminate the enhanced federal matching rate for personal care services and supports provided under the Community First Choice Act, beginning in 2020.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

CBO and JCT estimate that, on net, enacting the legislation would reduce federal deficits by $473 billion over the 2017-2026 period; that change would result from a $1,429 billion reduction in outlays partially offset by a $956 billion decrease in revenues (see Tables 1 and 2, at the end of this document).

BASIS OF ESTIMATE

For this cost estimate, CBO and JCT assume that the legislation will be enacted by July 31, 2017, and measure the budgetary effects relative to CBO's March 2016 baseline. The agencies have provided an overall estimate of the budgetary effects of the provisions that affect insurance coverage, and not separate estimates for each provision, for three related reasons. First, the agencies' modeling is done in an integrated way. Second, there are important interactions among the provisions, so the sum of the parts (when considered separately) does not equal the whole. Third, the order in which the provisions are

1. CBO expects that this provision would be implemented in a way that the prohibition would apply only if at least one entity, affiliate, subsidiary, successor, or clinic satisfied all of the criteria specified in the legislation; CBO identified only one organization that would be affected: Planned Parenthood Federation of America and its affiliates and clinics. If the provision was implemented in a way that affiliates, subsidiaries, successors, and clinics could satisfy the criteria separately, then the provision could apply to more organizations, perhaps many more.

considered would matter. For the other provisions, the agencies have done separate estimates.

Use of the March 2016 Baseline

On the basis of consultation with the budget committees, CBO and JCT measured the costs and savings in this estimate relative to CBO's March 2016 baseline projections, with adjustments for legislation that was enacted after that baseline was produced. That approach is not unusual: The budgetary effects of reconciliation legislation are typically estimated relative to the baseline that underlies the budget resolution that specified the reconciliation instructions and that was the basis for the deficit reduction goals stated in the resolution. Also, using the March 2016 baseline facilitates comparison because it has been used by CBO and JCT for cost estimates for all pieces of legislation related to the budget reconciliation process for 2017, including this one. The agencies have not had time to undertake a follow-on analysis of the effects of this legislation under the agencies' most recent baseline.

Methodology for Estimating Effects of Health Insurance Coverage

This legislation would change the pricing of nongroup insurance, the eligibility for and the amount of subsidies to purchase that insurance, and the willingness of insurers to participate in the nongroup market. It would also lead to changes in eligibility for Medicaid and spending for that program. The legislation's effects on health insurance coverage would depend in part on how individuals responded to changes in the prices, after subsidies, they had to pay for nongroup insurance; on changes in their eligibility for public coverage; and on their underlying desire for such insurance. Effects on coverage 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.[2]

Budgetary Effects of Health Insurance Coverage Provisions

CBO and JCT estimate that provisions directly affecting health insurance coverage would yield a net decrease in federal deficits of $1.1 trillion over the 2017-2026 period (see Table 3, at the end of this document). That amount includes the following:

- A net reduction of $842 billion in federal outlays for Medicaid (most of which would have been spent to provide benefits for adults under 65 whose income is equal to or less than 138 percent of the federal poverty level (FPL) and who became eligible under the ACA),

- A net reduction of $679 billion in subsidies for nongroup health insurance, and

- Additional savings totaling $6 billion from repealing a tax credit for certain small businesses that provide health insurance to their employees.

Those gross savings would be partly offset by these revenue reductions and added costs:

- A decline in revenues of $171 billion from eliminating penalty payments by employers,

- A reduction in revenues of $38 billion from eliminating penalty payments by uninsured people,

- A net increase in spending of $21 billion for the Medicare program stemming from changes in payments to hospitals that serve a disproportionate share of low-income patients, and

- Other budgetary effects, mostly involving revenues, associated with shifts from taxable to nontaxable compensation resulting from net increases in employment-based health insurance coverage—which would, on net, increase deficits by $210 billion.

2. For additional information, see Congressional Budget Office, "Methods for Analyzing Health Insurance Coverage" (accessed July 18, 2017), www.cbo.gov/topics/health-care/methods-analyzing-health-insurance-coverage.

Budgetary Effects of Other Provisions

This legislation would also make changes to spending for other federal health care programs and to federal revenues. CBO and JCT estimate that those provisions would result in a net increase in federal deficits of $613 billion over the 2017-2026 period. That projected increase over the 10-year period consists of a $606 billion decrease in revenues and an $8 billion increase in direct spending.

