Repeal of the Affordable Care Act

Potential Effects on Coverage, Government Spending, and Provider Revenue

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Summary

Presidential candidate Donald Trump has again proposed repealing and replacing the Affordable Care Act (ACA). This paper reviews major publications by the Congressional Budget Office (CBO) and the Urban Institute (Urban) that analyzed the most important repeal legislation introduced in 2016 and 2017. These studies provided largely consistent estimates on the effects of repeal on coverage and spending. Specifically, the number of uninsured would increase by 21–24 million with full repeal and 30–32 million with partial repeal; in the latter, Medicaid expansion and premium subsidies are eliminated, but insurance reforms are not. Federal spending would fall by about $1 trillion over 10 years under a full repeal and somewhat more with partial repeal. State spending would fall because of the elimination of the Medicaid provisions in the ACA, but that would be more than offset by funding to help providers with increased uncompensated care burdens. Providers would see reductions in revenues of about $1.7 trillion over 10 years for all services under partial repeal, including about $600 billion for hospitals. The demand for uncompensated care would increase, and whether and how this is paid for is unknown, whether through increased federal or state spending or by providers themselves.

Introduction

Presidential candidate Donald J. Trump has declared in numerous campaign speeches his intent to revisit efforts to "repeal and replace" the ACA.[1] The ACA was enacted in 2010 and implemented in 2014. The law expanded Medicaid, introduced premium tax credits in the nongroup market, and substantially reformed the private insurance market, including introducing insurance exchanges or "Marketplaces" in the nongroup market. The result was a substantial increase in Medicaid and subsidized nongroup coverage and a large reduction in the uninsured. No evidence suggests the ACA resulted in higher health care costs, but the evidence does suggest that expenditures after the enactment of the ACA were well below Center for Medicare & Medicaid Services (CMS) forecasts (Holahan and McMorrow 2015; McMorrow and Holahan 2016). Premium growth in the ACA's Marketplaces has also been low compared with the commercial insurance market (Holahan, O'Brien, and Wengle 2024).

Proposals to repeal the ACA have been highly controversial and would have major effects on insurance coverage and the number of people uninsured, federal and state health care spending, and premiums facing households in the nongroup insurance market. In this paper, we review studies of past efforts to repeal the ACA conducted by CBO and Urban. There were many repeal efforts dating back to the law's passage; we limit our review to the studies done during 2016 and 2017, the period of the most aggressive legislative action, and one in 2020 in response to a Supreme Court case, *California v. Texas*. A review of these earlier analyses provides a background on the changes ACA challengers are likely to pursue and their broad implications for households, insurers, providers, and the government.

A Brief History

Efforts to repeal the ACA have a long and complicated history.[2] Several attempts at repeal were made between enactment and 2015, but none were successful. They either did not pass in Congress or were vetoed by President Obama. In 2015, the most significant efforts began.

On October 1, 2015, a reconciliation bill that allowed for partial repeal was introduced. A partial repeal would affect only the budget provisions of the ACA and thus could be passed in the Senate through a reconciliation bill with only 51 votes instead of the typically required 60. The Senate eventually passed a version of the bill and returned it to the House, where it was passed on January 6, 2016. President Obama vetoed it.

On March 20, 2017, House Republicans introduced the American Health Care Act. It was designed as a replacement for the ACA. On May 4th, the House of Representatives voted to pass the American Health Care Act by a narrow margin, and the bill moved to the Senate. The American Health Care Act would have eliminated most of the ACA's important provisions starting in 2017, including income-related premium tax credits and cost-sharing subsidies, individual and employer mandates, and three-to-one age rating limits, instead allowing states to adopt their own ratios. It would have converted Medicaid funding from an open-ended matching grant entitlement program to a program based on per capita allotments and limits on annual growth.

The Senate did not vote on the House bill, choosing to write their own repeal-and-replace bill called the Better Care Reconciliation Act (BCRA) of 2017. The BCRA would also have eliminated most of the ACA's key provisions beginning in 2017, converting Medicaid from an open-ended federal entitlement program to a program based on per capita allotments with limits on per capita growth. It would have eliminated the ACA's cost-sharing reductions and premium tax credits to people with incomes up to 350 percent of the federal poverty level (FPL). Tax credits would be tied to health plans with a 58 percent actuarial value rather than the ACA's 70 percent. The BCRA would also have eliminated individual and employer mandate penalties, three-to-one premium age rating limits, the minimum medical loss ratios for private insurance, and tax credits for low-wage small employers. This bill did not have enough support to pass the Senate. The Senate then voted on the House-passed American Health Care Act, but it was defeated in the Senate with two Republicans voting against it.

On January 12, 2017, the Senate introduced an amendment to the American Health Care Act, known as the Obamacare Repeal Reconciliation Act of 2017. It would have repealed the states' optional expansion of Medicaid beginning in 2020, repealed subsidies for health insurance coverage beginning in 2020, eliminated the individual and employer mandate penalties, and eliminated many of the revenue provisions of the ACA. Importantly, the reconciliation amendment did not repeal any of the insurance market reforms in the ACA, such as the prohibition on preexisting condition exclusions, modified community rating, essential health benefit requirements, and actuarial value standards. These were deemed unrelated to the budget and could not be considered via a reconciliation bill. The amendment was defeated in the Senate.

On July 27th, 2017, the Healthcare Freedom Act was introduced. It would have eliminated the individual mandate but maintained the Medicaid expansion. It was also defeated, with three Republicans voting against it. That was the end of the major efforts to repeal the ACA.

However, on October 12, 2017, President Trump ended direct federal reimbursement of insurers for expenses associated with the ACA's cost-sharing reductions. However, insurers were still legally obligated under the ACA to provide cost-sharing subsidies to people with incomes up to 250 percent of FPL who enrolled in silver-level insurance plans.[3] In response, insurers in most states began increasing all silver plan premiums to incorporate the average cost associated with providing cost-sharing reductions.[4] This strategy remains in place today.

Finally, on November 2, 2017, the House introduced a bill that ended the ACA's tax penalty for not having insurance, effectively eliminating the individual mandate. This bill was passed in both the House and Senate and signed into law by President Trump.

The failure of ACA legislative repeal efforts also led opponents to file lawsuits to have the courts strike down the law. Although some efforts were successful at lower court levels, none succeeded before the US Supreme Court. The most prominent was *California v. Texas*, which argued that the law should be ruled unconstitutional because the individual mandate was effectively eliminated.

CBO and Urban Analyses of Repeal Efforts

CBO and the Urban reports estimated the implications of changes to the ACA. However, there are important differences between the approaches each institution takes in estimating the implications of changes to the ACA. CBO analyses more closely followed the details of the legislation reviewed, making estimates for even relatively small provisions. CBO researchers analyzed the American Health Care Act, the Better Care Reconciliation Act, and the Obamacare Repeal Reconciliation Act. CBO provided 10-year estimates, primarily focusing on federal spending and revenues and impacts on the federal deficits. They also presented results for changes in premiums and the number of people uninsured. CBO focuses on 10-year estimates and captures the phasing-in of legislative effects over the period.

