Additional Information About CBO's Baseline Projections of Federal Subsidies for Health Insurance Provided Through Exchanges

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This document responds to questions that the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have received about how federal subsidies for health insurance will increase over time in the insurance exchanges established under the Patient Protection and Affordable Care Act (or PPACA, Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). In particular, CBO and JCT have been asked how the growth of federal subsidies for premiums will compare with the increase in the consumer price index (CPI) in the latter portion of the 2012 to 2021 period. The document describes how CBO approached its baseline projections of federal subsidies and reflects CBO and JCT's interpretation of the relevant statutes; ultimately, the Administration will be responsible for interpreting and implementing the legislation.

This discussion addresses subsidies for insurance premiums only and does not cover subsidies for cost sharing.[1] Under current law, certain individuals with lower income will also be entitled to subsidies to reduce the amount they will be required to pay for cost sharing for medical services. Those subsidies for cost sharing will increase over time roughly in line with the growth of costs for medical care and the growth in the number of people receiving those subsidies. This document does not address that provision because it is not directly related to how federal subsidies for premiums will grow over time.

Federal Subsidies for Premiums and Enrollees' Payments for Insurance Provided Through the Exchanges

Under PPACA and the Reconciliation Act, individuals who have income below 400 percent of the federal poverty level (FPL), who do not have

[1] CBO's baseline projections show the component parts of total federal subsidies provided via the exchanges—both premium subsidies and cost-sharing subsidies. See "CBO's March 2011 Baseline: Health Insurance Exchanges," available at www.cbo.gov/budget/factsheets/2011b/HealthInsuranceExchanges.pdf.

access to affordable employer-based insurance, who are not eligible for Medicaid, and who meet certain other conditions will be eligible for federal subsidies to cover some of the cost of a health insurance plan purchased through an exchange. The federal premium subsidy for an individual or a family will equal the difference between the premium for a "reference" plan and a specified percentage of income.[2] The reference plan is the "silver" plan in the exchange with the second-lowest premium for an individual's age group (for single coverage) or with the second-lowest premium among family plans. A silver plan has an actuarial value of 70 percent, which represents the average share of costs for covered benefits that will be paid by the plan. (The other 30 percent represents amounts that enrollees will pay, on average, for medical services in the form of deductibles or other cost sharing.)

The specified percentage of income—which represents the amount that an individual or a family will have to pay to enroll in the reference plan—varies depending on how the individual's or family's income compares with the FPL.[3] For example, in 2014, people with income below 133 percent of the FPL who are not eligible for Medicaid will pay no more than 2 percent of their income to enroll in a reference plan, and people with higher income will pay larger shares of their income, reaching 9.5 percent for income between 300 percent and 400 percent of the FPL. People with income above 400 percent of the FPL will not be eligible for federal subsidies in the exchanges.

The maximum percentages of income that enrollees at a given income level will have to pay will increase over time in two ways. First, through 2018, the percentage of income will "be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year."[4] CBO and JCT interpret that adjustment as being equal to the difference between (1) the percentage change in average premiums for private health insurance for the nonelderly nationwide between the prior year and the year before that and (2) the percentage change in average U.S. household income between those same two years. In this analysis, that provision is referred to as the "regular

[2] PPACA and the Reconciliation Act define what will constitute the family grouping (among taxpayers and their dependents) for the purpose of determining eligibility for exchange subsidies. This document uses the term "family" interchangeably with that definition.

[3] The specified percentage of income is the maximum amount that an enrollee will pay for the reference plan. If the specified percentage exceeds the premiums for the reference plan, then the enrollee will pay the lesser amount. However, that outcome will be uncommon, CBO expects.

[4] See section 1401 of PPACA, amending section 36B(b)(3)(A)(ii)(I) of the Internal Revenue Code.

indexing" for enrollees' payments. Because private health insurance premiums generally grow faster than income, the regular indexing provision will keep the share of the premium paid by an enrollee at a given income level and the government roughly constant from year to year.[5]

Second, beginning in 2019, the maximum percentages of income that enrollees will have to pay will continue to increase through that regular indexing formula but may increase further "to reflect the excess (if any) of the rate of premium growth … over the rate of growth in the consumer price index."[6] CBO and JCT interpret that additional adjustment as being equal to the difference between (1) the growth of premiums, as calculated for the regular indexing provision, and (2) the percentage change in the consumer price index for all urban consumers (CPI-U). The law specifies that this "additional indexing" will occur if total federal subsidies through the exchanges (including subsidies for both premiums and cost sharing) exceed 0.504 percent of gross domestic product (GDP) in the preceding year.[7]

Because the amount of the federal subsidy per enrollee is the difference between the reference plan's premium and the required payment by the enrollee, the rate at which federal premium subsidies increase over time will depend on the rates at which those average premiums and average payments grow. According to CBO's projections, total federal subsidies for premiums will grow over time—starting at $21 billion in 2014 and reaching $118 billion by 2021—because of rising enrollment in the exchanges and an increasing average subsidy per enrollee.[8]

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[5] For example, if average income and the CPI-U grow at the same pace, an enrollee's income that increases at that average rate will not change relative to the FPL, and, with regular indexing, the share of premium paid by the enrollee and the government will stay constant. If average income grows faster than the CPI-U, an enrollee whose income grows at that average rate will pay a slightly larger share of the premium than before.

