



## CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

October 20, 2015

### **H.R. 3762** **Restoring Americans' Healthcare Freedom Reconciliation Act of 2015**

*As reported by the House Committee on the Budget on October 16, 2015*

#### **SUMMARY**

S. Con. Res. 11, the Concurrent Resolution on the Budget for Fiscal Year 2016, instructed several committees of the House of Representatives to recommend legislative changes that would reduce deficits over the 2016-2025 period. This bill reflects the combined recommendations of the House Committees on Energy and Commerce, Education and the Workforce, and Ways and Means.

CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting H.R. 3762 would decrease deficits by about \$130 billion over the 2016-2025 period. That estimate includes two components. First, excluding macroeconomic feedback effects, the legislation would reduce deficits by about \$79 billion. In addition, the macroeconomic feedback would reduce deficits by an additional \$51 billion, CBO and JCT estimate.<sup>1</sup> Those effects would result from changes to both direct spending and revenues. The 2016-2025 total consists of \$77 billion in on-budget savings and \$53 billion in off-budget savings.

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

- Repealing provisions of the Affordable Care Act (ACA) that require most people to obtain health insurance coverage and large employers to offer their employees health insurance coverage that meets specified standards or pay penalties; and
- Repealing the federal excise taxes imposed on the sale of medical devices and on certain employer-provided health coverage with premiums above specified amounts.

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1. Because of the magnitude of its budgetary effects, this bill is “major legislation,” as defined in section 3112 of S. Con. Res. 11. Hence, the cost estimate prepared by CBO and JCT incorporates the federal budgetary effects of changes in economic output and other macroeconomic variables that would result from enacting the legislation.

Other parts of the legislation that affect the budget would:

- Repeal the requirement that certain large employers automatically enroll new employees in health insurance plans and continue the enrollment of current employees in a health insurance plan;
- Eliminate the Prevention and Public Health Fund and rescind any unobligated balances of the fund;
- Prohibit federal funds from being made available, for one year, to certain entities that provide abortions;
- Increase the amount of funding authorized and appropriated to the Community Health Center Fund; and
- Repeal provisions of the ACA that establish the Independent Payment Advisory Board (IPAB).

As required by the Concurrent Resolution on the Budget for Fiscal Year 2016, CBO and JCT have assessed the effect of H.R. 3762 on long-term deficits and direct spending:

- Including macroeconomic feedback, CBO and JCT estimate that enacting the legislation would increase *net direct spending* as well as *on-budget deficits* by more than \$5 billion in one or more of the four consecutive 10-year periods beginning in 2026.
- Excluding macroeconomic feedback, CBO and JCT estimate that enacting the legislation would not increase *net direct spending* by more than \$5 billion in either of the first two consecutive 10-year periods beginning in 2026; however, the agencies are not able to determine whether enacting the legislation would increase net direct spending by more than \$5 billion in the third or fourth 10-year period.
- Excluding macroeconomic feedback, CBO and JCT estimate that enacting the legislation would increase *on-budget deficits* by more than \$5 billion in one or more of the four consecutive 10-year periods beginning in 2026.

Because enacting the legislation would affect direct spending and revenues, pay-as-you-go procedures apply.

CBO and JCT have determined that the legislation contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

## ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effects of H.R. 3762 are shown in Table 1. For this estimate, CBO and JCT assume that the legislation will be enacted near the end of calendar year 2015.

**TABLE 1. SUMMARY OF ESTIMATED EFFECTS ON DIRECT SPENDING AND REVENUES OF H.R. 3762, THE RESTORING AMERICANS' HEALTHCARE FREEDOM RECONCILIATION ACT OF 2015<sup>a</sup>**

	By Fiscal Year, in Billions of Dollars											
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016-2020	2016-2025
<b>ESTIMATED CHANGES WITHOUT MACROECONOMIC FEEDBACK</b>												
Effects on Outlays	-9.1	-17.5	-22.4	-26.1	-28.8	-31.0	-33.4	-35.0	-37.2	-37.7	-103.8	-278.2
Effects on Revenues	-11.5	-9.4	-11.2	-15.0	-17.5	-19.7	-22.6	-26.5	-30.5	-35.2	-64.6	-199.3
Effects on the Deficit	2.4	-8.0	-11.2	-11.1	-11.4	-11.4	-10.8	-8.5	-6.7	-2.4	-39.2	-78.9
<b>ESTIMATED BUDGETARY IMPACT OF MACROECONOMIC FEEDBACK</b>												
Effects on Outlays	*	-0.2	-0.3	-0.2	*	0.4	0.6	0.8	1.0	1.1	-0.7	3.1
Effects on Revenues	0.5	1.1	2.5	4.3	5.4	6.4	7.2	8.1	8.9	9.6	13.8	54.0
Effects on the Deficit	-0.6	-1.3	-2.8	-4.5	-5.3	-6.0	-6.6	-7.3	-8.0	-8.6	-14.5	-50.9
<b>TOTAL ESTIMATED CHANGES, INCLUDING MACROECONOMIC FEEDBACK</b>												
Effects on Outlays	-9.1	-17.6	-22.6	-26.4	-28.8	-30.7	-32.8	-34.2	-36.2	-36.6	-104.5	-275.1
Effects on Revenues	-11.0	-8.3	-8.7	-10.7	-12.1	-13.3	-15.4	-18.4	-21.6	-25.6	-50.8	-145.3
Effects on the Deficit	1.9	-9.3	-14.0	-15.7	-16.7	-17.4	-17.4	-15.8	-14.7	-11.0	-53.6	-129.8

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

Notes: Numbers may not add up to totals because of rounding; \* = an increase or decrease between zero and \$50 million.

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

Because the estimate of macroeconomic effects incorporates the impact of all of the bill's provisions taken together, the estimates of the bill's effects by individual provision do not reflect the macroeconomic feedback effects. Those estimates are shown in Table 2.

**TABLE 2. ESTIMATE OF DIRECT SPENDING AND REVENUE EFFECTS OF H.R. 3762, THE RESTORING AMERICANS' HEALTHCARE FREEDOM RECONCILIATION ACT OF 2015<sup>a</sup>**

