From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs

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Background

The expansion of Medicaid eligibility, financial assistance for purchasing private nongroup insurance, regulatory reforms, an individual responsibility requirement, and other components of the Affordable Care Act (ACA) led to substantial reductions in the number of uninsured, increased access to care, reduced uncompensated care, and eliminated explicit discrimination against the sick in private health insurance markets. However, three years after implementation of the full coverage reforms, significant problems remain. Though expanded coverage lowered costs for many people, many still found premiums and cost-sharing requirements too high to participate. A Supreme Court decision that made the Medicaid expansion optional for states left many poor adults in 17 states without any way to obtain affordable coverage. Adverse selection into the private nongroup market in some areas, and little to no provider and/or insurer competition in others, has led to high and, in certain years, rapidly growing premiums in some parts of the country. And some areas faced underinvestment in important administrative functions, including outreach and advertising and enrollment assistance.

In addition, policy changes since early 2017 have created new problems and exacerbated others. Congress and the Trump administration actively pursued bills that would repeal the ACA, and, later, repeal and replace it with policies reducing market regulations and government investment in health insurance. The administration made steep cuts in enrollment assistance and advertising, cut the open enrollment period in half (though some state-based Marketplaces extended the enrollment period on their own), and reduced the hours of access to the online Marketplaces. The administration and Congress removed the individual mandate penalties through its 2017 tax legislation, and the administration halted federal reimbursement of insurers' cost-sharing reduction payments through administrative actions. Recent regulations have expanded the availability of alternative coverage options, such as short-term plans and association health plans, likely exacerbating preexisting risk selection problems within the system. The administration has encouraged states to implement work

requirements to limit Medicaid eligibility and to apply for waivers that could change the financial assistance and coverage available to nongroup insurance purchasers.

In response to these recent measures, the remaining gaps in the health insurance system, and evidence of the increasing number of uninsured starting in 2017 (Henry J. Kaiser Family Foundation 2018; Skopec, Holahan, and Elmendorf 2019; Terlizzi, Cohen, and Martinez 2019; Witters 2019), several policy proposals have emerged. Some have been developed by members of Congress, others by researchers and policy analysts.[1] Many borrow significant components from the Medicare program and the ACA Marketplaces. These proposals range substantially in their federal and state budgetary implications, their effects on coverage, and how much they would fundamentally change the structure of the US health insurance system. Discussion of these health policy options for addressing the current system's shortcomings have become central to the 2020 presidential debates. To allow for more objective, thoughtful comparison of the advantages and disadvantages of various health system reforms, we created a uniform framework for comparing the coverage and cost implications of different proposals and the marginal effects of specific policies when added to a base set of reforms.

This report analyzes how eight health care reform packages intended to address the current system's shortcomings affect health insurance coverage and spending by government, households, and employers. We start with a set of incremental improvements to the ACA, similar to some of those in the Consumer Health Insurance Protection Act of 2019,[2] and end with a single-payer-type comprehensive reform similar to the Medicare for All Act of 2019.[3] Though we do not model particular bills, we present estimates for an array of reforms presented along a continuum ranging from less to more comprehensive in their effects on coverage and government costs. Because new bills are regularly introduced and specific details of existing bills will likely change, we delineate the specific reform approaches to demonstrate a range of possible changes to the current system without being constrained by particular pieces of legislation. We do not estimate specific revenue raising approaches to fund any of the modeled reforms; we restrict our financial estimates to the effects on spending because revenues can be raised in many different ways with very different distributional implications, depending upon the approach taken.

Methodology Overview

We estimate the effects of eight health care reform options, highlighting the national coverage and cost implications of each and how they compare with current law. Central estimates include the following:

- the distribution of health insurance coverage across

  » employer-sponsored insurance;[4]
  » nongroup insurance, subsidized and unsubsidized;
  » Medicaid/the Children's Health Insurance Program (CHIP);
  » Medicare/other government insurance;[5]
  » any new proposed coverage option, if applicable; and
  » the uninsured

- the distribution of health spending, under current law and postreform, across

  » households by income group, including premium payments and out-of-pocket costs;
  » employers;
  » governments, state versus federal; and
  » health care providers delivering uncompensated care

Our analysis relies on the Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (HIPSM) and new Medicare simulation model, MCARE-SIM, as well as Urban's Dynamic Simulation of Income Model (DYNASIM). HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options for the nonelderly (US residents below age 65 not enrolled in Medicare).[6] HIPSM is based on two years of the American Community Survey, which provides a representative sample of families large enough to produce estimates for individual states. The population is aged to future years using projections from the Urban Institute's Mapping America's Futures program (Martin, Nichols, and Franks 2017). HIPSM is designed to incorporate timely, real-world data when they become available, and we regularly update the model to reflect published Medicaid and Marketplace enrollment and costs in each state. The current version accounts for each state's Marketplace premiums and enrollment after the 2019 open enrollment period. The enrollment experience in each state under current law affects how the model simulates policy alternatives.

MCARE-SIM is based on data from the 2015 Medicare Current Beneficiary Survey, projected here to 2020. It is designed to simulate changes to household and government costs[7] because of changes in benefits, cost sharing, and premiums for people ages 65 and older and younger people enrolled in the Medicare program (Garrett et al. 2019). In addition to estimating how a policy proposal would change spending by payer (Medicare, Medicaid, other supplemental, and beneficiary out of pocket) as compared with current law, the model calculates potential behavioral responses to changes in enrollee cost sharing (i.e., induced demand). The model calculates how policy changes would affect beneficiary

subgroups of interest (e.g., income group, demographic group, or level of health care utilization). The model simulates health care spending and costs for Medicare enrollees in the traditional program (Parts A, B, and D) and in Medicare Advantage, as well as supplemental coverage like Medigap. For this report, we use MCARE-SIM to estimate the spending and distributional consequences of single-payer reforms that would affect not only the nonelderly (the ACA target population) but those enrolled in Medicare under current law. In this analysis, data from MCARE-SIM simulations are statistically matched to the population in HIPSM's merged American Community Survey file to allow for joint analyses of the entire US population for single-payer approaches.

In addition, one of the single-payer reforms simulated here includes benefits for long-term services and supports (LTSS). These estimates are developed using estimates from recent historical data sources, including the Health and Retirement Study, National Health Interview Survey, and National Health and Aging Trends Study, combined with estimates from DYNASIM and a range of estimates from published reports.

We begin each simulation with a current-law baseline in 2020, and then we estimate the effects of implementing each of the eight health care reform options. We also provide results from sensitivity analyses on the two single-payer approaches included. Plus, we compute 10-year estimates (2020–29) of the increase in federal government costs associated with each reform and each sensitivity. All estimates assume reforms are fully phased in and in equilibrium beginning in 2020.

Additional discussion of specific methodological issues can be found in the appendix.

Simulated Reform Packages

We present results for the distribution of health insurance coverage and health spending under current law and eight health reform simulations. In addition, for two of those simulations, we provide three sensitivity analyses of factors that could increase or decrease costs. To ease comparison across the reform options, the simulations are all presented as fully phased in reforms in 2020, assuming an equilibrium has been reached for consumer and provider behavior. We also provide estimates of federal government costs over 10 years. We do not, however, analyze particular tax mechanisms designed to fund the government costs associated with these reforms. Table 1 describes the reform components of each package; shading in the first column indicates a change from current law, and shading in succeeding columns indicates a difference from the immediately preceding reform package. The eight reform packages are summarized below.

Current law. In addition to the other details of the ACA's coverage components, the current-law simulation reflects no federal individual mandate but does reflect state individual mandates in California, the District of Columbia, Massachusetts, and New Jersey; expanded availability of short-term, limited-duration plans (STLDs) under federal regulations in states that have not prohibited them; insurer costs associated with ACA cost-sharing reductions built into silver-level plans only; and reinsurance in states with their own programs.[8]

Reform 1: Enhanced subsidies and reinsurance. This incremental reform maintains the current-law ACA but increases the generosity of the Marketplace premium tax credits and cost-sharing reductions for eligible people; this includes tying premium tax credits to plans with an 80 percent actuarial value instead of 70 percent as under current law. It also provides a $10 billion annual reinsurance program in the nongroup market. The second and fifth columns of table 2 show the enhanced premium tax credit and cost-sharing reduction schedules.

Reform 2: Adds reinstatement of the ACA's individual mandate and reversal of expanded access to STLDs to reform 1. This incremental reform package builds on the preceding one, adding in the individual mandate penalties that were repealed effective in 2019 and reversing the administration's regulatory expansion of availability of STLDs. STLDs are plans offered to individual purchasers that are not required to comply with the ACA's consumer protections (e.g., essential health benefit requirements, actuarial value standards, modified community rating rules, or guaranteed issue).

Reform 3: Adds filling in the Medicaid eligibility gap to reform 2. Fourteen states have not adopted the ACA's Medicaid expansion, and another three have adopted the expansion through state ballot initiatives, but it is unclear whether these three states will implement them. Thus, in 17 states many people with incomes below the federal poverty level (FPL) are not eligible for any financial assistance to help them enroll in health insurance coverage, a clear inequity across states. This reform builds on the previous one by extending Marketplace premium tax credit and cost-sharing reduction eligibility to people living in nonexpansion states with incomes below the FPL. These low-income people are made eligible for Marketplace assistance consistent with the other nonincome eligibility rules (e.g., those regarding legal residency, ineligibility for other public coverage, and absence of an affordable employer-based insurance offer). Newly eligible people enrolling in coverage receive the same financial assistance as those with incomes at the FPL. In states that have already expanded Medicaid, the federal government pays all the costs associated with the expansion population, instead of just 90 percent of these costs under current law. In addition, in every state, Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) participants are autoenrolled in free coverage (in the Medicaid program in expansion states and, for those with incomes below the FPL, who

are eligible for zero-premium coverage, in a private insurance option at or below the premium subsidy benchmark in nonexpansion states).

Reform 4: Adds a public option and/or capped provider payment rates in the nongroup market to reform 3. In addition to all the reforms included in the previous packages, this approach introduces a public option into the nongroup market and/or caps all nongroup insurer provider payment rates at approximately traditional Medicare levels.[9] As we have discussed elsewhere, capping provider payment rates for all insurers participating in the ACA-compliant nongroup insurance markets would have similar effects as introducing a public option without developing a government-administered risk-bearing plan, and it builds on a policy in place in the Medicare program that has not been politically controversial (Blumberg, Simpson, and Buettgens 2019; Holahan and Blumberg 2017, 2018). In this package, we also assume prescription drug manufacturers are required to provide nongroup insurers with rebates halfway between those provided through Medicaid and Medicare.

Reform 5: Adds Continuous Autoenrollment with Retroactive Enforcement (CARE) and elimination of the employer-sponsored insurance offer "firewall" to reform 4. Reform 4 allows for a public option and/or capped provider payment rates for private nongroup insurers, but reform 5 requires that a public option be offered (capped payment rates for private insurers could be included as well). People not actively enrolling in insurance coverage for the year are enrolled in the public option and are charged income-related premiums. This is the first reform package in the series that effectively achieves universal coverage for all legally present US residents. The approach eliminates the ACA's employer requirement penalties and the "firewall" that prohibits workers and their dependents from accessing Marketplace financial assistance if they are considered to have access to affordable employer-based coverage.[10] Residents are required to enroll in an insurance plan through employment, Medicaid, Medicare, or the nongroup market. Those not responding to a broad-based public relations campaign by actively enrolling in a plan during the open enrollment period and whom are not enrolled in other coverage (e.g. employer insurance, CHAMPUS, VA) are deemed enrolled in Medicaid (if eligible) or the public option, and the tax system will collect any appropriate income-related public option premium for the full year, not just premiums for the months actively enrolled. Any excess health care risk and costs associated with late enrollees in the public option are covered by general federal revenues.[11] This approach protects private insurers in the market from adverse selection that can occur when enrolling people when they seek medical care. In the assumed rare circumstance where the public option is not one of the two lowest-premium options, the full premium facing the public option enrollees would be set equal to that of the second-lowest-priced option, such that any enrollee (late or otherwise) could obtain that coverage at no more than the applicable percent-of-income cap.

Reform 6: Adds further enhanced premium and cost-sharing subsidies to reform 5. This approach increases the generosity of federal financial assistance beyond that provided in the previous five reforms. The third and sixth columns of table 2 show the further enhanced premium tax credit and cost-sharing schedules.

Reform 7: Single-payer with ACA essential benefits and sliding-scale cost-sharing requirements. Under this policy, all legally present US residents are deemed enrolled in a single health insurance plan developed and regulated by the federal government (excluding undocumented immigrants). The plan does not charge premiums but has a sliding-scale cost-sharing schedule based upon income (the same schedule used for simulations 1 through 5 and shown in table 2, column 5). The base actuarial value for the plan is 80 percent, with people with incomes below 400 percent of FPL eligible for higher actuarial value coverage, consistent with the schedule described above. As they do today in the Marketplaces, under this reform, individuals and families would apply for reduced cost sharing every year. Those not explicitly enrolling in the national plan are enrolled by health care providers when they seek medical care. Covered benefits are consistent with the essential health benefits covered in the ACA Marketplaces. No private insurer can offer health insurance coverage. Payment rates for all services are set at current Medicare rates, except for hospital services, which are set at 115 percent of Medicare rates.

Reform 8: Single-payer with enhanced benefits and no cost-sharing requirements. This option expands upon simulation 7, eliminating all cost-sharing requirements, adding additional benefits for adult dental, vision, and hearing care and LTSS. Because the single-payer (or Medicare for All) proposals currently being discussed would provide coverage to undocumented immigrants, we include all US residents in these estimates. The LTSS benefits are designed to capture the general spirit of that component of the Medicare for All Act of 2019.[12] However, the LTSS provisions of that bill are vague, and, therefore, we have assumed a set of eligibility and benefit standards consistent with expanding upon current practices and the ACA's Community Living Assistance Services and Supports (CLASS) Act provisions (which were repealed on January 1, 2013). The LTSS benefit modeled here provides extensive home- and community-based services for those whose disabilities are classified as meeting Health Insurance Portability and Accountability Act standards.[13] The maximum benefit is set at approximately $150 per day and then indexed for inflation.[14] People served in institutional settings and covered by Medicaid under current law continue to be covered by Medicaid. The benefit structure is assumed to be service reimbursement.[15]

TABLE 1
Health Reforms Simulated

	Reform 1: Enhanced financial assistance	Reform 2: Federal individual mandate and STLD prohibitions	Reform 3: Filling the Medicaid eligibility gap	Reform 4: Public option and/or capped provider payment rates	Reform 5: CARE, no ESI firewall	Reform 6: Further enhanced financial assistance	Reform 7: Single-payer lite	Reform 8: Single-payer enhanced
Reform builds on or replaces ACA?	Builds on	Builds on	Builds on	Builds on	Builds on	Builds on	Replaces	Replaces
Household premiums	Lower Marketplace percent-of-income caps than ACA, which are extended to higher incomes; ranging from 0 to 8.5% of income for those 400% FPL or higher	Lower Marketplace percent-of-income caps than ACA, which are extended to higher incomes; ranging from 0 to 8.5% of income for those 400% FPL or higher	Lower Marketplace percent-of-income caps than ACA, which are extended to higher incomes; ranging from 0 to 8.5% of income for those 400% FPL or higher	Lower Marketplace percent-of-income caps than ACA, which are extended to higher incomes; ranging from 0 up to 8.5% of income for those 400% FPL or higher	Lower Marketplace percent-of-income caps than ACA, which are extended to higher incomes; ranging from 0 to 8.5% of income for those 400% FPL or higher	Lower Marketplace percent-of-income caps than ACA, which are extended to higher incomes; ranging from 0 to 8.0% of income for those 600% FPL or higher	None	None
Cost-sharing	Premium percent-of-income caps tied to 80% AV plan; additional subsidies to lower cost sharing further for those up to 400% FPL	Premium percent-of-income caps tied to 80% AV plan; additional subsidies to lower cost sharing further for those up to 400% FPL	Premium percent-of-income caps tied to 80% AV plan; additional subsidies to lower cost sharing further for those up to 400% FPL	Premium percent-of-income caps tied to 80% AV plan; additional subsidies to lower cost sharing further for those up to 400% FPL	Premium percent-of-income caps tied to 80% AV plan; additional subsidies to lower cost sharing further for those up to 400% FPL	Premium percent-of-income caps tied to 80% AV plan; additional subsidies to lower cost sharing for those up to 500% FPL	Standard 80% AV with additional income-related cost-sharing assistance for those up to 400% FPL	None
Covered benefits	ACA essential health benefits	ACA essential health benefits	ACA essential health benefits	ACA essential health benefits	ACA essential health benefits	ACA essential health benefits	ACA essential health benefits	All medically necessary care, including LTSS, dental, vision, hearing

	Reform 1: Enhanced financial assistance	Reform 2: Federal individual mandate and STLD prohibitions	Reform 3: Filling the Medicaid eligibility gap	Reform 4: Public option and/or capped provider payment rates	Reform 5: CARE, no ESI firewall	Reform 6: Further enhanced financial assistance	Reform 7: Single-payer lite	Reform 8: Single-payer enhanced
Reinsurance	Permanent program, $10 billion per year funded by general revenues	Permanent program, $10 billion per year funded by general revenues	Permanent program, $10 billion per year funded by general revenues	Permanent program, $10 billion per year funded by general revenues	Permanent program, $10 billion per year funded by general revenues	Permanent program, $10 billion per year funded by general revenues	Not applicable; no private insurers	Not applicable; no private insurers
Penalties for remaining uninsured?	No; current law	Yes; restores ACA penalties	Yes; restores ACA penalties	Yes; restores ACA penalties	No; all legally present residents enrolled through CARE	No; all legally present residents enrolled through CARE	No; all legally present residents enrolled in government plan	No; all US residents enrolled in government plan
Expanded access to STLDs?	Yes; current law	No; returns to 2016 rules	No; returns to 2016 rules	No; returns to 2016 rules	No; all enrolled in compliant coverage	No; all enrolled in compliant coverage	No; all enrolled in government plan	No; all enrolled in government plan
Limits on provider payment rates?	No	No	No	Yes, in nongroup market: public plan pays rates equal to highly competitive market rates and/or private nongroup plans capped at same rates both in and out of network	Yes, in nongroup market: public plan pays rates equal to highly competitive market rates and private nongroup plans capped at same rates both in and out of network; requires a public option	Yes, in nongroup market: public plan pays rates equal to highly competitive market rates and private nongroup plans capped at same rates both in and out of network; requires a public option	Yes, all legally present US residents are enrolled in a single government insurance plan that pays providers at approximately Medicare rates[a]	Yes, everyone is enrolled in a single government insurance plan that pays providers at approximately Medicare rates[a]
Eliminates the Medicaid eligibility gap?	No	No	Yes; federal government pays all	Yes; federal government pays all	Yes; federal government pays all	Yes; federal government pays all	Yes; all enrollees, regardless of	Yes; all US residents, regardless of

	Reform 1: Enhanced financial assistance	Reform 2: Federal individual mandate and STLD prohibitions	Reform 3: Filling the Medicaid eligibility gap	Reform 4: Public option and/or capped provider payment rates	Reform 5: CARE, no ESI firewall	Reform 6: Further enhanced financial assistance	Reform 7: Single-payer lite	Reform 8: Single-payer enhanced
			Medicaid expansion population costs in expansion states and lowers Marketplace subsidy income threshold to just above that for Medicaid eligibility in nonexpansion states	Medicaid expansion population costs in expansion states and lowers Marketplace subsidy income threshold to just above that for Medicaid eligibility in nonexpansion states	Medicaid expansion population costs in expansion states and lowers Marketplace subsidy income threshold to just above that for Medicaid eligibility in nonexpansion states	Medicaid expansion population costs in expansion states and lowers Marketplace subsidy income threshold to just above that for Medicaid eligibility in nonexpansion states	income, are enrolled in the same government insurance plan with no premiums; low-income people (including those otherwise Medicaid eligible) receive additional cost-sharing subsidies	income, are enrolled in the same government insurance plan with no premiums or cost-sharing requirements
Excludes those with household ESI offers from federal subsidies?	Yes; current law	Yes; current law	Yes; current law	Yes; current law	No	No	No; eliminates employer-based insurance	No; eliminates employer-based insurance
Leads to universal coverage?	No	No	No	No	For legally present residents only	For legally present residents only	For legally present residents only	Yes
Do employers face a penalty for not insuring workers?	Yes for some employers with more than 50 workers; current law	Yes for some employers with more than 50 workers; current law	Yes for some employers with more than 50 workers; current law	Yes for some employers with more than 50 workers; current law	No	No	No	No

Notes: STLD = short-term, limited duration plan; CARE = Continuous Autoenrollment with Retroactive Enforcement; ESI = employer-sponsored insurance. ACA = Affordable Care Act; FPL = federal poverty level; LTSS = long-term services and supports; AV = actuarial value.