Urban's approach captured the key effects of legislation, including insurance coverage and the uninsured, federal and state government costs, and changes in provider revenue, but did not provide separate estimates of smaller provisions. Some reports did include tax revenue effects of legislative changes. These estimates provided a snapshot of the implications of changes as if the legislation was fully implemented in a given year (in this case, often 2017). Urban provided estimates of more outcomes than CBO. For example, unlike CBO, Urban estimates often included state government spending effects and provider revenue. In addition, the Urban model allowed for a broad range of state-by-state estimates, a type of analysis beyond the scope of CBO's mandate. Many of Urban's estimates focused exclusively on the noninstitutionalized population not enrolled in Medicare (largely, the nonelderly population) since that is the population affected by this legislation; CBO's estimates included the full US population. The two organizations have their own microsimulation models built on different datasets and behavioral assumptions, so their estimates differ, yet their broad conclusions are generally similar.

Results

In this paper, we rely on the following eight papers: three produced by CBO and five by Urban. A complete citation guide is available in an appendix on page 18.

- "American Healthcare Act of 2017" (CBO 2017a)
- "Better Care Reconciliation Act of 2017" (CBO 2017b)
- "The Cost of ACA Repeal" (Buettgens et al. 2016, referred to as Urban 2016a throughout this section)
- "Implications of Partial Repeal of the ACA through Reconciliation" (Blumberg, Buettgens, and Holahan 2016, referred to as Urban 2016b)
- "The Impact on Health Care Providers of Partial Repeal through Reconciliation" (Buettgens, Blumberg, and Holahan 2017, referred to as Urban 2017a)
- "Obamacare Repeal Reconciliation Act of 2017" (CBO 2017c)

- "Who Gains and Who Loses under the Better Care Reconciliation Act" (Blumberg et al. 2017, referred to as Urban 2017b)
- "The Potential Effects of a Supreme Court Decision to Overturn the Affordable Care Act: Updated Estimates" (Blumberg et al. 2020, referred to as Urban 2020)

The papers titled "The American Health Care Act of 2017" (CBO 2017a) and the "Better Care Reconciliation Act of 2017" (CBO 2017b) represented close to full repeal. The Urban paper "The Cost of ACA Repeal" (Urban 2016a) also intended to estimate the impacts of a full repeal. Other Urban papers, "Implications of Partial Repeal of the ACA through Reconciliation" (Urban 2016b) and "The Impact on Health Care Providers of Partial Repeal through Reconciliation" (Urban 2017a), focused on partial repeal that could be accomplished through reconciliation. The CBO paper, "Obamacare Repeal Reconciliation Act of 2017" (CBO 2017c), also focused on partial repeal. The fourth Urban paper, "Who Gains and Who Loses under the Better Care Reconciliation Act" (Urban2017b), focuses on the distributional effects of spending and tax provisions of repeal proposals, using the Better Care Reconciliation Act of 2017 as an example. The fifth Urban paper, "The Potential Effects of a Supreme Court Decision to Overturn the Affordable Care Act: Updated Estimates" (Urban 2020), in response to *California v. Texas*, updated earlier results on the effect of full repeal.

The difference between full repeal and partial repeal is important. The full repeal papers reflect efforts to fully repeal the law. The main provisions in the American Healthcare Act and the Better Care Reconciliation Act maintain some but not many of the ACA's coverage provisions. Under partial repeal—which is easier to enact as it can be done through a reconciliation act—only provisions that have budgetary effects can be considered. That is, all the insurance reforms of the ACA, such as the nongroup markets guaranteed issue provision, prohibition on existing condition exclusions, modified community rating, essential health benefit requirements, and actuarial value standards, would remain in place. These reforms would remain, but individuals in the nongroup market would no longer have premium subsidies, and no one would be required to have health insurance. This sets up conditions for a death spiral. Without a mandate, those who chose to buy coverage would likely be sicker than average. However, since the insurance market reforms restrict insurers' ability to adjust pricing for risk, deny coverage, and modify benefits, premiums would increase, and only an increasingly sick population would choose coverage. This would increase premiums, resulting in a smaller and sicker population seeking insurance. Eventually, the nongroup insurance market is wiped out, which has implications for insurance coverage, e.g., the number of uninsured is greater under partial repeal through reconciliation than under full repeal.

The results from the CBO and Urban reports are as follows:

Coverage

Repealing the ACA would reduce Medicaid and nongroup coverage and increase the number of uninsured.

"American Healthcare Act of 2017" (CBO 2017a): The number of uninsured would increase by 14 million in 2018, 19 million in 2020, and 23 million in 2026. The number of uninsured would increase from 28 million in 2017 to 51 million in 2026. The number on Medicaid in 2026 would have fallen by 14 million and in the nongroup market by 6 million.

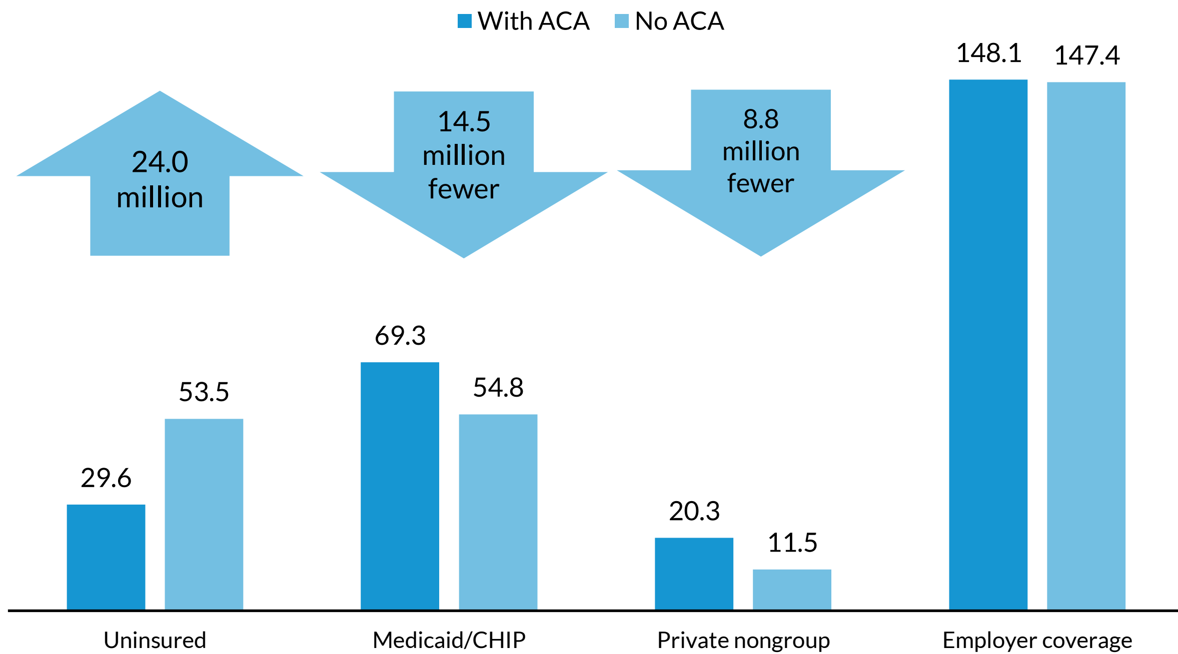
"Better Care Reconciliation Act of 2017" (CBO 2017b): The number of uninsured would increase by 15 million in 2018, 19 million in 2020, and 22 million by 2026, from 28 million in 2017 to 49 million in 2026. Medicaid would fall by 15 million in 2026 and nongroup coverage by 7 million.