	By Fiscal Year, in Billions of Dollars										2016-	2016-
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2020	2025
<b>ESTIMATED CHANGES WITHOUT MACROECONOMIC FEEDBACK</b>												
<b>Changes in Direct Spending</b>												
<b>Title I—Committee on Education and the Workforce</b>												
Auto-Enrollment for Certain Large Employers												
Estimated Budget Authority	0	0.1	0.2	0.4	0.5	0.5	0.5	0.6	0.6	0.7	1.3	4.3
Estimated Outlays	0	0.1	0.2	0.4	0.5	0.5	0.5	0.6	0.6	0.7	1.3	4.3
<b>Title II—Committee on Energy and Commerce</b>												
Prevention and Public Health Fund												
Estimated Budget Authority	-1.0	-1.0	-1.3	-1.3	-1.5	-1.5	-2.0	-2.0	-2.0	-2.0	-6.0	-15.5
Estimated Outlays	-0.2	-0.5	-0.9	-1.1	-1.3	-1.4	-1.6	-1.8	-1.9	-2.0	-4.1	-12.7
Medicaid												
Estimated Budget Authority	-0.2	*	*	*	*	*	*	*	*	0	-0.2	-0.2
Estimated Outlays	-0.2	*	*	*	*	*	*	*	*	0	-0.2	-0.2
Community Health Center Program												
Estimated Budget Authority	0.2	0.2	0	0	0	0	0	0	0	0	0.5	0.5
Estimated Outlays	0.1	0.2	0.1	*	0	0	0	0	0	0	0.5	0.5
<b>Title III—Committee on Ways and Means</b>												
Repeal Individual and Employer Mandates												
Estimated Budget Authority	-8.7	-17.2	-21.0	-24.3	-26.4	-28.3	-30.3	-31.9	-33.7	-35.1	-97.6	-256.9
Estimated Outlays	-8.7	-17.2	-21.0	-24.3	-26.4	-28.3	-30.3	-31.9	-33.7	-35.1	-97.6	-256.9
Repeal Excise Tax on Certain High-Premium Insurance Plans												
Estimated Budget Authority	0	0	-0.7	-0.9	-1.4	-1.6	-2.4	-3.1	-3.9	-4.1	-3.0	-18.2
Estimated Outlays	0	0	-0.7	-0.9	-1.4	-1.6	-2.4	-3.1	-3.9	-4.1	-3.0	-18.2
Repeal IPAB												
Estimated Budget Authority	0	0	0	0	0	0	0.6	1.5	1.9	3.1	0	7.1
Estimated Outlays	0	0	0	0	0	0	0.6	1.5	1.9	3.1	0	7.1
<b>Interaction Across Titles<sup>b</sup></b>												
Estimated Budget Authority	0	*	-0.1	-0.2	-0.3	-0.3	-0.3	-0.3	-0.2	-0.3	-0.7	-2.0
Estimated Outlays	0	*	-0.1	-0.2	-0.3	-0.3	-0.3	-0.3	-0.2	-0.3	-0.7	-2.0
<b>Total Changes in Direct Spending</b>												
Estimated Budget Authority	-9.7	-17.9	-22.8	-26.2	-29.0	-31.1	-33.8	-35.3	-37.3	-37.7	-105.7	-281.0
Estimated Outlays	-9.1	-17.5	-22.4	-26.1	-28.8	-31.0	-33.4	-35.0	-37.2	-37.7	-103.8	-278.2

Continued

**TABLE 2, Continued.**

	By Fiscal Year, in Billions of Dollars										2016-	2016-
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2020	2025
<b>Changes in Revenues</b>												
<b>Title I—Committee on Education and the Workforce</b>												
Auto-Enrollment for Certain Large Employers	0	0.2	0.8	1.4	0.8	1.1	1.7	1.9	2.1	2.2	3.3	12.2
<b>Title III—Committee on Ways and Means</b>												
Repeal Individual and Employer Mandates	-10.1	-8.0	-8.0	-9.8	-10.5	-10.9	-11.9	-12.9	-13.5	-14.1	-46.4	-109.8
Repeal Medical Device Tax	-1.4	-2.0	-2.1	-2.2	-2.3	-2.5	-2.6	-2.8	-2.9	-3.1	-10.0	-23.9
Repeal Excise Tax on Certain High-Premium Insurance Plans	0	0	-2.9	-8.1	-9.7	-11.5	-14.0	-17.1	-20.8	-25.0	-20.8	-109.3
Interaction within Title III	0	0	*	2.1	2.0	1.7	1.7	1.6	1.6	1.4	4.1	12.1
<b>Interaction Across Titles<sup>b</sup></b>	0	0.3	1.0	1.7	2.3	2.5	2.5	2.8	3.1	3.4	5.2	19.4
<b>Total Changes in Revenues</b>	-11.5	-9.4	-11.2	-15.0	-17.5	-19.7	-22.6	-26.5	-30.5	-35.2	-64.6	-199.3
On-Budget	-13.0	-13.7	-15.8	-19.7	-21.8	-24.1	-26.8	-30.2	-33.8	-37.7	-84.1	-236.6
Off-Budget <sup>c</sup>	1.5	4.3	4.6	4.8	4.4	4.4	4.2	3.7	3.3	2.4	19.7	37.6
<b>Net Increase or Decrease (-) in the Deficit Without Macroeconomic Feedback</b>												
<b>Impact on Deficit</b>	<b>2.4</b>	<b>-8.0</b>	<b>-11.2</b>	<b>-11.1</b>	<b>-11.4</b>	<b>-11.4</b>	<b>-10.8</b>	<b>-8.5</b>	<b>-6.7</b>	<b>-2.4</b>	<b>-39.2</b>	<b>-78.9</b>
On-Budget	3.9	-3.8	-6.6	-6.4	7.0	-7.0	-6.5	-4.8	-3.4	*	-19.5	-41.3
Off-Budget <sup>c</sup>	-1.5	-4.3	-4.6	-4.8	-4.4	-4.4	-4.2	-3.7	-3.3	-2.4	-19.7	-37.6
<b>ESTIMATED BUDGETARY IMPACT OF MACROECONOMIC FEEDBACK</b>												
Effects on Outlays	*	-0.2	-0.3	-0.2	*	0.4	0.6	0.8	1.0	1.1	-0.7	3.1
Effects on Revenues	0.5	1.1	2.5	4.3	5.4	6.4	7.2	8.1	8.9	9.6	13.8	54.0
Effects on the Deficit	-0.6	-1.3	-2.8	-4.5	-5.3	-6.0	-6.6	-7.3	-8.0	-8.6	-14.5	-50.9
On-Budget	-0.3	-0.8	-1.9	-3.1	-3.7	-4.2	-4.6	-5.1	-5.6	-6.0	-9.9	-35.4
Off-Budget <sup>d</sup>	-0.2	-0.4	-0.9	-1.4	-1.6	-1.8	-2.0	-2.2	-2.4	-2.6	-4.6	-15.5

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**TABLE 2, Continued.**

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	By Fiscal Year, in Billions of Dollars											2016- 2020	2016- 2025
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025			
<b>TOTAL ESTIMATED CHANGES, INCLUDING MACROECONOMIC FEEDBACK</b>													
Effects on Outlays	-9.1	-17.6	-22.6	-26.4	-28.8	-30.7	-32.8	-34.2	-36.2	-36.6	-104.5	-275.1	
Effects on Revenues	-11.0	-8.3	-8.7	-10.7	-12.1	-13.3	-15.4	-18.4	-21.6	-25.6	-50.8	-145.3	
Effects on the Deficit	1.9	-9.3	-14.0	-15.7	-16.7	-17.4	-17.4	-15.8	-14.7	-11.0	-53.6	-129.8	
On-Budget	3.6	-4.6	-8.5	-9.5	-10.7	-11.1	-11.2	-9.9	-9.0	-6.0	-29.4	-76.7	
Off-Budget <sup>d</sup>	-1.7	-4.7	-5.5	-6.2	-6.0	-6.2	-6.2	-5.9	-5.7	-5.0	-24.2	-53.1	

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

Notes: Numbers may not add up to totals because of rounding; IPAB = Independent Payment Advisory Board;

\* = an increase or decrease between zero and \$50 million.

- a. For outlays, a positive number indicates an increase (adding to the deficit) and a negative number indicates a decrease (reducing the deficit); for revenues, a positive number indicates an increase (reducing the deficit) and a negative number indicates a decrease (adding to the deficit); for the deficit, a positive number indicates an increase and a negative number indicates a reduction.
  - b. Includes the additional effects of combining the repeal of the auto-enrollment requirement for large employers with the repeal of the individual and employer mandates.
  - c. All off-budget effects would come from changes in revenues. (The payroll taxes for Social Security are classified as “off-budget.”)
  - d. Off-budget effects from macroeconomic feedback include changes in Social Security spending and revenues.
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## **BASIS OF ESTIMATE EXCLUDING MACROECONOMIC FEEDBACK**

Excluding macroeconomic effects, CBO and JCT estimate that, on net, enacting the legislation would reduce federal deficits by \$78.9 billion over the 2016-2025 period; that change would result from a \$199.3 billion reduction in revenues and a \$278.2 billion decrease in direct spending. (See “Net Effects on Health Insurance Coverage” for a discussion of the combined effects of the legislation on health insurance coverage.)