[a] Provider payment rates under single-payer options are set at traditional Medicare rates for physicians and at Medicare rates plus 15 percent for hospitals. Nongroup public option coverage is set to approximate Medicare rates by estimating premiums in each rating area as if there were at least five competing insurers and modestly competitive provider markets. See methodology appendix for additional detail.

TABLE 2
Enhanced Premium Tax Credit and Cost-Sharing Reduction Schedule

	PREMIUM TAX CREDIT SCHEDULE			COST-SHARING REDUCTION SCHEDULE		
	Household Premium (As % of Income)			AV of Plan Provided to Eligible Enrollees (%)		
Income (% of FPL)	2019 ACA schedule: Pegged to silver (70% AV) premium, indexed	Schedule for reforms 1–5: Pegged to gold (80% AV) premium, not indexed	Schedule for reform 6: Pegged to gold (80% AV) premium, not indexed	2019 ACA schedule: Coverage provided in a silver plan	Schedule for reforms 1–5 and 7: Coverage provided in a gold plan	Schedule for reform 6: Coverage provided in a gold plan
100–138	2.08	0.0–1.0	0.0	94	95	100
138–150	3.11–4.15	1.0–2.0	0.0	94	95	100
150–200	4.15–6.54	2.0–4.0	0.0	87	95	100
200–250	6.54–8.36	4.0–6.0	0.0–1.0	73	90	95
250–300	8.39–9.86	6.0–7.0	1.0–2.0	70	90	95
300–400	9.86	7.0–8.5	2.0–4.0	70	85	90
400–500	n/a	8.5	4.0–6.0	70	80	85
500–600	n/a	8.5	6.0–8.0	70	80	80
600+	n/a	8.5	8.0	70	80	80

Source: Urban Institute analysis.

Notes: ACA = Affordable Care Act; AV = actuarial value; FPL = federal poverty level; n/a = not applicable. Reform simulated in 2020. The Affordable Care Act premium tax credit schedule is available at https://www.irs.gov/pub/irs-drop/rp-18-34.pdf. The enhanced premium tax credit and cost-sharing reduction schedules are used in simulations 1–6; the enhanced cost-sharing reduction schedule alone is used in simulation 7.

Key Findings

Table 3 provides an overview of insurance coverage and health care spending levels under current law and each simulated reform, including three sensitivity analyses on the two modeled single-payer options. People without minimum essential coverage are those without any insurance and those with STLDs, and the uninsured are only those without any insurance coverage.[16] Though STLDs are considered substandard under the ACA because they do not meet minimum essential health benefit or actuarial value standards and are not subject to the law's consumer protections afforded through other individually purchased insurance, we exclude enrollees in these plans from our definition of uninsured. National spending is by households, employers, and government (state and federal) on acute care and LTSS. All results, unless otherwise specified, are presented as fully implemented and in equilibrium (i.e., any behavioral changes fully phased in) beginning in 2020.

Figures 1 through 3 show the effect of the eight reforms on national health spending and the additional federal revenues needed to finance them, accounting for income tax offsets related to lower

levels of employer-based insurance.[17] Also shown are changes to spending for the single-payer reforms under alternative assumptions.

The effects of each reform on health insurance coverage, health care spending, premiums and out-of-pocket costs for nongroup insurance enrollees, and nonelderly household spending by income group are discussed in detail below, reform package by reform package.

All simulations (current law and reforms) assume reversal of both the new Health Reimbursement Arrangement regulations that would allow employers of all sizes to make pretax contributions to nongroup insurance on behalf of their workers and the recent administrative action to remove millions of SNAP recipients from the rolls.[18] The former affects the share of employers continuing to offer health insurance (particularly under reforms 5 and 6), and the latter affects the reach of our proposed limited autoenrollment of low-income people in insurance coverage.

Summary of Insurance Coverage and Health Care Spending Estimates under Current Law and Eight Reforms, 2020

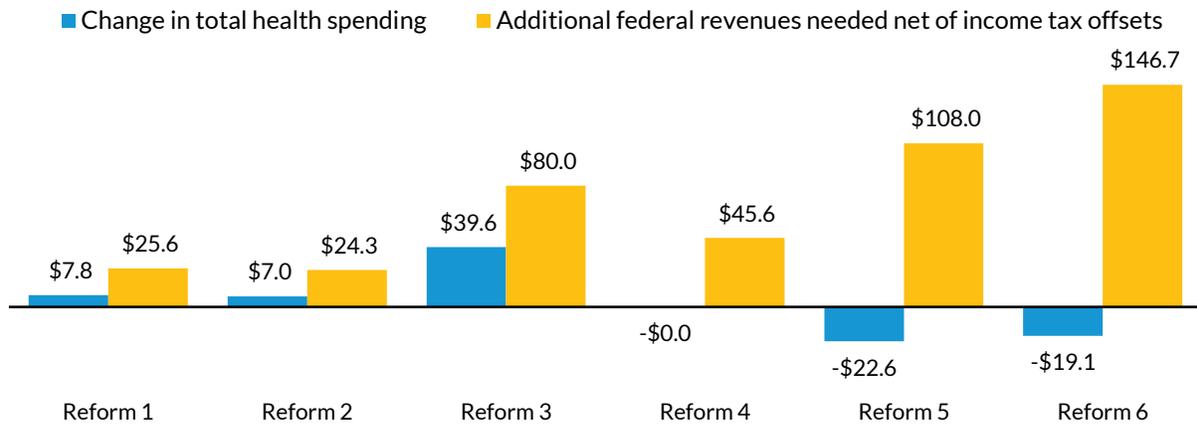| | HEALTH INSURANCE COVERAGE (MILLIONS OF PEOPLE) | | | | | HEALTH CARE SPENDING (BILLIONS OF DOLLARS) | | |
| | Without minimum essential coverage | Uninsured | | | ESI | Federal | State | National |
		Total	Legally present	Not legally present				
Current law (ACA)	34.6	32.2	25.6	6.6	147.6	1,284.3	302.3	3,496.8
Reform 1: Reinsurance + enhanced subsidies	30.0	28.2	21.6	6.6	146.8	1,310.0	298.9	3,504.5
Reform 2: Reform 1 + individual mandate + STLD prohibition	28.3	28.3	21.7	6.6	147.1	1,308.8	299.1	3,503.8
Reform 3: Reform 2 + filling the Medicaid eligibility gap	21.4	21.4	14.8	6.6	144.6	1,365.6	296.1	3,536.4
Reform 4: Reform 3 + public option or capped provider rates	21.3	21.3	14.7	6.6	144.9	1,331.0	296.2	3,496.7
Reform 5: Reform 4 + CARE + elimination of ESI firewall	6.6	6.6	0.0	6.6	132.6	1,406.4	296.6	3,474.2
Reform 6: Reform 5 + further enhanced subsidies	6.6	6.6	0.0	6.6	131.8	1,446.1	296.6	3,477.6
Reform 7: Single-payer lite with ACA benefits and income-related cost sharing	10.8	10.8	0.0	10.8	0.0	2,807.1	95.4	3,287.2
Reform 8: Single-payer enhanced with broad benefits and no cost sharing	0.0	0.0	0.0	0.0	0.0	4,128.9	42.7	4,216.5
Sensitivity analysis 7-1: Reform 7 with higher provider payment rates	10.8	10.8	0.0	10.8	0.0	2,934.3	95.4	3,418.4
Sensitivity analysis 7-2: Reform 7 with state maintenance of effort	10.8	10.8	0.0	10.8	0.0	2,614.8	287.7	3,287.2
Sensitivity analysis 7-3: Reform 7 with lower administrative costs	10.8	10.8	0.0	10.8	0.0	2,729.9	95.4	3,210.0
Sensitivity analysis 8-1: Reform 8 with higher provider payment rates	0.0	0.0	0.0	0.0	0.0	4,360.2	42.7	4,447.8
Sensitivity analysis 8-2: Reform 8 with state maintenance of effort	0.0	0.0	0.0	0.0	0.0	3,887.1	284.5	4,216.5
Sensitivity analysis 8-3: Reform 8 with lower administrative costs	0.0	0.0	0.0	0.0	0.0	4,012.2	42.7	4,099.8

Source: Urban Institute analysis.

Notes: ACA = Affordable Care Act. STLD = short-term, limited-duration plan. ESI = employer-sponsored insurance. CARE = Continuous Autoenrollment with Retroactive Enforcement. Reforms simulated as if fully phased in in 2020.

FIGURE 1

Change in Total Health Spending and Additional Federal Revenues Needed under Reforms 1–6

Billions of dollars

- ■ Change in total health spending
- ■ Additional federal revenues needed net of income tax offsets

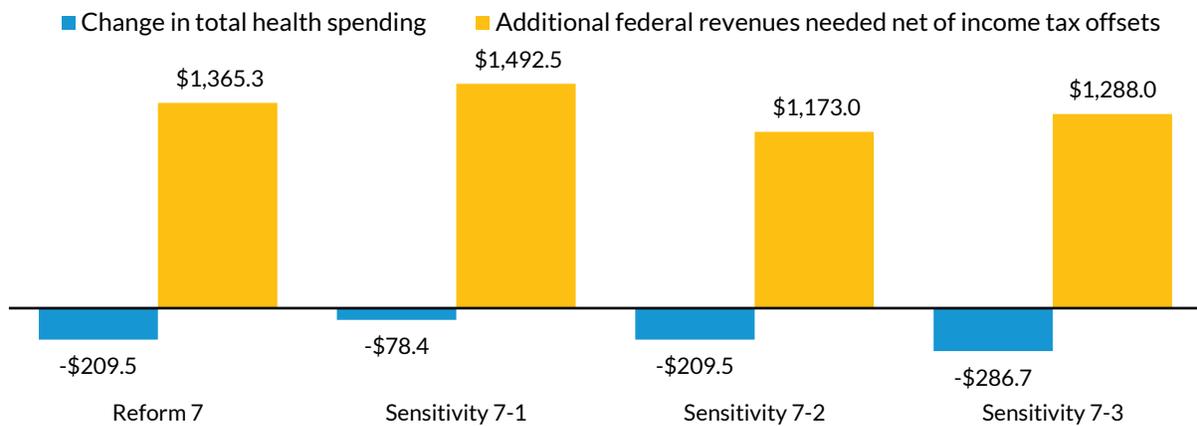|	Reform 1	Reform 2	Reform 3	Reform 4	Reform 5	Reform 6
Change in total health spending	$7.8	$7.0	$39.6	-$0.0	-$22.6	-$19.1
Additional federal revenues needed	$25.6	$24.3	$80.0	$45.6	$108.0	$146.7

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Source: Urban Institute analysis.

Notes: Reform 1 is reinsurance with enhanced subsidies. Reform 2 is reform 1 plus individual mandate and prohibition of short-term, limited-duration plans. Reform 3 is reform 2 plus filling the Medicaid eligibility gap. Reform 4 is reform 3 plus the public option and/or capped provider payment rates. Reform 5 is reform 4 plus Continuous Autoenrollment with Retroactive Enforcement and elimination of the employer-sponsored insurance firewall. Reform 6 is reform 5 plus further enhanced subsidies. Reforms simulated as if fully phased in 2020. Under reform 4, total health spending decreases slightly; the change rounds to $0.

FIGURE 2

Change in Total Health Spending and Additional Federal Revenues Needed under Single-Payer Lite (Reform 7) and Sensitivity Analyses

Billions of dollars

- ■ Change in total health spending
- ■ Additional federal revenues needed net of income tax offsets

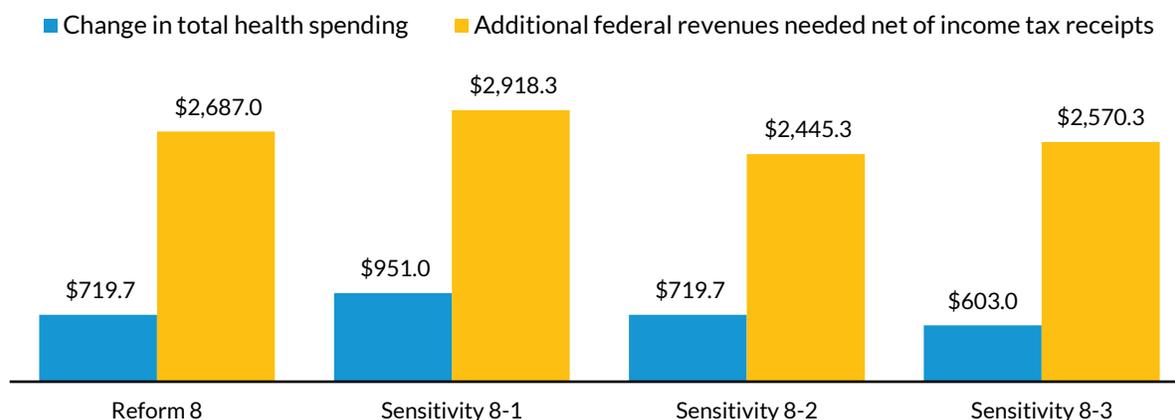|	Reform 7	Sensitivity 7-1	Sensitivity 7-2	Sensitivity 7-3
Additional federal revenues needed	$1,365.3	$1,492.5	$1,173.0	$1,288.0
Change in total health spending	-$209.5	-$78.4	-$209.5	-$286.7

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Source: Urban Institute analysis.

Notes: Single-payer lite has income-related cost sharing and Affordable Care Act benefits. Sensitivity 7–1 is reform 7 with higher provider payment rates. Sensitivity 7-2 is reform 7 with state maintenance of effort. Sensitivity 7-3 is reform 7 with lower administrative costs. Reforms simulated as if fully phased in 2020.

FIGURE 3

Change in Total Health Spending and Additional Federal Revenues Needed under Single-Payer Enhanced (Reform 8) and Sensitivity Analyses
Billions of dollars

■ Change in total health spending   ■ Additional federal revenues needed net of income tax receipts

	Reform 8	Sensitivity 8-1	Sensitivity 8-2	Sensitivity 8-3
Change in total health spending	$719.7	$951.0	$719.7	$603.0
Additional federal revenues needed net of income tax receipts	$2,687.0	$2,918.3	$2,445.3	$2,570.3

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Source: Urban Institute analysis.
Notes: Single-payer enhanced has enhanced benefits and no cost sharing. Sensitivity 8-1 is reform 8 with higher provider payment rates. Sensitivity 8-2 is reform 8 with state maintenance of effort. Sensitivity 8-3 is reform 8 with lower administrative costs. Reforms simulated as if fully phased in in 2020.

Detailed Findings for Each Simulated Reform

Simulation of Reform 1 Compared with Current Law

Includes enhanced and extended subsidies for nongroup coverage and adds permanent reinsurance

Coverage. The first reform scenario is estimated to reduce the uninsured by 4.0 million people, a 12.5 percent decrease; 4.6 million more people have minimum essential coverage (table 4), because some of those currently buying substandard STLDs use the additional subsidies to enroll in comprehensive coverage. Employer coverage is largely unaffected, and the number of people with nongroup coverage increases by 5.3 million (subsidized and unsubsidized combined). Though the number of people enrolled in nongroup coverage with tax credits increases by 58.7 percent, the number enrolled in ACA-compliant coverage without tax credits remains virtually unchanged.[19]

Health care spending. Federal government spending increases by $25.7 billion in 2020, the consequence of the expanded Marketplace subsidies and national reinsurance program. As the number of uninsured falls, federal costs associated with funding uncompensated care drop by $4.8 billion, offsetting a portion of the increased subsidy and reinsurance costs. The small decrease in employer-sponsored insurance leads to a very small increase in income tax revenue ($0.1 billion), as some

workers' compensation shifts from untaxable health insurance to taxable wages, so funding the reform requires an additional $25.6 billion in new federal revenues.

State government spending under this reform also decreases modestly ($3.4 billion, or 1.1 percent), largely because of decreased uncompensated care, with some additional savings to states funding reinsurance programs and/or enhanced Marketplace subsidies under current law.[20]

Aggregate household spending decreases modestly, by $5.0 billion (0.5 percent) in 2020 as more nonelderly people receive financial assistance for nongroup coverage and those previously receiving assistance receive more generous assistance. Some households newly obtaining coverage and making contributions to the costs of their insurance will increase their health spending, offsetting some of the total household savings. This does not necessarily make them worse off, however, because their risk of exposure to high out-of-pocket costs is lower under the reform, a factor not captured by out-of-pocket spending in a given year. In addition, some people newly enrolling in health insurance use more health care services, which may also make them better off than under current law. Employer spending on premiums decreases very modestly ($5.3 billion, or 0.6 percent) with the small reduction in employer-sponsored insurance.

Premiums and out-of-pocket costs for nongroup enrollees. Table 5 provides premium and out-of-pocket cost comparisons under current law and reform 1 for nongroup enrollees with different income levels, ages, and family statuses. These same comparisons apply to reforms 2 through 5 as well, because all these reforms use the same subsidy schedule. As the top section of the table shows, the largest premium savings (over $11,000 per year) accrue to families and older adults, particularly those currently ineligible for Marketplace assistance because they have incomes above 400 percent of FPL. Smaller, but still significant, savings accrue to younger adults and those with lower incomes under the enhanced schedule.[21] As incomes increase beyond the range shown here, the effect of the extended premium subsidies will decrease until the full premium cost falls below the new 8.5 percent-of-income cap and the federal subsidy is effectively zero.

In addition to premium savings, many families face substantially lower out-of-pocket costs under reforms 1 through 5. The cost-sharing levels shown in the bottom section of table 5 are examples based on median options offered in the ACA's federally facilitated Marketplaces, modified slightly using the Centers for Medicare & Medicaid Services (CMS) actuarial value calculator for 2020 to hit target actuarial value levels in that year.[22] ACA premium tax credits are tied to a 70 percent actuarial value plan, an example of which is shown here as having a single deductible of $2,500, an out-of-pocket maximum of $6,000, and 25 percent inpatient coinsurance. By comparison, an example 80 percent

actuarial value plan associated with the reforms' premium tax credits has a deductible $1,400 lower, an out-of-pocket maximum $2,000 lower, and lower coinsurance and outpatient care copayments as well. Lower-income people also reap savings from additional cost-sharing subsidies under the reforms. For example, compared with current law, single adults with income at 250 percent of FPL in typical plans have a $1,650 lower deductible, a $4,000 lower out-of-pocket maximum, and 10 percent inpatient coinsurance, instead of 20 percent.

BOX 1

Comparing Our Estimates and Federal Estimates of National Health Expenditures

CMS projects total national health expenditures of $4,031.1 billion in 2020 under current law.[23] Our current work projects $3,496.8 billion in spending in 2020. What accounts for the $534.3 billion difference? Our simulation models rely on different data, and they do not include some expenditures that the CMS national health expenditure accounts (NHEA) include. The NHEA relies on an array of aggregate sources of health care spending, and our microsimulation models rely on person-level data with some benchmarking to reliable national aggregate sources. HIPSM adjusts for the largest differences resulting from the use of different data sources, such as the undercount of very high health expenditures in household survey data (Sing et al. 2006). Thus, the largest source of differences between our aggregate estimate of spending and that in the NHEA is the categories of expenditures not captured by household data or our supplemental estimates of LTSS costs. These additional categories of expenses constitute most spending identified as "other health insurance programs" and "other third-party payers" in the NHEA.[24] Examples include health care services provided to active duty military personnel (both in the US and overseas) and to the families of military personnel and military retirees, services provided to foreign visitors, acute care provided to people living in institutions (e.g., prisons and nursing homes), and the value of new construction and equipment put in place by the medical sector.

As such, for those who wish to put our estimates in the context of the CMS NHEA projections, we suggest adding $534.3 billion to *both* our total current-law spending estimates and our total health spending estimates under reform. This amount represents health care costs we estimate would not change under reform. Our single-payer approach estimates (reforms 7 and 8) include offsets for the portion of health care spending under programs such as the Indian Health Service, Veterans Affairs, and the Department of Defense that would be covered by the single-payer reforms modeled.

