RESEARCH REPORT

Building on the Affordable Care Act to Achieve Universal Coverage

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Building on the Affordable Care Act to Achieve Universal Coverage

On November 5, 2024, Donald J. Trump was elected President of the United States, and Republicans gained control of the US Senate and House of Representatives. The new administration and Congress have not pursued policies likely to expand coverage. In fact, to partially offset the extension of 2017 tax cuts and various new expenditures, they have taken major steps that would reduce access to, and therefore spending on, Medicaid and Marketplace coverage. In March 2025, the US Department of Health and Human Services issued a proposed rule that would bring major changes to the health insurance Marketplaces, most of which will likely reduce coverage.[1] In July 2025, Congress passed the One Big Beautiful Bill Act (OBBBA), which contains provisions that restrict eligibility and make enrollment more difficult in both Medicaid and the Marketplaces.[2] President Trump signed this legislation into law on July 4th, 2025.

However, strong bipartisan opposition to at least some of the health care provisions of the OBBBA has emerged.[3] There are Democrats and Republicans who remain interested in expanding coverage and containing health care spending.[4] In this paper, we provide a roadmap of several steps that would build on the Affordable Care Act (ACA) to achieve universal coverage at a relatively low cost to the federal government.

The ACA has made major strides in expanding insurance coverage and improving access to care. Before the OBBBA, fewer than 27 million US residents were projected to be uninsured in 2025, including 2 million who have short-term coverage that doesn't provide comprehensive coverage (Banthin et al. 2024); before the enactment of the ACA in 2014, over 45 million people were uninsured (Skopec, Holahan, and Solleveld 2016). In 2025, over 20 million people will receive coverage through the ACA's Marketplaces, most of whom will receive PTCs and many of whom will receive cost-sharing subsidies. Additionally, 20 million more people will have Medicaid than before the ACA. Health care spending is considerably below original projections made when the ACA was enacted (Holahan and McMorrow 2019).

But many problems remained. First, nearly 27 million is still a large number of uninsured people, contributing to access and affordability issues, in part because 10 states have not expanded Medicaid. But coverage remained unaffordable for many, and thus, they remained uninsured. Second, even for many with coverage, affordability issues persist. Deductibles are high, particularly in the nongroup

market, and increasing evidence shows that individuals are incurring high levels of medical debt. Third, health care costs in the US are higher than in any other nation. The US spends almost 17 percent of its GDP on health, while most other advanced countries spend between 10 and 12 percent (Blumenthal et al. 2024). The OBBBA will make most of these problems worse.

Even with a change in political leadership in the next few years, efforts to enact a fully federally run health care system are unlikely, in part because Medicaid has proven to be fairly popular, and people have become more satisfied with the ACA. Raising sufficient amounts in tax revenue to fund a government-run system is unlikely to be politically feasible, even with offsetting savings to employers and households. Largely eliminating the private insurance industry is also likely unfeasible. Many observers have aimed to provide Medicare for all Americans, but even in the current Medicare program, over half of enrollees have some form of private insurance. It will likely be necessary to build on the ACA and employer-sponsored insurance (ESI), Medicare, and Medicaid to expand coverage and control spending. This report projects the likely effects on coverage and spending of a series of reforms that build on our existing health insurance foundation.

This report is modeled on a baseline of current law for 2025. Passage of the OBBBA, new Marketplace rules, and the scheduled expiration of enhanced PTCs are expected to decrease coverage and spending in future years. Application of the coverage and spending estimates presented here to future years would require first that the major health provisions of the OBBBA would be overridden, the enhanced premium tax credits would be reinstated, and the policy baseline returns to its 2025 state. We do not estimate the costs of this step. But this would likely cost over $1.0 trillion over 10 years and would restore coverage to about 16 million people.[5]

We analyze eight incremental steps to expand the ACA and contain health care costs. For each step, we add another layer of reform to the reforms in the preceding step, and then estimate the potential effects on health insurance coverage and government, household, and employer spending. These steps would be politically challenging, and most would raise budget concerns or face resistance from insurers, providers, or other stakeholders. However, in total, the policies proposed here are less extensive and will cost less than estimated in an earlier report of policies leading to universal coverage (Blumberg et al. 2019a,b).

