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OFFICE OF THE ACTUARY

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FROM: Paul Spitalnic
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SUBJECT: Estimated Financial Effect of the "American Health Care Act of 2017"

The Office of the Actuary has prepared this memorandum in our longstanding capacity as an independent technical advisor to both the Administration and the Congress. The costs, savings, and coverage impacts shown herein represent our best estimates for the American Health Care Act. The statements, estimates, and other information provided in this memorandum are those of the Office of the Actuary and do not represent an official position of the Department of Health & Human Services or the Administration.

Executive Summary

This memorandum summarizes the Office of the Actuary's estimates of the financial and coverage effects through 2026 of selected provisions of the "American Health Care Act of 2017" (H.R. 1628), which was passed by the House on May 4, 2017 and which is referred to in this memorandum as the AHCA. Included are the estimated impacts on net Federal expenditures, health insurance coverage, Medicaid enrollment and spending by eligibility group, gross and net premiums and out-of-pocket costs in the individual market, total National Health Expenditures, and the financial status of the Medicare Hospital Insurance (HI) trust fund. Not included in these estimates are the impacts of provisions that would affect other parts of the Federal Budget—such as those associated with repealing taxes or fees that do not have a direct effect on the Medicare or Medicaid program—and Federal administrative costs. A summary of the data, assumptions, and methodology underlying our estimates is available in Appendix A.

The key findings in this memorandum are as follows:

- Over fiscal years 2017-2026, selected provisions of the AHCA are anticipated to reduce Federal expenditures by over $328 billion primarily because of lower Medicaid spending.

- In 2018, the number of uninsured is estimated to be about 4 million higher under the AHCA than under current law, mainly due to the impact of repealing the individual mandate. By 2026, the number of uninsured is estimated to be roughly 13 million higher under the AHCA, mostly as a result of declines in eligibility for Medicaid, the impact of the repeal of the individual mandate, and the net reduction to the subsidies available for the purchase of individual insurance.

- In calendar year 2026, Medicaid enrollment is estimated to be 8 million lower under the AHCA than under current law due to the combination of two factors: (i) a decline of 6 million in enrollment for newly eligible adults under current law and (ii) a decline of 2 million in enrollment for all other Medicaid enrollees attributable to more frequent

eligibility redeterminations, the repeal of retroactive eligibility, and optional State work requirements for adults. When this effect is combined with the implementation of per capita allotments as specified under the AHCA, overall Medicaid spending is estimated to be $105 billion, or nearly 11 percent, lower under the AHCA than under current law in 2026.

- For the individual insurance market, average *gross* premiums are estimated to be roughly 13 percent lower in 2026 under the AHCA than under current law. However, average *net* premiums (that is, premium amounts after Federal and State subsidies are accounted for) are roughly 5 percent higher than under current law, and estimated average cost-sharing amounts are projected to be roughly 61 percent higher in 2026 under the AHCA than under current law. The impacts vary widely by age and income of the enrollee and depending on whether the enrollee resides in a State that applies for waivers for Essential Health Benefits (EHBs) or community rating.

- The assets of the HI trust fund are estimated to be depleted in 2026, 2 years earlier than under current law, and the HI actuarial deficit is estimated to increase from 0.73 percent to 1.18 percent.[1] This result is primarily due to the loss of revenue from the repeal of the additional Medicare tax on high-income earners and additional Medicare disproportionate share hospital (DSH) spending.

- Over calendar years 2017-2026:

    - Total national health spending is estimated to be $258 billion, or 0.6 percent, lower under the AHCA than under current law. The national health spending share of the Gross Domestic Product (GDP) is estimated to be 19.9 percent in 2026 under the AHCA—0.2 percentage point lower than under current law.

    - Households are estimated to finance $21 billion, or 0.2 percent, more of national health spending, as the expected increase in direct out-of-pocket expenditures of nearly $221 billion under the AHCA is almost entirely offset by lower spending because of declines in employer-sponsored coverage, a reduction in the additional Medicare tax for high-income earners, and the effect of the elimination of the health insurance tax on premiums.

    - The Federal Government is estimated to finance $253 billion, or 1.9 percent, less of national health spending; State and local governments are estimated to finance $37 billion, or 0.5 percent, more; and private businesses and other private revenues are expected to finance $63 billion, or 0.5 percent, less of such spending.

The AHCA provides funding from the Patient and State Stability Fund (PSSF) to reduce premiums in the individual market. The estimates presented in this memorandum generally assume that half of the funding would be targeted towards assistance for at-risk populations

[1] These estimates were developed based on the 2016 Medicare Trustees Report, known formally as *The 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

(lower income, older, and/or poorer health) and that the remaining half would be used to lower premiums for all enrollees.

Under the AHCA, States can apply for waivers that would allow them to (i) define EHBs and (ii) permit issuers to consider health status as a rating factor in lieu of the 30-percent surcharge that would otherwise apply for individuals who have not maintained continuous coverage (that is, waive community rating). While it is nearly impossible to predict how States will respond to these options, we have made several key assumptions about State behavior in developing these estimates. These assumptions are not intended to be a prediction of what an individual State will choose to do but are instead intended to produce ultimate outcomes that would be considered reasonable given the degree of uncertainties. The estimates assume that 25 percent of States would choose to waive the requirements of EHBs or community rating. Because of the range of possible outcomes, we also provide the cost and coverage sensitivity for several of those key assumptions.

The actual future impacts of the AHCA on health expenditures, insured status, individual and employer decisions, State behavior, and market dynamics are very uncertain. The legislation would result in substantial changes in the way that health care insurance is provided and paid for in the U.S. Accordingly, the estimates presented here are subject to greater uncertainty than is typical when estimating the impact of health care legislation. Moreover, the estimates provided in this memorandum assume that effects of various provisions would occur as early as 2018 even though the timing for actual implementation by that date would be quite challenging. Finally, while we have assumed that the individual market will be viable and stable under both current law and the AHCA, it is possible that certain waivers granted under the AHCA could result in a deteriorating or possibly failing individual market depending on how a State chose to implement the waiver.

The balance of this memorandum discusses these financial and coverage estimates—and their limitations—in greater detail.

Description of Key Provisions of the American Health Care Act of 2017 (AHCA)

The following is a list of the key AHCA provisions that were considered by the Office of the Actuary in estimating the impacts on costs and coverage:

- Beginning in 2020, repeal the Medicaid expansion (while allowing those already enrolled prior to 2020 to remain enrolled at the higher Federal matching rates and providing States the option to cover adults at the regular Federal matching rate), and allocate States per capita amounts to be used in the provision of medical assistance. Other changes to the Medicaid program include eliminating disproportionate share hospital (DSH) reductions, providing safety-net funding for non-expansion States under certain conditions, providing incentives for increased frequency of eligibility redeterminations, reducing retroactive eligibility periods, and permitting States to apply a work requirement for non-disabled, non-elderly, and non-pregnant adults.

- Eliminate the penalties charged to individuals and employers for not having or offering health insurance coverage, effective retroactively to December 2015.

- Beginning in 2020, eliminate the advanced premium tax credits (APTCs) and cost-sharing reduction subsidies (CSRs) available under current law for those purchasing coverage in the individual market, and provide a refundable tax credit based on the age of the enrollee who is purchasing coverage in the individual market.

- For insurance coverage offered on the individual market: (i) implement a 30-percent penalty on premiums beginning in 2019 for enrollees who did not maintain continuous coverage for more than 63 days over the prior year; (ii) change the permissible age variation in premiums to 5-to-1 beginning in 2018; and (iii) remove the requirement beginning in 2020 that plans must offer coverage of at least 60 percent of the cost of covered benefits.

- States may apply for a waiver from some current-law requirements, such as regarding age rating, Essential Health Benefits (EHBs), and community rating, as early as 2018.

- For 2018 to 2026, appropriate funds for grants to the Patient and State Stability Fund (PSSF) that States can use in a variety of ways in regulating their individual health insurance markets, including funds dedicated to be used for maternity and mental health, high-cost enrollees, and enrollees with pre-existing conditions.

- Delay the effective date of the excise tax on high-cost employer-sponsored insurance to 2026; repeal the fees on prescription medicines, medical devices, and health insurance beginning in 2017; repeal the elimination of the deduction for expenses allocable to the

Medicare Part D subsidy in 2017[2]; and repeal the Hospital Insurance (HI) tax on high-income earners beginning in 2023.[3,4]

The Estimated Effects on Federal Expenditures

Exhibit 1 presents the financial impacts of selected AHCA provisions[5] on the Federal Budget in fiscal years 2017-2026.[6] The baseline estimates for Federal spending are from the President's Fiscal Year 2018 Budget, which was released on May 23, 2017. (See Appendix A for more information on data, methods, and assumptions.) Because provisions of the AHCA start at various times and we assume transition effects over several years before full implementation of all AHCA provisions, the cost estimates shown in this memorandum do not represent a full 10-year cost for the new legislation.

We estimate that Federal expenditures would decrease by a net total of $328 billion during this period as a result of the selected AHCA provisions. The following is a brief description of the main provisions of the AHCA that affect Federal Budget expenditures:

- −$160 billion in Federal subsidies for those purchasing coverage in the individual insurance market. This amount reflects the net effect of spending reductions associated with the APTCs and CSRs in current law and spending increases associated with the refundable tax credit under the AHCA.

- +$135 billion in expenditures associated with the PSSF.

- −$42 billion in expenditures for the elimination of the Basic Health Program (BHP).

- +$121 billion increase in Federal Medicare expenditures or reduction in Federal Medicare revenues associated with the repeal of the (i) elimination of the deduction for expenses allocable to the Medicare Part D subsidy; (ii) additional Medicare tax on high-income earners; (iii) fee on prescription medications; and (iv) health insurance fee. This amount also includes the impact on DSH spending under Medicare Part A. (See Appendix B for detailed line-by-line estimates.)

[2] In this memorandum, the effects of these provisions are reflected in the Federal expenditure estimates on Medicare and Medicaid where applicable, but the revenue impacts from these provisions are not reflected. The provisions' impacts on coverage and national health spending are also reflected, where applicable.
[3] In this memorandum, the provision is estimated to reduce revenue for the Medicare program but does not affect coverage or national health spending.
[4] The impacts of all other tax provisions on Federal revenues are excluded from these estimates.
[5] Except where noted, we have not estimated the impact of the various tax and fee provisions or the impact on income and payroll taxes due to economic effects of the legislation. Similarly, the impact on Federal administrative expenses is excluded.
[6] While the current Budget estimates are based on fiscal years 2018-2027, the estimates shown in this memorandum are for fiscal years 2017-2026 because these years constitute the Budget period that was in place when the legislation was being drafted.

- −$383 billion in Federal Medicaid expenditures associated with the repeal of the Medicaid expansion and the implementation of the per capita allotment, as well as other Medicaid provisions. (See Appendix B for detailed line-by-line estimates.)