### **Title I—Committee on Education and the Workforce**

Title I would repeal the requirement that certain large employers automatically enroll new employees in health insurance plans and continue the enrollment of current employees in a health insurance plan. CBO and JCT estimate that enacting that title would reduce federal deficits by \$2 billion over the 2016-2020 period and by \$7.9 billion over the 2016-2025 period.

**Auto-Enrollment for Certain Large Employers.** Under current law, employers with more than 200 full-time employees that offer health insurance coverage to at least one employee must automatically enroll new full-time employees in one of the health insurance plans offered by the employer. Additionally, such employers must automatically continue enrollment of current employees in a health insurance plan offered by the employer. Employees retain the right to opt out of health insurance offered by their employer, and CBO and JCT anticipate that some individuals who gain health insurance coverage through automatic enrollment will do so. The agencies project that about 750,000 people will be enrolled in employment-based health insurance in most years after 2018 because of the automatic enrollment requirements.

Although the requirement was originally scheduled to take effect in 2014, it is not currently being enforced. The Department of Labor announced in 2012 that employers would not be required to comply with requirements to automatically enroll employees until it issues implementing regulations.<sup>2</sup> To date, those regulations have not been issued and CBO and JCT expect that the requirements will not be enforced during 2016. CBO expects that in future years the requirements will be enforced and will increase the number of people enrolled in health insurance through their employer.

CBO and JCT estimate that repealing the auto-enrollment requirement would reduce the number of people enrolled in employment-based health insurance coverage by about 750,000 people in most years after 2018, with smaller effects in 2017 and 2018 and no effect in 2016. Of those people who would not be enrolled in employment-based coverage as a result of this legislation, CBO and JCT estimate that about 90 percent would be uninsured because they would not take action to enroll in insurance in the absence of the automatic enrollment requirements for their employer. The remainder would enroll in Medicaid or, to a lesser extent, in nongroup coverage offered through an exchange established under the ACA. Although most people with an offer of health insurance from their employer are not eligible to receive subsidies to purchase insurance through an exchange, people with an unaffordable offer from their employer (as defined by the ACA) are eligible to receive subsidies.

CBO and JCT estimate that enacting title I would result in net budgetary savings to the federal government of \$7.9 billion over the 2016-2025 period. That projected decrease in federal deficits over the 10-year period consists of a \$12.2 billion increase in revenues, partially offset by a \$4.3 billion increase in direct spending.

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2. Department of Labor, Employee Benefits Security Administration, “Frequently Asked Questions from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods” (February 9, 2012), <http://www.dol.gov/ebsa/newsroom/tr12-01.html>.

The projected increase in revenues over the 2016-2025 period stems primarily from lower projected enrollment in employment-based insurance, as discussed above. Relative to current law, that change in coverage would result in a smaller share of total compensation taking the form of non-taxable health benefits, increasing the share taking the form of taxable wages and salaries. A small portion of the estimated increase in revenues comes from higher projected penalty payments paid by people who would become uninsured under the bill. The projected increase in direct spending over the 2016-2025 period primarily reflects higher projected enrollment in insurance obtained through Medicaid and exchanges.

## **Title II—Committee on Energy and Commerce**

Title II would eliminate the Prevention and Public Health Fund and rescind all unobligated balances. For one year following enactment, the bill would withhold federal funds from certain entities that provide abortions. The Community Health Center Fund also would receive additional funding. CBO estimates that enacting title II would decrease direct spending by \$12.5 billion over the 2016-2025 period.

**Prevention and Public Health Fund.** Section 1 of title II would repeal the provision of the ACA that established the Prevention and Public Health Fund and rescind all unobligated balances. The Department of Health and Human Services (HHS) awards grants through the fund to public and private entities to carry out prevention, wellness, and public health activities. The ACA provided annual funding for these purposes of \$1.0 billion in 2016, rising to \$2.0 billion in 2022 and each year thereafter. CBO estimates that eliminating that funding would reduce direct spending by \$12.7 billion over the 2016-2025 period.

**Medicaid.** Section 2 of title II would, for a one-year period following enactment, prohibit federal funds from being made available to an entity (defined to include its affiliates, subsidiaries, successors, and clinics) that, as of the date of enactment of this legislation, is:

- A nonprofit organization described in section 501(c)(3) of the Internal Revenue Code and exempt from tax under section 501(a) of the Code;
- An essential community provider that is primarily engaged in providing family planning and reproductive health services and related medical care;
- Provides abortions—other than an abortion if the pregnancy is the result of an act of rape or incest or in the case where a woman’s life is in danger; and
- In fiscal year 2014, had expenditures under the Medicaid program that exceeded \$350 million.

CBO expects that, using the above criteria, only Planned Parenthood Federation of America and its affiliates and clinics would be affected, although some other health care clinics may also be affected. Most federal funds received by such clinics come from payments for services provided to enrollees in states' Medicaid programs. The budgetary effects of this provision depend mostly on whether the clinics affected by the legislation would decide to continue providing services without Medicaid reimbursement. The extent to which federal funding would be replaced by nonfederal resources during the year in which the prohibition would be in effect is highly uncertain. The amount replaced would depend on actions taken by such clinics and by others, including state and local governments.

If none of the federal funds were replaced, CBO expects that some of the Medicaid beneficiaries who would obtain services from affected clinics under current law would not obtain services at all, leading to lower Medicaid spending. Other people would continue to receive services—from providers that are eligible for Medicaid reimbursement. For those people, CBO estimates that there would be little change in Medicaid spending.

If almost all federal funds were replaced, CBO expects that most Medicaid beneficiaries currently served by affected clinics would continue to obtain services from those clinics, but at no cost to Medicaid. Under that circumstance, there would be little change in the services provided by such clinics and a large reduction in Medicaid spending for those services.

CBO has no clear basis for assessing the extent to which clinics affected by the legislation would be able to replace Medicaid funding. Therefore, for this estimate, CBO assumed that in the one-year period in which federal funds would be not be available to such clinics, approximately half of the federal funds that such clinics would otherwise receive from Medicaid would be replaced, the center of a wide range of possible outcomes. CBO estimates the combination of the effects described above would reduce direct spending by \$295 million over the 2016-2025 period. Those savings would be partially offset by increased spending for other Medicaid services as discussed below.

To the extent that there would be reductions in access to care under the legislation, they would affect services that help women avert pregnancies. The people most likely to experience reduced access to care would probably reside in areas without access to other health care clinics or medical practitioners who serve low-income populations. However, the extent to which Medicaid beneficiaries served by affected clinics live in such areas is uncertain. On the basis of an analysis of Essential Community Providers that offer family planning services compiled by the Health Resources and Services Administration, CBO estimates that as little as 5 percent or as much as 25 percent of the individuals currently served by affected clinics would face reduced access to care. For this estimate CBO projects that 15 percent of those people would lose access to care, the center of the distribution of possible outcomes.

The government would incur some costs for Medicaid beneficiaries currently served by affected clinics because the costs of about 45 percent of all births are paid for by the Medicaid program. CBO estimates that additional births that would result from enacting the legislation would add to federal spending for Medicaid. In addition, some of those children would themselves qualify for Medicaid and possibly for other federal programs. In the one-year period in which federal funds for the affected clinics would be prohibited under the legislation, CBO estimates the number of births in the Medicaid program would increase by several thousand, increasing direct spending for Medicaid by \$20 million in 2016 and by \$60 million over the 2016-2020 period. Netting those costs against the savings estimated above, CBO estimates that implementing the provision would reduce direct spending by \$235 million over the 2016-2025 period.

