CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 23, 2018

H.R. 6311
Increasing Access to Lower Premium Plans Act of 2018

As reported by the House Committee on Ways and Means on July 19, 2018

SUMMARY

H.R. 6311, the Increasing Access to Lower Premium Plans Act of 2018, would change the definition of a qualified health plan (QHP) to allow enrollees to receive premium tax credits for certain nongroup insurance plans purchased outside of the marketplaces established under the Affordable Care Act (ACA) and for catastrophic plans. The bill also would allow any enrollee in the nongroup market to purchase a catastrophic plan.

On net, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting H.R. 6311 would increase the deficit by $10.9 billion over the 2019-2028 period relative to CBO's baseline projections. Enacting H.R. 6311 would affect direct spending and revenues; therefore, pay-as-you-go procedures apply.

CBO estimates that enacting H.R. 6311 would increase net direct spending by more than $2.5 billion and on-budget deficits by more than $5 billion in each of the four consecutive 10-year periods beginning in 2029.

JCT has determined that the tax provisions of H.R. 6311 contain no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

CBO has determined that the non-tax provisions of H.R. 6311 would impose a private-sector mandate as defined in UMRA, but the cost of the mandate would fall below the annual threshold established in UMRA for private-sector mandates ($160 million in 2018, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effect of H.R. 6311 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By Fiscal Year, in Millions of Dollars												
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-2023	2019-2028
INCREASES OR DECREASES (-) IN DIRECT SPENDING													
Definition of a QHP[a]													
Estimated Budget Authority	0	168	902	848	823	833	810	727	758	738	738	3,574	7,346
Estimated Outlays	0	168	902	848	823	833	810	727	758	738	738	3,574	7,346
Copper Plans[a]													
Estimated Budget Authority	0	-50	-74	-82	-91	-95	-96	-98	-99	-101	-105	-391	-890
Estimated Outlays	0	-50	-74	-82	-91	-95	-96	-98	-99	-101	-105	-391	-890
Total Changes													
Estimated Budget Authority	0	118	828	766	732	738	714	629	659	637	633	3,183	6,456
Estimated Outlays	0	118	828	766	732	738	714	629	659	637	633	3,183	6,456
INCREASES OR DECREASES (-) IN REVENUES[b]													
Definition of a QHP[a]	0	-220	-386	-404	-435	-462	-474	-479	-507	-546	-566	-1,907	-4,477
Copper Plans[a]	0	1	2	3	3	3	3	3	4	5	5	13	33
Total Changes	0	-219	-384	-401	-432	-459	-471	-476	-503	-541	-561	-1,894	-4,444
NET INCREASE IN THE DEFICIT													
Impact on Deficit	0	337	1,212	1,167	1,164	1,197	1,185	1,104	1,162	1,178	1,194	5,077	10,901

Note: QHP = Qualified Health Plan.

a. Policies affect both direct spending and revenues.
b. For revenues, a positive number indicates an increase (reducing the deficit), and a negative number indicates a decrease (adding to the deficit).

BASIS OF ESTIMATE

For this estimate, CBO assumes the legislation will be enacted near the end of fiscal year 2018. CBO and JCT estimate that enacting the legislation would increase federal deficits by $10.9 billion over the 2019-2028 period; that change would result from a $6.5 billion increase in outlays and a $4.4 billion decrease in revenues.

Definition of a Qualified Health Plan

Under current law, certain enrollees are eligible to receive premium tax credits for health insurance coverage purchased through the marketplace established under the ACA. In order to be eligible, enrollees must generally have income between 100 percent and 400 percent of the federal poverty guidelines and not be eligible for another source of

affordable health insurance. They also must enroll in a plan that is deemed a "qualified health plan" (QHP), is purchased through the marketplaces, and is not a catastrophic plan. Under current law, catastrophic plans are generally only available to people under the age of 30. The copper plans provision of H.R. 6311, discussed below, would change that. Catastrophic plans have a high deductible and do not cover any benefits until the deductible is met, except for three primary care visits annually.

Beginning in 2019, H.R. 6311 would change the definition of a QHP to allow people who are otherwise eligible for premium tax credits to receive them for some nongroup coverage purchased outside of the marketplaces or for catastrophic plans. The tax credits for plans purchased outside of the marketplaces would not be paid as advanced credits during the coverage year, but could be claimed when the enrollee filed their federal income taxes for the year.