Exhibit 1—Estimated Federal Costs (+) or Savings (−) under Selected Provisions of the American Health Care Act of 2017

(In billions)

	Fiscal year										
Provisions	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-26
Total[1]	0.0	$1.6	$0.8	−$8.2	−$28.8	−$43.1	−$48.9	−$55.4	−$65.1	−$81.1	−$328.2
Individual market subsidies	0.0	−10.8	−14.1	−14.2	−15.2	−16.3	−18.5	−21.3	−23.5	−25.8	−159.6
Advanced premium tax credits	0.0	−10.8	−14.1	−37.8	−48.3	−51.2	−54.2	−57.2	−60.4	−63.8	−397.8
Cost-sharing reduction subsidies	0.0	0.0	0.0	−5.7	−8.0	−8.5	−9.0	−9.5	−10.0	−10.6	−61.3
Refundable tax credits	0.0	0.0	0.0	29.2	41.1	43.4	44.7	45.4	47.0	48.6	299.5
Patient and State Stability Fund[2]	0.0	13.5	18.0	17.2	16.9	17.0	16.4	12.8	11.7	11.7	135.1
Basic Health Program	0.0	0.0	0.0	−3.8	−5.4	−5.8	−6.1	−6.5	−6.9	−7.3	−41.7
Medicare[3]	0.0	1.2	1.7	5.3	7.4	8.5	17.0	25.1	26.7	28.3	121.1
Medicaid	0.0	−2.3	−4.9	−12.6	−32.5	−46.6	−57.7	−65.4	−73.1	−88.1	−383.2
Repeal of expansion	0.0	0.0	0.0	−7.3	−24.1	−38.3	−44.8	−49.6	−52.8	−58.0	−274.8
Per capita allotment	0.0	0.0	0.0	−0.4	−4.0	−4.9	−8.6	−11.9	−16.1	−19.1	−64.9
Other Medicaid provisions[4]	0.0	−2.3	−4.9	−5.0	−4.4	−3.4	−4.3	−4.0	−4.2	−11.0	−43.4

[1] Excludes impacts from sections 101-102, 141, 203-210, 212, 215-217, 231, 241, and 251, and excludes Federal administrative costs.
[2] Includes funding to the Patient and State Stability Fund, including the funding that can be used for maternity, mental health, or substance abuse disorders, as well as Federal funding for (i) the Federal Invisible Risk-Sharing Program and (ii) States that obtain community rating waivers.
[3] Includes revenue and spending impacts from sections 211, 213, 221, and 222, along with the impacts on Medicare Part A DSH spending.
[4] Includes revenue and spending impacts from sections 103, 111, 113-117, and 222, along with the impacts from the interaction of sections 112 and 121 with other provisions.

Note: Totals do not necessarily equal the sums of rounded components.

The Estimated Effects on Health Insurance Coverage and Costs

Exhibit 2 summarizes the estimated impacts of the AHCA on insurance coverage during calendar years 2017-2026. The baseline estimates for health insurance coverage and spending are from the National Health Expenditure projections that were released on February 15, 2017 (see Appendix A).[7] The impact on insurance coverage reflects the net effect of several major AHCA provisions, most notably the repeal of the Medicaid expansion, the elimination of the individual and employer mandates, changes to the tax credits associated with individually purchased insurance, and funding associated with the PSSF.

In 2018 and 2019, under current law, the number of uninsured is projected to amount to roughly 27 million. Under the AHCA, we estimate that the number of uninsured will increase to 31 million in 2018 and to 32 million in 2019. The additional 4-6 million people who would become uninsured in 2018 and 2019 reflect the net impact of two main factors: (i) the repeal of the individual mandate, leading to a reduction of about 2 million with individually purchased coverage and a reduction of 1-2 million with employer-sponsored coverage; and (ii) a reduction of roughly 1 million with Medicaid coverage, which is associated with more frequent eligibility redeterminations, the repeal of retroactive eligibility, and optional State work requirements for adults.

[7] The estimates of health insurance coverage in the National Health Expenditure Accounts are consistent with the survey definitions upon which the estimates are based. The main data sources for private insurance coverage are the Current Population Survey, the National Health Interview Survey, and the Medical Expenditure Panel Survey—Household Component. The Medicare and Medicaid coverage and spending estimates discussed in this section do not reflect the updated Budget baseline released in May 2017.

Exhibit 2—Estimated Effect of the American Health Care Act of 2017 on Enrollment by Insurance Coverage
(In millions)

	Calendar year									
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Current Law										
Medicaid	72.4	73.6	74.8	75.9	76.8	77.7	78.5	79.2	79.9	80.6
Employer-sponsored	175.5	176.6	177.4	178.3	179.2	179.9	180.6	181.2	181.7	182.1
Individually purchased[1]	16.9	17.0	17.0	17.0	17.1	17.0	16.9	16.8	16.6	16.5
Uninsured	27.2	26.9	26.8	26.8	26.9	27.3	28.0	28.9	29.8	30.8
Insured share of population[2]	91.7%	91.8%	91.9%	92.0%	92.1%	92.0%	91.9%	91.7%	91.5%	91.3%
Proposed Law										
Medicaid	72.4	72.5	73.4	71.7	71.1	71.0	71.2	71.6	72.0	72.6
Employer-sponsored	175.5	175.5	175.4	176.1	176.6	176.8	177.5	178.1	178.6	178.8
Individually purchased[1]	16.9	14.8	14.9	15.3	15.5	15.8	15.6	15.3	15.3	15.2
Uninsured	27.2	31.3	32.3	34.9	36.7	38.5	39.7	41.1	42.1	43.4
Insured share of population[2]	91.7%	90.4%	90.2%	89.6%	89.2%	88.7%	88.5%	88.2%	88.0%	87.7%
Difference										
Medicaid	—	−1.2	−1.4	−4.2	−5.7	−6.7	−7.3	−7.7	−7.9	−8.0
Employer-sponsored	—	−1.1	−2.0	−2.2	−2.5	−3.2	−3.1	−3.1	−3.1	−3.3
Individually purchased[1]	—	−2.2	−2.1	−1.8	−1.6	−1.2	−1.2	−1.4	−1.4	−1.3
Uninsured	—	4.4	5.5	8.2	9.8	11.1	11.7	12.2	12.3	12.6
Insured share of population[2]	—	−1.4%	−1.7%	−2.4%	−2.9%	−3.3%	−3.4%	−3.5%	−3.5%	−3.6%

[1] Includes directly purchased insurance plans from the Health Insurance Marketplace, non-Marketplace Affordable Care Act (ACA)-compliant plans, non-Marketplace non-ACA-compliant plans, and unknown. Excludes Medigap.

[2] Represents those insured relative to the total population. Includes individuals who are not summarized above, such as those with exclusive health coverage from Medicare, the Department of Veterans Affairs, or the Department of Defense.

Note: Totals do not necessarily equal the sums of rounded components.

Beginning in 2020 and extending through the end of the projection period (2026), significant changes to the Medicaid program and the individual insurance market are expected to affect health insurance coverage in the U.S. For Medicaid, the change in eligibility for adults under the AHCA relative to current law is anticipated to reduce the number of Medicaid enrollees by roughly 4 million in 2020 and by 8 million by 2026. For employer-sponsored insurance, the continued impacts regarding the choice of employers to offer coverage and the choice of employees to take coverage result in 3 million fewer people with such insurance by 2026. Enrollment in the individual insurance market reflects the combination of (i) changes to the tax credits available to those eligible to purchase coverage; (ii) incentives to stay enrolled continuously; and (iii) the effects of the PSSF. Additionally, some who lose Medicaid or employer-sponsored insurance are estimated to purchase individual insurance. We anticipate that, in 2020, these factors will reduce enrollment in individually purchased coverage by roughly 2 million relative to current law and that, over the period 2021-2026, approximately 1-2 million fewer individuals will be covered through individually purchased insurance.

Taken together, we estimate that there will be 35 million uninsured in 2020 under the AHCA, a figure that is about 8 million higher than under current law. By calendar year 2026, the number of uninsured is estimated to increase from 31 million under current law to more than 43 million under the AHCA, an increase of roughly 13 million. The percentage of the U.S. population with health insurance coverage is estimated to decrease from 91.3 percent under current law in 2026 to 87.7 percent under the AHCA.

Medicaid

As shown in Exhibit 3, enrollment in Medicaid is estimated to decline by slightly more than 1 million due to the AHCA in 2018 and 2019. This decrease is a function of enrollees losing coverage as a result of more frequent eligibility redeterminations, the repeal of retroactive eligibility, and optional State work requirements for adults. Of those approximately 1 million who are estimated to lose coverage, less than half are newly eligible adults. The AHCA would also eliminate DSH reductions scheduled for 2018 through 2025 and provide safety-net funding for non-expansion States under certain conditions.

Under the AHCA, beginning in 2020, the expansion of Medicaid eligibility to adults at or below 138 percent of the Federal poverty level (FPL) is repealed, though the current cohort of newly eligible adults can retain coverage at the higher Federal Matching Assistance Percentage (FMAP). As a result, enrollment among newly eligible adults is estimated to decrease by nearly 12 million by 2026, at which time we project that about 2 million would remain in the grandfathered newly eligible adult group and receive the higher Federal matching rate. Under the current-law baseline, under which eligibility is based on 138 percent of the FPL, we had assumed that the proportion of the eligible population living in States that expanded eligibility would remain at the current level of 55 percent. Under the AHCA, we assume that, of the 55 percent of persons residing in expansion States, only 10 percent would ultimately reside in States that maintain that eligibility criterion. For the remaining 90 percent of the currently eligible adult population who reside in current expansion States, we assume that 30 percent would ultimately reside in States where eligibility would fall to 100 percent of the FPL and that the remaining 60 percent would ultimately reside in States where the eligibility would fall to 50 percent of the FPL. In States that have not previously expanded eligibility (which account for 45 percent of persons who would be potentially eligible under the expansion), we assume no changes in eligibility.

We estimate that of the 12 million persons who would no longer be covered as newly eligible adults in 2026, roughly 6 million would still be covered by Medicaid as States elect to insure these adults at different levels of the FPL and at a different Federal matching rate. Combining this 6-million increase with a 2-million reduction in other Medicaid enrollees due to other AHCA provisions, we estimate a net increase of nearly 4 million other Medicaid enrollees in 2026. For those Medicaid enrollees who would lose coverage under the AHCA, most are assumed to ultimately be uninsured, though a small fraction would choose to purchase individual insurance.

Exhibit 3—Estimated Effect of the American Health Care Act of 2017 on Medicaid Spending (Federal and State) and Enrollment