**Community Health Center Program.** Section 3 of title II would increase the funds available to the Community Health Center Program (CHC), which provides grant funds to health centers that offer primary and preventive care to patients regardless of their ability to pay. Under current law the program will receive \$3.6 billion in each of the fiscal years 2016 and 2017. The legislation would increase funding for the program by \$235 million in each of the fiscal years 2016 and 2017. CBO estimates that implementing the provision would increase direct spending by \$470 million over the 2016-2025 period.

Although increased funding to CHC could increase access to primary care and preventive services, generally, CBO does not anticipate that the increased funding would have any significant effect on the reduction in access to family planning services estimated in section 2 for two reasons. First, CBO anticipates that HHS would not be able to direct funding towards the provision of such services in time to prevent the disruption in access to services projected to occur in the first year. In addition, because the legislation would not direct HHS to provide the increased funding for specific types of services or clinics, CBO expects the increased funding would be allocated as under current law, for a wide variety of primary and preventive care services.

### **Title III—Committee on Ways and Means**

CBO and JCT estimate that enacting title III—which would repeal several provisions of the ACA—would reduce federal deficits by \$37.1 billion over the 2016-2025 period.

**Repeal of the Individual and Employer Mandates.** Title III would repeal both the individual mandate and the employer mandate. CBO and JCT estimate that repealing both mandates would result in net budgetary savings to the federal government of \$147.1 billion over the 2016-2025 period. That projected decrease in federal deficits over the 10-year period consists of a \$256.9 billion decrease in direct spending, partially offset by a \$109.8 billion reduction in revenues.

*Individual Mandate.* Under current law, people who do not obtain health insurance owe the greater of a flat dollar penalty or a percentage of a household's adjusted gross income in excess of the income threshold for mandatory tax-filing, both subject to a cap. Certain categories of people are exempt from paying penalties, including people with taxable income below the filing threshold, people without access to affordable coverage, unauthorized immigrants, and people who obtain a hardship waiver. CBO and JCT estimate that the equivalent of about 4 million people—on an annualized basis—will pay a penalty because they are uninsured in calendar year 2017.<sup>3</sup> The agencies estimate that the average penalty paid for being uninsured that entire year will be roughly \$925.<sup>4</sup> If the individual mandate was repealed, penalty payments for being uninsured would no longer be collected; CBO and JCT estimate that loss in penalty payments would total \$43.3 billion over the 2016-2025 period.

CBO and JCT estimate that, in addition to eliminating penalties for uninsured individuals, repealing the individual mandate would substantially reduce the number of people with health insurance coverage and, accordingly, reduce the estimated federal costs associated with some sources of health insurance coverage. Under current law, the agencies estimate that the existence of the individual mandate and its associated penalties spurs increased enrollment in federally-subsidized health insurance coverage through Medicaid, the Children's Health Insurance Program (CHIP), exchanges, and employment-based plans (which are subsidized indirectly because almost no premiums for that coverage are treated as taxable compensation). The estimated savings stemming from lower enrollment in such coverage would exceed the loss in revenues from eliminating penalty payments by uninsured people.

CBO and JCT estimate that repealing the individual mandate would also result in higher health insurance premiums in the nongroup market (that is, premiums for individually purchased health insurance) after 2016.<sup>5</sup> Insurers would still be required to provide

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3. CBO and JCT's estimates of health insurance coverage reflect average enrollment over the course of a year; therefore the agencies' estimates of the number of uninsured people paying a penalty are calculated on an annualized basis. As a result, two individuals that are each uninsured for six months of the year and pay a partial penalty would represent one person uninsured for a year in CBO and JCT's estimates. Since many of the people who are uninsured in a given year are uninsured for less than 12 months, it is likely that more than 4 million people will pay a penalty in 2017 and that the average penalty will be less than the annualized amount of \$925.
  4. The Internal Revenue Service (IRS) has released a preliminary review of tax return data through June 25, 2015, showing that 7.5 million tax returns included a penalty payment for being uninsured in 2014 and that the average penalty payment was roughly \$200 per return. Those figures are not directly comparable with CBO and JCT's estimates because a tax return may include multiple uninsured people and because CBO and JCT have estimated the number of full-year equivalents, not the actual number of individuals paying penalties. Also, CBO and JCT estimate that the number of people paying such a penalty was higher in 2014 than it will be in 2017 because more people were uninsured in 2014. The statutory penalty amounts were lower in 2014 because they increase gradually over a three-year period.
  5. CBO and JCT expect that insurers would not be able to change their 2016 premiums to reflect the increase in expected medical claims because the bill would be enacted after premiums are set for the 2016 plan year.

coverage to any applicant, would not be able to vary premiums to reflect enrollees' health status or to limit coverage of preexisting medical conditions, and would be allowed to vary premiums by age only to a limited degree. Those features are most attractive to applicants with relatively high expected costs for health care, so the agencies expect that repealing the individual mandate would tend to reduce insurance coverage less among older and less healthy people than among younger and healthier people, thus increasing premiums overall. Nevertheless, CBO and JCT anticipate that a significant number of relatively healthy people would still have a strong incentive to purchase insurance in the nongroup market because of the availability of government subsidies—and, therefore, that the market would not be subject to an unsustainable spiral of rising premiums. In years after 2016, CBO and JCT estimate that repealing the individual mandate would increase premiums for policies in the nongroup market by roughly 20 percent above what would be expected under current law, which would in turn increase the costs to the federal government of subsidies for eligible individuals who remain enrolled in individual policies purchased through the exchanges.

*Employer Mandate.* CBO and JCT estimate that repealing the employer mandate would yield two types of budgetary effects. First, employers that do not offer health insurance that meets specified standards would no longer be assessed penalties, which would reduce revenues by \$166.9 billion over the 2016-2025 period. Second, the agencies estimate that there would be small changes in health insurance coverage that would yield largely offsetting budgetary effects. Specifically, the agencies expect that some employers that are projected to offer health insurance to their employees under current law would no longer do so if the employer mandate were repealed because eliminating penalties would lower the cost of not offering health insurance. However, CBO and JCT expect that the reduction in offers of employment-based coverage would be limited because most employers construct compensation packages that comprise a mix of wages and nonwage benefits that will attract the best available workers at the lowest cost.<sup>6</sup> Those that would no longer enroll in employment-based coverage in the absence of the employer mandate would instead enroll in coverage through Medicaid, CHIP, the nongroup market (including individual policies purchased through the exchanges or directly from insurers in the nongroup market), or become uninsured.

**Repeal of the Medical Device Tax.** Title III also would repeal the medical device excise tax established by the ACA. Under current law, a tax of 2.3 percent is imposed on the sale of medical devices by the manufacturer or importer. Medical devices that are regularly available at retail for individual use and not primarily intended for use by a medical professional are exempt from the tax. The tax went into effect on January 1, 2013, and its repeal by the legislation would be effective starting in the first calendar quarter after the date of enactment. JCT estimates that repealing the medical device tax would reduce

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6. See Congressional Budget Office, *CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance* (March 2012), <http://www.cbo.gov/publication/43082>.

revenues, thus increasing federal deficits, by about \$23.9 billion over the 2016-2025 period.