The estimated $606 billion decrease in revenues results from provisions in the bill that would repeal many of the revenue-related provisions of the ACA (apart from the provisions related to health insurance coverage discussed above). Those with the most significant budgetary effects include a surtax on certain high-income taxpayers' net investment income, annual fees on health insurers, and an increase in the Hospital Insurance payroll tax rate for certain high-income taxpayers.

The projected $8 billion increase in direct spending is primarily the net result of an estimated $41 billion increase in payments from Medicaid to hospitals that treat a disproportionate share of uninsured or low-income patients, partially offset by savings from reducing outlays for Medicaid related to the Community First Choice Act ($19 billion), eliminating a limitation on recapturing excess advance payments of premium tax credits ($9 billion), and eliminating the Prevention and Public Health Fund ($8 billion).

Effects on Health Insurance Coverage and Premiums

This legislation would make two primary sets of changes that would affect insurance coverage and premiums. First, upon enactment, the legislation would eliminate penalties associated with the requirements that most people obtain health insurance and that large employers offer their employees health insurance that meets specified standards. Second, beginning in 2020, the legislation would also eliminate the ACA's expansion of Medicaid eligibility and the subsidies available to people who purchase health insurance through a marketplace established by the ACA. This legislation also contains other provisions that would have smaller effects on coverage and premiums.

Importantly, this legislation would leave in place a number of market regulations—rules established by the ACA that govern certain health insurance markets. Insurers that sell plans either through the marketplaces or directly to consumers are required to:

- Provide specific benefits and amounts of coverage;

- Not deny coverage or vary premiums because of an enrollee's health status or limit coverage because of preexisting medical conditions; and

- Vary premiums only on the basis of age, tobacco use, and geographic location.

According to CBO and JCT's analysis, this legislation would, upon enactment, reduce the number of people with insurance; and in 2018, premiums in the nongroup market would rise, and insurers' participation in that market would decline. Starting in 2020, the increase in the number of uninsured people and premiums would be greater, and insurers' participation in the nongroup market would decline further.

Estimated Changes Starting in 2018. Following enactment but before the Medicaid expansion and subsidies for insurance purchased through the marketplaces were eliminated, the effects of this legislation on insurance coverage and premiums would stem primarily from repealing the penalty associated with the individual mandate.

Effects on Insurance Coverage. In 2018, by CBO and JCT's estimates, about 17 million more people would be uninsured under this legislation than under current law.[3] That increase in the uninsured population would consist of about 10 million fewer people with coverage obtained in the nongroup market, roughly 4 million fewer people with coverage under Medicaid, and about 2 million fewer people with employment-based coverage. In 2018, an estimated 84 percent of all U.S. residents under age 65 would be insured, compared with 90 percent under current law.

Although most of those reductions in coverage would stem from repealing the penalty associated with the individual mandate, CBO and JCT also expect that insurers in some areas would leave the nongroup market in 2018. They would be leaving in anticipation of further reductions in enrollment and higher average health care costs among enrollees who remained after the subsidies for insurance purchased through the marketplaces were eliminated. As a consequence, roughly 10 percent of the population would be living in an area that had no insurer participating in the nongroup market.

In the nongroup market, some people would choose not to have insurance partly because they choose to be covered by insurance under current law to avoid paying the penalty. And, under this legislation, without the mandate penalty, some people would forgo insurance in response to the higher premiums that CBO and JCT project would be charged. Insurers would still be required to provide coverage to any applicant, and they would not be able to vary premiums to reflect enrollees' health status or to limit coverage of preexisting medical conditions. Those features are most attractive to applicants with relatively high expected costs for health care, so CBO and JCT expect that repealing the individual mandate penalty would tend to reduce insurance coverage less among older and less healthy people than among younger and healthier people. Thus, the agencies

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

estimate that repealing that penalty, taken by itself, would increase premiums in the nongroup market.

Under current law, the penalty associated with the individual mandate applies to some Medicaid-eligible adults and children. (For example, it applies to single individuals with income above about 90 percent of the FPL.) In addition, some people apply for coverage in the marketplaces because of the penalty and turn out to be eligible for Medicaid. And some who are not subject to the penalty think they would be if they did not enroll in Medicaid. The agencies do not expect that, with the penalty eliminated under this legislation, people enrolled in Medicaid would disenroll. However, among people who would become eligible for Medicaid under the legislation or who would need to recertify their eligibility, the proportion of people who enrolled in the program would, by CBO and JCT's expectations, be lower—closer to the proportions observed for those groups prior to the institution of the penalty.