	Calendar year								
	2018	2019	2020	2021	2022	2023	2024	2025	2026
Current Law									
Total Medicaid ($billions)	$621.8	$658.1	$696.7	$737.1	$779.7	$824.9	$873.2	$929.0	$988.4
Newly eligible adults[1]	$77.7	$82.7	$87.9	$93.3	$98.9	$104.6	$110.7	$117.0	$123.8
All other enrollees	$526.2	$558.5	$592.9	$629.1	$667.2	$707.7	$750.6	$796.7	$840.1
Disproportionate share hospital	$17.9	$16.9	$15.8	$14.7	$13.6	$12.5	$11.9	$15.3	$24.5
Enrollment (millions)	73.6	74.8	75.9	76.8	77.7	78.5	79.2	79.9	80.6
Newly eligible adults[1]	12.7	12.9	13.0	13.2	13.3	13.4	13.4	13.5	13.6
All other enrollees	60.9	61.9	62.9	63.6	64.4	65.1	65.8	66.4	67.0
Per enrollee[2]	$8,443	$8,797	$9,179	$9,592	$10,033	$10,509	$11,022	$11,627	$12,265
Newly eligible adults[1]	$6,118	$6,411	$6,762	$7,068	$7,436	$7,806	$8,261	$8,667	$9,103
All other enrollees	$8,634	$9,021	$9,427	$9,884	$10,358	$10,872	$11,404	$11,998	$12,542
Proposed Law									
Total Medicaid ($billions)	$617.1	$648.8	$676.6	$699.6	$730.2	$763.3	$802.2	$844.1	$883.9
Newly eligible adults[1]	$74.9	$78.6	$62.0	$40.6	$28.3	$21.3	$17.6	$15.4	$14.3
All other enrollees	$522.2	$549.6	$593.6	$637.5	$679.9	$719.5	$761.2	$804.7	$845.2
Disproportionate share hospital	$20.1	$20.5	$21.0	$21.5	$22.0	$22.5	$23.4	$24.0	$24.5
Enrollment (millions)	72.5	73.4	71.7	71.1	71.0	71.2	71.6	72.0	72.6
Newly eligible adults[1]	12.3	12.3	8.6	5.6	3.8	2.8	2.2	2.0	1.8
All other enrollees	60.2	61.2	63.1	65.5	67.2	68.3	69.3	70.0	70.7
Per enrollee[2]	$8,515	$8,834	$9,434	$9,834	$10,287	$10,723	$11,212	$11,717	$12,179
Newly eligible adults[1]	$6,106	$6,400	$7,186	$7,233	$7,447	$7,501	$7,848	$7,739	$7,761
All other enrollees	$8,673	$8,988	$9,408	$9,729	$10,120	$10,528	$10,983	$11,488	$11,948
Difference									
Total Medicaid ($billions)	−$4.6	−$9.4	−$20.1	−$37.6	−$49.5	−$61.5	−$71.0	−$85.0	−$104.5
Newly eligible adults[1]	−$2.8	−$4.1	−$25.9	−$52.7	−$70.6	−$83.3	−$93.1	−$101.6	−$109.5
All other enrollees	−$4.0	−$8.9	$0.7	$8.4	$12.7	$11.8	$10.6	$8.0	$5.0
Disproportionate share hospital	$2.2	$3.6	$5.2	$6.7	$8.4	$10.0	$11.6	$8.6	$0.0
Enrollment (millions)	−1.2	−1.4	−4.2	−5.7	−6.7	−7.3	−7.7	−7.9	−8.0
Newly eligible adults[1]	−0.4	−0.6	−4.4	−7.6	−9.5	−10.6	−11.2	−11.5	−11.8
All other enrollees	−0.7	−0.8	0.2	1.9	2.8	3.2	3.5	3.6	3.8
Per enrollee[2]	$73	$38	$254	$242	$254	$214	$190	$90	−$86
Newly eligible adults[1]	−$12	−$11	$424	$164	$11	−$305	−$413	−$928	−$1,342
All other enrollees	$39	−$33	−$19	−$155	−$238	−$344	−$421	−$510	−$594

[1] Adults with incomes up to 138 percent of the FPL who were made eligible by the ACA and at the higher FMAP.

[2] The per enrollee costs do not include disproportionate share hospital spending.

Note: Totals do not necessarily equal the sums of rounded components.

States would receive payments based on per capita allotments for most populations and services beginning in 2020. Under the AHCA, the per enrollee caps grow by the medical component of the Consumer Price Index (M-CPI) plus 1 percentage point for the aged and disabled, and by the M-CPI for children, adults, and new adults.[8] States would have the option to cover non-aged, non-disabled adults or non-aged, non-disabled adults and children in a block grant program or under the per enrollee cap system. The block grant amount would increase by the CPI and would not change based on the number of enrollees. All States are assumed to choose to operate within the per capita caps, for which average spending growth is projected to be roughly 0.5 percent per year lower than under current law; we assume that no States would choose to work under block grants, since the rates of annual growth are lower relative to the caps and States would assume additional risk (particularly if enrollment were to grow faster than anticipated). There is no estimated impact on Medicaid enrollment because of the presence of the per capita allotments.

By 2026, overall spending on Medicaid is estimated to be about $105 billion, or nearly 11 percent, lower under the AHCA than under current law. About 90 percent of this reduction

[8] As noted later in this memorandum, particularly over the longer range, we have concerns regarding the rates of increase in the caps that are below those experienced historically by the program and that could affect future health care access and quality.

would be in Federal spending, with the remainder a reduction in State spending (see Appendix C). Most of the reduced Medicaid spending is due to a drop in enrollment associated with the repeal of the Medicaid expansion, and the remainder is primarily due to the use of the per enrollee caps on spending.

On a per enrollee basis, we estimate that the AHCA will lower per enrollee Medicaid spending by roughly 1 percent in 2026 relative to current law. Underlying this aggregate result are several differential impacts by eligibility group. Those who remain in the newly eligible group in grandfathered status are assumed to have been more costly than all of the newly eligible group under current law, but this effect is more than outweighed by the impact of the per enrollee caps starting in 2023. As a result, the per enrollee cost for those remaining as newly eligible is estimated to decrease under the AHCA by nearly 15 percent in 2026. For all other Medicaid enrollees, the presence of the caps (along with the shift into this eligibility category of some previously newly eligible enrollees who have lower health spending than average Medicaid enrollees) lowers the per enrollee costs by roughly 5 percent in 2026.

Individually Purchased Insurance

Under the AHCA, there are significant proposed changes to insurance purchased in the individual market—most notably, beginning in 2020, a replacement of the APTC with a refundable premium tax credit that is based on the age of the enrollee and a repeal of the CSRs. In addition, the AHCA would (i) allow for the APTC to be used in 2018 and 2019 to purchase coverage through ACA-compliant plans outside of the Marketplace; (ii) implement a 30-percent penalty on premiums beginning in 2019 for enrollees who did not maintain continuous coverage for more than 63 days over the prior year; (iii) change the permissible age variation in premiums to 5-to-1 beginning in 2018; (iv) allow each State to apply for a waiver, which would allow States to determine the EHBs for plans beginning in 2019, apply greater than a 5-to-1 age rating beginning in 2018, or allow insurers to issue policies that consider health status as a rating factor beginning in 2018; (v) remove the requirement beginning in 2020 that plans must offer coverage of at least 60 percent of the cost of covered benefits; and (vi) appropriate funds to the PSSF from 2018 to 2026 that States could use in a variety of ways in operating their individual health insurance markets.

The PSSF, as defined in this memorandum, is inclusive of all Federal and State funding available to support markets for individual health insurance. There are several funding sources for the PSSF. First, the AHCA specifies annual Federal funding totaling $100 billion during 2018-2026, and States are required to provide matching amounts that increase over this period in order to receive the funding. Second, the Federal Invisible Risk-Sharing Program provides $15 billion over 2018-2026 that can be used by States to provide stability in their individual markets. Third, $15 billion is appropriated in 2020 for States to use for maternity coverage and newborn care and/or for prevention, treatment, or recovery support services for individuals with mental health or substance abuse use disorders. Fourth, $8 billion in funding for the period 2018-2023 is available for States that apply for waivers to provide premium and cost-sharing assistance for enrollees with pre-existing conditions.

For modeling purposes, we assume that the individual market would be viable and stable under both current law and the AHCA. Some AHCA provisions—such as the 30-percent surcharge for

individuals who do not maintain continuous coverage, the addition of the non-ACA compliant plans to the risk pool, and funding associated with the PSSF—could help improve the functioning of the individual market. Other AHCA provisions could worsen the viability and stability, such as the elimination of the individual mandate and the reductions in the value of the tax credits. The estimates included in this memorandum assume a functioning individual market.

It is worth noting, however, that certain waivers could be granted under the AHCA that would result in a deteriorating or possibly failing individual market. Our estimates do not reflect the implementation of waivers that would severely limit the EHB package or allow healthy individuals to be underwritten on an annual basis. If such actions were implemented, we would expect that the individual market in these areas would destabilize such that the premiums for comprehensive coverage for a significant proportion of the population would become unaffordable and the coverage would cease to be offered.

We estimate that the AHCA provisions that would affect 2018 and 2019 would reduce net enrollment in the individual market by about 2 million people, most of whom would move to uninsured status.[9] The key factor causing the enrollment impact is the elimination of the individual mandate; in particular, we expect that younger and healthier individuals would choose to be uninsured and that enrollees would, accordingly, be older and less healthy, on average. By itself, this effect would lead to higher *gross* premiums, higher *net* premiums (after current-law credits are taken into account), and increased cost sharing. However, two key factors work to offset the premium increases in these 2 years: (i) funding available through the PSSF, which we estimate to be used as reinsurance, would reduce average *gross* premiums in 2018 and 2019 under the AHCA compared to current law, as shown in Exhibit 4; and (ii) the APTC in 2018 and 2019 that is tied to an enrollee's income would be unchanged between current law and the AHCA, and as a result *net* premiums would not be materially affected.

Exhibit 4—Estimated Effect of the American Health Care Act of 2017
on Individually Purchased Insurance Premium Rates and Cost-Sharing Amounts
(Dollar amounts per member per month)

	Calendar year								
	2018	2019	2020	2021	2022	2023	2024	2025	2026
Gross Premium									
Current Law	$530	$559	$587	$618	$652	$687	$723	$761	$801
Proposed law	436	465	490	515	542	576	627	661	695
Change	−94	−94	−97	−103	−110	−110	−95	−100	−106
% change	−18%	−17%	−16%	−17%	−17%	−16%	−13%	−13%	−13%
Net Premium									
Current Law	$239	$251	$264	$278	$293	$309	$325	$342	$360
Proposed law	239	252	237	252	269	294	335	357	380
Change	0	1	−27	−26	−24	−15	10	15	19
% change	0%	0%	−10%	−9%	−8%	−5%	3%	4%	5%
Cost-Sharing Amounts									
Current Law	$161	$167	$176	$185	$194	$204	$214	$225	$236
Proposed law	168	174	271	284	298	317	343	361	380
Change	7	8	95	100	104	113	129	136	143
% change	5%	5%	54%	54%	54%	55%	60%	60%	61%

Note: Totals do not necessarily equal the sums of rounded components.

[9] Though it may be difficult for many of the provisions of the AHCA to be implemented for 2018, for purposes of this memorandum we assumed that they would be administered in a way to materially affect the 2018 coverage, premium, and cost-sharing estimates.

The AHCA is estimated to have a more profound impact on enrollment, premiums, and cost sharing in the individual insurance market beginning in 2020. We estimate that, relative to current law, individually purchased insurance coverage would decline relative to current law by roughly 1-2 million over the period 2020-2026, as shown in Exhibit 2. While there is a net decline in individual coverage under the AHCA relative to current law, roughly 1 million who previously had employer-sponsored insurance and about one-half million who previously had Medicaid coverage would be covered in an individually purchased plan.

The 2020-2026 impacts reflect some of the same factors that are anticipated to affect 2018 and 2019 (most notably the removal of the individual mandate and the change in age rating); however, numerous other factors contribute to an individual's decision to purchase insurance coverage on the individual market. The key factor is the expected change in the premium faced by the individual under the AHCA relative to his or her current premium. (See Appendix A for a further description of the modeling approach.) For the estimates presented in this memorandum, we made two additional assumptions that materially affected the results: (i) we assumed that 25 percent of States would apply for waivers regarding community rating and EHBs and that a portion of the PSSF funding would be used to lower the premium for high-risk individuals in these States; and (ii) we assumed that half of the remaining PSSF funding would be targeted to reduce premium costs for those who are lower income, older, and/or determined to be at higher risk and that the other half would be used to reduce premiums for all enrollees.[10] Later in this section we provide a sensitivity analysis of the results on premiums and coverage based on differing assumptions.

In 2020, the average *gross* premium, prior to the refundable premium tax credit, is estimated to be roughly 16 percent, or $97, lower under the AHCA than under current law. As shown in Exhibit 5, three key factors contribute to the lower premium: (i) a lower average generosity of coverage (62 percent actuarial value under the AHCA versus 69 percent under current law); (ii) the impact of States waiving EHBs and community rating; and (iii) the presence of the PSSF. These factors are slightly offset by other factors that increase premiums, primarily a less healthy population on average. For the average *net* premium (that is, the amount that an average individual would pay), we estimate a reduction of 10 percent, or $27, in 2020 as several factors contribute to significant positive and negative impacts. The change in the premium subsidy from an income basis under current law to an age basis under the AHCA and a less healthy population increase the net premium. However, these effects are more than offset by the additional Federal funding available through the PSSF (both for general and targeted use), the waiving of EHBs and community rating, and the lower average actuarial value—all of which decrease net premiums. Finally, the average cost-sharing amount is estimated to increase by 54 percent, or $95, in 2020 because of a lower average generosity of coverage and the elimination of the CSRs.[11]

[10] We assumed that the additional funding to the PSSF for maternity coverage and newborn care and/or for prevention, treatment, or recovery support services for individuals with mental or substance abuse use disorders would be administered through the issuers of insurance, given the complexities of administering payments directly through providers.