TABLE 4

Health Insurance Coverage and Health Care Spending in 2020 under Current Law and Reform 1

Health insurance coverage

	Current Law		Reform 1		Difference from Current Law	
	Millions of people	%	Millions of people	%	Millions of people	%
Insured with minimum essential coverage	**296.9**	**89.6**	**301.5**	**90.9**	**4.6**	**1.5**
Employer	147.6	44.5	146.8	44.3	-0.8	-0.5
Nongroup (with tax credits)	9.1	2.7	14.4	4.4	5.3	58.7
Nongroup (without tax credits)	6.4	1.9	6.3	1.9	-0.1	-1.3
Medicaid/CHIP	68.8	20.8	69.0	20.8	0.1	0.2
Medicare	60.4	18.2	60.4	18.2	0.0	0.0
Other	4.6	1.4	4.6	1.4	0.0	0.0
Lacking minimum essential coverage	**34.6**	**10.4**	**30.0**	**9.1**	**-4.6**	**-13.3**
Uninsured	*32.2*	*9.7*	*28.2*	*8.5*	*-4.0*	*-12.5*
Legally present	25.6	7.7	21.6	6.5	-4.0	-15.7
Not legally present	6.6	2.0	6.6	2.0	0.0	-0.1
Short-term, limited-duration plans	*2.4*	*0.7*	*1.9*	*0.6*	*-0.6*	*-23.4*
Total	**331.5**	**100.0**	**331.5**	**100.0**	**0.0**	**0.0**

Health care spending

	Current Law		Reform 1		Difference from Current Law	
	Billions of dollars	%	Billions of dollars	%	Billions of dollars	%
Federal government	**1,284.3**	**36.7**	**1,310.0**	**37.4**	**25.7**	**2.0**
Medicaid/CHIP	464.3	13.3	465.1	13.3	0.8	0.2
Marketplace PTCs and CSRs	59.2	1.7	80.2	2.3	20.9	35.4
Reinsurance	1.2	0.0	10.0	0.3	8.8	718.1
Medicare[a]	732.0	20.9	732.0	20.9	0.0	0.0
Uncompensated care	27.5	0.8	22.7	0.6	-4.8	-17.5
State government	**302.3**	**8.6**	**298.9**	**8.5**	**-3.4**	**-1.1**
Medicaid/CHIP	284.5	8.1	284.7	8.1	0.2	0.1
Marketplace PTCs and CSRs	0.1	0.0	0.0	0.0	-0.1	-100.0
Reinsurance	0.5	0.0	0.0	0.0	-0.5	-100.0
Uncompensated care	17.2	0.5	14.2	0.4	-3.0	-17.5
Employers	**954.7**	**27.3**	**949.4**	**27.1**	**-5.3**	**-0.6**
Households	**931.4**	**26.6**	**926.4**	**26.4**	**-5.0**	**-0.5**
In-kind uncompensated care from providers	**24.1**	**0.7**	**19.9**	**0.6**	**-4.2**	**-17.5**
Total	**3,496.8**	**100.0**	**3,504.5**	**100.0**	**7.8**	**0.2**
Increased federal spending					**25.7**	
Income tax revenue offset					**-0.1**	
Additional federal revenues needed net of increased income tax receipts					**25.6**	

Source: Urban Institute analysis.

Notes: CHIP = Children's Health Insurance Program. PTC = premium tax credit. CSR = cost-sharing reduction. Reform 1 includes federal reinsurance program and enhanced premium and cost-sharing subsidies. Reform simulated as if fully phased in 2020.

[a] Medicare spending is net of premiums.

TABLE 5

Example Premium and Out-of-Pocket Cost Comparisons, by Income Group, Reforms 1–5 and Current Law, 2020

Based on national median-priced 2019 plans offered by federally facilitated Marketplaces, adjusted using the 2020 CMS actuarial value calculator

	150% of FPL			250% of FPL			350% of FPL			450% of FPL		
	ACA (94% AV)	Reforms 1–5 (95% AV)[a]	Diff.	ACA (73% AV)	Reforms 1–5 (90% AV)[a]	Diff.	ACA (70% AV)	Reforms 1–5 (85% AV)[a]	Diff.	ACA (70% AV)	Reforms 1–5 (80% AV)[a]	Diff.
Premiums												
Single coverage Enrollee age												
25	$778	$375	-$403	$2,610	$1,874	-$737	$4,310	$3,388	-$922	$5,375	$4,777	-$598
45	$778	$375	-$403	$2,610	$1,874	-$737	$4,310	$3,388	-$922	$7,731	$4,777	-$2,953
64	$778	$375	-$403	$2,610	$1,874	-$737	$4,310	$3,388	-$922	$16,061	$4,777	-$11,284
Family of four (two age 35, two children)	$1,603	$773	-$830	$5,382	$3,863	-$1,519	$8,886	$6,985	-$1,902	$21,276	$9,849	-$11,427
Out-of-pocket requirements[b]												
Coinsurance on inpatient care	10%	5%	-5%	20%	10%	-10%	25%	10%	-15%	25%	20%	-5%
Single coverage Deductible	$200	$200	$0	$2,400	$750	-$1,650	$2,500	$1,150	-$1,350	$2,500	$1,100	-$1,400
Out-of-pocket maximum	$700	$500	-$200	$5,000	$1,000	-$4,000	$6,000	$2,100	-$3,900	$6,000	$4,000	-$2,000
Family coverage Deductible	$400	$400	$0	$4,800	$1,500	-$3,300	$5,000	$2,300	-$2,700	$5,000	$2,200	-$2,800
Out-of-pocket maximum	$1,400	$1,000	-$400	$10,000	$2,000	-$8,000	$12,000	$4,200	-$7,800	$12,000	$8,000	-$4,000

Source: Urban Institute analysis of federal Marketplace data.

Notes: CMS = Centers for Medicare & Medicaid Services. FPL = federal poverty level. ACA = Affordable Care Act. AV = actuarial value. Diff. = difference. Premiums displayed are annual.

[a] Endnote 23 provides additional cost-sharing details.

[b] Out-of-pocket requirements in this table also apply to reform 7; however, reform 7 does not charge premiums to households. Remaining costs are covered by tax revenue.

Simulation of Reform 2 Compared with Current Law

Restores ACA's individual mandate and prohibition of expanded STLDs, enhances and extends subsidies for nongroup coverage, and adds a permanent national reinsurance program

Coverage. In addition to the changes in reform 1, reform 2 restores the ACA's individual mandate and reverses the administration's 2018 executive order expanding access to STLDs. The full reform 2 package increases the number of people with minimum essential coverage (defined as meeting the ACA'S minimum standards for benefits and cost sharing and providing the ACA's consumer protections for those with health problems) by 6.3 million (table 6), an additional 1.7 million people beyond reform 1. The number of uninsured falls by just under 4 million people, very little difference from reform 1.

The number of uninsured people does not differ much with the addition of the individual mandate penalties and the prohibition on expanded STLDs because of underlying offsetting effects. The effect of increased coverage on the number of uninsured because of the new mandate penalty is reduced by those who lose short-term coverage under the reform and do not take up other coverage. Of the 2.4 million people with short-term plans under current law, 1.2 million get coverage through the Marketplace (including about 600,000 attracted by additional subsidies in reform 1), around 500,000 gain employer sponsored coverage, and about 700,000 become uninsured, with many paying a penalty.

Reform 2 increases ACA-compliant nongroup (subsidized and unsubsidized) coverage by 6.5 million people (an additional 1.2 million people beyond reform 1) and increases Medicaid enrollment very modestly (300,000 people).

Spending. Federal government spending in 2020 increases by $24.5 billion compared with current law, $1.2 billion less than reform 1. The federal government costs are somewhat lower in reform 2, despite more enrollees being in the subsidized Marketplaces, because reinstated individual mandate penalties and elimination of the expanded STLDs brings additional healthier-than-average people into the private nongroup insurance market. As that risk pool improves, premiums decrease, and, with lower premiums, federal subsidy costs decrease.

State government savings are $3.2 billion under reform 2, approximately the same as under reform 1. The individual mandate increases Medicaid enrollment modestly, increasing state costs by less than 1 percent. With slightly more employer coverage because of the reinstated individual mandate penalties, employer health care spending is slightly higher than in reform 1; employers see $4.9 billion less in premium spending than under current law. Total household health care spending decreases by $5.0 billion, again about the same as under reform 1.

TABLE 6

Health Insurance Coverage and Health Care Spending in 2020 under Current Law and Reform 2

Health insurance coverage

	Current Law		Reform 2		Difference from Current Law	
	Millions of people	%	Millions of people	%	Millions of people	%
Insured with minimum essential coverage	**296.9**	**89.6**	**303.2**	**91.5**	**6.3**	**2.1**
Employer	147.6	44.5	147.1	44.4	-0.4	-0.3
Nongroup (with tax credits)	9.1	2.7	14.7	4.4	5.6	61.6
Nongroup (without tax credits)	6.4	1.9	7.2	2.2	0.8	13.2
Medicaid/CHIP	68.8	20.8	69.2	20.9	0.3	0.5
Medicare	60.4	18.2	60.4	18.2	0.0	0.0
Other	4.6	1.4	4.6	1.4	0.0	0.0
Lacking minimum essential coverage	**34.6**	**10.4**	**28.3**	**8.5**	**-6.3**	**-18.3**
Uninsured	*32.2*	*9.7*	*28.3*	*8.5*	*-3.9*	*-12.1*
Legally present	25.6	7.7	21.7	6.6	-3.9	-15.2
Not legally present	6.6	2.0	6.6	2.0	0.0	-0.1
Short-term, limited-duration plans	*2.4*	*0.7*	*0.0*	*0.0*	*-2.4*	*-100.0*
Total	**331.5**	**100.0**	**331.5**	**100.0**	**0.0**	**0.0**

Health care spending

	Current Law		Reform 2		Difference from Current Law	
	Billions of dollars	%	Billions of dollars	%	Billions of dollars	%
Federal government	**1,284.3**	**36.7**	**1,308.8**	**37.4**	**24.5**	**1.9**
Medicaid/CHIP	464.3	13.3	465.7	13.3	1.4	0.3
Marketplace PTCs and CSRs	59.2	1.7	78.4	2.2	19.2	32.4
Reinsurance	1.2	0.0	10.0	0.3	8.8	718.1
Medicare[a]	732.0	20.9	732.0	20.9	0.0	0.0
Uncompensated care	27.5	0.8	22.6	0.6	-4.9	-18.0
State government	**302.3**	**8.6**	**299.1**	**8.5**	**-3.2**	**-1.1**
Medicaid/CHIP	284.5	8.1	285.0	8.1	0.5	0.2
Marketplace PTCs and CSRs	0.1	0.0	0.0	0.0	-0.1	-100.0
Reinsurance	0.5	0.0	0.0	0.0	-0.5	-100.0
Uncompensated care	17.2	0.5	14.1	0.4	-3.1	-18.0
Employers	**954.7**	**27.3**	**949.8**	**27.1**	**-4.9**	**-0.5**
Households	**931.4**	**26.6**	**926.4**	**26.4**	**-5.0**	**-0.5**
In-kind uncompensated care from providers	**24.1**	**0.7**	**19.8**	**0.6**	**-4.3**	**-18.0**
Total	**3,496.8**	**100.0**	**3,503.8**	**100.0**	**7.0**	**0.2**
Increased federal spending					24.5	
Income tax revenue offset					-0.1	
Additional federal revenues needed net of increased income tax receipts					24.3	

Source: Urban Institute analysis.
Notes: CHIP = Children's Health Insurance Program. PTC = premium tax credit. CSR = cost-sharing reduction. Reform 2 includes federal reinsurance and enhanced Marketplace subsidies and restores the Affordable Care Act's individual mandate and prohibition of expanded short-term, limited-duration plans. Reform simulated as if fully phased in in 2020.
[a] Medicare spending is net of premiums.

Simulation of Reform 3 Compared with Current Law

Fills the Medicaid eligibility gap, introduces limited Medicaid autoenrollment, restores ACA's individual mandate and prohibition of expanded STLDs, enhances and extends subsidies for nongroup coverage, and adds a permanent reinsurance program

Coverage. Providing eligibility for deeply subsidized nongroup coverage through the Marketplace to many low-income families in states that have not expanded Medicaid under the ACA has both direct and indirect effects on coverage. First and most prominently, the number of people enrolled in Marketplace coverage and receiving premium tax credits increases by 10.4 million people (table 7), an additional 4.8 million enrollees beyond reform 2. The nongroup market, in total, is two-thirds larger than under current law.

At the same time, the number of people enrolled in employer-based coverage decreases by approximately 3.0 million, largely because of the limited autoenrollment for people receiving SNAP or TANF, the largest effects of which occur in Medicaid expansion states. The limited autoenrollment approach increases Medicaid coverage among the otherwise uninsured, but it also increases Medicaid enrollment among those Medicaid eligible but enrolled in employer-based coverage under current law. Consequently, Medicaid/CHIP enrollment increases by 5.3 million more people than under reform 2.

Reform 3 lowers the number of uninsured people under current law by 10.8 million, or 6.9 million more people than under reform 2.

Health care spending. Federal government spending increases by $81.3 billion compared with current law. Compared with reform 2, the additional federal costs associated with reform 3 ($56.9 billion) are split between additional Marketplace subsidies and Medicaid costs. The federal Medicaid costs increase because the program begins paying for (1) the 10 percent of expansion population health care costs previously covered by states that expanded Medicaid eligibility and (2) the federal share of costs associated with additional enrollment under the reform. Larger decreases in employer-based insurance under this reform lead to $1.3 billion in additional income tax revenue to modestly offset the additional revenue needed to finance the reform.

TABLE 7

Health Insurance Coverage and Health Care Spending in 2020 under Current Law and Reform 3

Health insurance coverage

	Current Law		Reform 3		Difference from Current Law	
	Millions of people	%	Millions of people	%	Millions of people	%
Insured with minimum essential coverage	**296.9**	**89.6**	**310.1**	**93.5**	**13.2**	**4.5**
Employer	147.6	44.5	144.6	43.6	-3.0	-2.0
Nongroup (with tax credits)	9.1	2.7	19.5	5.9	10.4	114.2
Nongroup (without tax credits)	6.4	1.9	6.5	2.0	0.2	2.7
Medicaid/CHIP	68.8	20.8	74.5	22.5	5.6	8.2
Medicare	60.4	18.2	60.4	18.2	0.0	0.0
Other	4.6	1.4	4.6	1.4	0.0	0.0
Lacking minimum essential coverage	**34.6**	**10.4**	**21.4**	**6.5**	**-13.2**	**-38.2**
Uninsured	*32.2*	*9.7*	*21.4*	*6.5*	*-10.8*	*-33.5*
Legally present	25.6	7.7	14.8	4.5	-10.8	-42.1
Not legally present	6.6	2.0	6.6	2.0	0.0	-0.1
Short-term, limited-duration plans	*2.4*	*0.7*	*0.0*	*0.0*	*-2.4*	*-100.0*
Total	**331.5**	**100.0**	**331.5**	**100.0**	**0.0**	**0.0**

Health care spending

	Current Law		Reform 3		Difference from Current Law	
	Billions of dollars	%	Billions of dollars	%	Billions of dollars	%
Federal government	**1,284.3**	**36.7**	**1,365.6**	**38.6**	**81.3**	**6.3**
Medicaid/CHIP	464.3	13.3	497.6	14.1	33.3	7.2
Marketplace PTCs and CSRs	59.2	1.7	108.7	3.1	49.5	83.6
Reinsurance	1.2	0.0	10.0	0.3	8.8	718.1
Medicare[a]	732.0	20.9	732.0	20.7	0.0	0.0
Uncompensated care	27.5	0.8	17.3	0.5	-10.2	-37.2
State government	**302.3**	**8.6**	**296.1**	**8.4**	**-6.2**	**-2.0**
Medicaid/CHIP	284.5	8.1	285.3	8.1	0.8	0.3
Marketplace PTCs and CSRs	0.1	0.0	0.0	0.0	-0.1	-100.0
Reinsurance	0.5	0.0	0.0	0.0	-0.5	-100.0
Uncompensated care	17.2	0.5	10.8	0.3	-6.4	-37.2
Employers	**954.7**	**27.3**	**938.6**	**26.5**	**-16.1**	**-1.7**
Households	**931.4**	**26.6**	**921.0**	**26.0**	**-10.4**	**-1.1**
In-kind uncompensated care from providers	**24.1**	**0.7**	**15.1**	**0.4**	**-9.0**	**-37.2**
Total	**3,496.8**	**100.0**	**3,536.4**	**100.0**	**39.6**	**1.1**
Increased federal spending					**81.3**	
Income tax revenue offset					**-1.3**	
Additional federal revenues needed net of increased income tax receipts					**80.0**	

Source: Urban Institute analysis.

Notes: CHIP = Children's Health Insurance Program. PTC = premium tax credit. CSR = cost-sharing reduction. Reform 3 includes federal reinsurance and enhanced Marketplace subsidies; restores the Affordable Care Act's individual mandate and prohibition of expanded short-term, limited duration plans; and fills the Medicaid eligibility gap. Filling the Medicaid eligibility gap in this

simulation involves extending premium tax credits in nonexpansion states to people with incomes just above the current-law Medicaid income eligibility levels plus full federal funding of Medicaid expansion in states that have already expanded. Reform simulated as if fully phased in 2020.
ª Medicare spending is net of premiums.

State governments save $6.2 billion under this reform, driven by lower uncompensated care spending as uninsurance falls. Though savings accrue to expansion states because the federal government begins covering the 10 percent of expansion population health care costs previously covered by states, those savings are offset by increased state costs associated with higher enrollment in traditional Medicaid eligibility categories.

Employers' and households' health care costs decrease significantly compared with reform 2. Employer health costs drop by $16.1 billion and households' health costs drop by $10.4 billion compared with current law; these costs drop by about $5 billion each in reform 2. Autoenrollment into Medicaid reduces out-of-pocket costs for those otherwise uninsured or covered by employer-sponsored insurance. Providers save about $9.0 billion in uncompensated care because the number of uninsured drops substantially. National aggregate spending on health care increases by $39.6 billion, or 1.1 percent, because of the increases in coverage.

Simulation of Reform 4 Compared with Current Law

Introduces public option and/or capped provider payment rates in private nongroup market, fills Medicaid eligibility gap, adds limited Medicaid autoenrollment, restores ACA's individual mandate and prohibits expanded STLDs, enhances and extends subsidies for nongroup coverage, and adds a permanent reinsurance program

Coverage. The largest coverage difference between reforms 3 and 4 is that, under reform 4, the number of people enrolled in nongroup coverage with tax credits is lower and the number enrolled in nongroup coverage without tax credits is higher (table 8). This difference owes to the fact that the public option and/or capped provider payment rates introduced in reform 4 lower the average full (unsubsidized) cost of nongroup premiums. Lower premiums mean more people enrolling in nongroup coverage face full premiums that fall below the percent-of-income caps provided by the Marketplace tax credits. For example, premiums more commonly fall below 8.5 percent of income for higher-income people and families, dropping their tax credits to $0.

TABLE 8
Health Insurance Coverage and Health Care Spending in 2020 under Current Law and Reform 4

Health insurance coverage

	Current Law		Reform 4		Difference from Current Law	
	Millions of people	%	Millions of people	%	Millions of people	%
Insured with minimum essential coverage	**296.9**	**89.6**	**310.2**	**93.6**	**13.3**	**4.5**
Employer	147.6	44.5	144.9	43.7	-2.7	-1.8
Nongroup (with tax credits)	9.1	2.7	18.0	5.4	8.9	97.3
Nongroup (without tax credits)	6.4	1.9	7.8	2.4	1.5	23.1
Medicaid/CHIP	68.8	20.8	74.5	22.5	5.7	8.2
Medicare	60.4	18.2	60.4	18.2	0.0	0.0
Other	4.6	1.4	4.6	1.4	0.0	0.0
Lacking minimum essential coverage	**34.6**	**10.4**	**21.3**	**6.4**	**-13.3**	**-38.5**
Uninsured	*32.2*	*9.7*	*21.3*	*6.4*	*-10.9*	*-33.8*
Legally present	25.6	7.7	14.7	4.4	-10.9	-42.5
Not legally present	6.6	2.0	6.6	2.0	0.0	-0.1
Short-term, limited duration plan	*2.4*	*0.7*	*0.0*	*0.0*	*-2.4*	*-100.0*
Total	**331.5**	**100.0**	**331.5**	**100.0**	**0.0**	**0.0**

Health care spending

	Current Law		Reform 4		Difference from Current Law	
	Billions of dollars	%	Billions of dollars	%	Billions of dollars	%
Federal government	**1,284.3**	**36.7**	**1,331.0**	**38.1**	**46.7**	**3.6**
Medicaid/CHIP	464.3	13.3	497.7	14.2	33.4	7.2
Marketplace PTCs and CSRs	59.2	1.7	73.9	2.1	14.6	24.7
Reinsurance	1.2	0.0	10.0	0.3	8.8	718.1
Medicare[a]	732.0	20.9	732.0	20.9	0.0	0.0
Uncompensated care	27.5		17.4	0.5	-10.1	-36.6
State government	**302.3**	**8.6**	**296.2**	**8.5**	**-6.0**	**-2.0**
Medicaid/CHIP	284.5	8.1	285.3	8.2	0.9	0.3
Marketplace PTCs and CSRs	0.1	0.0	0.0	0.0	-0.1	-100.0
Reinsurance	0.5	0.0	0.0	0.0	-0.5	-100.0
Uncompensated care	17.2	0.5	10.9	0.3	-6.3	-36.6
Employers	**954.7**	**27.3**	**940.4**	**26.9**	**-14.3**	**-1.5**
Households	**931.4**	**26.6**	**913.8**	**26.1**	**-17.6**	**-1.9**
In-kind uncompensated care from providers	**24.1**	**0.7**	**15.3**	**0.4**	**-8.8**	**-36.6**
Total	**3,496.8**	**100.0**	**3,496.7**	**100.0**	**-0.0**	**-0.0**
Increased federal spending					**46.7**	
Income tax revenue offset					**-1.1**	
Additional federal revenues needed net of increased income tax receipts					**45.6**	

Source: Urban Institute analysis.