Incremental Reforms That Build on the ACA

We show eight reforms that build on the ACA (table 1). They are modeled as fully in place (no phase-in period) as of 2025, and therefore include the PTCs originally introduced in the American Rescue Plan Act and extended through 2025 by the Inflation Reduction Act (without additional action by Congress, the PTCs will return to the original ACA schedule in 2026).[6] Each reform builds incrementally on the preceding reforms, so the policy modeled in reform 2 includes reform 1 (e.g., improved cost-sharing subsidies) and the policies listed.

Reform 1—Enhanced Cost-Sharing Subsidies: Improve the cost-sharing subsidies in ACA plans. The amount of cost sharing expected at every income level up to 400 percent of the federal poverty level (FPL) would be reduced following the proposal in the Improving Health Care Affordability Act introduced by Senator Shaheen in 2021.[7] The federal government would pay cost-sharing subsidies (CSRs). PTCs would be tied to the gold medal tier, rather than the silver tier, providing plans that cover 80 percent of costs on average.

Reform 2—Other Low-Income Reforms: Introduce reinsurance nationally, prohibit the sale of short-term limited-duration policies, and remove the current firewall (which makes people with affordable employer health insurance offers not eligible for Marketplace subsidies) for people with incomes below 300 percent of FPL.

Reform 3—Filling the Medicaid Gap: Extend Marketplace coverage to individuals below 100 percent of FPL, which would help address the eligibility gap in 10 states that have not expanded Medicaid to very low-income adults. Because the Marketplace gap fill would be federally funded, to avoid penalizing current expansion states, we would increase the federal matching rate for the expansion population in all other states from 90 to 100 percent.

Reform 4—Automatic enrollment of Low-Income People: Automatically enroll uninsured people eligible for coverage with zero premiums. Those participating in SNAP, unemployment insurance, Social Security, and identified through federal tax filing, would be automatically enrolled into either Medicaid or Marketplace coverage. We would not include enrollment through provider contact or contingent coverage of the remaining uninsured in this reform (see reforms 7 and 8).

Reform 5—Capped Rates in the Nongroup and Small-Group Insurance Markets: Limit provider payment rates in the nongroup and small-group employer markets to a multiple of Medicare payments. Rates would be set at Medicare plus 15 percent for providers and Medicare plus 60 percent for hospitals. We do not assume caps on prescription drug prices in this reform.

Reform 6—Capped Rates in All Private Insurance Markets: Extend provider payment rate caps to the large-group employer market. All provider payments by private insurance would now be capped at Medicare plus 15 percent for professionals and Medicare plus 60 percent for hospitals. This would be similar to Medicare Advantage, which limits provider payment rates paid by private insurers to Medicare rates, though our proposed reform would cap rates above Medicare levels.

Reform 7—Automatic Enrollment of All Lawfully Present Residents: Remove the remaining firewall and introduce automatic enrollment of the entire lawfully present population. Autoenrollment would apply to uninsured people who could be identified with the same flags used in reform 4. Those not flagged would be insured through provider contact if they received a significant amount of care. Those not autoenrolled through either the flags or provider contact would be considered contingently covered—while not formally covered, they would be covered if they experienced large spending.

Reform 8—Coverage of Undocumented Residents to Reach Universal Coverage: The first seven reforms would still leave 6.6 million people uninsured. Reform 8 would be needed to reach universal coverage. It would extend Marketplace eligibility to undocumented immigrants, with the same premium and cost-sharing subsidies as others. It would include autoenrollment through the flags (though these would be rare for this population), provider contact, and contingent coverage, as described in the previous reform. There may need to be a waiting period for new entrants, but this is not accounted for in these estimates.