*"**The Cost of ACA Repeal" (Urban 2016a):*** The number of uninsured in 2021, a year in which full implementation is assumed, would increase by 24 million to 53.5 million (figure 1). When fully implemented, Medicaid would have fallen by 14.5 million and nongroup coverage by 9.4 million. With full repeal, 30 percent of the newly uninsured have incomes less than 100 percent of FPL, and another 34 percent have incomes between 100 and 200 percent of FPL. At the same time, 66 percent of the population lives in a household with one full-time worker. By race and ethnicity, 49 percent are white non-Hispanic, 14 percent are Black non-Hispanic, and 26 percent are Hispanic. Over 54 percent have a high school education or less.

FIGURE 1

Health Coverage of the Nonelderly in 2021

Millions of people



URBAN INSTITUTE

Source: Adapted from Matthew Buettgens, Linda J. Blumberg, John Holahan, and Siyabonga Ndwandwe, "The Cost of ACA Repeal," (Washington, DC: Urban Institute, 2016).
Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

"The Potential Effects of a Supreme Court Decision to Overturn the Affordable Care Act: Updated Estimates" (Urban 2020): The number of uninsured would increase by 21 million in 2022, from 30.8 to 51.9 million. The number on Medicaid would fall by 15.5 million, and the number with nongroup coverage would increase by 7.6 million.

With partial repeal through reconciliation, both CBO and the Urban Institute estimate much larger increases in the uninsured:

"Obamacare Repeal Reconciliation Act of 2017" (CBO 2017c): The number of uninsured would increase by 32 million by 2026, from 28 million in 2017 to 59 million in 2026. Medicaid would fall by 19 million, and nongroup coverage would fall by 23 million.

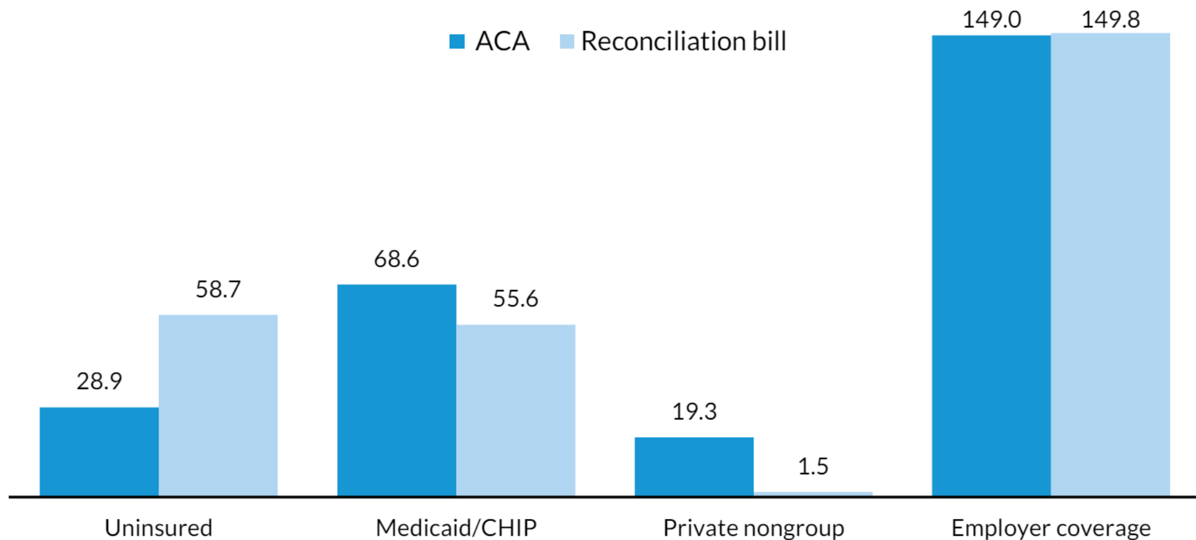
"Implications of Partial Repeal of the ACA through Reconciliation" (Urban 2016b): The number of uninsured would rise from 28.9 to 58.7 million in 2019, assuming full implementation (figure 2). This is an increase of 29.8 million people or more than doubling. The number on Medicaid would fall by 12.9 million, and the number with nongroup coverage would fall by 17.7 million. With partial repeal, 27 percent of the newly uninsured have incomes below 100 percent of poverty, and another 54 percent have incomes between 100 percent and 200 percent of FPL. At the same time, 66 percent of the

population is in a family with at least one full-time worker. By race and ethnicity, 56 percent are White non-Hispanic, 12 percent are Black non-Hispanic, and 22 percent are Hispanic. Finally, 54 percent have a high school education or less.

FIGURE 2

Health Insurance of the Nonelderly in 2019, under the ACA and an Anticipated Reconciliation Bill

Millions of people



Source: Linda J. Blumberg, Matthew Buettgens, and John Holahan, "Implications of Partial Repeal of the ACA through Reconciliation," (Washington, DC: Urban Institute, 2016).

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

Federal and State Spending

With repeal, government spending would fall because of the loss of the Medicaid expansion and premium tax credits.

CBO provides estimates of changes in federal spending between 2017 and 2026 and estimates of changes in revenues from various provisions. Together, they allow estimates of the impact on the federal deficit. Urban only provides estimates of changes in spending in the reports cited here, though other Urban reports include revenue effects. Urban does provide state estimates.