**Repeal of the Excise Tax on Certain High-Premium Insurance Plans.** Title III would repeal a federal excise tax that will be imposed on employment-based health plans whose total value is greater than specified thresholds.<sup>7</sup> Under current law, the excise tax will take effect in 2018 and will be equal to 40 percent of the difference between the total value of contributions and the applicable threshold. CBO and JCT estimate that repealing the tax would result in net budgetary costs to the federal government of \$91.1 billion over the 2016-2025 period. That projected increase in federal deficits over the 10-year period consists of a \$109.3 billion decrease in revenues, partially offset by an \$18.2 billion decrease in direct spending.

The decrease in revenues over the 2016-2025 period primarily reflects an \$87.3 billion reduction in revenues stemming from forgone excise tax receipts and from fewer employers and workers shifting to lower-cost health insurance plans to avoid paying the tax. That is, relative to current law, more people would remain in higher-cost health insurance plans and a larger share of total compensation would take the form of non-taxable health benefits, decreasing the share taking the form of taxable wages and salaries. (Also, increased enrollment in higher-cost health plans would probably place upward pressure on health insurance premiums.)

CBO and JCT estimate that tax revenues would further decrease by \$12.5 billion over the 2016-2025 period as some employers who are expected to stop offering health insurance under current law (instead of offering insurance whose total value exceeds the specified thresholds for the excise tax) would no longer do so, thereby further reducing the share of compensation taking the form of taxable wages and salaries. Similarly, some employees who are not expected to enroll in insurance offered by their employer under current law, would do so. Both of those changes would further reduce the share of compensation taking the form of taxable wages and salaries.

The remaining portion of the estimated net decrease in revenues comprises a \$12.1 billion reduction in projected penalty payments from people who, under current law, would be uninsured because of the tax, and employers that, under current law, would pay penalties for not offering health insurance coverage that meets certain standards to their employees, and a \$2.6 billion increase in revenues from other smaller effects. In addition, CBO and JCT estimate that direct spending would decrease by \$18.2 billion over the 2016-2025 period primarily because some of the people who would newly enroll in employment-based coverage in the absence of the excise tax on high-premium plans would have otherwise been enrolled in insurance obtained through Medicaid and exchanges.

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7. The total value includes employers' and employees' contributions for health insurance premiums and contributions made through health reimbursement arrangements, flexible spending arrangements, and health savings accounts for other health care costs.

**Repeal of Independent Payment Advisory Board.** The legislation would repeal the provisions of the ACA that established the Independent Payment Advisory Board (IPAB) and that created a process by which the board (or the Secretary of the Department of Health and Human Services) would be required under certain circumstances to modify the Medicare program to achieve specified savings. CBO estimates that repealing the IPAB provision would not have any budgetary impact between 2015 and 2021, but would increase direct spending by \$7.1 billion over the 2022-2025 period.<sup>8</sup>

**Interaction Effects Within Title III.** Repealing the excise tax on high-premium insurance plans would reduce the amount of penalty payments collected from employers and uninsured people. However, those penalties would be eliminated by the repeal of the individual and employer mandates. Therefore, the estimated cost of repealing the excise tax on high-premium insurance plans would be reduced if that action was taken in conjunction with other provisions of title III. Accounting for the interactions, CBO and JCT project that the total savings would be \$12.1 billion greater over the 2016-2025 period than the net savings from the two provisions when estimated separately.

### **Interaction Effects Across Titles**

CBO and JCT estimate that enacting title I and title III simultaneously would increase total savings resulting from the legislation by \$21.4 billion over the 2016-2025 period compared with the sum of the savings estimated for each title separately. Most of the additional savings would stem from a further reduction in employment-based insurance. Under current law, CBO and JCT estimate, both the individual and employer mandates and the auto-enrollment requirement for certain large employers would increase the number of people enrolling in employment-based coverage. Keeping the individual mandate while repealing the auto-enrollment requirement (or vice versa) would mitigate the reduction in employment-based coverage that would otherwise occur. As a result, enacting both titles would further reduce employment-based coverage compared with enacting one title alone. That reduction in the number of people with employment-based coverage would result in a smaller share of total compensation taking the form of non-taxable health benefits, increasing the share taking the form of taxable wages and salaries and thus boosting tax revenues.

### **Net Effects on Health Insurance Coverage**

CBO and JCT estimate that the number of nonelderly people in the United States with health insurance coverage would decline by about 16 million in most years (the agencies

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8. For a discussion of the CBO's approach to estimating the budgetary effect of repealing the IPAB provision, see *H.R. 1190, the Protecting Seniors' Access to Medicare Act of 2015*, June 11, 2015, <https://www.cbo.gov/publication/50294>.

estimate that 15 to 20 percent of those people would be children).<sup>9</sup> Nearly all of that reduction in coverage would arise from repealing the mandate on individuals to obtain health insurance coverage; however, other provisions in the legislation would have small effects on coverage as discussed below. Specifically, CBO and JCT estimate that, in most years:

- Roughly 5 million fewer people, on net, would enroll in employment-based coverage. The agencies estimate that more than 5 million people would no longer enroll in employment-based coverage because fewer employers would offer health insurance coverage and fewer employees would take up such coverage in the absence of the individual and employer mandates and the requirement that large employers auto-enroll new employees and continue enrollment for current employees. However, CBO and JCT estimate that repealing the excise tax on high-premium insurance plans would offset that loss in employment-based coverage by roughly 500,000 to 1 million people because some employers who are not expected to offer coverage and some employees who are not expected to enroll in coverage under current law because of the tax on high-premium plans would do so.
- Roughly 7 million fewer people, on net, would obtain coverage through the nongroup market (including individual policies purchased through the exchanges and directly from insurers). CBO and JCT estimate that repealing the individual mandate and, to a much lesser extent, repealing the excise tax on high-premium insurance plans would reduce the number of people that seek out and enroll in coverage through the nongroup market; however, that reduction would be partially offset by an increase in nongroup coverage among people who would no longer have an offer of employment-based coverage if the employer mandate was repealed.
- Roughly 4 million fewer people would enroll in Medicaid or CHIP (about 20 percent of those are estimated to be children). Nearly all of that reduction in coverage stems from people—particularly those with taxable income above the tax-filing threshold—who would have been induced to enroll in Medicaid or CHIP because of the existence of the individual mandate and associated penalties.

In years after 2016, CBO and JCT estimate that 42 million to 43 million nonelderly people, or roughly 15 percent of the nonelderly population, would be uninsured if the legislation were enacted. By comparison, the agencies project that 26 million to 27 million nonelderly people, or roughly 10 percent of the nonelderly population, will be uninsured under current law in those years.

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9. The macroeconomic effects of the legislation discussed below, particularly the estimated 0.4 percent increase by the end of the decade in aggregate hours worked, could increase the number of people with health insurance coverage. CBO and JCT have not estimated that effect, but believe that it would be small relative to the overall effects.

## **BASIS OF ESTIMATE OF MACROECONOMIC FEEDBACK EFFECTS**

CBO and JCT have determined that H.R. 3762 is major legislation as defined in section 3112 of S. Con. Res. 1, the Concurrent Resolution on the Budget for Fiscal Year 2016.<sup>10</sup> As a result, the budget resolution requires that CBO and JCT include macroeconomic effects in the cost estimate, to the greatest extent practicable. Therefore, the agencies have analyzed the effects this legislation would have on the U.S. economy and have estimated the resulting budgetary impact—or macroeconomic feedback. That macroeconomic feedback is included in this cost estimate and discussed below.

CBO and JCT estimate that the net effect of the legislation on the economy's output would be negligible in 2016 and 2017 but would grow after that. According to the agencies' estimates, from 2021 through 2025, the bill would increase gross domestic product (GDP) by about 0.2 percent, on average—mostly by repealing provisions of the ACA that, under current law, are expected to reduce the supply of labor.