Notes: CHIP = Children's Health Insurance Program. PTC = premium tax credit. CSR = cost-sharing reduction. Reform 4 includes federal reinsurance and enhanced Marketplace subsidies; restores the Affordable Care Act's individual mandate and prohibition of expanded short-term, limited-duration plans; fills the Medicaid eligibility gap; and introduces a public option or capped provider

payment rates in the nongroup market. Filling the Medicaid eligibility gap in this simulation involves extending premium tax credits in nonexpansion states to those with incomes just above the current-law Medicaid income eligibility threshold plus full federal funding of Medicaid expansion in states that have already expanded. Total health spending decreases slightly; the change rounds to $0. Reform simulated as if fully phased in in 2020.

[a] Medicare spending is net of premiums.

All other levels of coverage under reform 4 are similar to those under reform 3. The lower premiums in the nongroup market reduce costs (as described below) but do not increase coverage substantially more than the other reforms (approximately 11 million fewer people are uninsured than under current law). This is because the public option/capped provider payment rates only lower premiums for households facing the full cost of premiums in the nongroup market. With the expanded financial assistance introduced in the earlier reforms, fewer uninsured people face the full premium in the nongroup market, and those that do have considerably higher incomes and are therefore already highly likely to be insured.

Health care spending. The largest difference in spending between reforms 3 and 4 (the incremental effect of the nongroup market public option/capped provider payment rates) is that federal government spending on Marketplace subsidies is considerably lower under reform 4 ($73.9 billion compared with $108.7 billion under reform 3). Lower provider payment rates lead to lower premiums; lower premiums lead to lower premium tax credits. In addition, lower provider payment rates also result in lower out-of-pocket costs for some households (those spending below their out-of-pocket maximums) and lower cost-sharing subsidies for the federal government. Compared with current law, reform 4 lowers aggregate household health spending by $17.6 billion; under reform 3 these costs drop by $10.4 billion.[25]

Simulation of Reform 5 Compared with Current Law

Eliminates employer insurance firewall, adds CARE, introduces public option and may cap provider payment rates in full private nongroup market, fills Medicaid eligibility gap, restores 2016 prohibition of expanded STLDs, enhances and extends subsidies for nongroup coverage, and adds a permanent reinsurance program

Coverage. This is the first reform package that achieves universal coverage for the legally present US population. The CARE provisions enroll all legal residents not otherwise enrolling in an insurance plan into the Marketplace's public insurance option.[26] This means reform 5 reduces the number of people without minimum essential coverage by 28.0 million and decreases the number of uninsured people by 25.6 million but leaves 6.6 million people (all of them undocumented US residents) uninsured (table 9). This equals a 79.5 percent reduction in the uninsured compared with current law. Eliminating the employer insurance firewall allows people with employer insurance offers deemed affordable by the

ACA to obtain coverage with financial assistance in the Marketplaces if they prefer, decreasing the number of people with employer-based insurance. Combined with the other reforms, enrollment in employer coverage drops by 15.0 million people, or 10.2 percent.

Coverage in the nongroup insurance market increases by 30.8 million people compared with current law, with over 80 percent of the 46.3 million enrollees receiving federal financial assistance. The nongroup market is almost 80 percent larger under reform 5 than reform 4, because of more otherwise-uninsured people enrolling in Marketplace coverage and some workers opting for nongroup coverage over employer-based coverage.

Medicaid/CHIP coverage also increases markedly because of the CARE provisions. An additional 12.2 million people enroll in Medicaid/CHIP compared with current law, bringing total enrollment in those programs to 81.1 million people, or 24.4 percent of the US population.

Health care spending. With many more people enrolled in subsidized health insurance coverage, federal government health care costs increase. Reform 5 increases federal government health care spending by $122.1 billion; however, a $14.2 billion increase in income tax revenue (because of lower levels of employer-based coverage) means an additional $108.0 billion in revenue is needed to finance all of the reforms in 2020. Compared with reform 4, reform 5 increases both federal Medicaid and Marketplace subsidy costs, because of significantly higher enrollment in both. Reductions in state government spending are about the same under reforms 5 and 4 (around $6 billion), because higher Medicaid/CHIP costs are offset by lower uncompensated care costs in reform 5.

Lower enrollment in employer-based insurance in reform 5 translates into lower employer spending on premiums. Health care spending by employers is $91.6 billion (9.6 percent) lower than under current law. Household spending is $25.6 billion (2.7 percent) lower than under current law, owing to the reforms introduced under earlier packages and the shift of mostly modest-income workers previously buying employer-based insurance into the subsidized nongroup market once the firewall is eliminated. Health care providers decrease their uncompensated care costs by $21.8 billion (90.7 percent) compared with current law because of the near-elimination of uninsurance.

Reform 5 decreases aggregate health spending modestly, by $22.6 billion, or 0.6 percent, compared with current law. The total savings result because, though more people are enrolled in coverage, the lower provider payment rates slightly more than offset the costs associated with coverage expansion and the increased use of medical care by the uninsured.[27]

TABLE 9

Health Insurance Coverage and Health Care Spending in 2020 under Current Law and Reform 5

Health insurance coverage

	Current Law		Reform 5		Difference from Current Law	
	Millions of people	%	Millions of people	%	Millions of people	%
Insured with minimum essential coverage	**296.9**	**89.6**	**324.9**	**98.0**	**28.0**	**9.4**
Employer	147.6	44.5	132.6	40.0	-15.0	-10.2
Nongroup (with tax credits)	9.1	2.7	38.0	11.5	28.9	318.0
Nongroup (without tax credits)	6.4	1.9	8.2	2.5	1.9	29.4
Medicaid/CHIP	68.8	20.8	81.1	24.4	12.2	17.7
Medicare	60.4	18.2	60.4	18.2	0.0	0.0
Other	4.6	1.4	4.6	1.4	0.0	0.0
Lacking minimum essential coverage	**34.6**	**10.4**	**6.6**	**2.0**	**-28.0**	**-81.0**
Uninsured	*32.2*	*9.7*	*6.6*	*2.0*	*-25.6*	*-79.5*
Legally present	25.6	7.7	0.0	0.0	-25.6	-100.0
Not legally present	6.6	2.0	6.6	2.0	0.0	0.1
Short-term, limited duration plans	*2.4*	*0.7*	*0.0*	*0.0*	*-2.4*	*-100.0*
Total	**331.5**	**100.0**	**331.5**	**100.0**	**0.0**	**0.0**

Health care spending

	Current Law		Reform 5		Difference from Current Law	
	Billions of dollars	%	Billions of dollars	%	Billions of dollars	%
Federal government	**1,284.3**	**36.7**	**1,406.4**	**40.5**	**122.1**	**9.5**
Medicaid/CHIP	464.3	13.3	531.6	15.3	67.3	14.5
Marketplace PTCs and CSRs	59.2	1.7	130.2	3.7	70.9	119.8
Reinsurance	1.2	0.0	10.0	0.3	8.8	718.0
Medicare[a]	732.0	20.9	732.0	21.1	0.0	0.0
Uncompensated care	27.5	0.8	2.6	0.1	-25.0	-90.7
State government	**302.3**	**8.6**	**296.6**	**8.5**	**-5.7**	**-1.9**
Medicaid/CHIP	284.5	8.1	295.0	8.5	10.5	3.7
Marketplace PTCs and CSRs	0.1	0.0	0.0	0.0	-0.1	-100.0
Reinsurance	0.5	0.0	0.0	0.0	-0.5	-100.0
Uncompensated care	17.2	0.5	1.6	0.0	-15.6	-90.7
Employers	**954.7**	**27.3**	**863.1**	**24.8**	**-91.6**	**-9.6**
Households	**931.4**	**26.6**	**905.8**	**26.1**	**-25.6**	**-2.7**
In-kind uncompensated care from providers	**24.1**	**0.7**	**2.2**	**0.1**	**-21.8**	**-90.7**
Total	**3,496.8**	**100.0**	**3,474.2**	**100.0**	**-22.6**	**-0.6**
Increased federal spending					122.1	
Income tax revenue offset					-14.2	
Additional federal revenues needed net of increased income tax receipts					108.0	

Source: Urban Institute analysis.

Notes: CHIP = Children's Health Insurance Program. PTC = premium tax credit. CSR = cost-sharing reduction. CARE = Continuous Autoenrollment with Retroactive Enforcement. Reform 5 includes federal reinsurance and enhanced Marketplace subsidies; restores the 2016 prohibition of expanded short-term, limited-duration plans; fills the Medicaid eligibility gap; introduces a public option and (optionally) capped provider payment rates in the nongroup market; eliminates the employer insurance firewall; and implements Continuous Autoenrollment with Retroactive Enforcement. Reform simulated as if fully phased in 2020.
[a] Medicare spending is net of premiums.

Simulation of Reform 6 Compared with Current Law

Includes further enhanced subsidies for nongroup coverage and elimination of employer insurance firewall, adds CARE, introduces a public option and may cap provider payment rates in private nongroup market, fills the Medicaid eligibility gap, restores the 2016 prohibition of expanded STLDs, and adds a permanent reinsurance program

Coverage. Overall insurance coverage under reform 6 is the same as under reform 5; both include the CARE provisions that enroll all legally present US residents. The remaining 6.6 million uninsured are all undocumented immigrants (table 10). However, the further enhanced nongroup market subsidies in reform 6 compared with reform 5 (table 2) mean approximately 800,000 fewer people enroll in employer-based coverage than under reform 5. In addition, a higher percentage of people enrolled in nongroup insurance receive premium tax credits. About 89 percent of people insured in the nongroup market do so with federal financial assistance under reform 6, compared with 82 percent under reform 5.

Health care spending. The only difference between reforms 5 and 6 is the more generous federal subsidies provided to nongroup enrollees under reform 6. Consequently, federal government health care spending under reform 6 is higher, by an additional $161.8 billion compared with current law and an additional $39.7 billion beyond reform 5. Given the greater federal subsidization, household health care spending is $56.7 billion lower (6.1 percent) than under current law, more than double the aggregate household savings under reform 5.

TABLE 10

Health Insurance Coverage and Health Care Spending in 2020 under Current Law and Reform 6

Health insurance coverage

	Current Law		Reform 6		Difference from Current Law	
	Millions of people	%	Millions of people	%	Millions of people	%
Insured with minimum essential coverage	**296.9**	**89.6**	**324.9**	**98.0**	**28.0**	**9.4**
Employer	147.6	44.5	131.8	39.7	-15.8	-10.7
Nongroup (with tax credits)	9.1	2.7	41.9	12.6	32.8	360.2
Nongroup (without tax credits)	6.4	1.9	5.3	1.6	-1.1	-17.1
Medicaid/CHIP	68.8	20.8	81.0	24.4	12.1	17.6
Medicare	60.4	18.2	60.4	18.2	0.0	0.0
Other	4.6	1.4	4.6	1.4	0.0	0.0
Lacking minimum essential coverage	**34.6**	**10.4**	**6.6**	**2.0**	**-28.0**	**-81.0**
Uninsured	*32.2*	*9.7*	*6.6*	*2.0*	*-25.6*	*-79.5*
Legally present	25.6	7.7	0.0	0.0	-25.6	-100.0
Not legally present	6.6	2.0	6.6	2.0	0.0	0.1
Short-term, limited-duration plans	*2.4*	*0.7*	*0.0*	*0.0*	*-2.4*	*-100.0*
Total	**331.5**	**100.0**	**331.5**	**100.0**	**0.0**	**0.0**

Health care spending

	Current Law		Reform 6		Difference from Current Law	
	Billions of dollars	%	Billions of dollars	%	Billions of dollars	%
Federal government	**1,284.3**	**36.7**	**1,446.1**	**41.6**	**161.8**	**12.6**
Medicaid/CHIP	464.3	13.3	531.5	15.3	67.2	14.5
Marketplace PTCs and CSRs	59.2	1.7	170.0	4.9	110.8	187.1
Reinsurance	1.2	0.0	10.0	0.3	8.8	718.0
Medicare[a]	732.0	20.9	732.0	21.0	0.0	0.0
Uncompensated care	27.5	0.8	2.6	0.1	-25.0	-90.7
State government	**302.3**	**8.6**	**296.6**	**8.5**	**-5.7**	**-1.9**
Medicaid/CHIP	284.5	8.1	295.0	8.5	10.5	3.7
Marketplace PTCs and CSRs	0.1	0.0	0.0	0.0	-0.1	-100.0
Reinsurance	0.5	0.0	0.0	0.0	-0.5	-100.0
Uncompensated care	17.2	0.5	1.6	0.0	-15.6	-90.7
Employers	**954.7**	**27.3**	**858.1**	**24.7**	**-96.6**	**-10.1**
Households	**931.4**	**26.6**	**874.7**	**25.2**	**-56.7**	**-6.1**
In-kind uncompensated care from providers	**24.1**	**0.7**	**2.2**	**0.1**	**-21.8**	**-90.7**
Total	**3,496.8**	**100.0**	**3,477.6**	**100.0**	**-19.1**	**-0.5**
Increased federal spending					**161.8**	
Income tax revenue offset					**-15.1**	
Additional federal revenues needed net of increased income tax receipts					**146.7**	

Source: Urban Institute analysis.

Notes: CHIP = Children's Health Insurance Program. PTC = premium tax credit. CSR = cost-sharing reduction. Reform 6 includes federal reinsurance and further enhanced Marketplace subsidies; restores the 2016 prohibition of expanded short-term, limited-duration plans; fills the Medicaid eligibility gap; introduces a public option or capped provider payment rates in the nongroup

market; eliminates the employer insurance firewall; and adds Continuous Autoenrollment with Retroactive Enforcement. Reform simulated as if fully phased in in 2020.
a Medicare spending is net of premiums.

Premiums and out-of-pocket costs for nongroup enrollees. The more generous premium tax credits and cost-sharing reductions introduced in reform 6 lower household spending on premiums and out-of-pocket costs (top section of table 11). Premiums are also lower than under the schedule used in reforms 1 through 5 for each of our illustrative incomes and family statuses; the differences are largest for our example incomes of 250, 350, and 450 percent of FPL. Compared with current law, single adults with incomes at 250 percent of FPL save about $2,300 per year in premiums (compared with savings of roughly $740 per year under the schedule for reforms 1 through 5), and our illustrative family saves approximately $4,740 per year (compared with savings of roughly $1,520 under the other schedule). Savings for single adults with incomes at 350 percent of FPL are about $3,000 annually and about $6,180 for our illustrative family. Savings for consumers with incomes at 450 percent of FPL vary considerably by age but range from $2,565 to about $13,250 per year for singles at our example ages and almost $15,500 per year for our illustrative family.

Out-of-pocket cost exposure is also substantially lower under this schedule (bottom section of table 11). Again, these are examples of plans meeting the specified actuarial value levels, and the choices are based on median plans available in the federally facilitated Marketplaces, adjusted using the CMS actuarial value calculator to hit specified levels.[28] At each income level shown, consumer out-of-pocket exposure is typically much lower than for the schedule used in reforms 1 through 5. Compared with that schedule, for example, single coverage for a person with income at 350 percent of FPL could have the same inpatient coinsurance (15 percentage points below current law), a deductible $400 lower, and an out-of-pocket maximum $1,100 lower, in addition to lower copayments for outpatient physician care.

TABLE 11

Example Premiums and Out-of-Pocket Cost Comparisons, by Income Group, Reform 6 and Current Law, 2020

Based on national median-priced 2019 plans offered by federally facilitated Marketplaces, adjusted using the 2020 CMS actuarial value calculator

	150% of FPL			250% of FPL			350% of FPL			450% of FPL		
	ACA (94% AV)	Reform 6 (100% AV)[a]	Diff.	ACA (73% AV)	Reform 6 (95% AV)[a]	Diff.	ACA (70% AV)	Reform 6 (90% AV)[a]	Diff.	ACA (70% AV)	Reform 6 (85% AV)[a]	Diff.
Premiums												
Single coverage												
Enrollee age 25	$778	$0	-$778	$2,610	$312	-$2,298	$4,310	$1,311	-$2,999	$5,375	$2,810	-$2,565
Enrollee age 45	$778	$0	-$778	$2,610	$312	-$2,298	$4,310	$1,311	-$2,999	$7,731	$2,810	-$4,921
Enrollee age 64	$778	$0	-$778	$2,610	$312	-$2,298	$4,310	$1,311	-$2,999	$16,061	$2,810	-$13,251
Family of four (two age 35, two children)	$1,603	$0	-$1,603	$5,382	$644	-$4,738	$8,886	$2,704	-$6,183	$21,276	$5,794	-$15,482
Out-of-pocket requirements												
Coinsurance on inpatient care	10%	0%	-10%	20%	5%	-15%	25%	10%	-15%	25%	10%	-15%
Single coverage												
Deductible	$200	$0	-$200	$2,400	$200	-$2,200	$2,500	$750	-$1,750	$2,500	$1,150	-$1,350
Out-of-pocket maximum	$700	$0	-$700	$5,000	$500	-$4,500	$6,000	$1,000	-$5,000	$6,000	$2,100	-$3,900
Family coverage												
Deductible	$400	$0	-$400	$4,800	$400	-$4,400	$5,000	$1,500	-$3,500	$5,000	$2,300	-$2,700
Out-of-pocket maximum	$1,400	$0	-$1,400	$10,000	$1,000	-$9,000	$12,000	$2,000	-$10,000	$12,000	$4,200	-$7,800

Source: Urban Institute analysis of federal Marketplace data.

Notes: CMS = Centers for Medicare & Medicaid Services. ACA = Affordable Care Act. AV = actuarial value. Diff. = difference. Premiums displayed are annual.

[a] Endnote 29 provides additional cost-sharing details.

Simulation of Reform 7 Compared with Current Law

Single-payer lite program covering ACA essential health benefits and income-related cost sharing, enrolling all legally present US residents, prohibiting private health insurance coverage, and retaining current law Medicaid program for LTSS

Coverage. As with reforms 5 and 6, the single-payer lite approach insures all legally present US residents, thereby increasing the number of people with minimum essential coverage by 23.8 million and reducing the number with no insurance coverage at all by 21.4 million (table 12). Though 25.6 million uninsured people legally residing in the US gain insurance coverage under reform 7 (as in reforms 5 and 6), 4.2 million undocumented immigrants lose health insurance, lowering the net coverage effect of the reform. This increase in uninsurance for this population occurs because the reform eliminates private health insurance, but the new public program does not cover those not legally present in the US. Therefore, 4.2 million people with private insurance under current law (employer-based or nongroup) no longer have insurance coverage, bringing the total number of uninsured people to 10.8 million, all of whom are undocumented immigrants.

Theoretically, under an alternative specification, private insurance could be offered to the population not legally present, allowing them to purchase insurance with their own funds. However, because only the undocumented population would have reason to purchase such coverage, potential consumers may fear the government consequences of doing so (e.g., deportation). Additional subsidization of providers serving disproportionate shares of undocumented immigrants would likely be an effective approach. We do not estimate such costs here, beyond acknowledging that federal and state governments and providers continue to fund some uncompensated care.