"American Healthcare Act of 2017" (CBO 2017a): This version of ACA repeal passed by the House would reduce Medicaid spending by $834 billion and reduce subsidies for nongroup health insurance by $276 billion between 2017 and 2026 (figure 3). Overall spending would decrease by $1.1 trillion. Various provisions would reduce spending that would otherwise have occurred or increased revenues. These included funds that would have been sent to states or insurers to lower premiums, reductions in revenues from employer and individual mandate penalties, and repeal of various taxes. These would

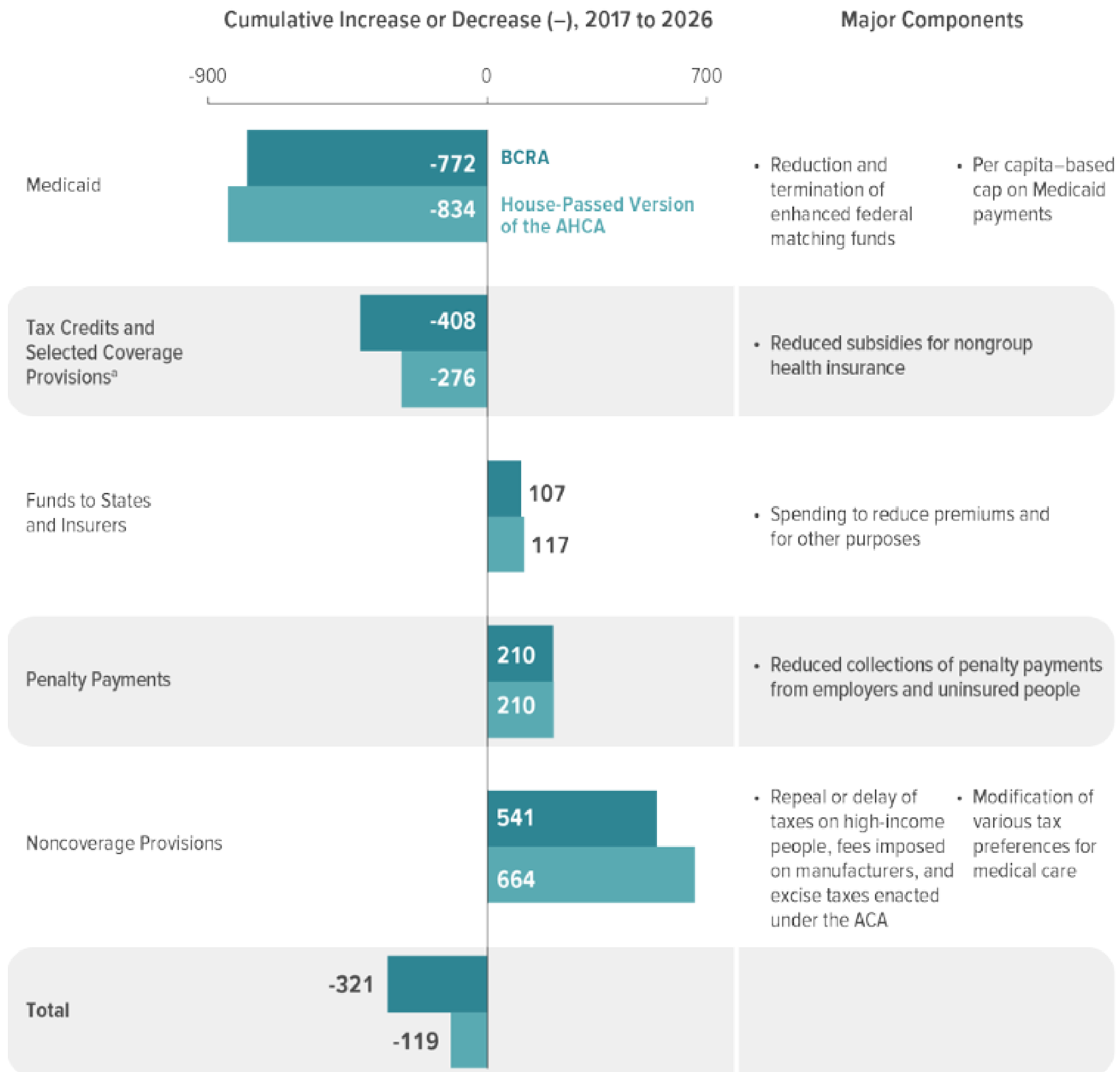
reduce government outlays or increase revenues by $1.0 billion. The reduction in the federal deficit would be $119 billion over the 10-year period.

"Better Care Reconciliation Act" (CBO 2017b): Under the BCRA, the 10-year reductions in Medicaid spending would be $772 billion. There would be a reduction in subsidies for nongroup insurance of $408 billion for a total of $1.2 trillion between 2017 and 2026 (figure 3). Other spending and revenue provisions would offset these: funds to states and insurers to reduce premiums, reduced collections from employer and individual mandates, and reduction in revenues from repeal or delay of various taxes on individuals and manufacturers together would add to about $900 billion. The net effect would be a reduction in the federal deficit of $321 billion.

FIGURE 3

Net Effects of the Better Care Reconciliation Act and of the House-Passed Version of the American Health Care Act on the Budget Deficit

Billions of dollars



Source: CBO (Congressional Budget Office), "Better Care Reconciliation Act of 2017, " H.R. 1628, (Washington, DC: CBO and Staff of the Joint Commission on Taxation, 2017).

Notes: The following notes accompanied the figure in the original CBO source: "These estimates are for two versions of H.R. 1628: the Better Care Reconciliation Act of 2017 (BCRA), a Senate amendment in the nature of a substitute, and the American Health Care Act of 2017 (AHCA), as passed by the House of Representatives.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation.

ACA = Affordable Care Act.

a. Includes subsidies for coverage through Marketplaces and related spending and revenues, small-employer tax credits, tax credits for nongroup insurance, Medicare, and other effects of coverage provisions on revenues and outlays."

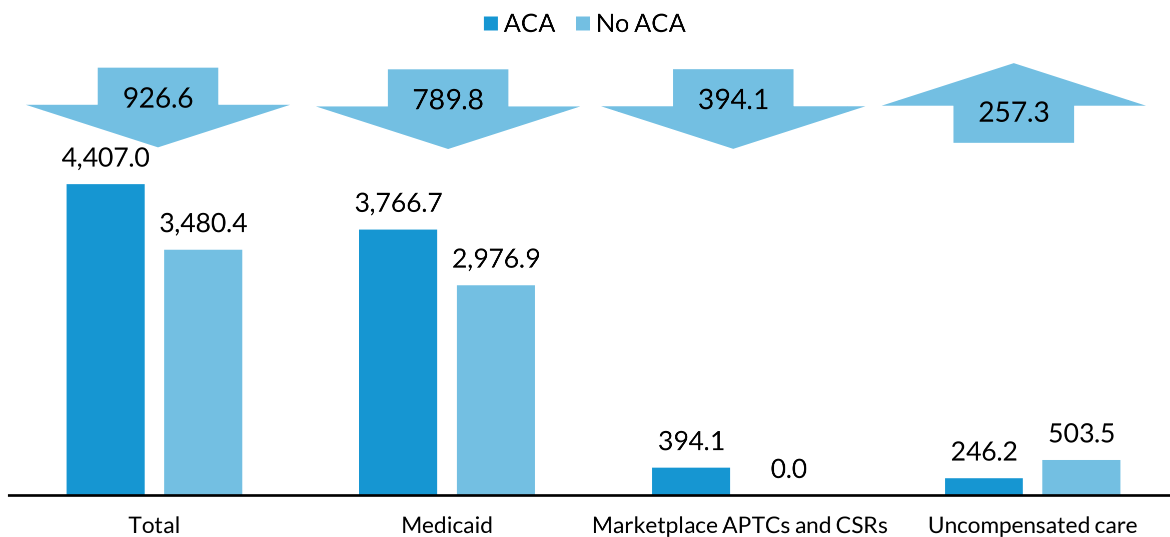
"The Cost of ACA Repeal" (Urban 2016a): Full repeal would result in a reduction in federal Medicaid and Children's Health Insurance Program spending of $790 billion between 2017 and 2026; Marketplace subsidies would fall by an additional $394 billion (figure 4). However, spending on uncompensated care because of the large number of newly uninsured would increase by $418 billion, assuming the federal government funds its historical share of uncompensated care. The net effect on federal spending is $926.6 billion. In this paper, Urban also estimates an increase in state and local spending of $68.5 billion. The savings on reduced state Medicaid matching funds would be more than offset by increased uncompensated care costs.