The macroeconomic feedback effects of H.R. 3762 would lower federal deficits by \$51 billion over the 2016–2025 period, CBO and JCT estimate. The largest effect would be an increase in revenues arising from the increased supply of labor, which in turn would boost employment and taxable income. After accounting for the feedback effects to revenues and spending, CBO and JCT estimate that the total impact of the legislation would be to reduce federal deficits by \$130 billion over the 2016–2025 period.

In general, CBO and JCT analyze the macroeconomic effects of changes in fiscal policy by examining similar policies that have been implemented previously and by using results from a variety of economic models. Both agencies also distinguish between longer- and shorter-term effects. Changes in fiscal policy affect output over the longer term by altering people's incentives to work and save and by changing businesses' incentives to invest, thereby changing potential output over the longer term. In the shorter term, changes in fiscal policies also can affect the economy by influencing the demand for goods and

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10. Section 3112 of S. Con. Res. 11 defines legislation that is covered by the resolution as major if it has a gross budgetary effect that is equal to or greater than 0.25 percent of projected gross domestic product in any fiscal year (before incorporating macroeconomic effects and not including timing shifts). As specified in the conference agreement to S. Con. Res. 11, that test is met if either the absolute value—that is, the magnitude regardless of sign—of any provision's budgetary effect or the sum of the absolute values of all of the provisions' effects on revenues and direct spending (including the effects of their interactions) exceeds the 0.25 percent threshold. For example, in the case of the legislation analyzed here, the sum of the absolute values of the budgetary effects of the provisions and their interactions, shown in Table 2, equals \$95 billion in fiscal year 2025 or 0.35 percent of projected GDP (according to CBO's January 2015 economic projections, which are currently used as the basis for CBO's cost estimates). As a result, the gross budgetary effect exceeds the threshold and this legislation is defined as major.

services, leading to changes in actual output relative to potential output (the maximum sustainable output of the economy).<sup>11</sup>

For this report, CBO and JCT collaborated to examine the macroeconomic effects of the legislation and those effects' feedback to the federal budget, with each agency focusing on different components of the analysis. JCT primarily analyzed the macroeconomic effects and feedback to federal revenues stemming from the repeal of the excise tax on medical devices and from the excise tax on certain high-premium insurance plans.<sup>12</sup> CBO primarily analyzed the macroeconomic effects and feedback to federal revenues arising from the other changes in fiscal policy that would stem from the legislation, as well as the feedback effects to federal outlays stemming from the legislation.<sup>13</sup> The estimates of macroeconomic effects and of their feedback to the federal budget presented in this report constitute a synthesis of those analyses.

### **Macroeconomic Effects from 2021 through 2025**

The largest macroeconomic effects of H.R. 3762 would take several years to arise. CBO and JCT estimate that, over the final five years of the current budget window—the period from 2021 to 2025—the bill would boost GDP by about 0.2 percent, on average, relative to current-law projections. During that period, the estimated effects on output stem from two main sources:<sup>14</sup>

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11. This analysis is based on an approach very similar to that employed in Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act* (June 2015), <https://www.cbo.gov/publication/50252>.
  12. JCT used its macroeconomic equilibrium growth (MEG) model, in which economic output in the longer run is determined by the supply of labor and capital, which in turn respond to the rates of taxation on wages and capital income. In the shorter run, output may be influenced by changes in consumer demand stemming from changes in after-tax income. For a description, see Joint Committee on Taxation, *Overview of the Work of the Staff of the Joint Committee on Taxation to Model the Macroeconomic Effects of Proposed Tax Legislation to Comply with House Rule XIII.3.(h)(2)*, JCX-105-03 (December 2003), <http://go.usa.gov/3XS2R>. For a discussion of the parameter values currently used in the MEG model, see Joint Committee on Taxation, *Macroeconomic Analysis of the "Tax Reform Act of 2014,"* JCX-22-14 (February 2014), <http://go.usa.gov/3XSTJ>.
  13. To estimate the effects of the Restoring Americans' Healthcare Freedom Reconciliation Act over the longer term, CBO employed a version of a widely used Solow-type growth model in which economic output is determined by the number of hours of labor that workers supply, the size and composition of the capital stock (such as factories and equipment), and the combined productivity of labor and capital (known as total factor productivity). In the short term, changes in fiscal policies also can affect the economy by influencing the demand for goods and services by consumers, businesses, and governments, which leads to changes in actual output relative to potential output. For a description see Congressional Budget Office, *How CBO Analyzes the Effects of Changes in Federal Fiscal Policies on the Economy* (November 2014), [www.cbo.gov/publication/49494](http://www.cbo.gov/publication/49494).
  14. Implementation of the legislation could affect GDP and other aspects of the economy in several other ways. For example, through various channels the legislation might also affect productivity or rates of private saving. In CBO and JCT's judgment, however, those effects would be quite small, on net. For details, see Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act* (June 2015), pp. 18-19, <https://www.cbo.gov/publication/50252>.

- The legislation’s largest effects on output are projected to result from repealing several provisions of the ACA that reduce the aggregate supply of labor by imposing taxes and fees that decrease some people’s incentives to work. Repealing those provisions would eliminate those particular disincentives to work. It would also reduce the number of people facing disincentives to work from other ACA-related provisions. As a result, the legislation would increase the supply of labor and increase output relative to baseline projections.
- The legislation is expected to increase the capital stock over the next decade. In particular, the bill would increase incentives for capital investment by increasing labor supply (which makes capital more productive). In addition, the decrease in deficits that would be brought about by the legislation would decrease federal borrowing and thus increase the money available for capital investment.

**Labor Supply.** CBO and JCT estimate that the legislation would increase the supply of labor and thus increase aggregate compensation (wages, salaries, and fringe benefits) by about 0.2 percent over the 2021–2025 period. That estimate has two components: First, repealing certain taxes and penalties on individuals and employers that were enacted as part of the ACA would increase incentives to work; second, those changes in law also would reduce the number of people obtaining subsidies for health insurance through the insurance exchanges or the Medicaid program, CBO and JCT estimate, so the adverse effects of those subsidies on work incentives also would be smaller, on net. Each of those components accounts for about half of the legislation’s estimated effects on aggregate labor supply.

Specifically, the legislation would repeal three sets of taxes and penalties that are estimated to have a noticeable effect on labor supply:<sup>15</sup>

- First, it would repeal the requirement that large employers offer their employees health insurance coverage that meets specified standards or pay penalties. The costs of those penalties will eventually be passed on to workers in the form of lower wages, CBO and JCT estimate, so repealing the penalties would increase workers’ wages and thus their incentive to work.
- Second, it would repeal a federal excise tax that will be imposed on employment-based health plans whose total value is greater than specified thresholds. Under current law, that excise tax is expected to lower after-tax compensation in two ways. First, firms that pay the tax are expected to pass the cost

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15. For additional information, see Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act* (June 2015), <https://www.cbo.gov/publication/50252> and Congressional Budget Office, *The Budget and Economic Outlook: 2015 to 2025* (January 2015), Appendix C, [www.cbo.gov/publication/49892](http://www.cbo.gov/publication/49892).

on to workers by decreasing compensation. Second, firms that avoid the tax by shifting to less expensive health plans are expected to increase other forms of compensation correspondingly. Because those other forms will mostly be taxable, after-tax compensation is expected to fall on balance. Repealing the excise tax would undo those two effects, slightly increasing workers' after-tax compensation and thus slightly increasing their labor supply.