Health care spending. We offset a portion of federal government spending for reform 7 to account for the single-payer benefits provided to people receiving benefits from Veterans Affairs, the Department of Defense, and Indian Health Services under current law ($31.0 billion). Accounting for those offsets, the elimination of acute-care spending under Medicaid/CHIP (LTSS is still covered by Medicaid as under current law), Marketplace subsidies, reinsurance, and Medicare, net federal government health care spending increases by $1.5 trillion under reform 7. With the elimination of employer-based insurance (reducing employer health care spending by $948.7 billion), taxable income increases, thereby increasing income tax revenues by $157.6 billion, requiring an additional $1.4 trillion in new federal revenues to finance the reform. National health spending falls by $209.5 billion, or 6.0 percent, reflecting that administrative savings and savings from lower provider payment rates outweigh the increased costs associated with near-universal coverage and reduced income-related cost-sharing requirements.[29]

TABLE 12

Health Insurance Coverage and Health Care Spending in 2020 under Current Law and Reform 7 (Single-Payer Lite)

Health insurance coverage

	Current Law		Reform 7		Difference from Current Law	
	Millions of people	%	Millions of people	%	Millions of people	%
Insured with minimum essential coverage	**296.9**	**89.6**	**320.7**	**96.7**	**23.8**	**8.0**
Employer	147.6	44.5	0.0	0.0	-147.6	-100.0
Nongroup (with tax credits)	9.1	2.7	0.0	0.0	-9.1	-100.0
Nongroup (without tax credits)	6.4	1.9	0.0	0.0	-6.4	-100.0
Medicaid/CHIP	68.8	20.8	0.0	0.0	-68.8	-100.0
Medicare	60.4	18.2	0.0	0.0	-60.4	-100.0
Other	4.6	1.4	0.0	0.0	-4.6	-100.0
Single-payer plan	0.0	0.0	320.7	96.7	320.7	n/a
Lacking minimum essential coverage	**34.6**	**10.4**	**10.8**	**3.3**	**-23.8**	**-68.7**
Uninsured	*32.2*	*9.7*	*10.8*	*3.3*	*-21.4*	*-66.4*
Legally present	25.6	7.7	0.0	0.0	-25.6	-100.0
Not legally present	6.6	2.0	10.8	3.3	4.2	64.4
Short-term, limited-duration plans	*2.4*	*0.7*	*0.0*	*0.0*	*-2.4*	*-100.0*
Total	**331.5**	**100.0**	**331.5**	**100.0**	**0.0**	**0.0**

Health care spending

	Current Law		Reform 7		Difference from Current Law	
	Billions of dollars	%	Billions of dollars	%	Billions of dollars	%
Federal government	**1,284.3**	**36.7**	**2,807.1**	**85.4**	**1,522.8**	**118.6**
Medicaid/CHIP	464.3	13.3	104.7	3.2	-359.6	-77.5
Marketplace PTCs and CSRs	59.2	1.7	0.0	0.0	-59.2	-100.0
Reinsurance	1.2	0.0	0.0	0.0	-1.2	-100.0
Medicare[a]	732.0	20.9	0.0	0.0	-732.0	-100.0
Single-payer plan	0.0	0.0	2,728.3	83.0	2,728.3	n/a
Uncompensated care	27.5	0.8	5.1	0.2	-22.4	-81.4
Offset to public health spending	0.0	0.0	-31.0	-0.9	-31.0	n/a
State government	**302.3**	**8.6**	**95.4**	**2.9**	**-206.9**	**-68.4**
Medicaid/CHIP	284.5	8.1	92.2	2.8	-192.3	-67.6
Marketplace PTCs and CSRs	0.1	0.0	0.0	0.0	-0.1	-100.0
Reinsurance	0.5	0.0	0.0	0.0	-0.5	-100.0
Uncompensated care	17.2	0.5	3.2	0.1	-14.0	-81.4
Employers	**954.7**	**27.3**	**6.0**	**0.2**	**-948.7**	**-99.4**
Households	**931.4**	**26.6**	**374.2**	**11.4**	**-557.2**	**-59.8**
In-kind uncompensated care from providers	**24.1**	**0.7**	**4.5**	**0.1**	**-19.6**	**-81.4**
Total	**3,496.8**	**100.0**	**3,287.2**	**100.0**	**-209.5**	**-6.0**
Increased federal spending					**1,522.8**	
Income tax revenue offset					**-157.6**	
Additional federal revenues needed net of increased income tax receipts					**1,365.3**	

Source: Urban Institute analysis.

State government health care spending decreases by $206.9 billion, accounting for the elimination of Medicaid/CHIP acute-care programs and savings resulting from reduced spending on uncompensated care. Household spending on premiums and out-of-pocket costs decreases by $557.2 billion. Premium spending is eliminated, but out-of-pocket costs, which would be income related for those covered by the new program, would continue (they are set, by design, at the same level as reform 5). And total out-of-pocket spending for those not legally present and becoming newly uninsured increases. Household spending on LTSS and other uncovered services continues as well.

Simulation of Reform 8 Compared with Current Law

Single-payer enhanced program covering all medically necessary health benefits (dental, vision, hearing, and nationally uniform home- and community-based LTSS), eliminating cost sharing, enrolling all US residents (including the undocumented population), maintaining Medicaid for institutionally based LTSS, and eliminating private health insurance coverage

Coverage. Reform 8 is the only one in this report that eliminates uninsurance among both the legally present and undocumented immigrant populations. This intent, clearly indicated as components in the most-discussed single-payer proposals,[30] introduces some additional uncertainty into the estimates. For example, we do not attempt to estimate any potential effect of additional residency (legal or otherwise) or medical tourism that could result from the reforms.[31] Nor do we estimate less than universal coverage among the undocumented population, some of whom might decline providing information to a government entity for fear of deportation. Thus, we estimate this single-payer program covers 331.5 million people (table 13), increasing minimum essential coverage by 34.6 million people compared with current law. The program eliminates all other forms of insurance coverage.

Health care spending. Net federal government health spending, accounting for savings from eliminating Medicare, Marketplace subsidies, the acute-care portion of Medicaid, and uncompensated care, as well as savings on other federal insurance programs, increases by $2.8 trillion in 2020.[32] Offsetting increases in income tax revenue mean $2.7 trillion in additional federal revenue is needed to finance the new program.

States' health care spending decreases by $259.6 billion, accounting for continuing Medicaid spending on institutionally based LTSS and savings from eliminating Medicaid/CHIP acute care, other

state-specific programs, and uncompensated care. Employer spending on health care decreases by $954.7 billion, and household spending falls by $886.5 billion. The only remaining household spending required is in the continuing Medicaid program for those using LTSS. Providers no longer face any uncompensated care because all care is financed through the federal government, reducing their aggregate spending by $24.1 billion.

Again, as noted above, including the undocumented population in this reform increases the uncertainty of the estimates. For example, if providers and the federal government cannot differentiate between permanent US residents and visitors, or if the availability of coverage for all residents increases immigration, the federal costs presented here underestimate the actual effects.

We do not assume limits on utilization of care because of supply constraints because our estimates assume a long-run equilibrium. That is, provider capacity expands to meet the increased demand for services that result from universal coverage, benefit expansion, and the elimination of cost-sharing requirements. This does not mean that under a reform like this one, there would be no supply constraints in the short run, which could mean increased waiting times for particular providers or services and unmet demand, which would translate into lower system costs than those presented here. And though we assume an equilibrium where supply ultimately expands to meet demand, we acknowledge some uncertainty around the expansion of long-run capacity in the face of reduced payment rates. There are two possible responses to lower payment rates: (1) the system becomes more efficient (e.g., use of lower-cost personnel increases and/or higher-cost providers are paid less and capacity increases through various strategies nonetheless), leading to greater service use, or (2) system capacity or the supply of services decreases, or, at least, capacity does not increase. In the latter case, the supply of particular services does not expand sufficiently to meet the increase in demand for those types of care. In that case, our estimates overstate the increase in national health spending resulting from this reform. In such an outcome, the promised improvements in access to care would not materialize either, at least not uniformly across all medical services.

TABLE 13

Health Insurance Coverage and Health Care Spending in 2020 under Current Law and Reform 8 (Single-Payer Enhanced)

Health insurance coverage

	Current Law		Reform 8		Difference from Current Law	
	Millions of people	%	Millions of people	%	Millions of people	%
Insured with minimum essential coverage	**296.9**	**89.6**	**331.5**	**100.0**	**34.6**	**11.7**
Employer	147.6	44.5	0.0	0.0	-147.6	-100.0
Nongroup (with tax credits)	9.1	2.7	0.0	0.0	-9.1	-100.0
Nongroup (without tax credits)	6.4	1.9	0.0	0.0	-6.4	-100.0
Medicaid/CHIP	68.8	20.8	0.0	0.0	-68.8	-100.0
Medicare	60.4	18.2	0.0	0.0	-60.4	-100.0
Other	4.6	1.4	0.0	0.0	-4.6	-100.0
Single-payer plan	0.0	0.0	331.5	100.0	331.5	n/a
Lacking minimum essential coverage	**34.6**	**10.4**	**0.0**	**0.0**	**-34.6**	**-100.0**
Uninsured	*32.2*	*9.7*	*0.0*	*0.0*	*-32.2*	*-100.0*
Legally present	25.6	7.7	0.0	0.0	-25.6	-100.0
Not legally present	6.6	2.0	0.0	0.0	-6.6	-100.0
Short-term, limited-duration plans	*2.4*	*0.7*	*0.0*	*0.0*	*-2.4*	*-100.0*
Total	**331.5**	**100.0**	**331.5**	**100.0**	**0.0**	**0.0**

Health care spending

	Current Law		Reform 8		Difference from Current Law	
	Billions of dollars	%	Billions of dollars	%	Billions of dollars	%
Federal government	**1,284.3**	**36.7**	**4,128.9**	**97.9**	**2,844.6**	**221.5**
Medicaid/CHIP	464.3	13.3	48.5	1.2	-415.8	-89.6
Marketplace PTCs and CSRs	59.2	1.7	0.0	0.0	-59.2	-100.0
Reinsurance	1.2	0.0	0.0	0.0	-1.2	-100.0
Medicare[a]	732.0	20.9	0.0	0.0	-732.0	-100.0
Single-payer plan	0.0	0.0	4,122.2	97.8	4,122.2	n/a
Uncompensated care	27.5	0.8	0.0	0.0	-27.5	-100.0
Offset to public health spending	0.0	0.0	-41.9	-1.0	-41.9	n/a
State government	**302.3**	**8.6**	**42.7**	**1.0**	**-259.6**	**-85.9**
Medicaid/CHIP	284.5	8.1	42.7	1.0	-241.7	-85.0
Marketplace PTCs and CSRs	0.1	0.0	0.0	0.0	-0.1	-100.0
Reinsurance	0.5	0.0	0.0	0.0	-0.5	-100.0
Uncompensated care	17.2	0.5	0.0	0.0	-17.2	-100.0
Employers	**954.7**	**27.3**	**0.0**	**0.0**	**-954.7**	**-100.0**
Households	**931.4**	**26.6**	**44.9**	**1.1**	**-886.5**	**-95.2**
In-kind uncompensated care from providers	**24.1**	**0.7**	**0.0**	**0.0**	**-24.1**	**-100.0**
Total	**3,496.8**	**100.0**	**4,216.5**	**100.0**	**719.7**	**20.6**
Increased federal spending					**2,844.6**	
Income tax revenue offset					**-157.6**	
Additional federal revenues needed net of increased income tax receipts					**2,687.0**	

Source: Urban Institute analysis.
Notes: CHIP = Children's Health Insurance Program. PTC = premium tax credit. CSR = cost-sharing reduction. n/a = not applicable. Reform 8 is single-payer enhanced, a single federally administered health insurance plan for all US residents (including those not legally present) without cost sharing at point of service or premiums and including a broad set of covered benefits (including Affordable Care Act essential health benefits plus dental, vision, hearing, and long-term services and supports). No private health insurance could be sold. Reform simulated as fully phased in in 2020.
a Medicare spending is net of premiums.

Sensitivity Analyses for Single-Payer Proposals

Of all the reforms presented here, the single-payer approaches have the greatest implications for federal costs. As such, we present three sensitivity analyses to indicate how particular changes in design or implementation could affect federal government costs associated with the programs (table 14). We do not present any sensitivities on coverage effects, because the populations enrolled do not differ under any of the alternative assumptions. The three sensitivities are separate (i.e., they do not build upon each other) and are as follows.

Sensitivity 1. This sensitivity assumes hospital payment rates are set at 140 percent of Medicare rates, instead of 115 percent of Medicare rates as in the base case simulation. All other providers are paid at the same levels as in the base case. This is an important point of reference given that it may be politically challenging to bring all hospital payment rates down to the level assumed in the base case, given the much higher average commercial provider payment levels and the enormous variation in payment rates across hospitals and commercial payers.

Sensitivity 2. This sensitivity analysis assumes states must make maintenance-of-effort (MOE) payments based on their current-law Medicaid spending. It accounts for at least one of the often-discussed single-payer approaches, the Medicare for All Act of 2019,[33] which includes a state MOE requirement that would lower federal reform spending but increase state reform spending relative to the base case.

Sensitivity 3. This sensitivity analysis assumes administrative costs associated with the single-payer program amount to 3 percent of claims costs, instead of the 6 percent assumed in the base case. As noted in the methods appendix, we believe 3 percent administrative costs would be insufficient to carry out necessary tasks under a single-payer program. Because a single-payer approach exposes the federal budget to greater financial risks than other reforms, processes to prevent fraud and abuse and programs to manage care and monitor quality and access under centralized provider payment rates will be even more important than they are today. Such programs require significant federal investments.

However, because advocates for single-payer approaches have taken issue with this assumption in the past, we show how the lower-cost assumption affects total federal program costs in table 14.

Hospital provider payment rates. With hospital provider payment rates set at 140 percent of Medicare rates, net federal government costs associated with single-payer lite are $2.9 trillion, $127.2 billion more than the base case (table 14). Accounting for income tax offsets, $1.5 trillion in additional federal revenues beyond current law are needed to finance the approach. The enhanced single-payer plan with the higher payment rates increases net federal government costs to $4.4 trillion, $231.3 billion more than under the base case. Accounting for income tax offsets, an additional $2.9 trillion in additional federal revenues beyond current law are needed to finance the approach.

State maintenance of effort. If states must make MOE contributions to help finance the lite single-payer approach, net federal government spending on health care would increase by $192.3 billion less than in the base case, and state health care spending would increase by an equal amount. In one year, this reduces federal net spending to $2.6 trillion and increases state spending to $287.7 billion, with state spending still lower than under current law because of savings on uncompensated care costs. State savings increase further in percentage terms over time (not shown) because we assume MOE payments increase with gross domestic product instead of baseline Medicaid/CHIP cost growth. We account for this assumption below in our 10-year estimates of federal spending under each reform option. Additional federal revenues needed, after accounting for the additional income tax revenues, are $1.2 trillion. In the enhanced single-payer approach, the state MOE requirement is larger than that in the lite approach, because the enhanced approach MOE offsets a portion of current-law state Medicaid spending on LTSS. Consequently, net federal spending under this approach is $3.9 trillion, $241.7 billion lower than under the single-payer enhanced base case. Accounting for higher income tax revenues, financing this approach requires an additional $2.4 trillion in federal revenues beyond current law.

Lower administrative costs. This sensitivity assumes single-payer programs incur lower administrative costs than our base case estimate (3 percent versus 6 percent) and that there are no offsetting claims costs resulting from lower levels of utilization review or care management, quite optimistic assumptions. In this case, net federal government costs for single-payer lite are $77.2 billion lower than the base case ($2.7 trillion total); for single-payer enhanced, the net federal government costs are $116.7 billion lower than the base case ($4.0 trillion total). Accounting for additional income tax revenue, single-payer lite requires an additional $1.3 trillion in federal revenues, and single-payer enhanced requires an additional $2.6 trillion, compared with current law.

TABLE 14

The Effects of Higher Hospital Payment Rates, State Maintenance of Effort, and Lower Administrative Costs on Enhanced and Lite Single-Payer Reforms (7 and 8) in 2020

Billions of dollars

	Base Case	Higher Hospital Payment Rate Assumption		Basic Hospital Payment Rate Assumption with State Maintenance of Effort		Basic Hospital Payment Rate Assumption, Lower Administrative Costs	
	Health care spending	Health care spending	Diff. from base case	Health care spending	Diff. from base case	Health care spending	Diff. from base case
Federal government	2,807.1	2,934.3	127.2	2,614.8	-192.3	2,729.9	-77.2
Medicaid/CHIP	104.7	104.7	0.0	104.7	0.0	104.7	0.0
Marketplace PTCs and CSRs	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Reinsurance	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicare[a]	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Single-payer plan	2,728.3	2,855.6	127.2	2,728.3	0.0	2,651.1	-77.2
Uncompensated care	5.1	5.1	0.0	5.1	0.0	5.1	0.0
State maintenance-of-effort payment	0.0	0.0	0.0	-192.3	-192.3	0.0	0.0
Offset to public health spending	-31.0	-31.0	0.0	-31.0	0.0	-31.0	0.0
State government	95.4	95.4	0.0	287.7	192.3	95.4	0.0
Medicaid/CHIP	92.2	92.2	0.0	92.2	0.0	92.2	0.0
Marketplace PTCs and CSRs	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Reinsurance	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Uncompensated care	3.2	3.2	0.0	3.2	0.0	3.2	0.0
State maintenance-of-effort payment	0.0	0.0	0.0	192.3	192.3	0.0	0.0
Employers	6.0	6.0	0.0	6.0	0.0	6.0	0.0
Households	374.2	378.1	3.9	374.2	0.0	374.2	0.0
In-kind uncompensated care from providers	4.5	4.5	0.0	4.5	0.0	4.5	0.0
Total	3,287.2	3,418.4	131.1	3,287.2	0.0	3,210.0	-77.2
Increased federal spending	1,522.8	1,650.0	127.2	1,330.5	-192.3	1,445.6	-77.2
Income tax revenue offset	-157.6	-157.6	0.0	-157.6	0.0	-157.6	0.0
Additional federal revenues needed net of increased income tax receipts	1,365.3	1,492.5	127.2	1,173.0	-192.3	1,288.0	-77.2

REFORM 7: SINGLE-PAYER LITE

	Base Case	Higher Hospital Payment Rate Assumption		Basic Hospital Payment Rate Assumption with State Maintenance of Effort		Basic Hospital Payment Rate Assumption, Lower Administrative Costs	
				REFORM 8: SINGLE-PAYER ENHANCED			
	Health care spending	Health care spending	Difference from base case	Health care spending	Difference from base case	Health care spending	Difference from base case
Federal government	**4,128.9**	**4,360.2**	**231.3**	**3,887.1**	**-241.7**	**4,012.2**	**-116.7**
Medicaid/CHIP	48.5	48.5	0.0	48.5	0.0	48.5	0.0
Marketplace PTCs and CSRs	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Reinsurance	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicare[a]	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Single-payer plan	4,122.2	4,353.5	231.3	4,122.2	0.0	4,005.5	-116.7
Uncompensated care	0.0	0.0	0.0	0.0	0.0	0.0	0.0
State maintenance-of-effort payment	0.0	0.0	0.0	-241.7	-241.7	0.0	0.0
Offset to public health spending	-41.9	-41.9	0.0	-41.9	0.0	-41.9	0.0
State government	**42.7**	**42.7**	**0.0**	**284.5**	**241.7**	**42.7**	**0.0**
Medicaid/CHIP	42.7	42.7	0.0	42.7	0.0	42.7	0.0
Marketplace PTCs and CSRs	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Reinsurance	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Uncompensated care	0.0	0.0	0.0	0.0	0.0	0.0	0.0
State maintenance-of-effort payment	0.0	0.0	0.0	241.7	241.7	0.0	0.0
Employers	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Households	**44.9**	**44.9**	**0.0**	**44.9**	**0.0**	**44.9**	**0.0**
In-kind uncompensated care from providers	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Total	**4,216.5**	**4,447.8**	**231.3**	**4,216.5**	**0.0**	**4,099.8**	**-116.7**
Increased federal spending	**2,844.6**	**3,075.9**	**231.3**	**2,602.8**	**-241.7**	**2,727.9**	**-116.7**
Income tax revenue offset	**-157.6**	**-157.6**	**0.0**	**-157.6**	**0.0**	**-157.6**	**0.0**
Additional federal revenues needed net of increased income tax receipts	**2,687.0**	**2,918.3**	**231.3**	**2,445.3**	**-241.7**	**2,570.3**	**-116.7**

Source: Urban Institute analysis.

Notes: Diff. = difference. CHIP = Children's Health Insurance Program. PTC = premium tax credit. CSR = cost-sharing reduction. Reforms simulated as if fully phased in in 2020.

[a] Medicare spending is net of premiums.

Household Spending on Premiums and Out-of-Pocket Costs by Income Group under Each Reform

Table 15 compares aggregate household health care spending (premiums plus out-of-pocket costs) under each reform for those below age 65 by income group. The table focuses exclusively on the nonelderly because reforms 1 through 6 affect this population alone, so including the 65-and-older population would disguise the magnitude of the reforms' relative effects on the target population.