[11] Since the current CSRs apply only to those individuals earning less than 250 percent of the FPL, the increase in cost sharing for this group is significantly larger than the average overall increase. For those over 250 percent of the FPL, there is no change in cost sharing due to the elimination of the CSRs.

Exhibit 5—Decomposition of Factors Affecting Individually Purchased Insurance: Gross Premiums, Net Premiums, and Cost Sharing

(Per member per month)

	2020			2026		
	Gross premium	Net premium	Cost sharing	Gross premium	Net premium	Cost sharing
Current Law	$587	$264	$176	$801	$360	$236
% change due to:						
Elimination of cost-sharing reduction subsidy	—	—	21%	—	—	23%
Premium subsidy based on age instead of income	—	38%	—	—	47%	—
Patient and State Stability Fund[1]	−6%	−26%	—	−5%	−24%	—
State option to waive EHBs and community rating[2]	−6%	−12%	—	−4%	−9%	7%
Actuarial value	−11%	−24%	23%	−11%	−24%	23%
Other[3]	5%	14%	10%	7%	16%	8%
Total	**−16%**	**−10%**	**54%**	**−13%**	**5%**	**61%**
Proposed Law	$490	$237	$271	$695	$380	$380

[1] Includes funding from the Patient State and Stability Fund and the Federal Invisible Risk-Sharing Program that is used for reinsurance purposes or non-waiver targeted efforts.

[2] Includes impacts associated with using dedicated funding sources for maternity, mental health, or substance abuse disorders and for States that obtain the community rating waiver, as well as funding as needed from the Patient and State Stability Fund or the Federal Invisible Risk-Sharing Program.

[3] Includes selection effects, impacts of the changing age-mix of enrollees, impacts of individuals who were previously covered by employer-sponsored insurance or Medicaid, elimination of the health insurance tax, and any interaction effects among the other factors.

Note: Totals do not necessarily equal the sums of rounded components.

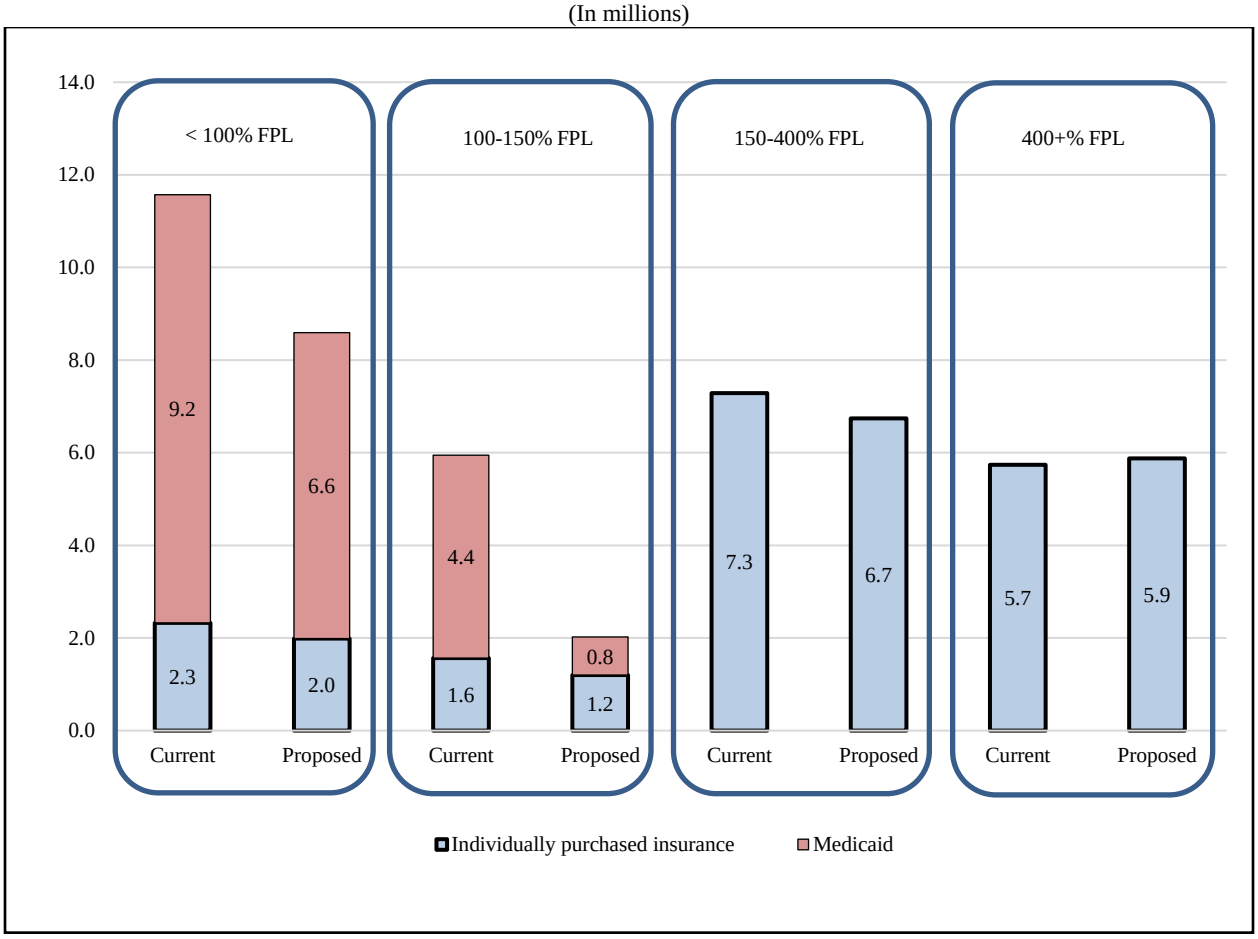
In 2026, an impact similar to that anticipated for 2020 is estimated to occur on the average *gross* premium and cost sharing, and for similar reasons. However, the average *net* premium in 2026 is estimated to increase by 5 percent, or $19, mainly because (i) the age-based premium subsidies (which are indexed to the CPI plus 1 percentage point) do not increase at the same rate as premium costs (the current-law subsidies are indexed to a factor related to increases in premiums and income); and (ii) the $15 billion and $8 billion in funding for maternity and mental health and pre-existing conditions, respectively, are exhausted. These funds are expected to be depleted in 2023, and at that time States are assumed to use portions of their PSSF to compensate for the shortfalls. By 2026 an individual would be anticipated to pay nearly 27 percent more, or $162, in combined monthly premiums and cost sharing under the AHCA relative to current law.

While the results shown in Exhibits 4 and 5 are for an average enrollee in the individual insurance market, the effects vary significantly by the age and income of the individual. As shown in Exhibit 6, for those with incomes less than 100 percent of the FPL and for those between 100 and 150 percent, enrollment in Medicaid expansion and in the individual insurance market is estimated to decrease significantly. For the group under 100 percent of the FPL, roughly 2.6 million people are anticipated to lose Medicaid coverage in 2026, as they would no longer be eligible to enroll given the repeal of the Medicaid expansion. For this same income group, roughly 0.3 million are anticipated to lose individually purchased insurance because of the elimination of the BHP. For the group between 100 and 150 percent of the FPL, the decline in Medicaid expansion enrollment is more significant at 3.6 million in 2026, and 0.4 million people are estimated to lose coverage in the individual market due to the elimination of the BHP, the change from an income-based subsidy to an age-based subsidy, and the elimination of the CSR under the AHCA. The assumption that roughly half of the PSSF would be used for targeted assistance for those at the lower end of the income scale mitigates some of this impact for these income groups.

For those earning between 150 and 400 percent of the FPL, coverage through individually purchased insurance is estimated to decline by about 0.6 million in 2026, primarily because of

the removal of income as a criterion when determining premium subsidies, along with the elimination of the CSR for those under 250 percent of the FPL. Though this is not the case for the other income groups, we estimate slightly higher enrollment in 2026 in individually purchased insurance for those over 400 percent of the FPL. For this group of individuals, who under current law are not eligible for APTCs, the reduction in gross premiums and the age-based tax credit under the AHCA would cause 0.2 million additional individuals to choose coverage.

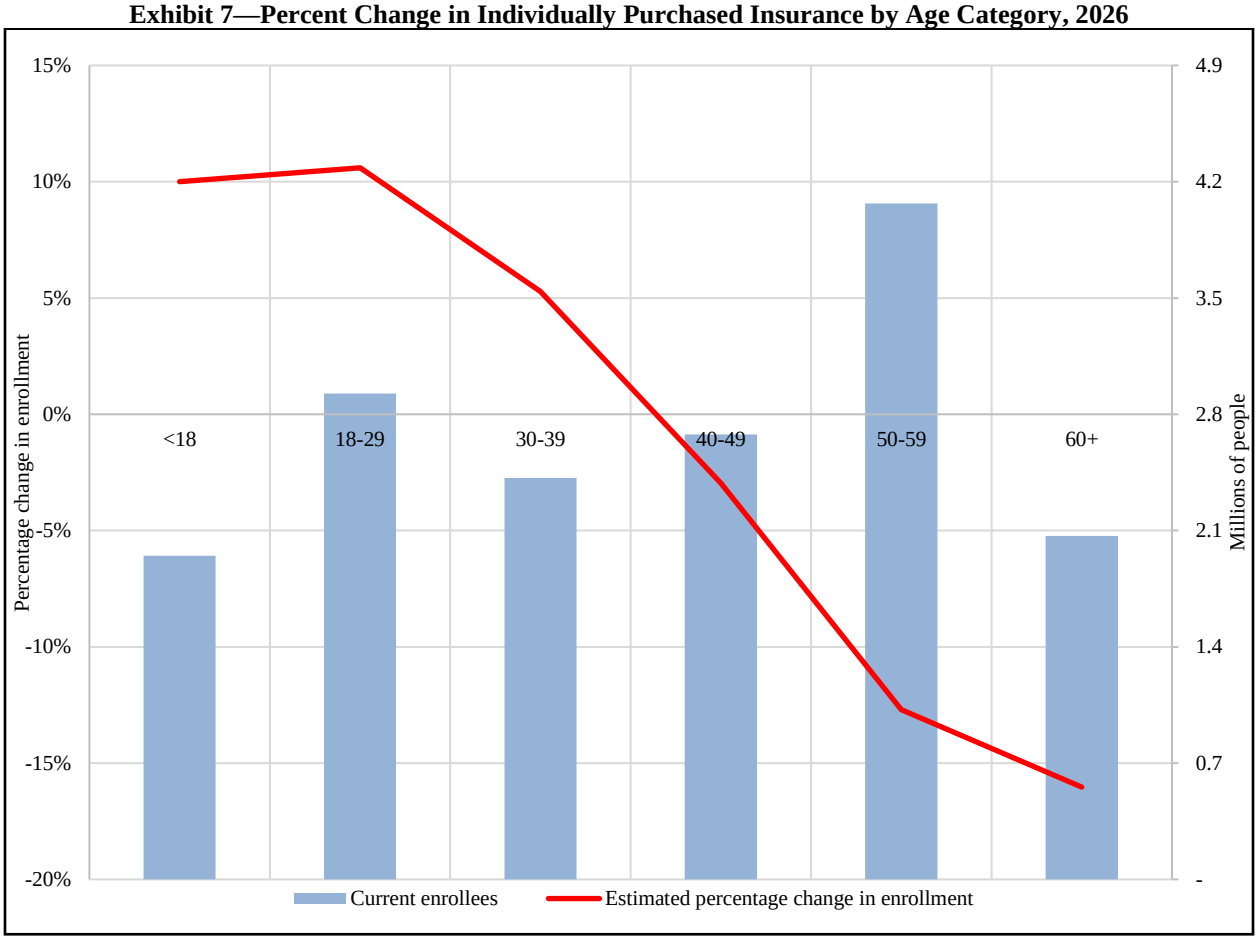
Exhibit 6—Medicaid and Individually Purchased Insurance Enrollment by Income Category, 2026
(In millions)



Note: The Medicaid amounts shown in the exhibit include only the expansion population.