Under current law, the prospect of paying the employer mandate penalty tips the scale for some businesses and causes them to decide to offer health insurance to their employees. Thus, eliminating that penalty would cause some employers to not offer health insurance. Similarly, the demand for insurance among employees is greater under current law because some employees want employment-based coverage so that they can avoid paying the individual mandate penalty. Eliminating that penalty would reduce such demand and would cause some employers to not offer coverage or some employees to not enroll in coverage they were offered, CBO and JCT estimate.

Effects on Premiums. According to CBO and JCT's analysis, average premiums for single policyholders in the nongroup market for "silver" plans would be roughly 25 percent higher than under current law in 2018.[4] The majority of that increase would stem from repealing the penalty associated with the individual mandate. Doing so would both reduce the number of people purchasing health insurance and change the mix of people with insurance. Average health care costs among the people retaining coverage would be higher, and insurers would have to raise premiums in the nongroup market to cover those higher costs. Lower participation by insurers in the nongroup market would place further upward pressure on premiums because the market would be less competitive.

4. Silver plans pay a percentage of the total cost of covered benefits that depends on the policyholders' income. That actuarial value is 70 percent for most people except for those with income between 100 percent and 250 percent of the FPL, who are eligible for silver plans with higher actuarial values: for people with income between 100 percent and 150 percent of the FPL, 94 percent; for people with income between 150 percent and 200 percent of the FPL, 87 percent; and for people with income between 200 percent and 250 percent of the FPL, 73 percent.

Estimated Changes Starting in 2020. The legislation's effects on insurance coverage and premiums would be greater once the repeal of the Medicaid expansion and of the subsidies for insurance purchased through the marketplaces took effect.

Effects on Insurance Coverage. By CBO and JCT's estimates, enacting this legislation would increase the number of people without health insurance coverage by about 27 million in 2020 and by about 32 million in 2026, relative to the number of uninsured people expected under current law. (The number of people without health insurance would be smaller if, in addition to the changes in this legislation, the insurance market regulations mentioned above were also repealed. In that case, the increase in the number of uninsured people would be about 21 million in 2020; that figure would rise to about 23 million in 2026.) In 2026, an estimated 79 percent of all U.S. residents under age 65 would be insured, compared with 90 percent under current law (see Table 4, at the end of this document).

The estimated increase of 32 million people without coverage in 2026 is the net result of roughly 23 million fewer with coverage in the nongroup market and 19 million fewer with coverage under Medicaid, partially offset by an increase of about 11 million people covered by employment-based insurance. By CBO and JCT's estimates, 59 million people under age 65 would be uninsured in 2026 (compared with 28 million under current law), representing 21 percent of everyone under age 65. By 2026, fewer than 2 million people would be enrolled in the nongroup market, CBO and JCT estimate.

Effects on Market Stability. According to the agencies' analysis, eliminating the penalty associated with the individual mandate and the subsidies for insurance while retaining the market regulations would destabilize the nongroup market, and the effect would worsen over time. The ACA's changes to the rules governing the nongroup health insurance market work in conjunction with the mandate and the subsidies to increase participation in the market and encourage enrollment among people of different ages and health statuses. But eliminating the penalty for not having health insurance would reduce enrollment and raise premiums in the nongroup market. Eliminating subsidies for insurance purchased through the marketplaces would have the same effects because it would result in a large price increase for many people.

Not only would enrollment decline, but the people most likely to remain enrolled would tend to be less healthy (and therefore more willing to pay higher premiums). Thus, average health care costs among the people retaining coverage would be higher, and insurers would have to raise premiums in the nongroup market to cover those higher costs. CBO and JCT expect that enrollment would continue to drop and premiums would continue to increase in each subsequent year.

Leaving the ACA's market regulations in place would limit insurers' ability to use strategies that were common before the ACA was enacted. For example, insurers would

not be able to vary premiums to reflect an individual's health care costs or offer health insurance plans that exclude coverage of preexisting conditions, plans that do not cover certain types of services (such as maternity care), or plans with very high deductibles or very low actuarial values (plans paying a very low share of costs for covered services).