"The Potential Effects of a Supreme Court Decision to Overturn the Affordable Care Act: Updated Estimates" (Urban 2020): Federal government spending would fall by $152 billion in 2022. The paper did not provide estimates of the effects on state spending.

FIGURE 4

Federal Government Health Spending for the Nonelderly, 2017–2026

Billions of dollars

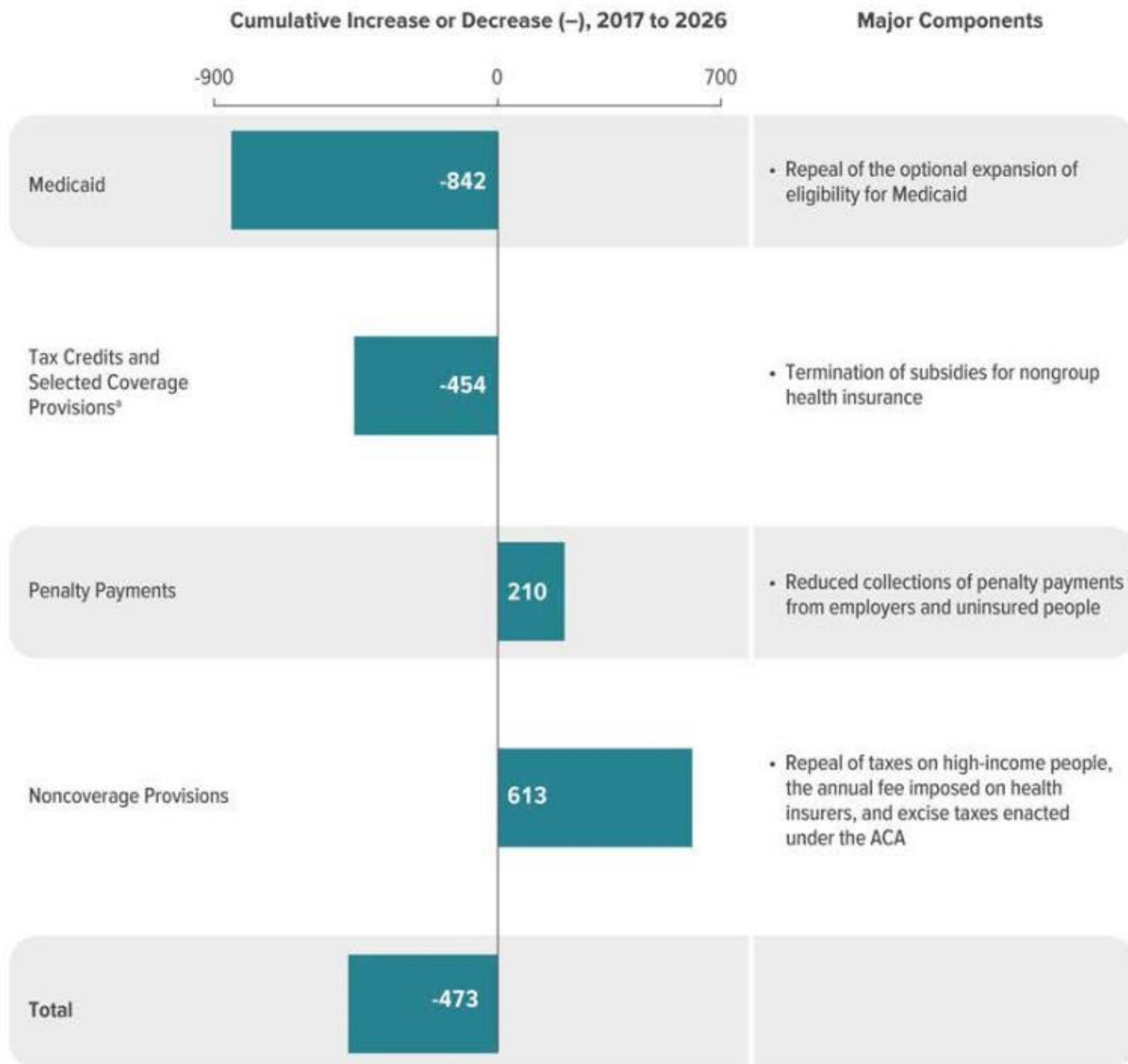


Source: Adapted from Matthew Buettgens, Linda J. Blumberg, John Holahan, and Siyabonga Ndwandwe, "The Cost of ACA Repeal," (Washington, DC: Urban Institute, 2016).
Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; APTC = advance premium tax credit; CSR = cost-sharing reduction.

"Obamacare Repeal Reconciliation Act of 201" (CBO 2017c): CBO's estimates of partial repeal were that federal Medicaid spending would fall by $842 billion from lower Medicaid spending and another $454 billion from the elimination of tax credits between 2017 and 2026. Thus, overall spending would fall by about $1.3 billion. There would be a reduction of $210 billion in revenues from the elimination of employer and individual mandate penalties and another $613 billion from the repeal of various taxes. Thus, the net effect on the deficit is a reduction of $473 billion (figure 5).

FIGURE 5

Net Effects of the Obamacare Repeal Reconciliation Act of 2017 on the Federal Deficit



Source: CBO (Congressional Budget Office), "Obamacare Repeal Reconciliation Act of 2017," H.R. 1628, (Washington, DC: CBO and Staff of the Joint Commission on Taxation, 2017).

Notes: The following notes accompanied the figure in the original CBO source: "These estimates are for the Obamacare Repeal Reconciliation Act of 2017, a Senate amendment in the nature of a substitute to H.R. 1628.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation.

ACA = Affordable Care Act.

a. Includes subsidies for coverage through Marketplaces and related spending and revenues, small-employer tax credits, tax credits for nongroup insurance, Medicare, and other effects of coverage provisions on revenues and outlays."