[6] See section 1401 of PPACA, amending section 36B(b)(3)(A)(ii)(II) of the Internal Revenue Code.

[7] In CBO's March 2011 baseline projections, total federal subsidies exceed 0.504 percent of GDP in 2018 and subsequent years in the 10-year budget window. Nevertheless, CBO's baseline projections account for uncertainty about whether that provision triggering additional indexing would apply.

[8] See "CBO's March 2011 Baseline: Health Insurance Exchanges," available at www.cbo.gov/budget/factsheets/2011b/HealthInsuranceExchanges.pdf. Premium subsidies are in the form of refundable tax credits that affect both revenues and outlays. Tax credits that reduce an individual's tax liability are categorized as a reduction in revenues, whereas such credits that exceed an individual's tax liability are categorized as an increase in outlays.

An Illustration of the Effect of the Indexing Provisions

The following table illustrates how the provisions for regular and additional indexing will affect the growth of federal premium subsidies and enrollees' payments over time. For simplicity, the table does not include the projected amounts for any particular year but uses illustrative values instead. The discussion focuses on premium subsidies for family coverage and notes instances in which the results would differ noticeably for single coverage.

In these examples, the CPI-U is assumed to increase at an annual rate of 2 percent, and the FPL is assumed to increase at the same rate; average household income is assumed to increase at an annual rate of 3 percent; and average premiums of reference plans in the exchanges, as well as average premiums for private health insurance nationwide, are assumed to increase at an annual rate of 6 percent. Each family's income is assumed to grow at the same rate as average family income.[9]

In the first year of the illustration, premiums for the reference plan for a family of four are assumed to be $15,000, and the federal poverty level is assumed to be $20,000. In this hypothetical example, a family with income equal to 150 percent of the FPL (or $30,000) will be required by the law to pay up to 4.0 percent of its income ($1,200) to enroll in the reference plan and thus will be entitled to a subsidy of $13,800 ($15,000 minus $1,200).[10] Families with higher income will be required to pay a larger percentage of their income to enroll in the reference plan. Specifically, a family with income equal to 250 percent of the FPL will pay 8.1 percent of its income to enroll in the reference plan (about $4,000) and will receive a subsidy of about $11,000, and a family with income equal to 350 percent of the FPL will pay 9.5 percent of its income (about $6,700) and will receive a subsidy of about $8,400.

In the second year of the illustration, family income is assumed to be 3 percent greater than it was in the first year; the federal poverty level is assumed to be 2 percent greater. As a result, the family whose income had

[9] Of course, families can experience changes in income from one year to the next that vary substantially around the average. As presented in the table, enrollees' payments and federal subsidies in any given year will apply to any family with income at the designated percentage of the FPL in that year, regardless of what that family's income was relative to the FPL in the preceding year.

[10] For the first illustrative year, the analysis uses the shares of income required to enroll in the reference plan for 2014, as specified in PPACA and the Reconciliation Act. Of course, additional indexing will not apply in 2015. CBO chose those values simply to show the effects of both types of indexing provisions on known starting values specified in the legislation. (See section 1401 of PPACA, amending section 36B(b)(3)(A)(i) of the Internal Revenue Code).

equaled 150 percent of the FPL in the first year will now have income equal to 151 percent of the FPL. Therefore, even apart from the indexing provisions, the family will be required to pay a larger percentage of its income to enroll in the reference plan. In addition, the regular indexing provision increases the maximum percentages of income that families will have to pay by the difference between growth in premiums and growth in income, or by about 3 percent in these examples. With those two factors taken together, the family whose income had been 150 percent of the FPL will now be required to pay 4.2 percent of its income to enroll in the reference plan in the second illustrative year. Similarly, with both factors incorporated, the family initially at 250 percent of the FPL will pay 8.4 percent of its income in the second year, and the family initially at 350 percent of the FPL will pay 9.8 percent. Altogether, the families in this example will pay about 6 percent to 8 percent more for their health insurance premiums in the second illustrative year than in the first.

If the additional indexing applies, then the shares of income that the families will be required to pay in the second illustrative year will be still larger. Specifically, those shares will equal the shares just described increased by the difference between growth in premiums and growth in the CPI-U, or by 4 percent in these examples. The family whose income in the first year had been at 150 percent of the FPL will be required to pay 4.4 percent of its income; the family initially at 250 percent of the FPL will pay 8.7 percent; and the family initially at 350 percent of the FPL will pay 10.2 percent. Thus, if the additional indexing applies, the families in this example will pay about 10 percent to 12 percent more for their health insurance premiums in the second illustrative year than in the first.