In CBO and JCT's estimation, the factors exerting downward pressure on enrollment and upward pressure on premiums in the nongroup market would lead to substantially reduced participation by insurers and enrollees in many areas. Prior experience in states that implemented similar nongroup market regulations without mandate penalties or subsidies has demonstrated the potential for market destabilization. Several states that enacted such market regulations later repealed or substantially modified those regulations in response to increased premiums and insurers' departure from the market.

After weighing the evidence from prior state-level reforms and input from experts and market participants, CBO and JCT estimate that about half of the nation's population lives in areas that would have no insurer participating in the nongroup market in 2020, and the share would continue to increase, extending to about three-quarters of the population by 2026. That contraction of the market would most directly affect people without access to employment-based coverage or public health insurance.

Effects on Premiums and Out-of-Pocket Payments. In total, as a result of reduced enrollment, higher average health care costs among remaining enrollees, and less participation by insurers, CBO and JCT project that average premiums for silver plans in the nongroup market would be about 50 percent higher in 2020—relative to projections under current law—and would about double by 2026. For people who would have received premium tax credits under current law, the increase in the net premium that they paid would be much greater.

The agencies expect that, under this legislation, a larger share of people enrolled in nongroup coverage would purchase insurance that pays for a smaller average share of health care costs in response to the increases in premiums. Those people would pay lower premiums than those for a silver plan, but they would have higher out-of-pocket spending on health care than under current law. Nevertheless, the premiums for any health insurance in the nongroup market would be a relatively high percentage of income for many low-income people and the deductibles—the amounts that people would pay out of pocket for most types of health care services before insurance makes any contribution—for plans with lower premiums would be high as well. As a result, few low-income people would purchase any plan, CBO and JCT estimate.

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 inexact 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 legislation are all difficult to predict.

CBO and JCT's projections under current law are themselves uncertain. For example, enrollment in the marketplaces under current law will probably be lower than was projected under the March 2016 baseline used in this analysis, which would tend to decrease the budgetary savings from this legislation. However, the average subsidy per enrollee under current law will probably be higher than was projected in March 2016, which would tend to increase the budgetary savings from this legislation.

Despite the uncertainty, the direction of certain effects of this legislation is clear. For example, the amount of federal revenues collected and the amount of spending on Medicaid would both be lower than under current law. And the number of uninsured people under this legislation would be greater than under current law.

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting this legislation would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027.

MANDATES ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

CBO and JCT have determined that the legislation would impose no intergovernmental mandates as defined in UMRA.

MANDATES ON THE PRIVATE SECTOR

CBO and JCT have determined that the legislation would impose two private-sector mandates as defined in UMRA. Specifically, the tax provisions of the legislation would recapture excess advance payments of premium tax credits (so that the full amount of excess advance payments would be treated as an additional tax liability for the individual) and repeal the small business (health insurance) tax credit.

On the basis of information from JCT, CBO estimates that the aggregate direct cost of the mandates imposed by the legislation would exceed the annual threshold established in

UMRA for private-sector mandates ($156 million in 2017, adjusted annually for inflation).

PREVIOUS CBO ESTIMATES

A year and a half ago, CBO and JCT analyzed similar legislation, so this analysis updates those earlier budgetary estimates using later effective dates and CBO's March 2016 baseline (rather than the March 2015 baseline).[5] The estimated net reduction in the deficit—as conventionally estimated, excluding any feedback to the budget from macroeconomic effects—is roughly $150 billion greater for this legislation than described in that previous analysis. In January 2017, CBO and JCT updated their estimates of the effects of such legislation on health insurance coverage and premiums; the estimates presented in this document are very similar to those.[6]

CBO's previous estimates included the budgetary impact of the macroeconomic effects of the legislation, indicating that those effects would further decrease budget deficits. Because of the very short time available to prepare this cost estimate, quantifying and incorporating those macroeconomic effects have not been practicable.

In June 2017, CBO and JCT analyzed a previous amendment in the nature of substitute to H.R. 1628.[7] The agencies estimated that enacting that amendment would reduce deficits by $321 billion over 10 years; spending and revenues would both be reduced by smaller amounts than are projected for the current amendment.