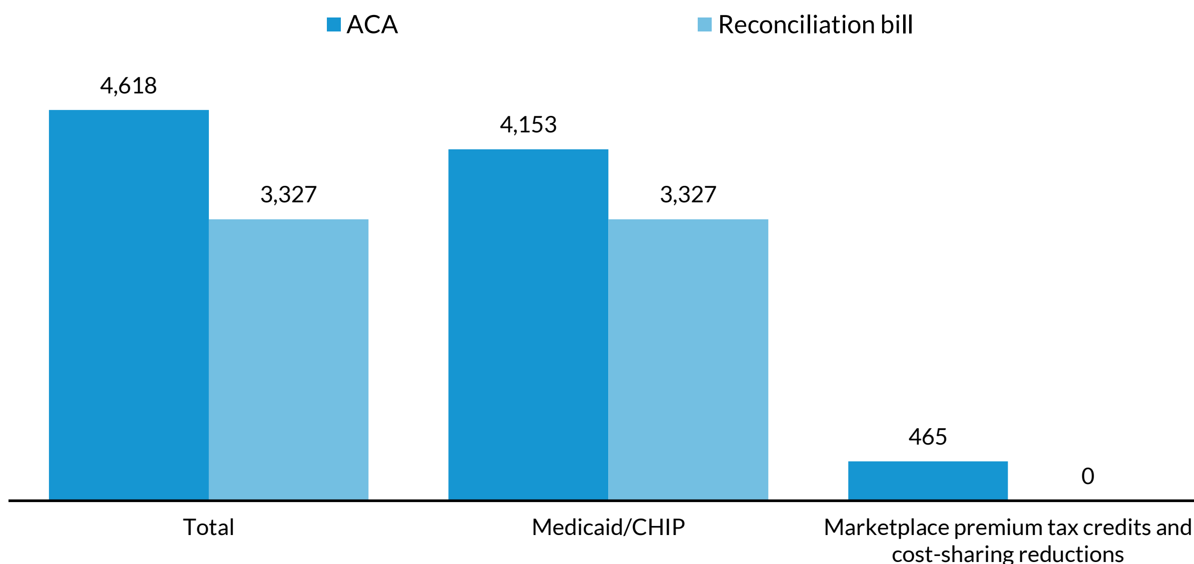
***"The Implications of Partial Repeal of the ACA through Reconciliation"* (Urban 2016b):** Urban found that with partial repeal, federal government spending on Medicaid/ Children's Health Insurance Program and Marketplace assistance would fall by $1.3 billion between 2019 and 2028 (figure 6). Of this, about

$800 billion would be reductions in Medicaid and $465 billion in Marketplace premiums and cost-sharing reductions. Reductions in state spending from Medicaid matching payments with partial repeal would fall by $76 billion between 2019 and 2028. These reductions in Medicaid matching payments would be more than offset by increased uncompensated care costs of $1.6 trillion, which would somehow be split between the states and providers.

FIGURE 6

Federal Government Spending on Medicaid/CHIP and Marketplace Assistance, 2019–28

Billions of dollars



URBAN INSTITUTE

Source: Linda J. Blumberg, Matthew Buettgens, and John Holahan, "Implications of Partial Repeal of the ACA through Reconciliation," (Washington, DC: Urban Institute, 2016).
Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

Provider Revenues

Because of the loss of coverage and reduced government spending, providers would be significantly affected by repeal.

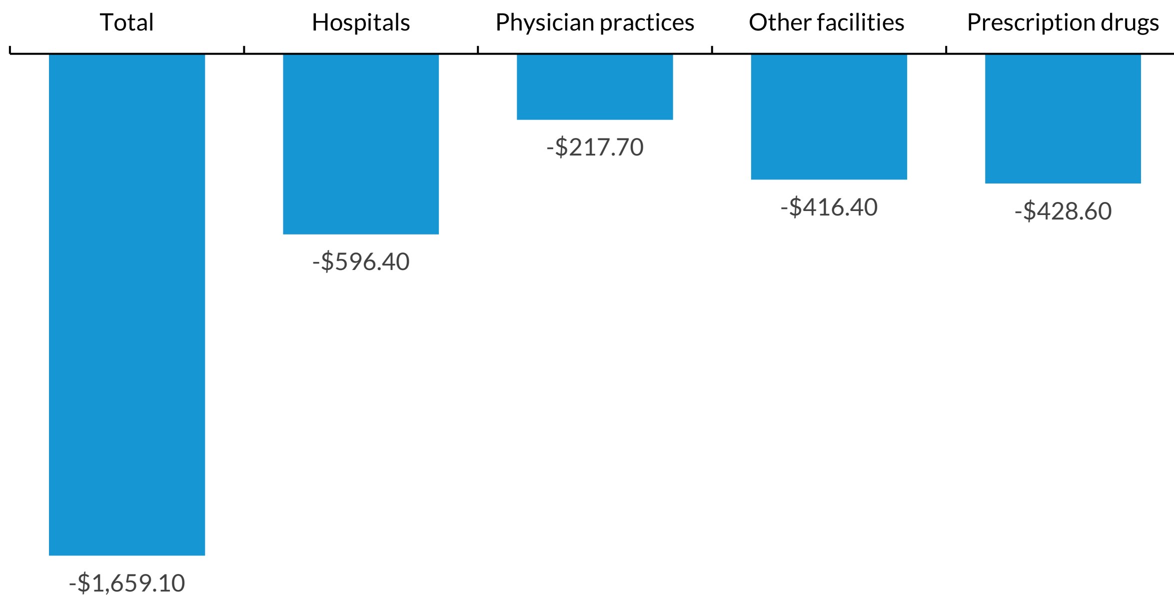
In a paper entitled "The Impact on Health Care Providers of Partial Repeal through Reconciliation" (Urban 2017a), Urban estimated provider impacts because of the substantial reductions in coverage, i.e., an increase in the uninsured of 29.8 million. Spending by insurers and households on all services would fall by $1.7 trillion between 2019 and 2028 (figure 7). Spending on hospital care would fall by $596.4 billion between 2019 and 2028; spending on care provided in physician offices, other services, and prescription drugs would be lowered by $1.1 trillion over this period.

The later paper, "The Potential Effects of a Supreme Court Decision to Overturn the Affordable Care Act: Updated Estimates" (Urban 2020), found that spending by insurers and households would fall by $135.5 billion in 2022. Of this, there would be $55.9 billion less spending on hospital care, $17.2 billion less on physician services, $29.7 less on prescription drugs, and $32.6 billion less on other services.

FIGURE 7

Impact of Partial ACA Repeal on Health Care Spending by Insurers (Public and Private) and Households, 2019–28

Billions of dollars



Source: Adapted from Matthew Buettgens, Linda J. Blumberg, and John Holahan, "The Impact on Health Care Providers of Partial ACA Repeal through Reconciliation," (Washington, DC: Urban Institute, 2017).

