Employers' Responsibilities in 2015. Under the ACA, certain employers with 50 or more FTE employees that do not offer health insurance coverage that meets the standards specified in law will be subject to penalties. That requirement initially was to take effect in January 2014, but in July 2013 the Administration delayed the requirement by one year and set it to take effect in January 2015.[23] That delay was incorporated into CBO and JCT's February 2014 projections.

In February 2014, the Department of the Treasury issued a final regulation providing additional transitional relief to employers. Employers with at least 50 but fewer than 100 FTE employees will be exempt from the employer requirement in 2015 if they certify that they have not made certain reductions to health insurance coverage or reduced their number of FTE employees to avoid the penalties. That final regulation also provided for a one-year relaxation of a related coverage requirement for employers subject to the requirement. That change took two forms. First, in 2015, those employers must offer coverage to at least 70 percent of their full-time employees—rather than the 95 percent specified in the proposed regulation. Second, in 2015, employers with at least 100 FTE employees are permitted to exclude the first 80 full-time employees from the penalty calculation (rather than the first 30 full-time employees, as will be the case in subsequent years).

That additional transitional relief was not included in the February 2014 projections. Incorporating the effects of that regulation led CBO and JCT to estimate slightly lower enrollment in employment-based coverage in 2015 and to estimate slightly less in revenues from penalties paid by employers in 2016. (Because penalties are collected the year after they are assessed, the 2015 delay will reduce collections in 2016.)

Availability of Noncompliant Plans. Under the ACA, health insurance policies sold by insurers must—in most cases—comply with certain rules, among them a prohibition on adjusting premiums on the basis of an applicant's health status and a requirement that insurers in the nongroup and small-group markets offer plans to all applicants that cover certain essential health benefits and that pay a specified minimum share of the cost of covered benefits. Those requirements apply to plans sold both within and outside of the exchanges. (For more information on the nongroup market under the ACA, see Box 1 on page 8.) However, in March 2014, the Department of Health and Human Services announced that, through October 1, 2016, state insurance commissioners could permit health insurers to re-enroll individuals and small businesses in existing plans that do not comply with certain market and benefit rules that took effect in 2014, allowing such coverage to continue through September 2017. That announcement extended an action announced in November 2013 that permitted the renewal of noncompliant policies through October 1, 2014 (extending that coverage through September 2015).

CBO and JCT estimate that the March 2014 announcement will slightly reduce enrollment in ACA-compliant plans because some people will take advantage of this option by renewing their coverage in noncompliant plans. CBO and JCT also estimate that the March announcement will slightly reduce spending for exchange subsidies because some people who would have enrolled in a subsidized plan through the exchanges will instead renew coverage in noncompliant plans (which cannot be sold through the exchanges and are not subsidized). In addition, the lower premiums that small employers and self-employed people are likely to pay for noncompliant plans will generate a small amount of additional tax revenues because of those enrollees' resulting increased taxable income.

CBO and JCT expect that people who renew noncompliant plans will be healthier, on average, than people who enroll in ACA-compliant plans, leading to slightly higher medical claims per enrollee among ACA-compliant plans. However, CBO and JCT expect that such adjustments will have a negligible effect on average premiums in exchange plans because the number of people who re-enroll in noncompliant plans will probably be small relative to total enrollment in exchange plans.

Risk Corridors. The ACA established several programs to reduce the risk of financial losses faced by insurers. Under the temporary risk corridor program, the government will make payments during the next few years to companies that offer individual and small-group plans sold on the exchanges (and will make payments for certain plans sold outside of the exchanges if the plans are substantially the

23. For an estimate of the budgetary effects of that delay, see Congressional Budget Office, letter to the Honorable Paul Ryan providing an analysis of the Administration's announced delay of certain requirements under the Affordable Care Act (July 30, 2013), www.cbo.gov/publication/44465.

same as plans sold by the same carriers within the exchanges) when actual costs for medical claims exceed expected costs by certain percentages. At the same time, the government will receive payments from those plans whose actual costs for medical claims fall short of their expected costs by certain percentages.[24]

In March 2014, the Department of Health and Human Services issued a final regulation stating that its implementation of the risk corridor program will result in equal payments to and from the government, and thus will have no net budgetary effect. CBO believes that the Administration has sufficient flexibility to ensure that payments to insurers will approximately equal payments from insurers to the federal government, and thus that the program will have no net budgetary effect over the three years of its operation. (Previously, CBO had estimated that the risk corridor program would yield net budgetary savings of $8 billion.)

Hardship Exemption. In December 2013, the Department of Health and Human Services announced that it was allowing people whose nongroup plans were canceled by their insurers for 2014 to apply for a hardship waiver that would allow them either to remain uninsured without paying a penalty or to purchase lower-cost catastrophic coverage (plans with particularly high out-of-pocket costs for which most people would not ordinarily be eligible under the ACA).[25] In March 2014, the Department of Health and Human Services announced that this hardship waiver would be extended until October 1, 2016.[26]

People who apply for this hardship waiver will need to verify that they had been covered by a health insurance plan that was canceled. Because CBO and JCT expect that most of the people whose plans have been canceled will seek alternative sources of coverage rather than become uninsured, the agencies expect that this additional hardship exemption will have a negligible effect on the amount of penalties collected from uninsured people. In addition, CBO and JCT expect that, for three reasons, a very small number of people who are permitted to enroll in a catastrophic plan will actually do so: Catastrophic plans have lower actuarial value than other types of coverage, people who enroll in catastrophic plans are ineligible for exchange subsidies, and CBO and JCT expect that many people either obtained coverage from another source for 2014 before the announcement or were unaware of that option at the time they sought coverage.

Changes in the Estimates Since February 2014

CBO and JCT currently estimate that the insurance coverage provisions of the ACA will have a net cost over the 2015–2024 period that is $104 billion less than the agencies estimated in February 2014. The difference stems from the following changes in estimates of the government's spending and collections (see Figure 2 on page 19 and Table 4 on page 14):

- A reduction of $165 billion (or 8 percent) in the gross cost of the coverage provisions, almost entirely because exchange subsidies and related spending are now projected to cost $1,032 billion, compared with the previous estimate of $1,197 billion; and

- A partially offsetting net reduction of $61 billion in savings as a result of lower expected penalty payments from uninsured people and employers, higher expected revenue resulting from the excise tax on certain high-premium employment-based insurance plans, and lower savings from other budgetary effects (mostly decreases in tax revenues).

Exchange Subsidies and Related Spending. CBO and JCT have not changed their previous estimate of the number of people who will purchase coverage through the exchanges in 2014. After 2014, however, CBO and JCT's estimates of enrollment are slightly higher than those in the previous projection—by less than 1 million people annually for most years. That increase has various origins, as discussed above, including lower expected premiums in the exchanges and less expected employment-based coverage for early retirees, both of which would increase the number of people purchasing insurance through the exchanges. Partially offsetting those factors are a slight downward shift in the expected income distribution (which reduces the number of people anticipated to be eligible for exchange subsidies) and

24. For more information, see Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, Appendix B (February 2014), www.cbo.gov/publication/45010.

25. See Centers for Medicare & Medicaid Services, "Options Available for Consumers With Cancelled Policies" (December 19, 2013), http://go.usa.gov/KHTw (PDF, 110 KB).

26. See Centers for Medicare & Medicaid Services, "Insurance Standards Bulletin Series—Extension of Transitional Policy Through October 1, 2016" (March 5, 2014), http://go.usa.gov/KHbh (PDF, 148 KB).