As shown in Exhibit 7, the AHCA provisions that change the age rating from 3-to-1 to 5-to-1, and that base tax credits on age (instead of income) and vary those credits by a ratio of only 2-to-1, have a differential impact on enrollment by age. For those under age 18 or between the ages of 18 and 29, individually purchased insurance enrollment is anticipated to increase in 2026 by roughly 0.5 million, or about 10 percent, as these individuals face lower premiums due to the change in the age rating and as many become eligible to receive a credit based on their age. Those between the ages of 50 and 59 and those aged 60 and over, however, would face higher premiums because of the age rating, and many would receive lower premium credits relative to current law. As a result, we estimate that enrollment in individual insurance would decline for this group by roughly 0.8 million, or about 14 percent. Again, our assumption that approximately half of the PSSF would be used for more targeted assistance for those at older ages mitigates some of this impact.

Exhibit 7—Percent Change in Individually Purchased Insurance by Age Category, 2026



The Basic Health Program (BHP), which is a State-operated program that provides coverage to individuals with incomes up to 200 percent of the FPL who are otherwise eligible for APTCs and CSRs, would also end under the AHCA. Under current law, the Federal Government pays 95 percent of what it would have paid in APTCs and CSRs if these individuals had been enrolled in the Marketplace instead. Currently two States operate BHPs, and ending the program is estimated to reduce Federal spending by roughly $7 billion in 2026 and reduce coverage by about 0.8 million persons. We assume that some individuals would enroll in individually purchased insurance and receive applicable subsidies after losing BHP coverage.

As shown in Exhibit 1, for fiscal years 2017-2026, the AHCA reduces Federal expenditures for APTCs by about $398 billion, for CSRs by about $61 billion, and for BHPs by about $42 billion. Offsetting these reductions, the payments for AHCA refundable tax credits for the same time period increase Federal costs by approximately $300 billion. When including the $135-billion PSSF funding for individually purchased plans, the overall impact for fiscal years 2017-2026 is a savings of about $66 billion.

To determine the range of possible impacts on our estimates, we conducted a sensitivity analysis on the assumptions related to the use of the PSSF funding and whether States would apply for waivers for EHBs and community rating. For the PSSF, as stated previously, we had generally assumed that half of the funding would be targeted towards lower income or older individuals

and that the remainder would be used to reduce premiums for everyone in the market. If, instead, all of the funding were used to buy down premiums, gross premiums would be reduced by another 5 percent in 2026. Since the total PSSF funding is unchanged, the average net premium would be largely unchanged, but the impacts by income and age would be more extreme than those shown in Exhibits 6 and 7. Because of the more dramatic net premium changes, enrollment in the individual market would be expected to fall by an additional one-half million in 2026. Conversely, if all of the PSSF funding were targeted to lower income or older individuals, gross premiums would be about 5 percent higher in 2026, but the net premium impacts by income and age would be less severe, resulting in greater enrollment and fewer uninsured in 2026 than shown throughout this memorandum.

For the decision by States regarding whether to waive the requirements of EHBs or community rating, the estimates presented in this memorandum assume that 25 percent of States would choose to do so. However, if we had assumed that no States had done so, the $8 billion in funding for States waiving the community rating requirement would not be required. In addition, premium rates would be about 4 percent higher, and enrollment would decrease slightly, in 2026. If every State were assumed to waive these requirements, the $8 billion would represent only a small portion of the funding necessary to pay benefits for individuals with pre-existing conditions who did not maintain continuous coverage. We assume that amounts needed in excess of the $8 billion to cover the costs of these individuals would be drawn from the other PSSF allotments. As a result, the large premium reduction resulting from removing these high-cost individuals is largely offset by the reduced PSSF funds available to buy down the premium. Overall, we estimate that gross premiums would be about 3 percent lower if every State had waived these requirements and that individually purchased enrollment would be slightly further reduced in 2026.

Medicare

The AHCA affects Medicare spending and Medicare financing (see Appendix B and Exhibit 1) but does not have an impact on Medicare coverage. Several of the key provisions affecting Medicare are related to revenue provisions, most notably the repeal of the additional Medicare tax on high-income earners, the repeal of the health insurance tax, the repeal of the tax on prescription medications, and the repeal of the elimination of the deduction for expenses allocable to the Medicare Part D subsidy. Additionally, the expected increase in the number of uninsured under the AHCA relative to current law is anticipated to result in increased Medicare DSH payments. Together, the provisions are anticipated to increase Federal spending on Medicare or reduce Federal Medicare revenues by roughly $121 billion over fiscal years 2017-2026.

Under budget accounting rules, Medicare contributes to higher Federal spending under the AHCA as a result of the higher costs and lower tax revenues; this increase is more than offset by lower Federal spending in other areas under the AHCA. However, trust fund accounting considers the same higher expenditures and lower revenues as affecting the exhaustion date and the actuarial balance of the HI trust fund. Based on the AHCA estimates presented in this memorandum, the assets of the HI trust fund would be exhausted in 2026 compared to 2028 under current law—earlier by 2 years. In addition, the HI actuarial deficit is estimated to increase

from 0.73 percent under current law to 1.18 percent under the AHCA,[12] primarily due to the loss of revenue from the repeal of the additional Medicare tax on high-income earners and additional Medicare DSH spending.

Employer-Sponsored Insurance

The two major AHCA provisions that affect enrollment in employer-sponsored insurance are (i) the elimination of the requirement that individuals purchase insurance or face a tax penalty and (ii) the requirement that employers offer insurance or face a required contribution (with some exceptions). As shown in Exhibit 8, we estimate that by 2026 about 3 million fewer people will have employer-sponsored coverage under the AHCA than under current law. Roughly half would choose not to enroll given the elimination of the individual mandate, and the remaining individuals would no longer be offered coverage due to the elimination of the employer mandate. For those losing an employer offer, they are anticipated to be disproportionately younger and to earn less income. We anticipate that slightly more than 1 million of the 3 million losing employer-sponsored insurance will ultimately obtain insurance through the individual insurance market.

The delay of the implementation of the excise tax on high-cost employer-sponsored insurance from 2020 to 2026 has a negligible effect on employer-sponsored insurance enrollment over this period but is anticipated to slightly increase spending on such insurance. This result occurs as the generosity of employer plans, and in turn the premiums, are not reduced in order to avoid the impacts of the tax. Under current law, over the years 2020-2025, we estimated that premiums would be lowered (and out-of-pocket costs raised) given the incentives of the tax; under the AHCA, these incentives are not in place over this period, and, accordingly, these behavioral changes are not estimated to occur until 2026. Finally, the elimination of the health insurance tax and of the fees on prescription medicines and medical devices is the major reason that employer-sponsored insurance spending per enrollee is lower by about 1 percent in 2026 relative to current law.

Exhibit 8—Estimated Effect of the American Health Care Act of 2017 on Employer-Sponsored Insurance (ESI)

	Calendar year									
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Current Law										
ESI spending ($billions)	$1,065	$1,127	$1,190	$1,247	$1,311	$1,379	$1,449	$1,522	$1,596	$1,673
ESI enrollment (millions)	176	177	177	178	179	180	181	181	182	182
ESI per enrollee	$6,071	$6,384	$6,712	$6,994	$7,318	$7,663	$8,023	$8,402	$8,786	$9,188
Proposed Law										
ESI spending ($billions)	$1,065	$1,111	$1,168	$1,221	$1,282	$1,343	$1,412	$1,483	$1,555	$1,630
ESI enrollment (millions)	176	175	175	176	177	177	177	178	179	179
ESI per enrollee	$6,068	$6,332	$6,659	$6,936	$7,257	$7,598	$7,953	$8,327	$8,707	$9,116
Difference										
ESI spending ($billions)	−$0	−$16	−$22	−$26	−$29	−$36	−$38	−$40	−$41	−$43
ESI enrollment (millions)	—	−1	−2	−2	−3	−3	−3	−3	−3	−3
ESI per enrollee	−$2	−$52	−$53	−$58	−$62	−$66	−$70	−$75	−$79	−$72

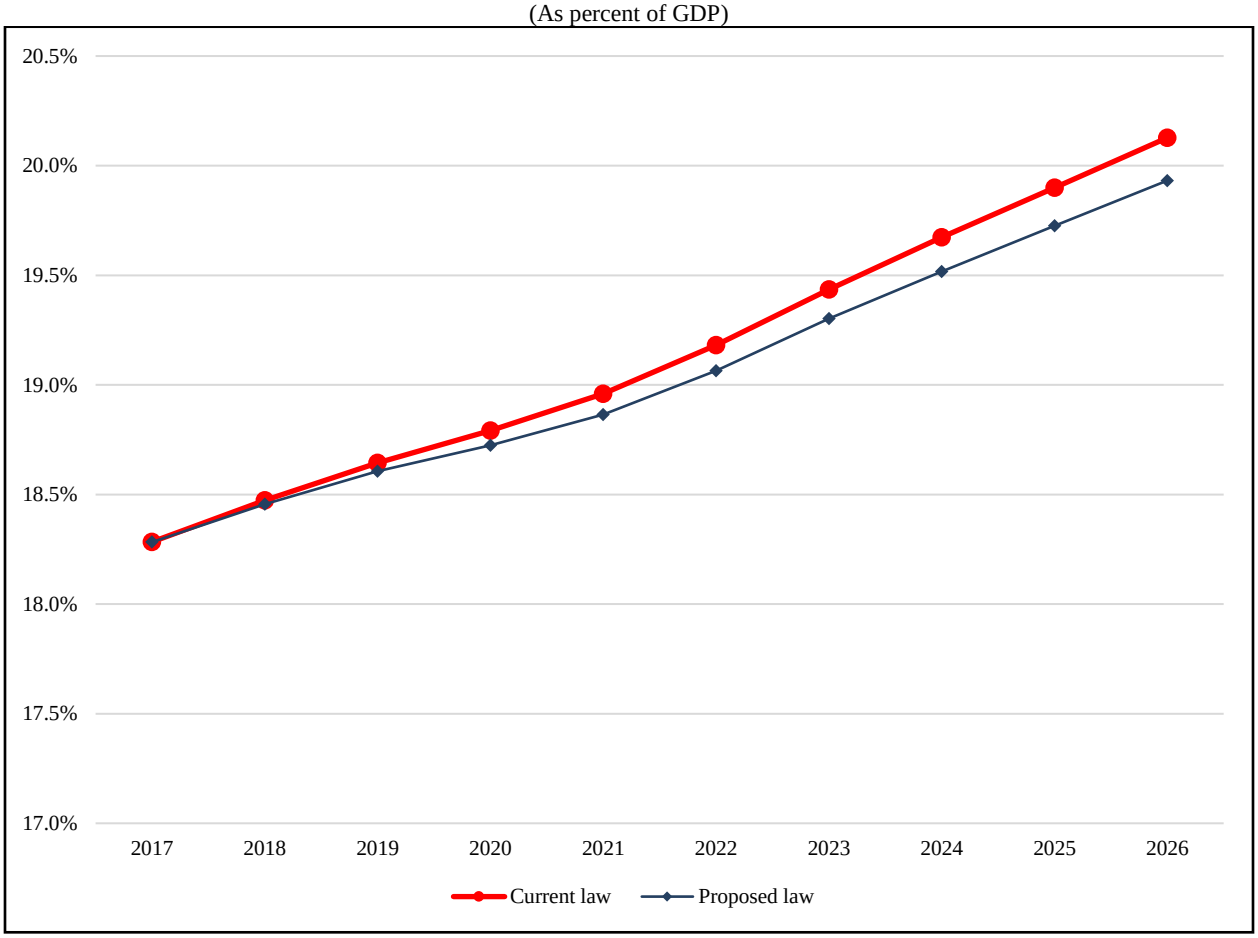
Note: Totals do not necessarily equal the sums of rounded components.