In CBO's baseline, fewer than 500,000 people in any given year who otherwise meet the eligibility requirements for premium tax credits are projected to enroll in nongroup plans purchased outside of the marketplaces. Those people would become eligible for premium tax credits under H.R. 6311. In addition, on the basis of information from the Department of Health and Human Services, CBO and JCT estimate that about 1 percent of people enrolled in the marketplaces (fewer than 100,000 in 2019) are in catastrophic plans in each year of CBO's baseline projections. Those enrollees would newly be eligible for premium tax credits under H.R. 6311.

The agencies do not expect a significant number of people to enroll in nongroup plans outside of the marketplaces as a result of H.R. 6311 because the tax credit would not be advanceable: the enrollee would have to pay the full cost of the premium during the year and receive the tax credit retroactively when they filed their taxes. CBO and JCT expect that delay would limit the affordability of those insurance plans for most people with incomes that make them eligible for tax credits. The agencies also do not expect a significant number of people to enroll in catastrophic plans as a result of H.R. 6311 because the characteristics of catastrophic plans are largely similar to bronze plans, for which potential enrollees can receive subsidies under current law.

CBO and JCT estimate that allowing premium tax credits for QHPs purchased outside of the marketplaces and for catastrophic plans would increase the deficit by $11.8 billion over the 2019-2028 period. That total consists of an increase in outlays of $7.3 billion and a decrease in revenues of $4.5 billion. (The subsidies for health insurance premiums are structured as refundable tax credits; following the usual procedures for such credits, CBO and JCT classify the portions that exceed taxpayers' income tax liabilities as outlays, and the portions that reduce tax payments as reductions in revenues.) In CBO's baseline, premium tax credits are projected to total $703 billion over the 2019-2028 period.

Copper Plans

Under current law, only certain people, most of whom are under the age of 30, may enroll in a catastrophic plan in the nongroup insurance market. Beginning in 2019, H.R. 6311 would allow any nongroup enrollee to choose a catastrophic plan (those plans would be called copper plans). In addition, the legislation would require insurers to include catastrophic plans as part of the single risk pool when pricing premiums in the nongroup market, alongside most other plans. (Under current regulations, catastrophic plans are treated separately from other nongroup plans for purposes of the risk-adjustment program.)

CBO and JCT estimate that this provision would not substantially change the total number of people purchasing insurance through the nongroup market. However, the agencies estimate that making catastrophic plans part of the single risk pool would slightly lower premiums for other nongroup plans, because the people who enroll in catastrophic plans tend to be healthier, on average, than other nongroup market enrollees. As a result of the slightly lower estimated premiums, CBO and JCT expect that federal costs for subsidies for insurance purchased through a marketplace would be reduced by $923 million over the 2019-2028 period. That decrease in the deficit is composed of a decrease in outlays of $890 million and an increase in revenues of $33 million.

PAY-AS-YOU-GO CONSIDERATIONS

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays and revenues that are subject to those pay-as-you-go procedures are shown in the following table.

CBO Estimate of Pay-As-You-Go Effects for H.R. 6311, as reported by the House Committee on Ways and Means on July 19, 2018

	By Fiscal Year, in Millions of Dollars												
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-2023	2019-2028
NET INCREASE OR DECREASE (-) IN THE ON-BUDGET DEFICIT													
Statutory Pay-As-You-Go Impact	0	337	1,212	1,167	1,164	1,197	1,185	1,104	1,162	1,178	1,194	5,077	10,901
Memorandum:													
Changes in Outlays	0	118	828	766	732	738	714	629	659	637	633	3,183	6,456
Changes in Revenues	0	-219	-384	-401	-432	-459	-471	-476	-503	-541	-561	-1,894	-4,444

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting the legislation would increase net direct spending by more than $2.5 billion and on-budget deficits by more than $5 billion in each of the four consecutive 10-year periods beginning in 2029.

MANDATES

JCT has determined that the tax provisions of H.R. 6311 contain no intergovernmental or private-sector mandates as defined in UMRA.

CBO has determined that the non-tax provisions of H.R. 6311 would impose a private-sector mandate as defined in UMRA by requiring insurers to consider enrollees in catastrophic plans to be part of the single risk pool with all enrollees in health plans in the nongroup market. CBO estimates that the cost of the mandate would fall below the annual threshold established in UMRA for private-sector mandates ($160 million in 2018, adjusted annually for inflation).

PREVIOUS CBO ESTIMATE

On March 19, 2018, CBO transmitted a cost estimate for the Bipartisan Health Care Stabilization Act of 2018, which contained the same Copper Plan provision as H.R. 6311. That estimate was relative to CBO's summer 2017 baseline; this estimate is relative to CBO's spring 2018 baseline. The differences in estimated costs for that provision reflect differences between CBO's baselines.

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