- Third, it would repeal a penalty on individuals who do not obtain health insurance. For higher-income people who are uninsured, the penalty increases with income and thus has the same effect as an income tax. Repealing that penalty would undo that effect and, as a result, increase their incentives to work. The affected workers account for less than one percent of earnings in the economy, so the resulting increase in labor supply and aggregate earnings would be minimal.

Repealing those provisions—particularly the individual mandate—also would affect the number of people receiving subsidized health insurance and thus their incentive to work. Those subsidies have the effect of discouraging work both because they are phased out as recipients' income rises—creating an implicit tax on additional earnings—and because the subsidies, along with expanded eligibility for Medicaid, effectively increase enrollees' income. Under the legislation, the number of people receiving exchange subsidies would be about 30 percent lower than is projected under current law.

Having fewer workers receive subsidies would reduce that dampening effect on labor supply, so labor supply would be larger than is projected under current law. An offsetting consideration is that repealing the individual mandate also would increase average premiums in the exchanges, and thus would increase the value of subsidies for the remaining recipients—which in turn would increase the implicit tax on labor that stems from the phase-out of those subsidies. In CBO and JCT's judgment, however, the effects on labor supply of having fewer subsidy recipients would outweigh the effects of having remaining recipients face higher effective tax rates.

In percentage terms, the increase in total hours worked is estimated to be larger than the increase in aggregate compensation because the largest increases in labor supply would occur among lower-wage workers whose incentives would be most strongly affected. Specifically, relative to current law the legislation would increase the aggregate number of hours worked by about 0.4 percent over the 2021–2025 period, CBO and JCT estimate.

**Capital Stock.** CBO and JCT estimate that the legislation would increase the capital stock over the 2021–2025 period by somewhat less than the 0.2 percent increase in labor supply. The bill would increase the capital stock for two main reasons. First, the increase in labor supply resulting from the legislation would increase the rate of return on investment and thus increase incentives to save and invest. The resulting increase in saving and investment—relative to current law—thus would gradually boost the capital stock;

consequently, output would be higher. CBO and JCT also considered the extent to which the legislation would affect output through its reduction in federal deficits. Smaller deficits would leave more money for private investment, which increases investment and output. An additional, minimal contributor to the increase in investment is a slight reduction in business costs due to the repeal of taxes on medical devices and certain high premium health plans. Altogether, the effects on output of those changes in the capital stock would be smaller than the increases in output stemming from changes in the supply of labor.

### **Macroeconomic Effects From 2016 through 2020**

CBO and JCT estimate that H.R. 3762 would have smaller effects on output in the next few years than would occur later in the coming decade. In particular, the legislation would have a positive but negligible effect on output in 2016 and 2017, rising to about 0.1 percent in 2020, CBO and JCT estimate. (The effect would continue to rise over the next five years.) The estimated increase in the size of the effect through 2020 stems primarily from a growing boost over those years to the number of hours worked (due to increased work incentives).

**Labor Supply.** CBO estimates that the increase in labor supply and hours worked would become larger over the next several years relative to projections under current law. That conclusion reflects an expectation that the provisions of the ACA that the legislation would repeal would dampen labor supply gradually. Hence, undoing those effects is estimated to affect the labor market gradually. A second consideration is that the increase in labor supply stemming from the legislation would have a somewhat muted effect on total hours worked over the next two years or so, when there will still be some slack in the labor market, according to CBO's baseline projections. Thus, if some workers increase the number of hours they work or successfully get jobs rather than leave or stay out of the labor force altogether, some other underemployed workers or people who are not actively looking for employment but are willing to work will probably work less than they would under current law. As a result, the increase in labor supply would partly result in greater employment and partly result in more people being unemployed or underemployed relative to CBO's baseline projections.

**Aggregate Demand.** CBO and JCT estimate that the legislation would, on net, decrease aggregate demand for goods and services in the short-term. The largest negative effects on aggregate demand would come from individuals who would no longer obtain insurance through the exchanges because of the repeal of the individual mandate. Those people, as a group, would spend less on health care and spend more on other goods and services, but they would have less to spend overall because they would not be receiving subsidies for health insurance. Hence, total spending by those households would fall by close to the same amount as the decline in subsidies. That decrease in spending would in turn be partly offset by an increase in spending by those who owe less in taxes because of the repeal of various tax provisions. CBO and JCT estimate that, overall, the increase in spending due to

tax reductions would be smaller than the reduction in spending by those no longer receiving subsidies, for two reasons. The reduction in subsidies would be larger, in dollar terms, than the reduction in taxes; and a portion of those receiving tax cuts would be in higher-income households, who are estimated to be relatively less responsive to changes in disposable income.

### **Budgetary Feedback From Macroeconomic Effects**

Taking into account the factors described above, CBO and JCT estimate that the macroeconomic effects of H.R. 3762 would lower federal deficits by \$51 billion over the 2016–2025 period. Most of that reduction would stem from an increase in revenues resulting from higher employment and taxable income, relative to projections under current law. Specifically, the increase in output that would result from the legislation would boost revenues by \$54 billion over the 2016-2025 period.

Outlays would primarily be affected by the estimated changes in interest rates, rising slightly over the decade. Interest rates would be slightly higher because the relative scarcity of capital (given the increase in labor supply) would push up the rate of return to investment. That effect would more than offset the dampening effect on interest rates from the reduction in federal borrowing. On net, CBO estimates that the macroeconomic effects of the legislation would increase outlays by \$3 billion over 2016-2025 period.<sup>16</sup>

Combined with the estimated effects of the legislation on federal deficits excluding macroeconomic feedback, the total result of changes in direct spending and revenues would amount to a decrease in federal deficits of \$130 billion over 10 years.

CBO and JCT’s estimates of those macroeconomic feedback effects and the methods used to generate them depend in part on the types of provisions and categories of feedback being analyzed. In estimating the feedback effects on revenues of repealing the excise tax on certain high-premium insurance plans and the medical device tax, JCT projected effects on the net effective tax rates for several different types of taxable income (including wages, interest, dividends, capital gains, and business income). In analyzing the insurance coverage provisions—which affect the economy primarily through their impact on labor supply—CBO estimated that the resulting increases in GDP would raise revenues in a roughly proportional way, primarily because income and payroll taxes would rise with higher compensation and income.

To estimate the effects of macroeconomic feedback on federal spending, CBO generally uses a simplified method that accounts for changes in GDP and interest rates, among other factors, but does not involve the sort of detailed program-by-program analysis that the

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16. Reflecting a long-standing convention, CBO does not include in cost estimates the budgetary effects of changes in interest payments stemming from changes in the amount of debt incurred. However, the macroeconomic effects of those changes in interest payments are incorporated into the agency’s macroeconomic analysis.

agency uses for official cost estimates. As a rule, increases in GDP would have much smaller effects on federal spending than on revenues. CBO's estimates for discretionary programs incorporate the assumption that spending generally remains at the amounts projected in its budgetary baseline even if output changes.<sup>17</sup> For mandatory programs, CBO estimates, aggregate spending would be affected only slightly by a change in the rate of economic growth.<sup>18</sup>

## UNCERTAINTY

Estimates of the effects of the legislation—which would repeal several major provisions of the ACA—are subject to substantial uncertainty, which stems at least in part from the difficulty in projecting the effects of those provisions themselves. Although initial data are available about some particular effects, the ways in which individuals, employers, insurers, and other affected parties will respond to the changes made by ACA—and the ways in which those same people and organizations would respond to repealing some of its provisions—are all difficult to predict, and the responses could deviate in either direction from CBO and JCT's estimates. Another source of uncertainty is that the legislation's effects on labor markets, GDP, and other macroeconomic variables—and the resulting budgetary feedback—could be smaller or larger than the agencies have estimated.