[12] These estimates were developed based on the 2016 Medicare Trustees Report, known formally as *The 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

The Estimated Effects on National Health Expenditures

We estimate that overall National Health Expenditures under the AHCA would decrease by a total of $258 billion (0.6 percent) during calendar years 2017-2026 relative to current law (see Appendix C). As shown in Exhibit 9, as a share of the Gross Domestic Product (GDP), National Health Expenditures are anticipated to account for 19.9 percent in 2026, 0.2 percentage point lower than under current law.

Exhibit 9—Estimated Effect of the American Health Care Act of 2017 on National Health Expenditures
(As percent of GDP)



The major effect on National Health Expenditures is the reduction in the number of people with insurance coverage, along with the associated impact that this status has on their utilization of health care services. The major provisions that lower health care spending are the repeal of the Medicaid expansion, the changes in the tax credits for those who purchase coverage in the individual market, and reductions in employer-sponsored health coverage due mainly to the elimination of the individual and employer mandates. As fewer people have insurance coverage, a greater proportion of health care spending is estimated to be paid for out-of-pocket and through other private and public sources that are used to assist in paying for care for the uninsured.

Out-of-pocket spending is projected to be $221 billion higher under the AHCA than under current law, principally reflecting the net impact of (i) higher spending from more people without health

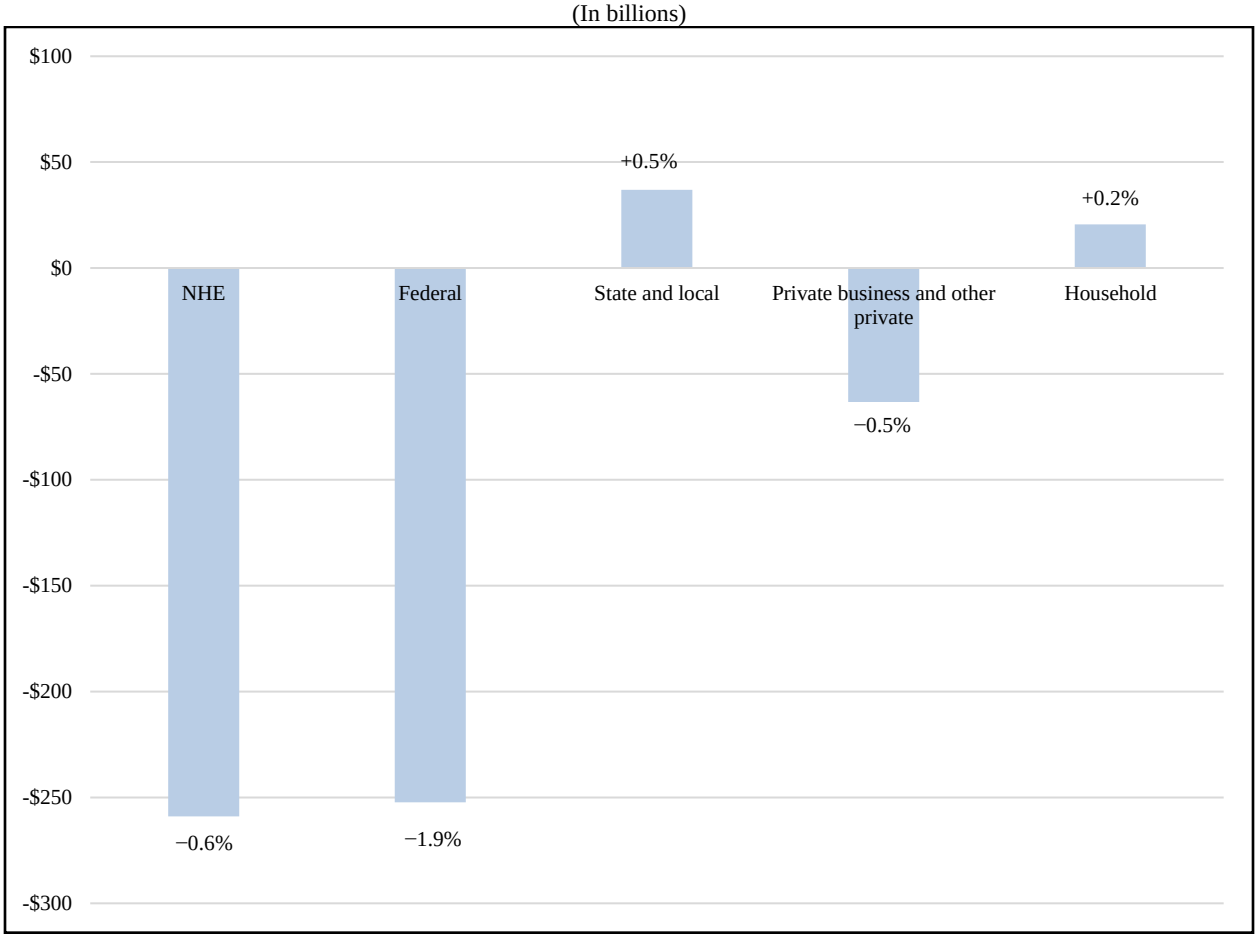
insurance, the elimination of the CSRs, and a reduction in the generosity (actuarial value) of coverage for those with individually purchased insurance; and (ii) lower spending due in large part to the delay in the implementation of the excise tax on employer-sponsored insurance.

By 2026, under the AHCA, the amount of health spending sponsored by households, private businesses, and governments is anticipated to change relative to current law.[13] As shown in Exhibit 10, Federal Government financing of overall National Health Expenditures is expected to decrease by 1.9 percent during the period 2017-2026, mainly because of lower Medicaid spending as well as fewer payments that help subsidize coverage in the individual market. Private businesses and other private programs are estimated to have a roughly 0.5-percent reduction in spending over 2017-2026, mostly due to lower employer-sponsored insurance spending.

The other two major sponsors of health care—households and State governments—are anticipated to experience higher spending. Households are projected to increase their spending by approximately 0.2 percent, or $21 billion, over the years 2017-2026. This relatively small increase reflects the net effect of two large changes that nearly offset. As explained previously, out-of-pocket spending by households is anticipated to increase by $221 billion over the period, primarily due to the elimination of the CSR that mainly affects low-income individuals, a lower actuarial value for individual insurance plans, and more uninsured individuals relative to current law. On the other hand, household spending is estimated to decline by about $200 billion as a result of the elimination of the additional Medicare tax on high-income earners, loss of employer-sponsored insurance, and the elimination of the health insurance tax. State and local governments are projected to spend an additional 0.5 percent over this period, as required contributions to the PSSF, along with payments by other State programs for increased spending by the uninsured, are only partially offset by reduced spending on Medicaid.

[13] In the National Health Expenditure Accounts, spending by sponsor category indicates who is financing the care, as opposed to who is providing coverage or providing the service. More information on sponsor definitions can be found in Appendix A and at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/DSM-15.pdf.

Exhibit 10—Estimated Effect of the American Health Care Act of 2017 on Sponsors of National Health Expenditures, 2017-2026
(In billions)



Caveats and Limitations of Estimates

The Federal costs and savings, changes in health insurance coverage, and effects on total National Health Expenditures presented in this memorandum represent the Office of the Actuary's best estimates. Although we believe that these estimates are reasonable and fairly portray the likely future effects of this comprehensive package of health care reforms, they are subject to much greater uncertainty than a typical estimate. The following caveats should be noted, and the estimates should be interpreted cautiously in view of their limitations.

- These financial and coverage impacts are based on the provisions of the American Health Care Act of 2017 as passed by the House on May 4, 2017.

- The behavioral responses to changes introduced by national health reform legislation are impossible to predict with certainty. In particular, the responses of individuals, employers, insurance companies, and States could differ significantly from the assumptions underlying the estimates presented here.

- The nominal dollar amounts of costs and savings under national health reform are sensitive to the assumed trajectory of future health cost trends. Relative measures, such as the cost as a percentage of GDP, are less sensitive.

- Due to the very substantial challenges inherent in modeling national health reform legislation, these estimates could vary from those of other experts and agencies, and future costs and coverage effects could lie outside of the range of estimates provided by the various estimators.

- Certain Federal costs and savings not included in the estimates are outside of the scope of the Office of the Actuary's expertise and could be prepared by other agencies. In particular, we did not include any Federal savings pertaining to the delay of the excise tax on high-cost employer-sponsored health insurance coverage and the repeal of the fees on prescription medicines or insurance plans, the excise tax on devices, and other non-Medicare revenue provisions of the AHCA, as those estimates are typically prepared by the Department of the Treasury. (In contrast, any impacts of these provisions on National Health Expenditures are reflected.) Similarly, Federal administrative expenses associated with the AHCA are not included here.

- These estimates make an assumption about how States would, if applicable, use funding associated with the PSSF and any other Federal funding appropriated to be used in operating a State's individual insurance market. However, there is significant uncertainty regarding how States would actually proceed, ranging from fully using the funding for reinsurance purposes to fully using the funding to target specific populations (their premiums and/or their out-of-pocket or cost-sharing requirements). The estimates highlighted in this memorandum assume only one of many possible paths.

- While the estimates included in this memorandum extend only through 2026, the reforms under the AHCA will have impacts beyond that date. One notable issue is that the refundable tax credits available to those who are eligible and purchase individual insurance are indexed to the CPI plus 1 percentage point, whereas health insurance premiums are anticipated to grow faster than that—a disparity that would make coverage less affordable over the long run. Similarly, the Medicaid per capita allotments are indexed to the M-CPI or M-CPI plus 1 percentage point, while average underlying health care costs are assumed to grow at a comparable or faster rate, and this difference could provide additional pressure on the long-term access to, and quality of, health care for the Medicaid program.

Conclusion

The Office of the Actuary at the Centers for Medicare & Medicaid Services has estimated the effects of selected provisions of the AHCA on Federal outlays, health insurance coverage, individual market premiums and cost sharing, and overall National Health Expenditures. Our estimates are based on available data sources and what we believe to be reasonable assumptions regarding individual, employer, and health plan responses to the legislation, together with analyses of the likely changes in the cost and use of health care services.

It is my opinion that (i) the techniques and methodology used herein to evaluate the impact of the AHCA are based upon sound principles of actuarial practice and are generally accepted within the actuarial profession; and (ii) the principal assumptions used, and the resulting actuarial estimates are, individually and in the aggregate, reasonable for the purpose of evaluating the effects the legislation. I am a member of the American Academy of Actuaries, and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I hope that the information presented in this memorandum will be of value to the public and policy makers as they debate the implications of the American Health Care Act.