TABLE 1

Incremental Reforms Leading to Universal Coverage of Nonelderly US Residents

	Reform 1	Reform 2	Reform 3	Reform 4	Reform 5	Reform 6	Reform 7	Reform 8
	Enhanced cost-sharing subsidies	**Other low-income reforms**	**Filling the Medicaid gap**	**Automatic enrollment of low-income people**	**Capped rates in nongroup and small-group insurance markets**	**Capped rates in all private insurance markets**	**Automatic enrollment of all lawfully present US residents**	**Automatic enrollment of all US residents**
Incremental policy	Enhance ACA CSRs and tie subsidies to the gold tier	Federal reinsurance, prohibit STLD plans and drop the employer firewall for people with incomes less than 300% of FPL	Fill the Medicaid gap in the 10 states that have not expanded by extending Marketplace eligibility below 100% of FPL; increase expansion FMAP to 100% in expansion states	Automatically enroll uninsured people with other program participation who are eligible for zero-premium coverage in Medicaid or Marketplace coverage	Cap provider payment rates in the nongroup and small-group ESI markets at Medicare rates plus 15% for providers and Medicare plus 60% for hospitals	Cap provider payment rates in the large-group ESI market at Medicare rates plus 15% for providers and Medicare plus 60% for hospitals	Drop the employer firewall, automatically enroll uninsured people with other program participation who are eligible for Medicaid or Marketplace coverage (all lawfully present), and contingently cover remaining eligible people	Extend eligibility for ACA Marketplace subsidies (PTCs and CSRs) to undocumented people, and contingently cover those who do not actively enroll in coverage
ACA premium schedule	IRA enhanced (unchanged from 2025 current law)	IRA enhanced (unchanged from 2025 current law)	IRA enhanced (unchanged from 2025 current law)	IRA enhanced (unchanged from 2025 current law)	IRA enhanced (unchanged from 2025 current law)	IRA enhanced (unchanged from 2025 current law)	IRA enhanced (unchanged from 2025 current law)	IRA enhanced (unchanged from 2025 current law)

	Reform 1	Reform 2	Reform 3	Reform 4	Reform 5	Reform 6	Reform 7	Reform 8
	Enhanced cost-sharing subsidies	**Other low-income reforms**	**Filling the Medicaid gap**	**Automatic enrollment of low-income people**	**Capped rates in nongroup and small-group insurance markets**	**Capped rates in all private insurance markets**	**Automatic enrollment of all lawfully present US residents**	**Automatic enrollment of all US residents**
Cost-sharing	Premium percent-of-income caps tied to 80% AV gold plan; additional CSRs to lower cost sharing further for those up to 400% of FPL	Premium percent-of-income caps tied to 80% AV gold plan; additional CSRs to lower cost sharing further for those up to 400% of FPL	Premium percent-of-income caps tied to 80% AV gold plan; additional CSRs to lower cost sharing further for those up to 400% of FPL	Premium percent-of-income caps tied to 80% AV gold plan; additional CSRs to lower cost sharing further for those up to 400% of FPL	Premium percent-of-income caps tied to 80% AV gold plan; additional CSRs to lower cost sharing further for those up to 400% of FPL	Premium percent-of-income caps tied to 80% AV gold plan; additional CSRs to lower cost sharing further for those up to 400% of FPL	Premium percent-of-income caps tied to 80% AV gold plan; additional CSRs to lower cost sharing further for those up to 400% of FPL	Premium percent-of-income caps tied to 80% AV gold plan; additional CSRs to lower cost sharing further for those up to 400% of FPL
Reinsurance	By state using waivers	Permanent $10 billion per year funded by general revenues	Permanent $10 billion per year funded by general revenues	Permanent $10 billion per year funded by general revenues	Permanent $10 billion per year funded by general revenues	Permanent $10 billion per year funded by general revenues	Permanent $10 billion per year funded by general revenues	Permanent $10 billion per year funded by general revenues
Expanded access to STLDs?	Yes, current law	No, return to 2016 rules	No, return to 2016 rules	No, return to 2016 rules	No, return to 2016 rules	No, return to 2016 rules	No, return to 2016 rules	No, return to 2016 rules
Eliminates the Medicaid gap?	No	No	Yes, through Marketplace expansion	Yes, through Marketplace expansion	Yes, through Marketplace expansion	Yes, through Marketplace expansion	Yes, through Marketplace expansion	Yes, through Marketplace expansion, including undocumented people