Notes: ACA = Affordable Care Act. Health care spending includes claims paid by public and private insurers and out-of-pocket spending by both insured and uninsured households.

The Need for Uncompensated Care

Because of the increase in the number of uninsured, the need for free or uncompensated care would increase with the repeal.

"The Impact on Health Care Providers of Partial Repeal through Reconciliation" (Urban 2017a) estimates that the newly uninsured would seek $1.1 trillion in additional uncompensated care from 2019 through 2028; this includes $286.1 billion in hospital care, with the remainder spread among physician care, prescription drugs, and other services (figure 8). Without new legislation, federal funding of uncompensated care would increase very little; only Medicare disproportionate share hospital

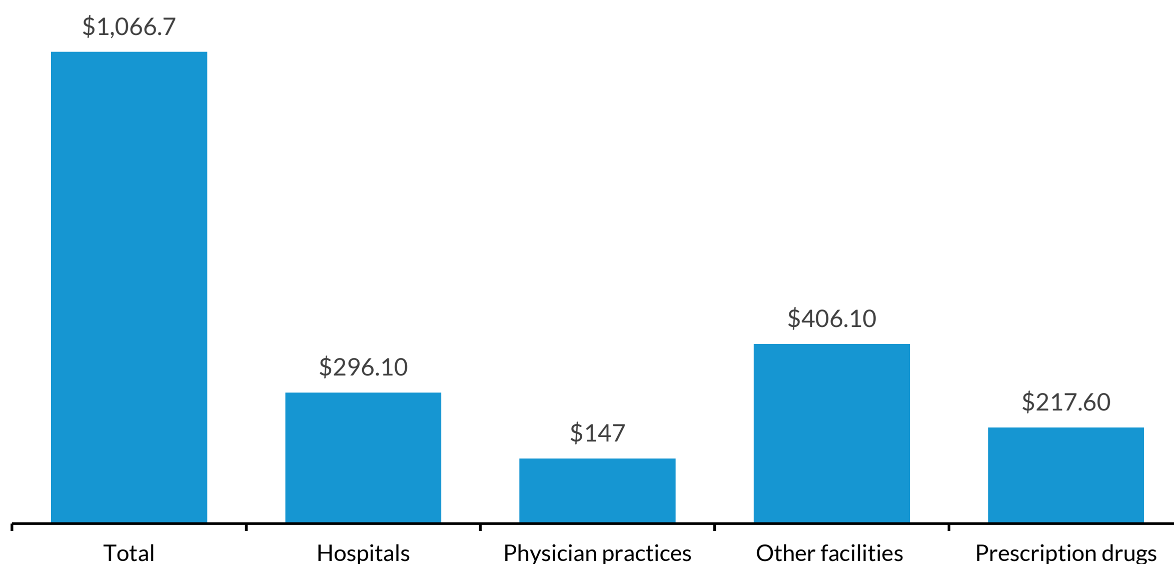
funding would automatically increase by $35 billion between 2019 and 2028. The reconciliation bill does not allocate any additional funds to support uncompensated care. Without new federal funding, the burden would fall to states and localities or providers themselves; of course, there would be some substantial increase in unmet need. However, most likely, the primary burden would fall on providers.

In "The Potential Effects of a Supreme Court Decision to Overturn the Affordable Care Act: Updated Estimates" (Urban 2020), Urban found that the amount of uncompensated care sought would increase by $58.0 billion in 2022, with increases of $17.4 for hospitals, $6.9 for physician services, $12.0 for prescription drugs, and $30.2 for other services.

FIGURE 8

Additional Uncompensated Care Sought as Result of Partial ACA Repeal, 2019–28

Billions of dollars



URBAN INSTITUTE

Source: Adapted from Matthew Buettgens, Linda J. Blumberg, and John Holahan, "The Impact on Health Care Providers of Partial ACA Repeal through Reconciliation," (Washington, DC: Urban Institute, 2017).
Notes: ACA = Affordable Care Act. Uncompensated care is funded by a mix of federal, state, and local government programs and care delivered by health care providers without outside funding. Federal funding for uncompensated care would automatically increase by $35.0 billion over the 2019–28 period under reconciliation, less than 4 percent of the increase in uncompensated care that would be sought by the newly uninsured.

Distributional Effects

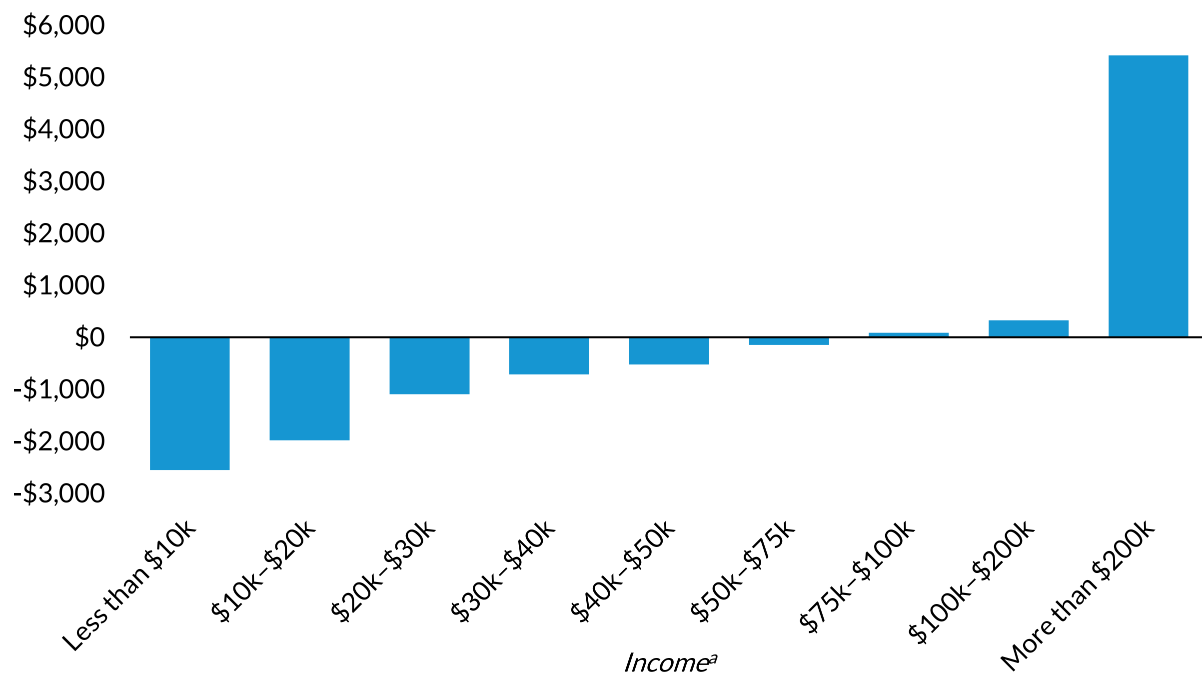
Repeal of the ACA would harm lower-income people and benefit higher-income individuals.