Federal subsidies for premiums equal the difference between reference premiums and enrollees' required payments. With regular indexing alone, federal premium subsidies per enrollee increase at roughly the rate of premium growth: by 5.8 percent for the family with income initially equal to 150 percent of the FPL, by 5.7 percent for the family with income initially equal to 250 percent of the FPL, and by 6.0 percent for the family with income initially equal to 350 percent of the FPL. With the additional indexing provision as well, federal premium subsidies increase more slowly, especially for families with higher income: by 5.5 percent for the lowest-income family in these examples, by 4.1 percent for the family with higher income, and by 2.7 percent for the family with still-higher income. Additional indexing reduces the growth rate of the federal subsidy more for higher income enrollees because a given percentage increase in their required share of income will be a larger dollar amount and therefore will cover a larger portion of the premium.

Even with the additional indexing in place, federal premium subsidies per enrollee increase more rapidly than the CPI-U for all three families in this illustration—as do the enrollees' costs. The difference between the growth of subsidies and the growth of the CPI-U is substantially larger for families with lower income, who will receive most of the subsidies. The results would generally be similar for subsidies for single coverage, with the exception that, with additional indexing, subsidies for a single policyholder in the highest income group will grow more slowly than the CPI-U (in fact, will decrease) in the second illustrative year.

Total federal subsidies for premiums are expected to grow faster than the CPI-U because of both rising enrollment and growing subsidies per enrollee—even if the additional indexing is triggered in 2019. In CBO's baseline projections, that pattern continues through the end of the 10-year budget window in 2021.

Table 1.

Illustrative Examples of the Growth of Federal Subsidies for Premiums for Health Insurance Provided Through the Exchanges

(Dollars)

	Family with Income at 150 % of FPL in Year 1		Family with Income at 250 % of FPL in Year 1		Family with Income at 350 % of FPL in Year 1	
	Illustrative Year 1	Illustrative Year 2	Illustrative Year 1	Illustrative Year 2	Illustrative Year 1	Illustrative Year 2
Family Income	30,000	30,900	50,000	51,500	70,000	72,100
Federal Poverty Level (FPL)	20,000	20,400	20,000	20,400	20,000	20,400
Family Income Compared with the FPL (Percent)	150	151	250	252	350	353
Illustrative Share of Income Required to Enroll in a Reference Plan (Percent)	4.0		8.1		9.5	
Under regular indexing		4.2		8.4		9.8
With additional indexing (After 2018, if applicable)		4.4		8.7		10.2
Total Premium for Reference Plan	15,000	15,900	15,000	15,900	15,000	15,900
Enrollee's payment (Share of income times income)	1,200		4,025		6,650	
Under regular indexing		1,294		4,304		7,049
With additional indexing (After 2018, if applicable)		1,344		4,473		7,325
Federal subsidy (Premium minus enrollee's payment)	13,800		10,975		8,350	
Under regular indexing		14,606		11,596		8,851
With additional indexing (After 2018, if applicable)		14,556		11,427		8,575
Growth Rate (Percent, compared with amounts in year 1)						
Enrollee's payment						
Under regular indexing		7.8		6.9		6.0
With additional indexing (After 2018, if applicable)		12.0		11.1		10.2
Federal subsidy						
Under regular indexing		5.8		5.7		6.0
With additional indexing (After 2018, if applicable)		5.5		4.1		2.7

Source: Congressional Budget Office.

Notes: CBO's illustrative examples are based on a number of assumptions: that all households' incomes increase at an annual rate of 3 percent; that the consumer price index for all urban consumers (CPI-U) increases by 2 percent annually; and that the federal poverty level increases by 2 percent annually. In addition, average premiums for the "reference" plan in an insurance exchange (the reference plan is the one with the second-lowest premium among those with an actuarial value of 70 percent), as well as average premiums for private health insurance for the nonelderly nationwide, are assumed to increase at an annual rate of 6 percent.

"Regular indexing" of the share of income required for enrollment is an adjustment between years based on the difference between (1) the percentage change in average premiums for private health insurance for the nonelderly nationwide between the prior year and the year before that and (2) the percentage change in average U.S. household income between those same two years. "Additional indexing," a further adjustment that may apply after 2018, is based on the difference, if any, between (1) the growth of premiums, as calculated for regular indexing, and (2) the percentage change in the CPI-U.

For the first illustrative year (year 1), the analysis uses the shares of income required to enroll in the reference plan that are specified for 2014 in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act; CBO chose those values simply to show the effects of both indexing provisions on known starting values specified in the legislation. The actual shares would be somewhat higher by 2018, when additional indexing could be applied for the following year.

Amounts for federal subsidies shown here apply to premiums; separately, lower-income people will also be entitled to subsidies to reduce the amount they will be required to pay for cost sharing for medical services.