TABLE 15

Household Health Care Spending by the Nonelderly under Current Law and Eight Reform Options, by Income Group, 2020

Reform	< 138% FPL	138–250% FPL	250–400% FPL	> 400% FPL	Total
Current law (ACA)	51.8	92.5	135.2	280.8	560.3
Reform 1: Reinsurance + enhanced subsidies	53.2	89.6	134.9	277.6	555.3
Difference from current law (billions of $)	1.4	-2.9	-0.2	-3.2	-5.0
Difference from current law (%)	2.7	-3.1	-0.2	-1.1	-0.9
Reform 2: Reform 1 + STLD prohibition and individual mandate	52.8	89.3	134.6	278.6	555.3
Difference from current law (billions of $)	1.0	-3.2	-0.5	-2.2	5.0
Difference from current law (%)	1.9	-3.4	-0.4	-0.8	-0.9
Reform 3: Reform 2 + filling the Medicaid eligibility gap	46.7	89.2	135.1	278.8	549.8
Difference from current law (billions of $)	-5.1	-3.3	0.0	-2.0	-10.5
Difference from current law (%)	-9.9	-3.5	0.0	-0.7	-1.9
Reform 4: Reform 3 + public option or capped provider rates	45.4	88.7	134.1	274.5	542.7
Difference from current law (billions of $)	-6.4	-3.8	-1.1	-6.3	-17.6
Difference from current law (%)	-12.4	-4.1	-0.8	-2.2	-3.1
Reform 5: Reform 4 + eliminated ESI firewall and CARE	40.8	83.0	131.2	279.7	534.7
Difference from current law (billions of $)	-11.1	-9.5	-3.9	-1.1	-25.6
Difference from current law (%)	-21.3	-10.2	-2.9	-0.4	-4.6
Reform 6: Reform 5 + further enhanced subsidies	40.2	74.1	113.6	275.7	503.6
Difference from current law (billions of $)	-11.7	-18.4	-21.5	-5.1	-56.7
Difference from current law (%)	-22.5	-19.9	-15.9	-1.8	-10.1
Reform 7: Single-payer lite with ACA benefits and income-related cost sharing	7.2	18.3	33.0	98.6	157.1
Difference from current law (billions of $)	-44.7	-74.2	-102.2	-182.2	-403.2
Difference from current law (%)	-86.2	-80.2	-75.6	-64.9	-72.0
Reform 8: Single-payer enhanced with expanded benefits and no cost sharing	0.0	0.0	0.0	0.0	0.0
Difference from current law (billions of $)	-51.8	-92.5	-135.2	-280.8	-560.3
Difference from current law (%)	-100.0	-100.0	-100.0	-100.0	-100.0

Source: Urban Institute analysis.
Notes: FPL = federal poverty level. ACA = Affordable Care Act. STLD = short-term, limited-duration plan. ESI = employer-sponsored insurance. CARE = Continuous Autoenrollment with Retroactive Enforcement. Reform simulated in 2020.

Under reform 1, as additional low-income people (below 138 percent of FPL) enroll in coverage, some use more medical services than they did while uninsured, and because they face modest out-of-pocket costs, their aggregate health spending increases by 2.7 percent. Higher-income groups see a decrease in health spending because of the additional financial assistance provided under the reform, ranging from a 0.2 percent decrease in spending for those with incomes between 250 and 400 percent of FPL to a 3.1 percent decrease among those with incomes between 138 and 250 percent of FPL.

Under reform 2, changes in household spending by income group are similar to reform 1, because the largest changes are associated with the improved Marketplace subsidies available in each approach. However, the individual mandate penalties introduced in reform 2 lower household savings modestly for the highest-income group (400 percent of FPL and above) compared with reform 1, because more people enroll in coverage and make premium contributions.

Under reform 3, filling the Medicaid eligibility gap leads to significantly larger savings for the lowest-income group. Under reform 4, household savings in each income group increase more than under reform 3 because the public option/capped provider payment rates decrease the full cost of health insurance in the nongroup market. The largest additional savings over reform 3 accrue to the highest-income group, which is most likely to face the full premiums in the nongroup market.

Under reform 5, the lowest-income group experiences the largest health care savings, spending 21.3 percent less than under current law. Those in the three lowest income groups, up to 400 percent of FPL, save significantly more under reform 5 than reform 4, largely because they are allowed access to federal financial assistance in the Marketplaces regardless of employer insurance offer status. In total, people with incomes above 400 percent of FPL save modestly ($1.1 billion, 0.4 percent) compared with current law, but they spend slightly more on health care in reform 5 than in reform 4. This owes to the larger number of people making premium contributions as they are enrolled in coverage under the CARE provision.

The differential between the nongroup subsidy schedule used in reforms 1 through 5 and that used in reform 6 (table 2) increases as income rises. Approximately 57 percent of the additional household savings (compared with those in reform 5) accrue to those with incomes between 250 and 400 percent of FPL.

Aggregate household savings are large for all income groups under reform 7, ranging from 86.2 percent lower health care spending for those with incomes below 138 percent of FPL to 64.9 percent lower spending for those with incomes above 400 percent of FPL. The income-related cost-sharing requirements and exclusion of some benefits from the package (e.g., dental, hearing, vision, and LTSS

services not covered by Medicaid) account for the remaining health care spending by households. The undocumented population, excluded from the reform, continues to incur out-of-pocket costs as well.

Finally, reform 8 effectively eliminates direct household spending on health care.

Ten-Year Estimates of Additional Federal Government Revenues Needed to Finance Reforms

Table 16 shows 10-year estimates (2020-2029) of the additional federal revenues needed to finance each of the eight reform approaches, as well as the sensitivity analyses for the single-payer options. Ten-year estimates are inherently challenging to produce. The larger the changes made by a reform, the more likely they will require a phased-in approach to implement effectively while limiting disruption to current systems of providing care. Depending on the reform approach, individual consumer behavior and awareness of reforms may take time to change. The range of reforms estimated here require different implementation preparation, which would tend to lower government costs in the earlier years, and different phase-ins for changing provider payment rates, which would tend to increase government costs in the early years. In addition, people may enroll in different programs at different rates over time, with slower enrollment tending to lower government costs in the early years. Accounting for all this complexity is beyond the scope of this report. Consequently, we estimate 10-year increases in federal government spending, net of increased income tax revenue from reduced tax expenditures on employer-sponsored insurance, as fully phased-in reforms in equilibrium. Admittedly, this is an oversimplification, but instructive nonetheless.

TABLE 16

Ten-Year Estimates of Increases in Federal Spending, Income Tax Revenue Offsets, and Additional Federal Revenues Needed to Finance Each Reform, 2020–29

Billions of dollars

	Increase in federal spending	Income tax revenue offset	Additional federal revenues needed
Reform 1: Reinsurance + enhanced subsidies	321	-1	320
Reform 2: Reform 1 + STLD prohibition and individual mandate	307	-2	305
Reform 3: Reform 2 + filling the Medicaid eligibility gap	1,030	-16	1,014
Reform 4: Reform 3 + public option or capped provider payment rates	590	-14	576
Reform 5: Reform 4 + CARE + elimination of ESI firewall	1,530	-177	1,353
Reform 6: Reform 5 + further enhanced subsidies	2,015	-189	1,825
Reform 7: Single-payer lite with ACA benefits and income-related cost sharing	17,622	-1,972	15,650
Reform 8: Single-payer enhanced with broad benefits and no cost sharing	33,988	-1,972	32,015
Sensitivity analysis 7-1: Reform 7 with higher provider payment rates	19,200	-1,972	17,228
Sensitivity analysis 7-2: Reform 7 with state maintenance of effort	15,248	-1,972	13,276
Sensitivity analysis 7-3: Reform 7 with lower administrative costs	16,664	-1,972	14,692
Sensitivity analysis 8-1: Reform 8 with higher provider payment rates	36,857	-1,972	34,884
Sensitivity analysis 8-2: Reform 8 with state maintenance of effort	31,003	-1,972	29,031
Sensitivity analysis 8-3: Reform 8 with lower administrative costs	32,541	-1,972	30,568

Source: Urban Institute analysis.

Notes: STLD = short-term, limited-duration plan. CARE = Continuous Autoenrollment with Retroactive Enforcement. ESI = employer-sponsored insurance. ACA = Affordable Care Act. Reforms simulated as fully phased in beginning in 2020.

The first two reforms expand and enhance ACA Marketplace subsidies and create a permanent national reinsurance program; the second also reimposes the individual mandate penalties while reversing the expansion of STLDs. These reforms reduce uninsurance by about 4 million people in 2020, roughly 12 percent below current law, and modestly affect the federal budget and national health spending (national health spending increases by less than half of 1 percent). The additional nongroup coverage and more generous subsidies result in a 10-year increase in federal spending of about $300 billion.

The third reform package expands subsidized coverage to low-income populations in states refusing to expand Medicaid and increases the federal matching rate in expansion states to 100 percent, in addition to the aforementioned reforms. We also introduce limited autoenrollment of low-income

people identifiable through their enrollment in SNAP or TANF. This approach reduces uninsurance by 11 million people compared with current law and increases the number of Americans with minimum essential coverage by 13 million in 2020. The reform adds $1.0 trillion in federal costs over 10 years.

The preceding reforms plus introducing a public option or capping provider payment rates in the nongroup market (reform 4) reduce the increase in federal spending to $590 billion over 10 years. The lower price tag reflects lower nongroup premiums resulting from lower provider payment rates. The public option, combined with the other reforms, reduces national health care expenditures because of the lower provider payment rates for those in the now larger nongroup market. This reform has little effect on the number insured compared with reform 3, however.

The next two reforms, 5 and 6, achieve universal coverage for the legally present population. Both reform packages enroll anyone not choosing coverage voluntarily into either Medicaid (if eligible) or the public option (if not eligible for Medicaid), in addition to the reforms in packages 1 through 4. Depending on their income, late enrollees may be responsible for full-year, income-related premium payments to support the public plan. In addition, these two reform options, one with even further enhanced subsidies than the prior reforms, allow people with employer insurance offers to opt for subsidized nongroup coverage if they prefer it to their employers' coverage. This addresses the "family glitch" and the inequities in the current system for low-income workers employed by firms offering insurance coverage. The approach using the base set of subsidies adds $1.5 trillion more in federal government spending over 10 years than would current law, primarily because of greater insurance coverage in the Marketplaces and the associated subsidies as well as greater Medicaid enrollment. Accounting for income tax revenue offsets (resulting from decreased employer-based insurance) means $1.4 trillion in additional revenue is needed to finance the reforms over 10 years. Increasing the Marketplace subsidies further in reform 6 leads to increases federal spending by $2.0 trillion over 10 years and requires $1.8 trillion in new revenues after income tax offsets. Reforms 5 and 6 achieve universal coverage at a relatively low cost because they maintain the employer-based insurance system and achieve coverage gains primarily through Medicaid expansion and additional subsidies for Marketplace coverage.

The two single-payer approaches prohibit private insurance, and everyone would be covered through a single federal plan without being charged premiums. Both would add considerably to federal spending. The lite single-payer approach (with benefits consistent with the ACA and income-related cost-sharing requirements) pays providers at roughly the same rates as the current-law Medicare program and includes all legally present US residents but excludes undocumented immigrants (therefore, 10.8 million people remain uninsured in 2020). Federal spending under single-payer lite

increases by $17.6 trillion over 10 years. Net of increased income tax revenue, an additional $15.6 trillion is needed to finance the reforms over that period.

The enhanced single-payer approach eliminates all cost-sharing, offers broader benefits, and includes all US residents, including undocumented immigrants. Uninsurance is thereby eliminated, providing 32.2 million more people with insurance coverage than under current law in 2020. The additional federal spending for this reform is $34.0 trillion over 10 years, or $32.0 trillion after tax offsets. Higher provider payment rates for hospitals (Medicare rates plus 40 percent, rather than 15 percent) adds $1.6 trillion to single-payer lite and $2.9 trillion to single-payer enhanced over 10 years. Net federal spending under a single-payer reform is lower if states must contribute to the costs through a maintenance-of-effort requirement. If states contribute an amount approximating what they would have spent on Medicaid/CHIP without further reforms (but with spending growing more slowly, consistent with gross domestic product), net federal spending over 10 years is $2.4 trillion lower under single-payer lite and $3.0 trillion lower under single-payer enhanced. We also provide a sensitivity estimate to our base assumption of 6 percent administrative costs necessary to effectively run a single-payer system. A 3 percent, instead of 6 percent, administrative load reduces the federal spending associated with single-payer lite by $1.0 trillion over 10 years and by $1.4 trillion over 10 years for single-payer enhanced. Income tax revenue offsets for any of these sensitivity analysis calculations amount to $2.0 trillion over 10 years.

Discussion

These reform options and the trade-offs they represent raise several issues, more than are feasible to discuss here. We raise five that we believe are particularly important:

1. Levels of provider payment rates

2. Phase-in periods

3. Effects on employer spending and wages

4. Effects on household spending

5. Effects on total national health spending

Levels of provider payment rates. Many of the health reforms discussed in the public sphere today revolve around at least some portion of insurance markets regulating payment rates for health care providers. This is true of our reforms 4 through 8. Today, payments to hospitals by commercial insurers

are about 89 percent higher than Medicare levels, on average (Maeda and Nelson 2017). Commercial payment rates for physicians also exceed Medicare's rates, on average, but the difference is smaller than for hospitals. In addition, payment rates vary widely across services, provider types, insurers, individual providers, and geographic areas. The optimal array of provider payment rates that would effectively balance costs, access to care, and quality of care are unknown. Consequently, deciding where health reform approaches should set provider payment rates and how fast the system should move to those desired rates is both critical and difficult to answer. Such decisions will likely differ depending on how much of the current system is regulated in this way.

The first three reforms we present have no appreciable impact on provider payment rates. When we introduce a public option and/or capped provider payment rates in reform 4, we introduce an insurance choice(s) that lowers system costs primarily by reducing provider payment rates in the private nongroup insurance market, about 8 percent of the population after reform. The public option/plans with capped rates in this approach do not affect 92 percent of the population, and the new approach could actually increase payments to physicians and hospitals on behalf of those otherwise uninsured.

When we eliminate the firewall between workers with employer insurance offers and the regulated nongroup insurance market in reforms 5 and 6, substantially more workers and their family members otherwise enrolled in employer coverage enroll in the nongroup insurance Marketplace instead, increasing the population covered by those regulated provider payment rates to about 15 percent, larger but still much smaller than the 40 percent of the population with employer insurance plans that generally pay providers higher rates.

In the two single-payer scenarios, reforms 7 and 8, everyone is enrolled in the same government-run plan using regulated rates set at Medicare levels or some multiple thereof. Payment rates fall considerably for a large number of Americans compared with current law and increase by a smaller amount for many others (those otherwise in Medicaid or uninsured). Provider payment rate cuts assumed under both single-payer approaches therefore represent a large average decrease relative to current law.

It is not clear whether cuts this large in average payment rates to health care providers are achievable for the full US population without significantly compromising access to and/or quality of care, at least in the short run. Adjustments upward for particular services and/or providers may be appropriate. If, however, the payment rates assumed here are achievable and advisable, responsible

implementation requires a considerable phase-in period to limit disruption of the health care delivery system.

Phase-in period. For exposition and ease of comparison across reforms, our estimates assume immediate full implementation of each set of reforms. As reforms increase in breadth and require greater changes to the health insurance and health care delivery systems, the necessary phase-in periods grow longer. In reality, the first years of a reform's implementation may focus on creating new eligibility and enrollment systems and developing new payment systems and other regulations to support the reforms, lowering total costs in the budget window. In addition, eligibility for larger programs could be phased in over time, and it may take time for newly eligible people to become aware of newly available coverage opportunities, all of which would lower coverage effects in the early years, again lowering costs during the budget window.

We believe that, in equilibrium, provider supply will expand to meet the increased demand for services resulting from reform, so we have not estimated constraints on the supply of medical services here. However, the expansion of supply for particular services may take somewhat longer than others, particularly under reform 8, which would engender the largest increase in demand. In this case, supply for some services may not meet all demand in some geographic areas in the near term, leading to somewhat lower levels of national health spending than estimated here. Such near-term supply constraints, if they materialize, would also mean the promised improvements in access to care under this reform would not occur uniformly.

Also, as noted above, the larger the population enrolled in coverage with lower regulated provider payment rates, the more important it will be to phase in those changes in reimbursement levels over time to minimize delivery system disruption. Such a phasing down of payment rates would lead to higher system-wide and government costs over the phase-in period than estimated here.

Effects on employer health care spending and wages. We estimate reductions in employers' health care spending for each set of reforms. These reductions increase as we move from incremental to more ambitious reforms. However, though employers' direct spending on health insurance premiums for their workers decreases under these reforms to different degrees, ultimately, employers will not see much savings in the total compensation they pay their workers. A substantial body of economic research indicates reductions in employer spending on health care are eventually passed back to their workers via higher wages (Gruber 2000). The pass-back may not be complete, particularly in the short term, and how the pass-back is distributed across workers is unclear, but a pass-back occurs nonetheless. Thus, though employers spend significantly less on health care under some reforms, they are unlikely to

experience considerable overall savings or improved profitability. For simplicity, we estimate the pass-back here to be complete and immediate, and therefore we overestimate the size of the resulting income tax offsets compared with what will likely occur in the first years of reform.

Effects on household spending. Depending on the reform approach and income level, households see considerable savings on health care costs under these reforms, with the greatest savings under the incremental approaches accruing to lower- and middle-income families. Health care savings are very large across the board in the single-payer reforms because of the elimination of insurance premiums and, in the enhanced version, elimination of all out-of-pocket costs as well. However, households will face increased taxes to finance any of these reforms, and we do not account for this. Taxes imposed to finance the reforms are unlikely to be distributed the same way as household savings on health care. Higher-income people will likely face the greatest increases in taxes, meaning their new tax burdens would likely exceed their savings; the reverse is likely true for lower-income populations.

Effects on total national health spending. The estimates presented here demonstrate that it is possible to design a set of insurance reforms that achieve universal coverage for the legally present US population without increasing national health spending. Reforms 5 and 6 do this through mechanisms that maintain sizable private insurance markets, and reform 7 relies entirely on a government insurance program. The two single-payer options (reforms 7 and 8) differ markedly on this measure, however.

Our analysis shows both single-payer approaches greatly increase federal expenditures because private insurance is eliminated, household spending drops, state spending on Medicaid acute care ends, and spending shifts to the federal budget. Whether a single-payer plan increases total national health spending depends on the intersection of several factors: how much utilization of care increases because of added benefits and reduced cost sharing, the levels at which provider payments are set, the administrative costs required to run the program compared with current-law averages, and the number of people covered. Provider payment rates and administrative costs are assumed to fall by the same amount under both single-payer approaches. However, national health spending falls relative to current law under the lite single-payer reform but increases under the enhanced single-payer reform. The source of the difference lies with the enhanced approach's higher costs associated with additional covered benefits, no cost-sharing requirements, and larger insured population (including about 11 million undocumented immigrants).

The reforms delineated and analyzed in this report help illuminate the numerous challenging trade-offs necessary when choosing an approach to health care reform. The greater the improvements in affordability for households (via lower premiums and out-of-pocket costs and broader benefits) and the

more people covered, the greater the additional federal spending needed. The more people with access to plans using lower provider payment rates, the greater the savings but the greater the potential for delivery system disruption, and the greater the need for more time to phase in the changes being made. The more costs are covered by the federal government instead of private entities (employers and households) and states, the greater the increase in federal taxes needed to finance them. Finally, additional financial assistance will increase voluntary enrollment in health insurance coverage; however, some people will choose not to enroll in coverage even with very generous assistance. Reaching true universal coverage (i.e., no remaining uninsured) requires that a portion of the population be required to enroll in and contribute to the costs of coverage, either via premiums or additional taxes, when they would prefer not to do so, a politically challenging trade-off regardless of the mechanism used.

Comparing Our Estimates with Our Earlier Work

In 2016, Urban Institute researchers estimated the costs associated with Senator Bernie Sanders's presidential campaign proposal (Holahan et al. 2016). At that time, we estimated that federal government health care spending would increase by $32.0 trillion over 10 years (2017–26) if the approach were fully implemented and phased in during that time. This estimate has been widely cited in the media and elsewhere.

That older estimate most closely parallels our 2020–29 estimate in table 16 for reform 8 of $34.0 trillion (before offsets for increased income tax revenue of approximately $2.0 trillion). Our current estimates are for a later time period, so why are they so close?