	Reform 1	Reform 2	Reform 3	Reform 4	Reform 5	Reform 6	Reform 7	Reform 8
	Enhanced cost-sharing subsidies	**Other low-income reforms**	**Filling the Medicaid gap**	**Automatic enrollment of low-income people**	**Capped rates in nongroup and small-group insurance markets**	**Capped rates in all private insurance markets**	**Automatic enrollment of all lawfully present US residents**	**Automatic enrollment of all US residents**
Automatic enrollment of uninsured people?	No	No	No	Yes, limited to people flagged through program participation and eligible for zero-premium coverage	Yes, limited to people flagged through program participation and eligible for zero-premium coverage	Yes, limited to people flagged through program participation and eligible for zero-premium coverage	Yes, for all lawfully present residents who would otherwise be uninsured; people not flagged through program participation are enrolled through provider contact or contingently enrolled	Yes, for all residents, including the undocumented

	Reform 1	Reform 2	Reform 3	Reform 4	Reform 5	Reform 6	Reform 7	Reform 8
	Enhanced cost-sharing subsidies	**Other low-income reforms**	**Filling the Medicaid gap**	**Automatic enrollment of low-income people**	**Capped rates in nongroup and small-group insurance markets**	**Capped rates in all private insurance markets**	**Automatic enrollment of all lawfully present US residents**	**Automatic enrollment of all US residents**
Limits on provider payment rates?	No	No	No	No	Yes, in the nongroup and small-group ESI markets; physicians and other providers paid at Medicare rates plus 15%; hospitals paid at Medicare rates plus 60%	Yes, in the nongroup, small-group ESI, and large-group markets; physicians and other providers paid at Medicare rates plus 15%; hospitals paid at Medicare rates plus 60%	Yes, in the nongroup, small-group ESI, and large-group markets; physicians and other providers paid at Medicare rates plus 15%; hospitals paid at Medicare rates plus 60%	Yes, in the nongroup, small-group ESI, and large-group markets; physicians and other providers paid at Medicare rates plus 15%; hospitals paid at Medicare rates plus 60%
Excludes people with affordable ESI offers from Marketplace subsidies?	Yes, current law	Yes, if household income is above 300% of FPL	Yes, if household income is above 300% of FPL	Yes, if household income is above 300% of FPL	Yes, if household income is above 300% of FPL	Yes, if household income is above 300% of FPL	No	No
Undocumented people eligible for subsidies?	No	No	No	No	No	No	No	Yes, eligible for Marketplace subsidies

Source: Authors' analysis.

Notes: CSR = cost-sharing reductions; STLD = short-term limited duration nongroup insurance; FPL = federal poverty level; FMAP = Federal Medical Assistance Percentage; IRA = Inflation Reduction Act; AV = actuarial value; ESI = employer-sponsored insurance. Shading indicates change in policy from previous reform.

Highlights in Brief

Overall, through this combination of policies, we show that achieving universal coverage is possible with fairly small effects on federal and national health spending.