5. See Congressional Budget Office, letter to the Honorable Mike Enzi regarding the budgetary effects of H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act, as passed by the Senate on December 3, 2015 (December 11, 2015), www.cbo.gov/publication/51090. CBO and JCT later updated those budgetary estimates following enactment of the Consolidated Appropriations Act, 2016; see Congressional Budget Office, cost estimate for H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act, as passed by the Senate on December 3, 2015, and following enactment of the Consolidated Appropriations Act, 2016 (January 4, 2016), www.cbo.gov/publication/51107. For additional information, see Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act* (June 2015), www.cbo.gov/publication/50252.

6. See Congressional Budget Office, *How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums* (January 2017), www.cbo.gov/publication/52371.

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

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Table 1 - SUMMARY OF THE DIRECT SPENDING AND REVENUE EFFECTS OF H.R. 1628, THE OBAMACARE REPEAL RECONCILIATION ACT OF 2017, AN AMENDMENT IN THE NATURE OF A SUBSTITUTE [LYN17479], AS POSTED ON THE WEBSITE OF THE SENATE COMMITTEE ON THE BUDGET ON JULY 19, 2017

Billions of Dollars, by Fiscal Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
CHANGES IN DIRECT SPENDING[a]												
Coverage Provisions												
Estimated Budget Authority	-4.3	-24.3	-35.2	-127.2	-173.9	-187.3	-201.1	-215.0	-227.6	-241.1	-364.9	-1,437.0
Estimated Outlays	-4.3	-24.3	-35.2	-127.2	-173.9	-187.3	-201.1	-215.0	-227.6	-241.1	-364.9	-1,437.0
Noncoverage Provisions												
Estimated Budget Authority	0.2	-1.1	-1.9	-0.3	1.1	0.9	1.7	1.7	1.3	0.6	-2.0	4.3
Estimated Outlays	-0.3	-1.5	-1.1	0.9	1.6	1.4	1.5	2.2	1.9	1.0	-0.4	7.5
Total Changes in Direct Spending												
Estimated Budget Authority	-4.1	-25.5	-37.0	-127.5	-172.8	-186.4	-199.4	-213.3	-226.3	-240.4	-366.9	-1,432.7
Estimated Outlays	-4.5	-25.9	-36.3	-126.3	-172.3	-185.9	-199.6	-212.8	-225.7	-240.1	-365.4	-1,429.5
CHANGES IN REVENUES[b]												
Coverage Provisions	-4.0	-14.8	-20.7	-25.2	-36.9	-42.7	-46.3	-50.0	-53.5	-56.2	-101.6	-350.3
Noncoverage Provisions	-2.0	-45.1	-48.1	-55.3	-63.1	-68.1	-73.7	-80.3	-87.8	-82.3	-213.6	-605.8
Total Changes in Revenues	-6.0	-59.9	-68.8	-80.5	-100.0	-110.8	-120.0	-130.3	-141.3	-138.5	-315.3	-956.1
INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES												
Net Increase or Decrease (-) in the Deficit	1.4	34.0	32.5	-45.7	-72.3	-75.1	-79.6	-82.5	-84.5	-101.6	-50.1	-473.4

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

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation.
The costs of this legislation fall within budget functions 550 (health), 570 (Medicare), 600 (income security), and 650 (Social Security).
Numbers may not add up to totals because of rounding.

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

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

Table 2 - ESTIMATE OF THE DIRECT SPENDING AND REVENUE EFFECTS OF H.R. 1628, THE OBAMACARE REPEAL RECONCILIATION ACT OF 2017, AN AMENDMENT IN THE NATURE OF A SUBSTITUTE [LYN17479], AS POSTED ON THE WEBSITE OF THE SENATE COMMITTEE ON THE BUDGET ON JULY 19, 2017