We changed our approach to estimating single-payer proposals, and each change led to some components being priced higher and others lower than before. We also changed our growth rate assumptions. By chance, these changes in approach largely offset one another. Below is a brief summary of the changes we made to our methodology since our 2016 work:

- The base case estimates are produced for 2020 and the 10-year period 2020–29, instead of 2017 and 2017–26, respectively. Data have been updated to reflect changes in spending since we completed our earlier work. All else equal, this change makes our current cost estimates higher than our previous ones.

- In 2016, our estimates of the single-payer costs associated with those currently enrolled in Medicare were based on aggregate data adjusted to account for additional benefits and reduced cost sharing. The estimates presented in this report are based on person-level data in the Urban Institute's new microsimulation model for the Medicare population, MCARE-SIM. Other things equal, this change increases our current cost estimates relative to our earlier ones.

- HIPSM estimates of the effects of a single payer program on the population not covered by Medicare under current law are constructed differently. In our earlier work, HIPSM first simulated its full population's costs as if everyone were enrolled in Medicaid, and then we increased provider payment rates to account for differences between Medicaid rates and the single-payer target rates. Our current work only uses the Medicaid simulation for the low-income population and, for others, uses a base of simulated Marketplace premiums adjusted for cost-sharing and benefit differences. We believe this new approach better reflects the middle- and high-income populations' use of medical care. Other things equal, this change reduces our cost estimates compared with the earlier ones.

- Our current prescription drug savings estimates reflect findings from a new analysis that indicates that larger savings would result from single-payer reforms than we assumed earlier (Hwang and Kesselheim, forthcoming). Other things equal, this change decreases single-payer costs compared with our earlier estimates.

- Our current 10-year estimates of government costs use different growth rates for spending under a single-payer program and savings resulting from the elimination of other government programs (e.g., Medicaid/CHIP, Medicare, uncompensated care, Marketplace subsidies) to better reflect the offsets' higher growth trajectory. Our prior estimates used a uniform growth assumption. Other things equal, this change lowers our current estimates of 10-year costs compared with our earlier estimates.

- There are differences in the LTSS benefit modeled here and that modeled previously. Our current estimates are based on a fully phased-in new home- and community-based care policy with fewer eligibility limits and a higher daily dollar limit. The prior estimates assumed that the supply of care workers would take several years to catch up to increased home care demand. Other things equal, these changes increase the costs associated with the single-payer reform relative to our previous estimates.

- Our earlier estimates did not include a government cost offset for single-payer program spending attributable to people receiving care through the Department of Defense, the Indian Health Service, or Veterans Affairs. We include an offset in the current estimates, which, other things equal, lowers the additional costs associated with a single-payer approach compared with our earlier estimates.

- Our earlier estimates did not quantify the offset for increased income tax revenue when employer-based insurance is eliminated. We provide an offset estimate here, separately and combined with the increase in federal spending under each single-payer approach.

- Our earlier estimates did not account for a portion of the costs associated with the current-law Medicare program being financed by household premiums. Consequently, we underestimated both the savings to households under a single-payer reform and the additional federal revenue necessary to finance the reforms.

Appendix A. Methodology

Health system reforms are challenging to model. The Urban Institute has three applicable microsimulation models that, used together, can estimate the effects of health policy reforms on coverage and costs for all populations and payers involved. We estimate acute health care for the nonelderly using HIPSM. Acute care for those currently covered by Medicare (the elderly as well as the nonelderly with disabilities) is estimated using Urban's new Medicare model, MCARE-SIM. We model LTSS using the Urban Institute's DYNASIM model in conjunction with data from other sources noted below. Combining estimates from all three models produces projections for current law and reforms. Of the reform options included in this report, only reforms 7 and 8 include changes that affect people enrolled in Medicare under current law, and only reform 8 includes changes to LTSS benefits and eligibility for such benefits. All reforms affect coverage and acute-care spending for the nonelderly, and therefore all use HIPSM.

Reforms That Build on the ACA

Reforms 1 through 6 build on the ACA, adding to program eligibility, enhancing subsidies, and, in some reforms, introducing cost controls for particular populations not covered by Medicare. Under all of the first six reforms, costs and coverage remain unchanged for those enrolled in the current-law Medicare program. Our estimates for the coverage and costs for reforms 1 through 6 are based on HIPSM, though current-law estimates for Medicare enrollees and spending on LTSS shown under each reform come from MCARE-SIM and DYNASIM, respectively.

HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. HIPSM is based on two years of the American Community Survey, which provides national- and state-representative samples. The population is aged to future years using projections from the Urban Institute's Mapping America's Futures program (Martin, Nichols, and Franks 2017). HIPSM is designed to incorporate timely, real-world data when they are available. We regularly update the model to reflect published Medicaid and Marketplace enrollment and costs in each state. The enrollment experience in each state under current law affects how the model simulates policy alternatives. The current version of HIPSM is calibrated to state-specific targets for Marketplace enrollment following the 2019 open enrollment period, 2019 Marketplace premiums, and late 2018 Medicaid enrollment from CMS monthly enrollment snapshots. As of this publication, no 2019 data are available on off-Marketplace or non-ACA-compliant nongroup

coverage; coverage in these markets is therefore simulated in HIPSM using estimates of premium growth.

Simulation of Insurance Coverage and Health Care Spending under Current Law, 2020

We begin by estimating health insurance coverage and health care spending by governments, employers, and households under current law. We capture the collective effect of policy changes implemented by the Trump administration by benchmarking the current-law simulation to 2019 Marketplace enrollment, the most recent Medicaid enrollment data, and nongroup market premium changes between 2018 and 2019. We then age these benchmarks to our analysis year, 2020, accounting for estimated premium growth, changing demographics, and anticipated shifts in the income distribution. Because the individual mandate penalties are set to $0 under current law, our 2020 current-law estimates simulate elimination of these penalties, except in California, the District of Columbia, Massachusetts, and New Jersey, which have passed legislation enacting their own penalties. In addition, effects of the Trump administration's finalized regulations allowing the expansion of sales of STLDs will not be fully realized until at least 2020. States regulate these policies differently, so we explicitly estimate the effects of expanded sales of STLDs and eliminating the individual mandate penalties by state and incorporate these estimates in our simulation of current law in 2020. Our 2020 current-law simulation also assumes all states would instruct their insurers to add the costs associated with cost-sharing subsidies into their silver-level premiums, because CMS permits this approach as of 2020.

Simulation of Reforms

In HIPSM, current-law health care coverage and costs are based on American Community Survey–reported insurance status, adjusted to match the latest available benchmarks, but in each iteration, the model also computes hypothetical costs for each individual under each possible health insurance status (i.e., enrollment in employer coverage, private nongroup coverage, Medicaid, a new public program, or uninsurance). These hypothetical health care costs are used if a simulation indicates the individual would change his or her health insurance status.

Enhanced Subsidies

Subsidies—premium tax credits and cost-sharing reductions—available to nongroup coverage purchasers are enhanced beyond those under current law in reforms 1 through 5, and reform 6 includes further enhanced subsidies. HIPSM computes a household's expected out-of-pocket and premium costs under these enhanced subsidies, and simulated households decide on coverage based on these values. Larger subsidies lower the cost of nongroup insurance, making it more attractive and thereby increasing nongroup coverage. At the same time, the enhanced subsidies lower costs for those already enrolled in nongroup coverage.

Eligibility and Autoenrollment

Reforms 3 and 4 assume people who receive SNAP or TANF benefits will be enrolled in no-premium public coverage if they are eligible. In states that have expanded Medicaid coverage, these SNAP and TANF beneficiaries with incomes below 138 percent of FPL will get Medicaid unless they have other public insurance; in states that have not expanded Medicaid, SNAP and TANF beneficiaries with incomes below the FPL (and so eligible for Marketplace coverage without premiums) who do not have other public insurance or an affordable offer of employment-based insurance will be enrolled in Marketplace insurance. In reforms 5 and 6, all US citizens and legally present immigrants will be eligible for coverage, and anyone without other insurance will be automatically enrolled.

Limits on Provider Payment Rates and Rebates on Prescription Drugs

Reform 4 caps provider payment rates both in and out of network for the ACA-compliant nongroup market, or, equivalently, introduces a public option that would pay the same rates. HIPSM simulates a Marketplace public option and capping provider payment rates for all nongroup insurers at the same level that the public option would pay as having the same implications for federal subsidy costs and private spending. Though capping provider payment rates at a given level would directly affect all insurers in the market, a public option would likely catalyze price competition by private insurers as well. Therefore, it is difficult to predict the ultimate differences in household spending by nongroup insurance enrollees that could result from the introduction of a public option alone versus capping nongroup insurer provider payment rates alone. HIPSM simulations assume the public option would be the benchmark premium for premium subsidy calculations, and capped provider payment rates would lower the benchmark premium to a comparable level.

As noted, reform 4 introduces either a public plan, capped provider payment rates, or both into the private nongroup market. Reforms 5 and 6 require a public option be part of the reform, though the approach could *also* require capping private nongroup insurers' provider payment rates at the same level. The public option is necessary in these approaches because continuous autoenrollment requires a plan into which people can be placed late (i.e., if they neglect to participate in the open enrollment period) and a means for collecting premiums retroactively.

Markets with little or no insurer or provider competition are associated with high private insurance premiums (Holahan, Wengle, and Blumberg 2019). For reforms 4 through 6, we estimate payment rates in each rating region as if the provision of health care in the region were highly competitive, having five or more active insurers in the nongroup market and low market concentration for hospitals. We use this as a proxy for the most efficient provider payment rates achievable under reform (roughly Medicare rates) because there is insufficient claims data available from nongroup insurers nationwide to explicitly compute average claims relative to Medicare rates.

In reforms 4 through 6, we also assume the federal government requires prescription drug manufacturers to provide rebates in this market that would be halfway between those provided to Medicaid and Medicare (Hwang and Kesselheim, forthcoming). These rebates apply to the population enrolled in the nongroup market, reducing the portion of private health spending on the nonelderly devoted to prescription drugs, with that percentage computed to be consistent with the 2016 Medical Expenditure Panel Survey.[34]

Single-Payer Reforms

This section describes our estimates of costs under single-payer reforms. Both single-payer reforms, lite and enhanced (reforms 7 and 8, respectively), replace existing forms of health coverage with a new federal plan. Under these new single-payer plans, all eligible people—all US citizens and legally present immigrants under the lite reform and all US residents under the enhanced reform—are covered. The lite reform assumes the plan covers ACA essential health benefits and requires income-related cost sharing. The enhanced option assumes a broader set of benefits (dental, vision, and hearing services for all enrollees, as well as a new home- and community based-care LTSS benefit). We use HIPSM to estimate costs under the new system for people who would not have been on Medicare under current law. Unlike reforms 1 through 6, the single-payer reforms replace Medicare and bring people who would be Medicare beneficiaries under current law into the new system. Costs for these people, including the elderly and nonelderly with disabilities, are based on the MCARE-SIM model.

Costs for Acute Care for the Nonelderly

HIPSM computes costs for single-payer plans differently for two enrollee populations: (1) current-law Medicaid enrollees and other people with incomes below the poverty level and (2) all other nonelderly people not otherwise enrolled in Medicare. Single-payer plan costs associated with the first group, the low-income population, are simulated based on the health care costs this population would incur if they were each enrolled in Medicaid (a program with broad benefits and little to no cost-sharing requirements). Using spending reflective of Medicaid is most appropriate for this population because their spending patterns are presumably similar to people like them observed in this program. These simulated health care costs are then adjusted upward to account for the assumption that the single-payer plan uses higher provider payment rates than the Medicaid program. For people in the second group, a higher-income population than group 1, we first simulate health care spending as if each person is enrolled in Marketplace nongroup coverage. From there, we adjust each person or family's spending to account for any reduced cost sharing or additional benefits the single-payer approach may provide. Finally, we adjust spending downward to account for differences in assumed provider payment rates. The approach for the second group more closely reflects that income group's spending patterns and leads to lower cost estimates for them than would basing their single-payer spending on Medicaid population patterns.

Single-payer estimates in this analysis assume physicians and other nonhospital providers are reimbursed at Medicare rates.[35] Payments for prescription drugs reflect rebates roughly halfway between those currently received by Medicare and Medicaid. We assume hospitals are paid 15 percent above current Medicare rates, reflecting estimates that aggregate Medicare payments are insufficient to meet the costs of delivering care to patients (American Hospital Association 2019). Because these rates, assumed in our base case, are still well below average hospital reimbursement levels from commercial insurers, and therefore may not be achievable under a single-payer system, we also estimate the costs associated with paying hospitals at Medicare rates plus 40 percent as a sensitivity analysis. Like our estimates for reforms 1 through 6, our single-payer estimates do not assume supply constraints because, thus far, the evidence is not convincing that they would materialize, particularly in a fully phased-in equilibrium, as we are simulating.

Costs of providing care under single-payer enhanced are higher than under single-payer lite for two reasons. First, the enhanced approach eliminates all cost sharing (lite includes income-related cost sharing), which increases the use of health care services. The health economics literature finds that reducing consumers' out-of-pocket costs for health services increases use of services. Eliminating cost sharing makes the cost of single-payer enhanced greater than the costs of the lite approach, but both

lead to higher total consumption of health services for people otherwise privately insured. Employer-sponsored insurance plans pay roughly 80 percent of the cost of covered benefits, and most private nongroup plans pay a lower share, 70 percent for standard coverage but as low as 60 percent for some ACA-compliant plans. Standard coverage under single-payer lite has an actuarial value of 80 percent, but low- and middle-income enrollees receive higher actuarial value plans (i.e., lower cost sharing).

Second, single-payer enhanced includes more covered benefits than does lite, and neither approach places any service or dollar limits on benefits, meaning they are more generous than many private insurance plans available today. Under single-payer enhanced, services for adult dental, vision, and hearing care are added to other services covered by single-payer lite, again with no out-of-pocket cost to the consumer. We used the Medical Expenditure Panel Survey Household Component to estimate spending for the nonelderly on dental and vision care relative to base medical care; hearing services cannot be isolated in the Medical Expenditure Panel Survey, making this calculation low relative to costs for all three benefits combined. We found that, under current-law insurance arrangements, spending on dental and vision care for the nonelderly amounts to about 10 percent of nondental and nonvision medical costs.

However, 10 percent is an underestimate for an add-on to medical costs for dental, vision, and hearing benefits under a single payer for several reasons. First, as noted, we could not isolate hearing costs from base medical costs. Second, dental care (and presumably vision and hearing) are much more likely to be "underinsured" under current law (either excluded as benefits or offered with significant coverage limits) than are basic medical services. All of the private dental insurance plans we could identify (those sold through Marketplaces and employer plans we could check) have significant limits on the benefits provided, and many people do not have dental coverage. According to the Health Reform Monitoring Survey and the National Health Interview Survey (Vujicic, Buchmueller, and Klein 2016),[36] dental care is more frequently cited as care that people do not obtain because of costs than is medical care. Consequently, we expect that providing dental, vision, and hearing benefits on par with medical care would lead to a larger increase in spending on those services combined than would occur for other medical services. Thus, we modestly increased our adjustment for providing these services, from the 10 percent of medical costs observed under current law to 12 percent under a single payer. We believe this to be a reasonably conservative approach.

Costs for People Who Would Be Covered by Medicare under Current Law

MCARE-SIM is designed to estimate the effects of Medicare policy changes on beneficiary and program spending. The model is based primarily on data from the 2015 Medicare Current Beneficiary Survey (MCBS) and is augmented with data from other sources. Survey respondents are Medicare beneficiaries enrolled in traditional fee-for-service (FFS) Medicare or Medicare Advantage (MA) for at least one month of 2015, including those under age 65 with disabilities and those residing in facilities. The survey includes information on sociodemographic characteristics, sources of supplemental insurance coverage, health status, access to health care, use of medical services, and medical expenditures. The MCBS allows estimation of population statistics for those continuously or ever enrolled in the year and can be adjusted to reflect average monthly enrollment.

In addition to its survey data, the MCBS Cost and Use file contains administrative data on service utilization, Medicare outlays, and out-of-pocket liability for covered services linked to individual survey respondents, with an initial sample size of about 10,000. We use reported Medicare outlays and service utilization from the Cost and Use file to measure Medicare spending for FFS enrollees, but we calculate third-party and out-of-pocket spending based on a given year's Medicare cost-sharing rules. We align enrollment and spending amounts in 2015 to administrative benchmarks and apply assumed growth rates to project them to 2020. For additional information on MCARE-SIM, see Garrett and colleagues (2019).

We extended the MCARE-SIM model for this analysis in three ways. First, we statistically matched MCBS observations to comparable individual records in the HIPSM baseline file (based on the American Community Survey). This step integrates the two models and provides a common population base for analyses. Second, because the MCBS lacks spending data on MA enrollees for Parts A and B services, we impute expected spending for these services based on other CMS data. By imputing these spending amounts, we can calculate the spending for all Medicare enrollees under current law. Finally, we estimate what MA enrollees would hypothetically cost if they were enrolled in traditional Medicare under current law. This is a necessary intermediate step for estimating what MA enrollees would cost under reforms 7 and 8.

To implement the statistical match to HIPSM (restricted to Medicare enrollees), we first impute MA enrollment status for individuals in the HIPSM baseline file based on observed relationships between MA enrollment status and individual characteristics in the MCBS. We then reweight HIPSM observations to equal total reported numbers of FFS and MA enrollees by county. Second, we statistically match individuals in the MCBS to HIPSM baseline enrollees separately by MA enrollment,

Medicaid enrollment, and sex. Within each matching group, we use predictive mean matching (based on observed relationships in the MCBS for FFS enrollees) to match records based on their expected total Medicare spending given common covariates, including age, race/ethnicity, marital status, income, and geographic factors. For matched-case FFS enrollees, we bring over to HIPSM all spending and utilization data from the matched MCBS respondents. Because Part D spending data is measured comparably for FFS and MA enrollees in the MCBS, we also bring over to HIPSM the Part D spending and utilization data from the matched MCBS respondents for MA enrollees.

To estimate MA spending under current law for Parts A and B services, we use county- and plan-level MA data from CMS. Because the American Community Survey–based HIPSM file contains county-level (or public use microdata area–level) identifiers, we can aggregate the CMS data to the county level and then link it to our MCBS-HIPSM matched file by county. To do this, we start with data on county-average plan payments and rebates; the difference between these estimates yields the plan bid, or the expected cost of providing Medicare benefits to MA enrollees given a risk score of 1.0, including administrative costs (assumed to be 15 percent). Assuming an actuarial value of 84 percent (absent rebates) and that 25 percent of each rebate dollar is used to buy down enrollee out-of-pocket costs, we calculate average out-of-pocket spending for enrollees in each county. We scale average county Medicare spending and out-of-pocket spending (for a standard risk population) by the county's average MA risk score. The result is an estimate of county-level average Medicare/plan and enrollee spending linked to each MA enrollee in the county, reflecting what is known about plan payments and risk levels in the county (or public use microdata area).

Dental, vision, and hearing spending are assessed separately within the MCBS. We use enrollee-reported total and out-of-pocket spending for dental, vision, and hearing expenditures in the MCBS to establish spending under current law for Medicare enrollees.

Costs for Those with Medicare Coverage under Reforms 7 and 8

To determine spending for each Medicare enrollee under single-payer reforms (7 and 8), we first convert actual spending for MA enrollees to an FFS-equivalent total. Using the area-level ratio of FFS to MA spending for Parts A and B services and the MA average risk score, we calculate the FFS equivalent of Medicare and out-of-pocket spending for MA enrollees. To allocate overall MA spending to Parts A and B services, we split the total by the ratio of Part A to Part B spending observed among FFS enrollees by supplemental coverage group in the MCBS. We then proceed in modeling reforms 7 and 8, treating all Medicare enrollees as FFS enrollees.

Given changes from current law to new policies under a single-payer reform for Medicare enrollees, we calculate changes in spending by payer and service type under each policy, including a potential behavioral response to changes in enrollee cost sharing. Under the enhanced single-payer proposal (reform 8), for example, we set new out-of-pocket spending at zero for all enrollees. We first compute how program, out-of-pocket, and third-party spending would change under each policy's cost-sharing rules, holding utilization fixed. Then for each enrollee we compute how much his or her total health care spending for each service type would change because of changes in cost sharing (increased demand for services due to consumers facing lower prices for care). We assume the following price elasticities of demand for health care by service type: -0.1 for Part A services, -0.2 for Part B services, -0.3 for Part D services, -0.3 for dental care, and -0.35 for vision or hearing care. We implement these elasticities using an arc elasticity approach suitable for modeling the effects of policies involving reducing health care prices to zero. Specifically, we produce a response factor curve, with utilization of free care normalized to 1.0, which declines as cost sharing increases from free to 100 percent. Using this curve, we compute the percent change in total spending induced from changing cost sharing from one level to another. The curve is set so that the arc elasticity over the arc from free care (0 percent coinsurance) to 25 percent effective coinsurance equals the assumed elasticity value.