- We show that the number of uninsured among lawfully present individuals can be reduced with various policies, including full autoenrollment, leaving 6.6 million undocumented immigrants without coverage. Reducing the number of uninsured to zero requires providing coverage to this population. We recognize the political difficulty of this step, but point out that it would be required to achieve universal coverage. It would also provide financial relief to the providers who now care for this population.
- Federal spending would increase with added coverage and improved affordability. The increases in federal spending are somewhat smaller under reforms that limit payment rates in the nongroup market.
- Households would save with the coverage and affordability provisions. They would also save from the caps on provider payments, particularly if they were extended to the entire private insurance industry. Many of the people who save would have low or middle incomes.
- Employers would spend less on premiums because some provisions would result in people choosing to forgo employer coverage and go to the individual market. Employers also spend considerably less on premiums under capped rates, particularly if extended to small and large firms. We assume these savings would be passed on to employees through higher wages and subject to income tax, thus increasing revenue, offsetting some of the increases in federal spending.

Results

Reform 1. Enhanced Cost-Sharing Subsidies

POLICY

The CSR schedule would be made more generous, improving actuarial value for those currently eligible for CSRs by up to 20 percentage points, extending CSRs to people with incomes up to 400 percent of

FPL, and tying premium subsidies to the gold tier (see appendix table 1). CSRs would be federally funded, which would eliminate silver loading.

COVERAGE

The number of people without comprehensive health insurance would fall from 26.8 million to 25.7 million,[8] a reduction of 1.1 million (figure 1). ESI would fall by 1.2 million because some people, mostly those with unaffordable offers, would drop ESI because of the more generous cost-sharing reductions in the Marketplace. Private nongroup coverage would increase by 2.2 million because of the more generous offerings in the Marketplace. Subsidized coverage would increase by 1.2 million and unsubsidized coverage by 1.0 million. However, many of those now counted as unsubsidized previously received small subsidies and now pay less in premiums.

SPENDING

Federal government spending increases by $14.5 billion, driven by spending for the improved cost-sharing subsidies.

Household spending falls by $7.6 billion because of the reduction in cost-sharing payments made by households, offset somewhat by new premium payments made by people gaining coverage.

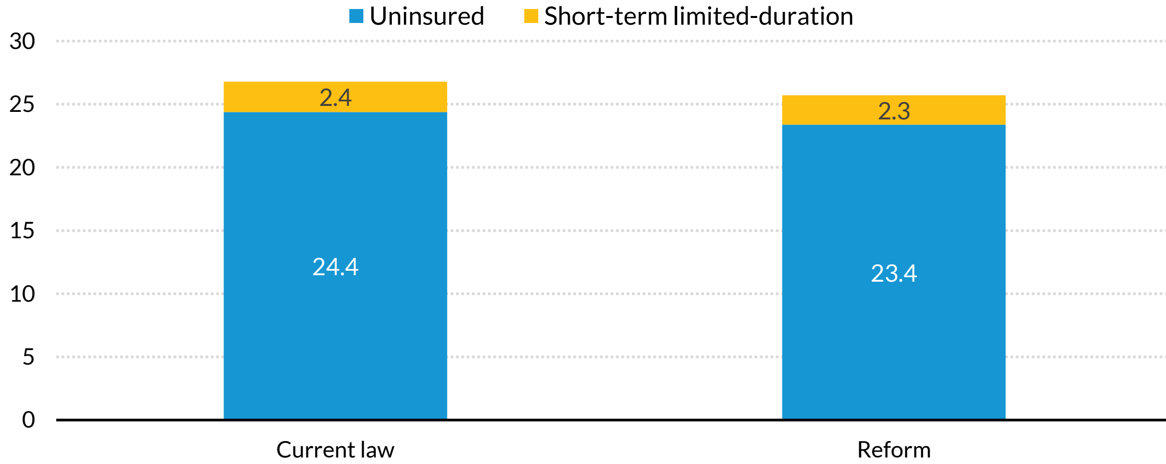
Employer spending on premiums would fall by $6.0 billion because fewer people have employer coverage.

National health spending would fall slightly by $0.3 billion, despite the added coverage and improved cost sharing, because people move from ESI to less expensive coverage.