Paul Spitalnic, ASA, MAAA
Chief Actuary

APPENDIX A—DATA, ASSUMPTIONS, AND METHODS

The Office of the Actuary at the Centers for Medicare & Medicaid Services developed the estimates for health sector reforms using its health reform model, also referred to as OHRM. In essence, OHRM is an amalgam of various estimation approaches involving Federal programs, employer-sponsored insurance, and individual insurance choice models that ensure consistent estimates of coverage and spending in considering legislative changes to current law. This appendix describes the key data, assumptions, and methods used in developing these estimates.

Baseline Federal Expenditure, Insurance Coverage, National Health Expenditure, and Medicare HI Trust Fund Estimates

The baseline Federal expenditure estimates for Medicaid, Medicare, and the Health Insurance Marketplace are from the President's Fiscal Year 2018 Budget, which extends through fiscal year 2027. The baseline enrollment (including estimates of the uninsured) and National Health Expenditure estimates are consistent with the concepts used in the calendar-year projections for the period 2016-2025, which were published on February 15, 2017.[14] The projections were extended through 2026 using the 2025 growth rates. The baseline estimates on the status of the HI trust fund and the HI actuarial deficit are from the 2016 Medicare Trustees Report.

Estimating Medicaid Impacts

Repeal of Medicaid Expansion

Projected Medicaid expenditures and enrollment for newly eligible adults are based on data from the CMS-64 through fiscal year 2016. Thirty-one States and the District of Columbia have expanded Medicaid eligibility, and under current law we assume that no additional States will expand eligibility in the future. For the estimate of repealing the Medicaid expansion eligibility, we have several key assumptions. Our first assumption is that, starting in 2020, about 25 percent of enrollees would disenroll from the newly eligible adult group every 6 months and that this rate would decline steadily to about 5 percent every 6 months by 2025.

Our second assumption is that States would cover persons who would otherwise be newly eligible adults and would receive the regular Federal matching rate for these enrollees—but, in most States, at lower income levels. Under the current-law baseline, under which eligibility is based on 138 percent of the FPL, we had assumed that the proportion of the eligible population living in States that expanded eligibility remained at the current level of 55 percent. Under the AHCA, we assume that, of the 55 percent of persons residing in expansion States, only 10 percent would ultimately reside in States that maintain that eligibility criterion. For the remaining 90 percent of the currently eligible adult population who reside in current expansion States, we assume that 30 percent would ultimately reside in States where eligibility would fall to 100 percent of the FPL and that the remaining 60 percent would ultimately reside in States where the eligibility would fall to 50 percent of the FPL. We assume no changes in eligibility in States

[14] More information on these projections can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

that have not previously expanded eligibility (which account for 45 percent of persons who would be potentially eligible under the expansion.)

Our third assumption is that the enrollees remaining in the newly eligible adult group would have higher costs than the average of those projected in the group under current law; the costs for those remaining in the newly eligible adult group compared to the average costs of all newly eligible adults under current law are projected to increase and would be about 75 percent higher than under current law by 2026 (excluding the impact of the per enrollee caps).

Per Enrollee Caps

Medicaid expenditures and enrollment are based on expenditure data from the CMS-64 (through fiscal year 2016) and data on expenditures and enrollment by eligibility group from the Medicaid Analytic eXtract (MAX) through 2013. We developed the per enrollee caps by State and by eligibility group based on estimates of 2016 expenditures and enrollment and then projected forward using the change in the medical component of the CPI (M-CPI). The M-CPI was used for children and adults, and the M-CPI plus 1 percentage point was used for the aged and persons with disabilities. The caps are calculated in aggregate by State and compared to projected spending under current law. If projected spending is lower than the cap, we assume no financial impact in that year (and do not assume that the State would increase spending to reach the cap); if projected spending is greater than the cap, we assume that the difference would be savings. We assume that the caps would have no impact on enrollment or eligibility and that States would be able to operate their programs under the caps through 2026 by means of a combination of (i) lower provider reimbursement rates; (ii) managing utilization and program efficiency; and (iii) reducing optional services. (Over a longer time period, it may be more difficult for States to operate their Medicaid programs without making more significant changes to their programs.)

We estimated the impact of the per enrollee caps after considering the impact of the repeal of the Medicaid eligibility expansion.

We assume that no States would elect the block grant option provided under section 121. While States may have greater flexibility in changing their Medicaid programs than they would under the per enrollee caps, the difference in the amount of Federal funds available under the per enrollee caps and the block grants is likely to be significant over time, and, moreover, the block grants do not adjust for changes in enrollment. For the groups that would be subject to the block grants, we estimate that the annual growth rate of Federal Medicaid funds would be lower than the per enrollee cap updates by about 2 to 3 percent per year.

Estimating Employer Behavior

The employer component of OHRM was estimated using employer-sponsored insurance data from the National Health Expenditures and from the 2016 Kaiser Family Foundation and Health Research and Educational Trust (HRET) Employer Health Benefits Survey. The employer-sponsored insurance estimates were developed using baseline assumptions of employer offer and employee take-up rates by firm size and firm characteristics, such as the age and income of the workforce. When reform provisions are anticipated to affect an employer's decision to offer health insurance or an employee's decision to take insurance, OHRM uses historical experience of changes in offer and take-up rates based on specific conditions and requirements to estimate the impact on health care coverage and spending. Using information from the Medical Expenditure Panel Survey—Household Component (MEPS-HC), the employer model results are developed to estimate impacts by the age and income of the worker.

Estimating Individual Insurance Choices

OHRM includes a modeling component that allows for estimates of health reform on enrollment and spending for those in the individual insurance market. The model is based upon the MEPS-HC.[15] The person-level survey data from the MEPS-HC include the following characteristics of the sample population:

- Socio-demographics, including family structure;
- Personal and household income;
- Cost and use of health services by type, and source of payment for those services;
- Types of health insurance coverage; and
- Employment status.

The OHRM database starts with the MEPS-HC data for 2012-2014 (providing roughly 100,000 total observations) and is supplemented with data from the Health Insurance Marketplace. This information is inflated to 2016 using growth rates from the National Health Expenditure projections and is then reweighted to equal the estimated amounts for spending and insurance coverage. In particular, the sample weights for individuals are adjusted to reproduce the 2016 population, disaggregated by age, sex, and health insurance status, as well as the spending totals by type of service and payer.

Any individual or family that is uninsured, is enrolled in individual insurance coverage, or would experience a loss of coverage from an employer or through Medicaid would be considered through the individual insurance market model that determines the probability that they would purchase insurance. This decision of whether to purchase insurance is based on (i) whether the individual or family is currently insured; (ii) the change in the premium cost they would face;

[15] More information about MEPS data is available at http://www.meps.ahrq.gov/mepsweb/.

(iii) the change in the value of the insurance coverage; and (iv) characteristics of the individual or family (demographic, economic, health care spending).

The premium change is based on the lowest premium available that could be used to purchase qualified coverage. Under current law, the lowest premiums are for bronze-level coverage. Under the AHCA, we assume that the lowest-cost plan would be the lowest that could be offered while meeting the statutorily required maximum out-of-pocket cost, which we estimate to have an actuarial value of roughly 59 percent. The *gross* premium rate for this plan is determined using a 5-to-1 age rating. The AHCA's age-based credits and the impact from the PSSF are applied to these rates to determine the *net* premium rate faced by an individual. Since it was not specified how the PSSF is to be used, we generally assumed that half of the funds would be used to reduce premiums for all of those insured and that the other half would be targeted to low-income and older individuals.

The starting coverage status of the individual or family is used as part of the decision choice such that anyone insured who faces a decline in premium would continue to take coverage and anyone uninsured facing a rising premium would remain uninsured. For everyone else, we apply an elasticity to determine the percentage chance that they will either drop coverage (if they are insured and their premium increases) or obtain coverage (if they are uninsured and their premium decreases). The average elasticity used is 0.5 and is adjusted based on the income, health status, and out-of-pocket costs of the individual.

Individuals with health insurance use more services than those without since they have to pay only a portion of the cost. Moreover, as the level of cost-sharing requirements for those with health insurance decreases, the demand for services increases. Accordingly, the health care expenditures for those who are newly covered or change coverage are adjusted to reflect changes in cost sharing. For those who currently have coverage through Medicaid, expenditures are also adjusted by 30 percent to account for the price difference between Medicaid and the private market.

Once the changes in coverage are determined, the premium rates are re-calculated based on those individuals who are assumed to be covered. The insurance decision model in OHRM is estimated on an iterative basis until there is convergence to a stable set of results.

The model is run separately for each year, reflecting the annual changes in the age-based credits, which are indexed to the CPI plus 1 percentage point, and the funding from the PSSF, which includes an increasing State contribution each year. Once the enrollment results are determined, we adjust the average premium rate to reflect the expected plan purchases. For the AHCA, we assume that the actuarial value of the average plan purchased will be 62 percent.

The AHCA allows the States an opportunity to waive the federally mandated EHBs as well as community rating. We assume that 25 percent of States would apply for these waivers. For those that waive community rating, we assume that insurers would be permitted to charge individuals who did not meet the continuous coverage requirements a surcharge based on their medical conditions for one year. We assume that these additional costs would be paid for from the AHCA's funding allotted for this purpose ($8 billion) until this funding is exhausted, at which point the States would pay for such costs from the other high-risk pool funding sources (the

Federal Invisible Risk-Sharing Program and the PSSF). In determining the premium effect for the States that applied for waivers, we assume that the average waiver impact would equate to the elimination of the covered costs for maternity and mental health and substance abuse disorders, which we estimated at 7 percent of premium costs.

Estimating National Health Expenditure Impacts

The National Health Expenditure impacts are determined by categorizing the changes in spending associated with changes in coverage or other proposed law provisions into mutually exclusive categories. The impacts are shown on two dimensions in this memorandum: (i) payers and programs and (ii) sponsors.[16] On the payer and program dimension, expenditures are reported based on the entity responsible for paying for medical goods and services that are rendered to treat or prevent a specific disease or condition in a specific person. For example, health care payments that are paid by an insurer for an individual who has employer-sponsored insurance are classified as employer-sponsored insurance in the National Health Expenditure Accounts. If that individual were to also pay directly at the point of service for his or her care, that spending would be classified as out-of-pocket spending. Thus, under the health reform impacts reported here, any spending changes that were associated with a change in health insurance coverage would be classified in the category associated with that coverage, except for care that was paid for directly out-of-pocket.

On the sponsor dimension, spending is reported by the entity that finances the health care payments (government, household, private business, or other private). In many instances, multiple sponsors are involved with paying for health insurance coverage. For example, for employer-sponsored insurance in the private sector, both the employer (private business) and the employee (household) contribute towards the insurance premium. Likewise, for directly purchased insurance, an individual could pay a portion of the premium (household) while also receiving a subsidy from the Federal Government to cover the remaining portion of the premium (government). When estimating the health reform impacts reported here, all of the National Health Expenditure impacts by payer and program are translated to a sponsor basis to ensure accurate accounting for who is financing the care.

[16] More information on the classification of spending, as well as definitions of coverage, can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/DSM-15.pdf.