Billions of Dollars, by Fiscal Year	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
ESTIMATED CHANGES IN DIRECT SPENDING[a]												
Coverage Provisions												
Estimated Budget Authority	-4.3	-24.3	-35.2	-127.2	-173.9	-187.3	-201.1	-215.0	-227.6	-241.1	-364.9	-1,437.0
Estimated Outlays	-4.3	-24.3	-35.2	-127.2	-173.9	-187.3	-201.1	-215.0	-227.6	-241.1	-364.9	-1,437.0
On-Budget	*-4.3*	*-24.3*	*-35.2*	*-127.2*	*-173.8*	*-186.9*	*-200.3*	*-213.9*	*-226.4*	*-239.9*	*-364.9*	*-1,432.1*
Off-Budget	*0*	*	*	*	*-0.1*	*-0.4*	*-0.8*	*-1.2*	*-1.2*	*-1.2*	*-0.1*	*-4.9*
Title I												
Sec. 101 - Recapture Excess Advance Payments of Premium Tax Credits												
Estimated Budget Authority	-0.2	-3.1	-3.9	-1.2	0	0	0	0	0	0	-8.5	-8.5
Estimated Outlays	-0.2	-3.1	-3.9	-1.2	0	0	0	0	0	0	-8.5	-8.5
Sec. 102 - Premium Tax Credit												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 103 - Small Business Tax Credit												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 104 - Individual Mandate												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 105 - Employer Mandate												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 106 - Federal Payment to States												
Estimated Budget Authority	*	-0.1	*	*	*	*	*	*	*	*	-0.2	-0.1
Estimated Outlays	*	-0.1	*	*	*	*	*	*	*	*	-0.2	-0.1
Sec. 107 - Medicaid (Coverage)												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											
Sec. 107 - Medicaid (Noncoverage)												
Estimated Budget Authority	0	0	0	-1.1	-1.9	-2.5	-3.2	-3.3	-3.5	-3.7	-3.0	-19.3
Estimated Outlays	0	0	0	-1.1	-1.9	-2.5	-3.2	-3.3	-3.5	-3.7	-3.0	-19.3
Sec. 108 - Repeal of DSH Allotment Reductions												
Estimated Budget Authority	0	1.4	2.2	3.1	4.0	4.9	5.9	6.8	6.8	6.3	10.7	41.5
Estimated Outlays	0	1.4	2.2	3.1	4.0	4.9	5.9	6.8	6.8	6.3	10.7	41.5
Title II												
Sec. 201 - Prevention and Public Health Fund												
Estimated Budget Authority	0	0	-0.9	-1.0	-1.0	-1.5	-1.0	-1.7	-2.0	-2.0	-2.9	-11.1
Estimated Outlays	0	0	-0.1	-0.4	-0.8	-1.0	-1.1	-1.3	-1.4	-1.7	-1.3	-7.9
Sec. 202 - Support for State Response to Substance Abuse Public Health Crisis												
Estimated Budget Authority	0	0.8	0.8	0	0	0	0	0	0	0	1.5	1.5
Estimated Outlays	0	0.1	0.5	0.6	0.2	*	*	0	0	0	1.4	1.5
Sec. 203 - Community Health Center Program												
Estimated Budget Authority	0.4	0	0	0	0	0	0	0	0	0	0.4	0.4
Estimated Outlays	0	0.2	0.2	*	0	0	0	0	0	0	0.4	0.4
Sec. 204 - Funding for Cost-Sharing Payments[b]												
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	0	0	0	0	0	0	0	0	0	0	0
Sec. 205 - Repeal of Cost-Sharing Subsidy Program												
Estimated Budget Authority	*included in estimate of coverage provisions*											
Estimated Outlays	*included in estimate of coverage provisions*											