Supply Constraints

We assume supply constraints will not have a significant effect under the reforms. As more people become eligible for care with lower out-of-pocket costs, and (in reforms 4 through 8) payments to providers are constrained, increases in demand and/or reduced provider willingness to deliver services could limit the volume of services provided. There is, however, little evidence of measurable supply constraints. An analysis of regions with large coverage gains under the ACA showed providers responded to increased demand by expanding staff, including hiring more advanced-practice clinicians (such as nurse practitioners) and care coordinators, opening new or expanding existing health care sites, and/or extending their office hours (Wishner and Burton 2017). Our approach implicitly accounts, however, for existing gaps in capacity, such as those for adult dental care or treatment for opioid use disorder.

Relatedly, we assume provider payment rates for hospitals would be set, at a minimum, to cover hospital costs (estimated as Medicare rates plus 15 percent, on average; American Hospital Association 2019). We assume this to ensure the supply of services would not be cut because revenue falls below the cost of providing care. The additional 15 percent adjustment for hospital spending is made on top of our proxy for Medicare payment rates in the nonelderly population (i.e., what premium levels in each

rating region would be with five or more competing Marketplace insurers and reasonably competitive provider markets), as explained above. Developers of public option and single-payer plans have not stated that they intend to contain costs by limiting supply of services below the level of demand, and they do not usually indicate the specific payment levels upon which their systems would rely. Therefore, assuming reimbursements would at least cover the costs of providing care seems an appropriate and conservative assumption for analytic purposes.

In addition, we do not assume reducing provider payment rates under a public option or a single-payer approach would increase the volume of services provided (i.e., volume offsets). No convincing empirical evidence shows such volume offsets occurred when Medicare payment rates were reduced previously.

Other Public Coverage

The federal government pays for health services for select groups through programs beyond Medicare, Medicaid, and the Marketplaces. These programs include Veterans Affairs, the Indian Health Service, and the Department of Defense. Because these programs provide particular benefits and services beyond those included in a single-payer plan, we assume these programs continue even under reforms 7 and 8. However, because people receiving services through these programs would also have coverage under a single-payer plan, we also calculate an offset to federal spending equal to the single-payer plan costs associated with people enrolled in these other programs.

State Maintenance of Effort

At least one active single-payer bill includes a provision that would require states to contribute to the government costs associated with the reform, with those payments based on the states' current-law Medicaid spending.[37] In our simulated single-payer reforms, states are still responsible for their share of Medicaid's LTSS, and in single-payer lite some uncompensated care costs persist, but our central estimates do not include MOE payments from states. The legality of requiring states to make these payments is uncertain given the Supreme Court's ruling in National Federation of Independent Business v. Sebelius, which indicated the federal government cannot force states to pay into a new program as a condition of getting other federal benefits. However, state contributions to Medicare drug benefit costs for dual eligibles, popularly known as the "clawback" (Schneider 2004), are an MOE requirement, and it has not been challenged in the courts. Though reforms 7 and 8 do not contain MOE provisions, such provisions are included in a sensitivity analysis for both reforms. In these cases, states remit an amount

equal to their projected baseline spending on acute care Medicaid in 2020 (i.e., the payments do not include LTSS) to the federal government. These payments lower federal spending and increase state spending but do not change national expenditures on health care. Our 10-year estimates assume these payments grow with gross domestic product, not projected increases in Medicaid spending, leading to additional state savings over time.

Administrative Costs

Our base case analysis sets administrative costs for the simulated single-payer plans to 6 percent of health care claims. A new system would require a host of administrative functions to effectively operate, such as rate setting for many different providers and services of different types; quality control over care provision; development, review, and revision of regulations; provider oversight and standards enforcement; claims payments to providers; and other functions. And though we recognize our 6 percent assumption is likely imprecise, we believe it is critical when estimating the costs of such a substantial change, as is being proposed to the largest industry in the United States, to account for the many responsibilities required to effectively administer it. It would be inadvisable to cut administrative costs so much that important functions could not be carried out effectively under a new system. Arguably, the Medicare FFS system does not invest sufficiently in several of these areas, particularly coordination of care, and therefore the lowest possible measures of administrative costs are not necessarily the most advisable. In fact, respected analyses suggest Medicare could save money overall if it spent more on administration (Berenson 2003).

We base our administrative cost estimates on Medicare's costs to administer the entire Medicare program (Sullivan 2013); 6 percent is slightly below the administrative costs attributed to the largest employers under current law but greater than the administrative costs for FFS Medicare. Some reviews of single-payer plans assume administrative costs could be significantly lower. Though we consider those lower rates unlikely to be consistent with an effectively and efficiently run single-payer system, we provide sensitivity analyses on reforms 7 and 8 that assume administrative costs of 3 percent of claims (half of our base case assumption). The lower administrative costs reduce federal costs of single-payer lite by $77 billion and enhanced by $117 billion in 2020.

Long-Term Services and Supports

Under current law, LTSS are paid for in part by households, including contributions to private long-term care insurance plans and household contributions to Medicaid-covered benefits. The Medicaid

program, funded jointly by states and the federal government, pays for most of the remainder. [38] Under reforms 1 through 7, spending on LTSS by households or by Medicaid does not change. Reform 8, the enhanced single-payer reform, introduces a new home- and community-based care benefit while retaining Medicaid's institutional care benefit. The LTSS benefit would provide extensive new home- and community-based services for those whose disabilities are classified as meeting Health Insurance Portability and Accountability Act standards (two or more activities of daily living limitations or need for supervision because of severe cognitive impairment). The maximum benefit would be set at approximately $150 per day and then indexed for inflation at an assumed 3 percent per year; at national median prices, this would amount to about seven hours of care per day. People currently served in institutional settings and covered by Medicaid would continue to be covered by Medicaid. The benefit structure is assumed to be service reimbursement.

Consequently, some of the LTSS costs currently borne by households and Medicaid would fall to the new federally funded single-payer plan. In addition, substantial amounts of home-based care currently provided by family members (unpaid provision of care) would be supplemented by formal care paid for under the new plan, increasing overall spending on LTSS.

We generate our estimates using a range of data sources. These include published reports (Eiken 2017; Eiken et al. 2018; Musumeci, Chidambaram, and O'Malley Watts 2019a, 2019b; National Association of Insurance Commissioners 2018; Peebles et al. 2017); tabulations of data from the National Health Interview Survey, Health and Retirement Study, and National Health and Aging Trends Study; and simulations from DYNASIM, the Urban Institute's simulation model designed to analyze the distributional consequences of retirement and aging issues, including projections of needs and expenditures for LTSS (Favreault, Smith, and Johnson 2015). The estimates are based on current utilization patterns for formal services and informal care, trends in limitations of activities of daily living and severe cognitive impairment, and assumptions that about half of care currently provided by informal caregivers would be supplemented or replaced by paid care and that the new program would thus markedly reduce caregiver burdens and levels of un- or undermet need. Following the literature, we also assume some "inflation" in disability levels.

We focus here on assumptions specific to estimating costs paid by the single-payer system and costs that will continue to be paid by Medicaid and households. DYNASIM's baseline LTSS assumptions about disability prevalence and service use have been documented elsewhere (Favreault, Gleckman, and Johnson 2015). Because DYNASIM's LTSS model focuses on the population ages 65 and older, we use simplifying assumptions derived from National Health Interview Survey tabulations and literature about the nonelderly LTSS population to scale DYNASIM's estimates to the full age distribution,[39]

accounting for service use mix to approximate total plan costs. We attempt to include care costs families incur in private transactions that may not be captured in the National Health Expenditure Accounts.[40] We exclude care currently provided by Veterans Affairs from these LTSS calculations.

Notes

1 Examples include Consumer Health Insurance Protection Act of 2018, S. 2582, 115th Cong. (2018); Medicare-X Choice Act of 2019, S. 981. 116th Cong. (2019); Choose Medicare Act, S. 1261, 116th Cong. (2019); Medicare for America Act of 2018, H.R. 7339, 115th Cong. (2018); and Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019). Blumberg and colleagues (2019) proposed the Healthy America Program.

2 Consumer Health Insurance Protection Act of 2019, S. 1213, 116th Cong. (2019).

3 Medicare for All Act of 2019, S. 1129, 116th Cong. (2019).

4 Includes government employee plans.

5 In addition to Medicare, this category includes the Civilian Health and Medical Program of the Uniformed Services and Veterans Affairs coverage. We count people who receive health benefits through the Indian Health Service and who do not report other insurance coverage as uninsured.

6 In other words, people younger than 65 enrolled in Medicare because they have a qualifying disability are not included in HIPSM.

7 Throughout this analysis, the federal government costs associated with the Medicare program are presented net of premiums paid by households. The premiums are shown within the estimates of household spending.

8 At the time of this writing, 12 states were expected to operate state-specific reinsurance programs; see "Section 1332: State Innovation Waivers," Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, accessed September 11, 2019, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html. These states include Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon, and Wisconsin, which currently have reinsurance programs in place, as well as Colorado, Delaware, Montana, North Dakota, and Rhode Island, whose waiver applications have been approved since late July 2019. To derive federal and state contributions to program costs before federal pass-through funds to states with reinsurance programs are announced in the fall, we use estimates in the waiver application from the five states in the newly approved group.

9 Because we do not have representative claims data for the private nongroup insurance market, we approximate the desired payment rate levels by estimating the premiums in each rating region as if they were highly competitive (i.e., at least five participating insurers and hospital Herfindahl-Hirschman Index of no more than 5,000). As has been shown in our other work, as the number of insurers increases and hospital concentration decreases in the ACA Marketplaces, premiums decrease significantly, controlling for other factors. Thus, we assume that pricing in highly competitive insurance markets (many of which include managed-care insurers that offered coverage only in the Medicaid program before the ACA) is a reasonable proxy for Medicare rates in the public option/capped rate plans.

10 Under the ACA, all family members are deemed to have access to affordable employer-based insurance (and therefore prohibited from receiving subsidies to purchase Marketplace coverage) if at least one family member is offered worker-only coverage for which the direct cost to the worker is less than 9.78 percent of family income (for 2020) and has an actuarial value of at least 60 percent.

11 The number of people enrolling in a plan past the open enrollment period can be expected to shrink over time, but we do not model this phased-in change in behavior.

12 Medicare for All Act of 2019, S. 1129, 116th Cong. (2019).

13 Health Insurance Portability and Accountability Act definitions require eligible people to have two or more limitations on activities of daily living or need for supervision because of severe cognitive impairment.

14 At national median prices, this amounts to about seven hours of care per day.

[15] A detailed description of the LTSS program modeled here, along with two alternative approaches, are provided in Favreault (forthcoming).

[16] Those reporting coverage through the Indian Health Service alone are considered uninsured.

[17] Consistent with the economic literature, we assume decreases in employer spending on health insurance premiums for active workers (i.e., not retirees) are passed back to firms' workers via increased wages. Because employer contributions to health insurance are not taxable as income but wages are, this shift in the form of compensation increases income tax revenue in equilibrium.

[18] Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 84 Fed. Reg. 28888 (Jun. 20, 2019); "Proposed Rule – Revision of Categorical Eligibility in the SNAP," US Department of Agriculture, Food and Nutrition Service, July 24, 2019, https://www.fns.usda.gov/snap/fr-072419.

[19] However, this latter observation of almost no change disguises some underlying dynamics. Approximately 1.5 million people paying full nongroup premiums under current law get subsidized coverage with the expanded tax credits under the reform. At the same time, an additional 1.0 million uninsured people and about 200,000 people enrolled in STLDs under current law enroll in ACA-compliant nongroup coverage without tax credits. The shift of 1.2 million people into full-pay nongroup coverage occurs because the premiums in the entire nongroup market decline as more people enter because of the enhanced subsidies. Because the nongroup market (subsidized and unsubsidized) constitutes a single risk pool, changes in one portion affect the other as well.

[20] As part of its 2020 budget, the state of California passed a law that will enhance the financial assistance available to Marketplace enrollees with incomes below 400 percent of FPL and extend assistance to those with incomes between 400 and 600 percent of FPL for the first time; see "Governor Newsom Signs 2019–20 State Budget," Office of Governor Gavin Newsom, June 27, 2019, https://www.gov.ca.gov/2019/06/27/governor-newsom-signs-2019-20-state-budget/. The legislation includes levels of funding for the assistance but not a particular subsidy schedule. Without further details on the structure of those additional subsidies by income group, we could not include them in our 2020 baseline when this analysis was completed. Our analysis does not account for the part of the law that newly expands Medicaid-type coverage to young adult immigrants without documented status, but we account for the implementation of a new state individual mandate in 2020.

[21] For those with lower incomes, savings do not vary by age because the ACA currently limits their premium contributions as a percentage of income.

[22] Plans of any given actuarial value could take many forms, so these represent only examples of possible coverage structures at each level. Additional details on the example plans used for this analysis are as follows: 95% AV plan includes $10 primary care physician visit copay, $30 specialist visit copay, $5 generic drug copay, $20 preferred-brand drug copay, 5% coinsurance after deductible for nonpreferred-brand drug, and 5% coinsurance after deductible for specialty drug; 94% AV plan includes $10 primary care physician visit copay, $30 specialist visit copay, $7 generic drug copay, $30 preferred-brand drug copay, $100 nonpreferred drug copay, and 10% coinsurance after deductible for specialty drugs; 90% AV plan includes $20 primary care physician visit copay, $30 specialist visit copay, $5 generic drug copay, $30 preferred-brand drug copay, 10% coinsurance after deductible for nonpreferred drug, and 10% coinsurance after deductible for specialty drug copay; 85% AV plan includes $10 primary care physician visit copay, $30 specialist visit copay, $7 generic drug copay, $30 preferred-brand drugs, 10% coinsurance after deductible for nonpreferred drugs, and 10% coinsurance after deductible for specialty drugs; 80% AV plan includes $20 primary care physician visit copay, $40 specialist visit copay, $15 generic drug copay, $50 preferred-brand drugs, $150 nonpreferred drugs, and 50% coinsurance after deductible for specialty drugs; 73% AV plan includes $10 primary care physician visit copay, $50 specialist visit copay, $7 generic drug copay, $30 preferred-brand drugs, $100 nonpreferred drugs, and 20% coinsurance after deductible for specialty drugs; and 70% AV plan includes $25 primary care physician visit copay, $55

specialist visit copay, $7 generic drug copay, $45 preferred-brand drugs, $150 nonpreferred drugs, and 25% coinsurance after deductible for specialty drugs.

23 "Projected National Health Expenditure Data," Centers for Medicare & Medicaid Services, updated February 26, 2019, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html.

24 Some of the costs in each "other" category are included in HIPSM estimates. For example, provider-funded uncompensated care is included in HIPSM and would be identified as "other third-party payers" in the NHEA; CHIP is included in HIPSM but is found in "other health insurance programs" in the NHEA.

25 In addition to autoenrolling low-income people in Medicaid and highly subsidized nongroup plans, the public option's lower provider payment rates reduce household out-of-pocket spending. Some of the aggregate household savings are offset by increased coverage and use of care.

26 As noted earlier, late enrollees can take advantage of their public option coverage as their health care needs arise during the course of the year; however, regardless of whether they use medical care, the tax system will collect the appropriate postsubsidy premium from them.

27 Out-of-pocket costs decrease for some people as they move from employer-based coverage into subsidized cost-sharing plans. Some people who would otherwise be uninsured spend more out of pocket once insured because they use more medical services.

28 Additional details on the example plans used for this analysis are as follows: 95% AV plan includes $10 primary care physician visit copay, $30 specialist visit copay, $5 generic drug copay, $20 preferred-brand drug copay, 5% coinsurance after deductible for nonpreferred-brand drug, and 5% coinsurance after deductible for specialty drug; 94% AV plan includes $10 primary care physician visit copay, $30 specialist visit copay, $7 generic drug copay, $30 preferred-brand drug copay, $100 nonpreferred drug copay, and 10% coinsurance after deductible for specialty drugs; 90% AV plan includes $20 primary care physician visit copay, $30 specialist visit copay, $5 generic drug copay, $30 preferred-brand drug copay, 10% coinsurance after deductible for nonpreferred drug, and 10% coinsurance after deductible for specialty drug copay; 85% AV plan includes $10 primary care physician visit copay, $30 specialist visit copay, $7 generic drug copay, $30 preferred-brand drug, 10% coinsurance after deductible for nonpreferred drugs, and 10% coinsurance after deductible for specialty drugs; 73% AV plan includes $10 primary care physician visit copay, $50 specialist visit copay, $7 generic drug copay, $30 preferred-brand drug, $100 nonpreferred drugs, and 20% coinsurance after deductible for specialty drugs; and 70% AV plan includes $25 primary care physician visit copay, $55 specialist visit copay, $7 generic drug copay, $45 preferred-brand drug, $150 nonpreferred drugs, and 25% coinsurance after deductible for specialty drugs.

29 We assume administrative costs in a single-payer option (reforms 7 and 8) would amount to approximately 6 percent of claims costs. However, we also present sensitivity analyses on the costs if the administrative percentage were 3 percent instead. See methodology appendix for additional discussion.

30 Medicare for All Act of 2019, S. 1129, 116th Cong. (2019); Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019).

31 By one estimate from the US International Trade Commission (Chambers 2015), residents of foreign countries spent $3.3 billion in the US on medical care in 2013, up from $1.6 billion in 2003. We do not include these costs in our estimates of the reforms. If, as a practical matter, undocumented immigrants cannot be distinguished from foreign medical tourists, this amount could grow faster, and such medical tourism care could add significantly to the cost of a system like that of reform 8. In addition, US residents spent $1.4 billion on health care received in foreign countries in 2013, up from $168 million in 2003. We do not include these expenditures in our direct estimates or in the National Health Expenditure Accounts (because it is not spending in the US). To the extent spending by US residents abroad results from consumers seeking lower-cost services elsewhere, that

care could revert back to the US under a single-payer system, particularly one with no cost-sharing requirements. In that case, our estimates understate the total costs associated with such a reform.

[32] We assume administrative costs in a single-payer option (reforms 7 and 8) would amount to approximately 6 percent of claims costs. However, we also present sensitivity analyses on administrative costs if they equaled 3 percent of claims costs instead. See methodology appendix for additional discussion.

[33] Medicare for All Act of 2019, S. 1129, 116th Cong. (2019).

[34] "Medical Expenditure Panel Survey HC-192: 2016 Full Year Consolidated Data File," Agency for Healthcare Research and Quality, accessed September 30, 2019, https://meps.ahrq.gov/data_stats/download_data_files_detail.jsp?cboPufNumber=HC-192.

[35] As noted earlier, for the population below age 65, we proxy Medicare payment rates as those resulting from competitive insurance markets (with five or more competing insurers) and reasonably competitive provider markets (Herfindahl-Hirschman indices of no more than 5,000). For the current-law Medicare population, Medicare rates are inherent in the data on current-law spending.

[36] Adele Shartzer and Genevieve M. Kenney, "QuickTake: The Forgotten Health Care Need: Gaps in Dental Care for Insured Adults Remain under ACA," Health Reform Monitoring Survey, Urban Institute, September 24, 2015, http://hrms.urban.org/quicktakes/Gaps-in-Dental-Care-for-Insured-Adults-Remain-under-ACA.html.

[37] Medicare for All Act of 2019, S. 1129, 116th Cong. (2019).

[38] Veterans Affairs also provides LTSS, as do agencies funded under the Older Americans Act.

[39] For example, see population-based studies such as Kaye, Harrington, and LaPlante (2010); Medicaid studies such as Eiken (2017) and Eiken and colleagues (2018); and provider studies such as Harris-Kojetin and colleagues (2019).

[40] See Newquist, DeLiema, and Wilber (2015) or Seavey (2011) for discussion.

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John Holahan is an Institute fellow in the Health Policy Center, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, and developing proposals for health system reform, including the 2006 Massachusetts reforms. He examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on 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. His 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

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Matthew Buettgens is a senior fellow in the Health Policy Center, where he is the mathematician leading the development of the Urban Institute's Health Insurance Policy Simulation (HIPSM) model. The model has been used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington, as well as to the federal government. His recent work includes papers analyzing proposals to repeal and replace the Affordable Care Act, both nationally and state by state. His research topics have included the costs and savings of health reform for both federal and state governments, state-by-state analysis of changes in health insurance coverage and the remaining uninsured, the effect of reform on employers, the role of the individual mandate, the affordability of coverage under health insurance exchanges, and the implications of age rating for the affordability of coverage. Buettgens was previously a major developer of the HIRSM model—the predecessor to HIPSM—used in the design of the 2006 roadmap to universal health insurance coverage in Massachusetts.

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