Appendix B—Estimated Medicare and Medicaid Costs (+) or Savings (–) under the American Health Care Act of 2017

Section	Provision	Fiscal year, in millions										Total,	
		2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-21	2017-26
	Title I—Energy and Commerce												
	Subtitle A—Patient Access to Public Health Programs												
101	The Prevention and Public Health Fund												
102	Community Health Center Program					***No impact on Medicare/Medicaid***							
103	Federal Payments to States	0	180	170	150	140	120	110	100	90	80	640	1,140
	Subtitle B—Medicaid Program Enhancement												
111	Repeal of Medicaid provisions	0	0	0	-550	-830	-870	-930	-1,010	-1,100	-1,170	-1,380	-6,460
112	Repeal of Medicaid expansion	0	0	0	-7,280	-24,130	-38,310	-44,750	-49,570	-52,770	-58,010	-31,410	-274,820
113	Elimination of DSH cuts	0	1,220	2,020	2,880	3,780	4,690	5,600	6,510	6,490	0	9,900	33,190
114	Reducing State Medicaid costs	0	-2,270	-3,450	-3,650	-3,870	-4,120	-4,380	-4,660	-4,950	-5,260	-13,240	-36,610
115	Safety net funding for non-expansion States	0	2,000	2,000	2,000	2,000	2,000	0	0	0	0	8,000	10,000
116	Providing incentives for increased frequency of eligibility redeterminations	0	-1,250	-2,500	-3,750	-4,500	-4,500	-4,500	-5,250	-5,250	-5,250	-12,000	-36,750
117	Permitting States to apply a work requirement for non-disabled, non-elderly, non-pregnant adults under Medicaid	0	-800	-1,600	-2,500	-3,300	-3,500	-3,700	-3,900	-4,200	-4,400	-8,200	-27,900
	Subtitle C—Per Capita Allotment for Medical Assistance												
121	Per capita allotment for medical assistance	0	0	0	-400	-3,950	-4,900	-8,600	-11,900	-16,100	-19,050	-4,350	-64,900
	Subtitle D—Patient Relief and Health Insurance Market Stability												
131	Repeal of cost-sharing subsidy												
132	Patient and State Stability Fund												
133	Continuous health insurance coverage incentive												
134	Increasing coverage options												
135	Change in permissible age variation in health insurance premium rates												
	Subtitle E—Implementation Funding												
141	American Health Care Implementation Funding												
	Title II—Committee on Ways and Means												
	Subtitle A—Repeal and Replace of Health-Related Tax Policy												
201	Recapture excess advance payments of premium tax credits					***No impact on Medicare/Medicaid***							
202	Additional modifications to premium tax credit												
	Premium Tax Credits												
	Cost-sharing Subsidies												
203	Small business tax credit												
204	Individual mandate												
205	Employer mandate												
206	Repeal of the tax on employee health insurance premiums and health plan benefits												
207	Repeal on tax on over-the-counter medications												
208	Repeal of increase of tax on health savings accounts												
209	Repeal of limitation on contributions to flexible spending accounts												
210	Repeal of medical device excise tax												
211	Repeal of elimination of deduction for expenses allocable to Medicare Part D subsidy												
	Part D, gross	0	-120	-270	-360	-360	-410	-380	-360	-440	-470	-1,110	-3,170
	Part D, net of premium	0	-80	-170	-210	-190	-230	-180	-150	-210	-230	-650	-1,650
	Part D, net of premium/clawback	0	-80	-180	-230	-230	-270	-240	-200	-270	-290	-720	-1,990
212	Reduction of income threshold for determining medical care deduction					***No Medicare/Medicaid impact***							
213	Repeal of Medicare tax increase												
	Part A income	0	0	0	0	0	0	8,823	16,957	18,577	20,361	0	64,717
214	Refundable tax credit for health insurance coverage												
215	Maximum contribution limit to health savings account increased to amount of deductible and out-of-pocket limitation					***No Medicare/Medicaid impact***							
216	Allow both spouses to make catch-up contributions to the same health savings account												
217	Special rule for certain medical expenses incurred before establishment of health savings account												

Appendix B—Estimated Medicare and Medicaid Costs (+) or Savings (–) under the American Health Care Act of 2017

Section	Provision	Fiscal year, in millions										Total,	
		2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-21	2017-26
	Subtitle B—Repeal of Consumer Taxes												
221	Repeal of tax on prescriptions medications												
	Part B general revenue	0	1,050	770	3,310	4,100	4,210	3,070	2,260	2,170	2,010	9,230	22,950
	Part D, gross	0	0	0	-120	-170	-200	-200	-200	-220	-250	-290	-1,360
	Part D, net of premium	0	0	0	-100	-140	-170	-170	-170	-190	-210	-240	-1,150
	Part D, net of premium/clawback	0	0	0	-100	-130	-150	-150	-140	-160	-180	-230	-1,010
222	Repeal of Health Insurance Tax												
	Part A	0	-400	-550	-580	-620	-670	-730	-780	-830	-920	-2,150	-6,080
	Part B, gross	0	-500	-710	-760	-820	-890	-970	-1,060	-1,130	-1,260	-2,790	-8,100
	Part B, net of premium	0	-370	-530	-570	-610	-660	-730	-790	-850	-940	-2,080	-6,050
	Part D, gross	0	-720	-1,060	-1,180	-1,280	-1,470	-1,490	-1,480	-1,690	-1,820	-4,240	-12,190
	Part D, net of premium	0	-580	-850	-950	-1,030	-1,200	-1,200	-1,170	-1,360	-1,470	-3,410	-9,810
	Part D, net of premium/clawback	0	-580	-850	-950	-1,030	-1,200	-1,200	-1,170	-1,360	-1,470	-3,410	-9,810
	Medicaid	0	-1,400	-1,500	-1,600	-1,700	-1,800	-2,000	-2,100	-2,300	-2,400	-6,200	-16,800
	Subtitle C—Repeal of Tanning Tax												
231	Repeal of tanning tax	***No Medicare/Medicaid impact***											
	Subtitle D—Remuneration From Certain Insurers												
241	Remuneration from certain insurers	***No Medicare/Medicaid impact***											
	Subtitle E—Repeal of Net Investment Income Tax												
251	Repeal of net investment income tax	***No Medicare/Medicaid impact***											
	Interaction - Medicaid (section 112/121 with other provisions)	0	0	0	2,070	3,860	4,600	5,460	6,340	7,020	7,400	5,930	36,750
	Interaction - Medicare DSH (Part A impact)	0	1,620	3,050	4,410	5,870	7,250	8,140	8,930	9,410	9,720	14,950	58,400

Interaction between the proposals is not fully reflected.

Appendix C—Estimated Increases (+) or Decreases (–) in National Health Expenditures under the American Health Care Act of 2017

Current law	Calendar Year, in billions										Total, 2017-2026
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	
Total National Health Expenditures (NHE)	$3,539.3	$3,745.7	$3,965.5	$4,196.7	$4,441.8	$4,700.4	$4,972.2	$5,254.6	$5,548.8	$5,859.4	$46,224.4
Medicare	718.7	767.9	824.9	890.5	958.8	1,033.2	1,113.9	1,196.1	1,277.8	1,365.2	10,147.1
Medicaid	586.5	621.8	658.1	696.7	737.1	779.7	824.9	873.2	929.0	988.4	7,695.5
Federal	361.5	383.7	404.5	426.3	450.7	476.7	504.3	533.8	567.6	603.6	4,712.7
State & Local	225.0	238.1	253.6	270.4	286.5	303.0	320.6	339.4	361.4	384.8	2,982.8
CHIP	17.6	18.8	19.8	20.7	21.8	23.0	24.1	25.4	26.6	28.0	225.8
Other public	401.6	421.9	444.5	469.1	494.9	521.4	548.2	575.5	604.3	634.6	5,116.0
Out-of-pocket	365.8	382.7	401.2	424.3	446.2	468.7	492.0	516.6	542.3	569.3	4,609.1
Employer-sponsored private health insurance	1,065.4	1,127.2	1,190.4	1,247.1	1,311.2	1,379.0	1,449.3	1,522.3	1,596.1	1,673.4	13,561.3
Direct purchase private health insurance	112.3	121.0	127.9	134.9	142.5	149.9	157.0	164.5	172.3	180.4	1,462.6
Other private	240.3	252.2	265.6	279.5	294.3	309.4	325.2	341.9	359.5	378.1	3,046.1
NHE as percent of Gross Domestic Product (GDP)	18.3%	18.5%	18.6%	18.8%	19.0%	19.2%	19.4%	19.7%	19.9%	20.1%	

Proposed law — AHCA	Calendar Year, in billions										Total, 2017-2026
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	
Total National Health Expenditures (NHE)	$3,539.1	$3,742.1	$3,957.6	$4,181.7	$4,419.5	$4,671.9	$4,938.1	$5,212.8	$5,500.7	$5,802.6	$45,966.0
Medicare	719.1	767.6	825.7	892.4	961.8	1,037.2	1,118.6	1,201.4	1,283.1	1,370.4	10,177.4
Medicaid	585.6	617.1	648.8	676.6	699.6	730.2	763.3	802.2	844.1	883.9	7,251.4
Federal	360.9	380.7	397.7	408.7	414.6	427.4	444.7	466.4	490.8	512.9	4,304.9
State & Local	224.6	236.4	251.1	267.8	284.9	302.9	318.7	335.8	353.3	371.0	2,946.5
CHIP	17.6	18.8	19.8	20.7	21.8	23.0	24.1	25.4	26.6	28.0	225.8
Other public	402.1	425.1	449.4	476.2	505.3	534.3	563.2	592.0	623.2	656.8	5,227.6
Out-of-pocket	365.9	386.2	406.9	443.2	469.9	496.3	522.7	549.6	579.0	610.8	4,830.5
Employer-sponsored private health insurance	1,065.0	1,111.1	1,167.9	1,221.4	1,281.9	1,343.1	1,411.6	1,482.7	1,554.8	1,630.2	13,269.7
Direct purchase private health insurance	112.2	127.8	134.2	128.6	136.7	145.5	152.3	157.0	164.8	173.2	1,432.2
Other private	240.5	256.2	271.8	288.7	307.7	326.2	344.6	363.4	384.2	407.2	3,190.5
NHE as percent of Gross Domestic Product (GDP)	18.3%	18.5%	18.6%	18.7%	18.9%	19.1%	19.3%	19.5%	19.7%	19.9%	

Impact of AHCA	Calendar Year, in billions										Total, 2017-2026
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	
Total National Health Expenditures (NHE)	−$0.2	−$3.6	−$8.0	−$15.1	−$22.3	−$28.4	−$34.0	−$41.8	−$48.1	−$56.9	−$258.3
Medicare	0.4	−0.3	0.8	1.9	3.0	4.0	4.7	5.3	5.3	5.2	30.3
Medicaid	−0.9	−4.6	−9.4	−20.1	−37.6	−49.5	−61.5	−71.0	−85.0	−104.5	−444.1
Federal	−0.6	−3.0	−6.8	−17.6	−36.0	−49.4	−59.6	−67.3	−76.8	−90.7	−407.8
State & Local	−0.4	−1.7	−2.6	−2.5	−1.5	−0.1	−1.9	−3.6	−8.2	−13.8	−36.3
CHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other public	0.6	3.2	4.9	7.1	10.4	12.9	15.0	16.5	18.9	22.3	111.7
Out-of-pocket	0.1	3.5	5.7	18.9	23.6	27.6	30.7	33.0	36.7	41.5	221.4
Employer-sponsored private health insurance	−0.4	−16.0	−22.5	−25.7	−29.4	−35.8	−37.7	−39.6	−41.3	−43.2	−291.6
Direct purchase private health insurance	−0.0	6.7	6.3	−6.3	−5.8	−4.4	−4.8	−7.5	−7.5	−7.3	−30.5
Other private	0.2	4.0	6.2	9.2	13.4	16.8	19.5	21.4	24.7	29.1	144.5
NHE as percent of Gross Domestic Product (GDP)	−0.0%	−0.0%	−0.0%	−0.1%	−0.1%	−0.1%	−0.1%	−0.2%	−0.2%	−0.2%	