Continued

Table 2 Continued. Billions of Dollars, by Fiscal Year	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
Total Changes in Direct Spending												
Estimated Budget Authority	**-4.1**	**-25.5**	**-37.0**	**-127.5**	**-172.8**	**-186.4**	**-199.4**	**-213.3**	**-226.3**	**-240.4**	**-366.9**	**-1,432.7**
Estimated Outlays	**-4.5**	**-25.9**	**-36.3**	**-126.3**	**-172.3**	**-185.9**	**-199.6**	**-212.8**	**-225.7**	**-240.1**	**-365.4**	**-1,429.5**
On-Budget	*-4.5*	*-25.9*	*-36.3*	*-126.3*	*-172.3*	*-185.4*	*-198.7*	*-211.7*	*-224.5*	*-238.9*	*-365.3*	*-1,424.5*
Off-Budget	*0*	*	*	*	*-0.1*	*-0.4*	*-0.8*	*-1.2*	*-1.2*	*-1.2*	*-0.1*	*-4.9*
ESTIMATED CHANGES IN REVENUES[c]												
Coverage Provisions	-4.0	-14.8	-20.7	-25.2	-36.9	-42.7	-46.3	-50.0	-53.5	-56.2	-101.6	-350.3
On-Budget	*-4.3*	*-17.8*	*-22.6*	*-21.2*	*-30.2*	*-35.7*	*-39.2*	*-43.1*	*-47.0*	*-46.7*	*-96.1*	*-307.8*
Off-Budget	*0.3*	*3.0*	*1.9*	*-4.1*	*-6.7*	*-6.9*	*-7.1*	*-6.9*	*-6.5*	*-9.5*	*-5.5*	*-42.5*
Title I												
Sec. 101 - Recapture of Excess Advance Payments of Premium Tax Credits	0.1	0.8	1.2	1.0	0	0	0	0	0	0	3.2	3.2
Sec. 102 - Premium Tax Credit	*included in estimate of coverage provisions*											
Sec. 103 - Small Business Tax Credit	*included in estimate of coverage provisions*											
Sec. 104 - Individual Mandate	*included in estimate of coverage provisions*											
Sec. 105 - Employer Mandate	*included in estimate of coverage provisions*											
Sec. 109 - Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits[d]	0	0	0	-3.4	-6.9	-8.7	-10.7	-13.4	-16.4	-6.6	-10.3	-66.0
Sec. 110 - Repeal of Tax on Over-the-Counter Medications	*	-0.5	-0.5	-0.6	-0.6	-0.6	-0.6	-0.7	-0.7	-0.7	-2.3	-5.6
Sec. 111 - Repeal of Tax on HSAs	*	*	*	*	*	*	*	*	*	*	*	-0.1
Sec. 112 - Repeal of Limitations on Contributions to Flexible Spending Accounts	0	-0.3	-1.2	-1.6	-1.7	-1.8	-2.2	-2.6	-3.3	-4.1	-4.7	-18.6
Sec. 113 - Repeal of Tax on Prescription Medications	0	-4.0	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-12.1	-25.7
Sec. 114 - Repeal of Medical Device Excise Tax	0	-1.4	-1.9	-2.0	-2.1	-2.2	-2.3	-2.4	-2.6	-2.7	-7.4	-19.6
Sec. 115 - Repeal of Health Insurance Tax	0	-12.8	-13.5	-14.3	-15.1	-15.9	-16.8	-17.8	-18.7	-19.7	-55.7	-144.7
Sec. 116 - Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy	*	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.7	-1.8
Sec. 117 - Repeal of Chronic Care Tax	*	-3.5	-3.1	-3.4	-3.6	-3.9	-4.2	-4.5	-4.8	-5.1	-13.6	-36.1
Sec. 118 - Repeal of Medicare Tax Increase	-0.4	-6.5	-10.1	-11.4	-12.3	-13.2	-14.1	-15.2	-16.5	-17.6	-40.8	-117.3
Sec. 119 - Repeal of Tanning Tax	0	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
Sec. 120 - Repeal of Net Investment Tax	-1.6	-16.7	-15.9	-16.7	-17.8	-18.7	-19.7	-20.7	-21.7	-22.7	-68.7	-172.2
Sec. 121 - Remuneration	*	-0.1	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.5
Total Changes in Revenues	**-6.0**	**-59.9**	**-68.8**	**-80.5**	**-100.0**	**-110.8**	**-120.0**	**-130.3**	**-141.3**	**-138.5**	**-315.3**	**-956.1**
On-Budget	*-6.2*	*-62.7*	*-70.1*	*-75.0*	*-91.2*	*-101.2*	*-109.7*	*-119.3*	*-129.6*	*-126.5*	-305.3	-891.5
Off-Budget	*0.3*	*2.8*	*1.3*	*-5.5*	*-8.8*	*-9.6*	*-10.3*	*-11.0*	*-11.7*	*-12.1*	*-10.0*	*-64.6*
INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES[e]												
Net Increase or Decrease (-) in the Deficit	**1.4**	**34.0**	**32.5**	**-45.7**	**-72.3**	**-75.1**	**-79.6**	**-82.5**	**-84.5**	**-101.6**	**-50.1**	**-473.4**
On-Budget	*1.7*	*36.8*	*33.8*	*-51.3*	*-81.0*	*-84.3*	*-89.1*	*-92.3*	*-94.9*	*-112.4*	*-60.0*	*-533.0*
Off-Budget	*-0.3*	*-2.8*	*-1.3*	*5.5*	*8.7*	*9.1*	*9.5*	*9.8*	*10.5*	*10.8*	*9.9*	*59.6*