On balance, CBO and JCT estimate that the most likely outcome of enacting the legislation would be to reduce budget deficits over the 2016–2025 period. That estimate is designed to represent the middle of a broad range of possible outcomes. In light of the many uncertainties involved, over the full range of likely outcomes, the legislation could increase deficits over that period or could reduce them by more than the agencies have estimated. Over the longer term, the agencies expect that the legislation would ultimately increase federal deficits, but the uncertainty surrounding the magnitude of that estimate grows over time as well.

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17. Changes in projected prices and rates of inflation affect CBO's baseline projections of discretionary spending after 2021, when discretionary spending is no longer capped under current law. However, CBO estimates that the effects of the legislation on inflation would be small. Assuming appropriation actions consistent with the bill discretionary spending would be reduced by less than \$1 billion over the next decade.

18. CBO recently estimated that a reduction in the real (inflation-adjusted) GDP growth rate of 0.1 percentage point per year over the next decade—which would reduce GDP by about 1 percent in 2025—would reduce mandatory spending only by \$4 billion over that period. According to that rule of thumb, a corresponding increase in the rate of GDP growth over the next decade would be expected to increase mandatory spending by roughly the same amount. See Congressional Budget Office, *The Budget and Economic Outlook: 2015 to 2025* (January 2015), Appendix C, [www.cbo.gov/publication/49892](http://www.cbo.gov/publication/49892).

## 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, with and without macroeconomic feedback. Only on-budget changes to outlays or revenues are subject to pay-as-you-go procedures.

**TABLE 3. CBO AND JCT ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 3762, THE RESTORING AMERICANS' HEALTHCARE FREEDOM RECONCILIATION ACT OF 2015, AS REPORTED BY THE HOUSE COMMITTEE ON THE BUDGET ON OCTOBER 16, 2015**

	By Fiscal Year, in Millions of Dollars											2016-	2016-		
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2020	2025			
<b>NET INCREASE OR DECREASE (-) IN THE ON-BUDGET DEFICIT EXCLUDING MACROECONOMIC FEEDBACK</b>															
Statutory															
Pay-As-You-Go Effects	3,900	-3,800	-6,600	-6,400	-7,000	-7,000	-6,500	-4,800	-3,400	0	-19,500	-41,300			
<b>Memorandum:</b>															
Changes in Outlays	-9,100	-17,500	-22,400	-26,100	-28,800	-31,000	-33,400	-35,000	-37,200	-37,700	-103,800	-278,200			
Changes in Revenues	-13,000	-13,700	-15,800	-19,700	-21,800	-24,100	-26,800	-30,200	-33,800	-37,700	-84,100	-236,600			
<b>NET INCREASE OR DECREASE (-) IN THE ON-BUDGET DEFICIT INCLUDING MACROECONOMIC FEEDBACK</b>															
Statutory															
Pay-As-You-Go Effects	3,600	-4,600	-8,500	-9,500	-10,700	-11,100	-11,200	-9,900	-9,000	-6,000	-29,400	-76,700			
<b>Memorandum:</b>															
Changes in Outlays	-9,100	-17,600	-22,600	-26,300	-28,700	-30,600	-32,800	-34,200	-36,200	-36,600	-104,400	-274,900			
Changes in Revenues	-12,700	-13,000	-14,200	-16,900	-18,100	-19,500	-21,600	-24,200	-27,200	-30,600	-74,800	-197,900			

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

Note: Numbers may not add up to totals because of rounding.

## INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

As required by the Concurrent Resolution on the Budget for Fiscal Year 2016, CBO and JCT have assessed the effect of H.R. 3762 on long-term deficits and direct spending.

## Deficits

CBO and JCT estimate that enacting the bill would increase deficits (on both a unified and on-budget basis) by more than \$5 billion in one or more of the four consecutive 10-year periods beginning in 2026, with or without macroeconomic feedback.

- Excluding macroeconomic feedback, revenues stemming from the excise tax on certain high-premium insurance plans are expected to grow more rapidly under current law than some other components of the estimate because an increasing portion of employer plans are affected by the tax over time. In the longer term, the loss of those revenues would more than offset the savings from other provisions of the bill, causing an increase in budget deficits soon after 2025.
- Macroeconomic feedback is estimated to ultimately increase deficits despite the boost to incentives to work. In particular, the increase in deficits that would occur after 2025 excluding macroeconomic feedback would increase federal borrowing and thus leave less money available for private investment, putting upward pressure on interest rates across the economy. The result of that effect, alongside the upward pressure on interest rates from the scarcity of capital relative to the larger supply of labor, would increase interest rates on government debt and result in larger interest payments.

## Direct Spending

Excluding macroeconomic feedback, CBO and JCT estimate that enacting the bill would not increase net direct spending by more than \$5 billion in either of the first two consecutive 10-year periods beginning in 2026, but the agencies cannot determine whether enacting the bill would increase net direct spending by more than \$5 billion in the third or fourth 10-year period. However, when macroeconomic feedback effects are included, CBO and JCT estimate that enacting the bill would increase direct spending by more than \$5 billion in one or more of the four consecutive 10-year periods beginning in 2026. Two factors would cause those outcomes:

- Over time, the cost of repealing IPAB is expected to grow more rapidly than the estimated reductions in spending resulting from other provisions of the legislation. CBO and JCT expect that cost would eventually exceed the estimated spending reductions resulting from other provisions of the bill. However, the agencies cannot determine whether that would happen in the third or fourth 10-year period beginning in 2026, or whether it would occur later.
- When the macroeconomic feedback to interest rates and the resulting larger interest payments that are described above are included, projected spending is greater. As a result, CBO and JCT estimate that in at least one of the four consecutive 10-year

periods beyond 2026, the costs of repealing IPAB combined with those larger interest costs would exceed the reductions in spending resulting from the other provisions of the legislation by more than \$5 billion.

## **INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT**

CBO has reviewed titles I and II and the non-tax provisions of title III (subtitle B) and determined those provisions contain no intergovernmental or private-sector mandates as defined in UMRA. JCT has determined that subtitle A of title III contains no intergovernmental or private-sector mandates as defined in UMRA.

## **PREVIOUS COST ESTIMATES**

On October 2, 2015, CBO transmitted cost estimates for three sets of reconciliation recommendations ordered reported by the House Committees on Education and the Workforce, Energy and Commerce, and Ways and Means. H.R. 3762 includes each of these recommendations. CBO and JCT's estimates of the budgetary effects of the three recommendations combined are the same as those reported earlier with two exceptions. This estimate includes an interaction effect between title I, which contains the reconciliation recommendations of the House Committee on Education and the Workforce, and title III, which contains the reconciliation recommendations of the House Committee on Ways and Means. That interaction further reduces the estimated net deficit by \$21.4 billion over the 2016-2025 period. This estimate also includes the effect of macroeconomic feedback as a result of the legislation. Those macroeconomic effects would decrease deficits by an additional \$51 billion over the 2016-2025 period, CBO and JCT estimate.

**ESTIMATE PREPARED BY:**

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CONGRESSIONAL BUDGET OFFICE  
U.S. Congress  
Washington, DC 20515

*Keith Hall, Director*

October 20, 2015

Honorable Tom Price, M.D.  
Chairman  
Committee on the Budget  
U.S. House of Representatives  
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015.

If you wish further details on this estimate, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Keith Hall".

Keith Hall

Enclosure

cc: Honorable Chris Van Hollen  
Ranking Member