Both the "American Healthcare Act of 2017" (CBO 2017a) and the "Better Care Reconciliation Act of 2017" (CBO 2017b) would have significant distributional effects, with people experiencing poverty being worse off from reduced spending and the highest income groups better off because of lower tax

payments. In this discussion, we focus on the results of the paper "Who Gains and Who Loses under the Better Care Reconciliation Act" (Urban 2017b). The American Health Care Act has very similar distributional effects. The BCRA would cap Medicaid funding and reduce but not eliminate premium tax credits. It would repeal nearly all of the ACA's revenue provisions starting in 2017. As shown in figure 9, tax units with less than $10,000 of income would be worse off by $2,250, a net reduction in income of nearly 60 percent. Tax units with income of more than $200,000 would be better off by $5,420, or about 1 percent. Using federal poverty levels, those with incomes below 400 percent of FPL would experience net benefits and tax losses, while those above 400 percent of FPL would experience net gains. The greatest gains would go to those at the very top of the income distribution.

FIGURE 9

Distribution of Change in Average Net Transfers (Benefits Less Taxes) under the BCRA, 2026



Source: Linda J. Blumberg, Matthew Buettgens, John Holahan, Gordon B Mermin, and Philip Stallworth, "Who Gains and Who Loses under the Better Care Reconciliation Act," (Washington, DC: Urban Institute, 2017).

Notes: BCRA = Better Care Reconciliation Act.

[a] Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Analysis includes both filing and nonfiling units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals. Analysis includes provisions from the discussion draft version of BCRA released by the Senate Budget Committee on June 22, 2017.

Premiums and Marketplace Stability

CBO made estimates of provisions in the repeal legislation that would affect Marketplace premiums. In the "Obamacare Repeal Reconciliation Act of 2017" (CBO 2017c), CBO estimates the impact of partial

repeal on premiums in the nongroup market. They estimated increases in premiums of about 25 percent in 2018 relative to the current law baseline. By 2020, the increase would be about 50 percent, and by 2026, premiums would roughly double. They assume some of this effect is because of eliminating the employer and individual mandates, which results in a less healthy risk pool. The elimination of the Medicaid expansion and subsidies available to purchase nongroup coverage through the Marketplaces would also reduce the number of particularly healthy individuals from purchasing through the Marketplace. The effects of these provisions would occur with both full and partial repeal.

But the partial repeal legislation also leaves in place insurance market regulations in which insurers could not deny coverage, would be required to offer specified benefits, and could not vary premiums based on health status. With many relatively healthy individuals no longer participating, insurers would increase premiums to protect themselves against adverse selection or leave the market. Higher premiums would result in doubling by 2026. And large numbers of insurers would leave the market. CBO estimates that about half of the nation's population would live in areas with no insurer participation in 2020 and about three-fourths of the population by 2026. Thus, premiums would be substantially higher, and fewer insurers would offer coverage.

What If Studies Were Done Today?

The effects on all the outcomes discussed above would likely be larger if these studies were conducted today. The nonelderly population of the US has increased only slightly since 2017, but health care costs are significantly higher. For example, national health spending increased by about 42 percent from 2017 to 2024.[5] Over the same period, Marketplace benchmark premiums, to which federal tax credits are tied, increased by about 33 percent; the national average monthly benchmark premium increased from $356 to $473. Relative increases in spending for other health programs would be in this ballpark. With higher spending levels, the savings to federal and state governments from coverage reductions would be greater.

Between 2017 and 2024, the number of states with Medicaid expansion increased from 32 to 41. This would mean the base of coverage under Medicaid would be greater today, and reductions because of the repeal of the ACA would also be greater. The American Rescue Plan Act and Inflation Reduction Act increased the generosity of premium tax credit subsidies, increasing Marketplace enrollment. Marketplace plan selection reached an all-time high of 21 million in 2024 compared with 12 million in 2017. The elimination of Marketplace subsidies because of repeal would therefore have a bigger impact on nongroup coverage today. The new enrollment because of Medicaid expansion and the IRA have reduced the uninsured. The number of people uninsured was 27.6 million in 2017 and is projected to be 24 million in 2024. Thus, the increases in uninsurance resulting from full repeal or partial repeal, if enacted today, would be greater than were reported in the 2017 studies.

Conclusions

Repealing the ACA would have substantial implications for the well-being and stability of the US health system. There would be major effects on insurance coverage, mostly affecting lower-income people. The number of uninsured would jump substantially, increasing by about 100 percent in some scenarios. Federal spending would fall even though some of the reductions in spending on Medicaid and tax credits would be offset by any spending in response to increases in uncompensated care. The federal deficit would also fall slightly. State spending on Medicaid matching rates will also fall, but states would also face large increases in the demand for uncompensated care. Providers would see substantial reductions in revenues at the same time as the need for uncompensated care would increase. Whether and how uncompensated care is paid for depends on whether the federal government adopts new legislation to support the nation's hospitals, how much states increase their spending, and the amount that providers bear, or whether there is simply more unmet need. Finally, any repeal legislation would have substantial distributional effects; the reductions in coverage are largely among lower-income people, and the savings from reduced taxes are largely among high-income people.

Appendix: Guide to Citations

CBO 2017a: CBO (Congressional Budget Office). 2017a. "American Health Care Act of 2017." H.R. 1628. Washington, DC: CBO and Staff of the Joint Commission on Taxation.

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Notes

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This history of ACA repeal efforts is also developed from the sources in the reference section below.

[3] ACA Marketplace nongroup coverage is categorized by actuarial value (AV), with bronze plans at 60 percent AV, silver plans at 70 percent AV, gold plans at 80 percent AV, and platinum plans at 90 percent AV. Marketplace individual purchasers eligible for premium tax credits and with incomes below 250 percent of FPL are eligible for cost-sharing reductions if and only if they enroll in a silver-tier plan. These cost-sharing reductions raise AV of silver plans from 70 percent to 94 percent for those with incomes up to 150 percent of FPL, up to 87 percent for those with incomes between 150 and 200 percent of FPL, and up to 73 percent for those with incomes between 200 and 250 percent of FPL. These higher AV plans lower the enrollees' out-of-pocket costs (deductibles, copayments, coinsurance, out-of-pocket maximums) compared with those associated with standard silver plans.

[4] As Urban researchers estimated, the higher federal government costs associated with the increased silver-level premiums led to higher federal government costs than would have been the case had direct insurer reimbursement for the cost-sharing reductions remained (Holahan, Wengle, and O'Brien 2023).

[5] "National Health Expenditure Data: Historical," CMS.gov, accessed June 7, 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.

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John Holahan is an Institute fellow in the Health Policy Center at the Urban Institute, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion and the macroeconomic effects of the law. Holahan has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. He has written about competition in insurer and provider markets, the implications for premiums and government subsidy costs, and the cost-containment provisions of the ACA.

Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

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