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

Numbers may not add up to totals because of rounding.
DSH = Disproportionate Share Hospital; HSA = health savings account.
* = between -$50 million and $50 million.

a. For outlays, a positive number indicates an increase (adding to the deficit), and a negative number indicates a decrease (reducing the deficit).
b. Section 204 would appropriate such sums as may be necessary to make payments for cost-sharing subsidies through 2019. Because such payments are already in CBO's baseline, CBO estimates that the provision would not affect direct spending or revenues, relative to that baseline.
c. For revenues, a positive number indicates an increase (reducing the deficit) and a negative number indicates a decrease (adding to the deficit).
d. This estimate does not include effects of interactions with other subsidies; those effects are included in estimates for other relevant provisions.
e. CBO and JCT estimate that titles I and II would each reduce on-budget deficits by more than $1 billion over the 2017-2026 period.

Table 3 - ESTIMATE OF THE NET BUDGETARY EFFECTS OF THE INSURANCE COVERAGE PROVISIONS OF H.R. 1628, THE OBAMACARE REPEAL RECONCILIATION ACT OF 2017

Billions of Dollars, by Fiscal Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total, 2017-2026
Medicaid	*	-15	-26	-75	-99	-108	-116	-125	-134	-144	-842
Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	-5	-14	-16	-65	-87	-91	-95	-99	-102	-106	-679
Elimination of Small-Employer Tax Credits[b,c]	*	*	*	*	-1	-1	-1	-1	-1	-1	-6
Elimination of Penalty Payments by Employers[c]	2	16	20	15	16	18	19	20	22	23	171
Elimination of Penalty Payments by Uninsured People	3	3	3	3	4	4	4	4	4	5	38
Medicare[d]	0	3	5	5	3	2	1	1	1	*	21
Other Effects on Revenues and Outlays[e]	-1	-3	-1	14	26	31	33	35	37	39	210
Total Effect on the Deficit	*****	**-10**	**-14**	**-102**	**-137**	**-145**	**-155**	**-165**	**-174**	**-185**	**-1,087**
Memorandum: Additional Detail on Marketplace Subsidies and Related Spending and Revenues											
Premium Tax Credit Outlay Effects	-3	-10	-12	-42	-57	-60	-62	-65	-68	-70	-449
Premium Tax Credit Revenue Effects	-1	-2	-2	-8	-11	-11	-11	-12	-12	-13	-81
Subtotal, Premium Tax Credits	-4	-11	-14	-49	-68	-71	-74	-77	-80	-83	-530
Cost-Sharing Outlays	-1	-2	-2	-9	-13	-13	-14	-14	-15	-16	-99
Outlays for the Basic Health Program	*	*	*	-6	-6	-7	-7	-7	-8	-8	-50
Total, Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	-5	-14	-16	-65	-87	-91	-95	-99	-102	-106	-679

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

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

Numbers may not add up to totals because of rounding.

* = between -$500 million and $500 million.

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

b. Includes effects on both outlays and revenues.

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

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

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

Table 4 - EFFECTS OF H.R. 1628, THE OBAMACARE REPEAL RECONCILIATION ACT OF 2017, ON HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER AGE 65

Millions of People, by Calendar Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Population Under Age 65	273	274	275	276	276	277	278	279	279	280
Uninsured Under Current Law	26	26	27	27	27	27	27	28	28	28
Change in Coverage Under the Legislation										
Medicaid[a]	*	-4	-6	-15	-17	-17	-18	-18	-18	-19
Nongroup coverage, including marketplaces	-1	-10	-11	-22	-22	-22	-22	-23	-23	-23
Employment-based coverage	*	-2	*	10	11	11	11	11	11	11
Other coverage[b]	*	*	*	-1	-1	-1	-1	-1	-1	-1
Uninsured	1	17	18	27	29	29	30	31	31	32
Uninsured Under the Legislation	28	43	45	55	56	57	57	58	59	59
Percentage of the Population Under Age 65 With Insurance Under the Legislation										
Including all U.S. residents	90	84	84	80	80	80	79	79	79	79
Excluding unauthorized immigrants	92	86	86	82	82	82	81	81	81	81

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

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

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

* = between -500,000 and zero.

a. Includes noninstitutionalized enrollees with full Medicaid benefits.

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