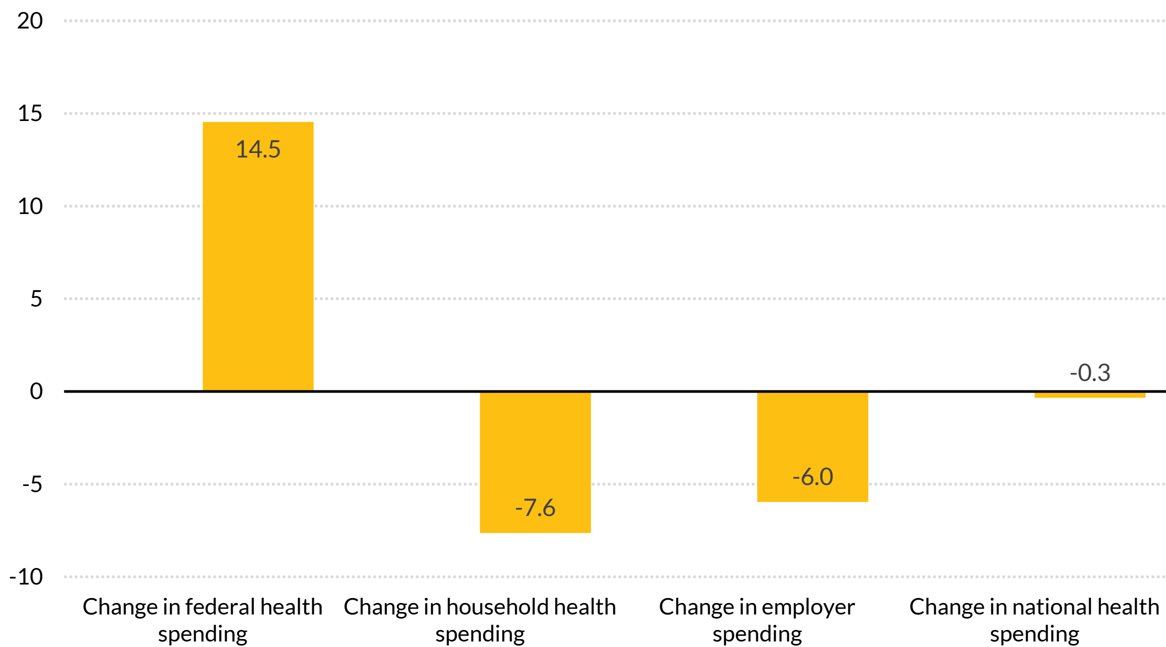
FIGURE 1

Coverage and Changes in Spending under Reform 1, Enhanced Cost-Sharing Subsidies, Compared with Current Law, 2025

Millions of people



Billions of dollars



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Source: Urban Institute Health Policy Simulation Model, 2024.

Notes: Because of the decline in employer spending on health care, wages and income tax revenues would increase, and the change in the federal deficit, $12.5 billion, would be smaller than the change in federal spending.

Reform 2. Other Low-Income Reforms

POLICY

Adds to previous reform by increasing federal reinsurance to $10 billion, eliminating short-term limited-duration policies, and removing the employer firewall for those with incomes below 300 percent of FPL.

COVERAGE

This reform increases the number of people with comprehensive coverage by 2.6 million compared with current law and by 1.5 million compared with reform 1. ESI coverage falls by 7.1 million, primarily because of the elimination of the firewall for those with incomes below 300 percent of FPL. Private nongroup coverage increases by 9.2 million, including an increase in subsidized Marketplace coverage of 9.4 million. About 0.4 million more people are covered by Medicaid, mainly children who are found to be eligible when their family switches to Marketplace coverage. Most of the coverage effect stems from the firewall provision, which allows lower-income people to obtain subsidies in the Marketplace.

SPENDING

Federal government spending increases by $66.3 billion compared with current law and $51.7 billion compared with reform 1 (figure 2). This increase is largely because of the increased number of people in the subsidized Marketplace.

Household spending falls by $26.4 billion primarily because of the elimination of the firewall and the introduction of reinsurance.

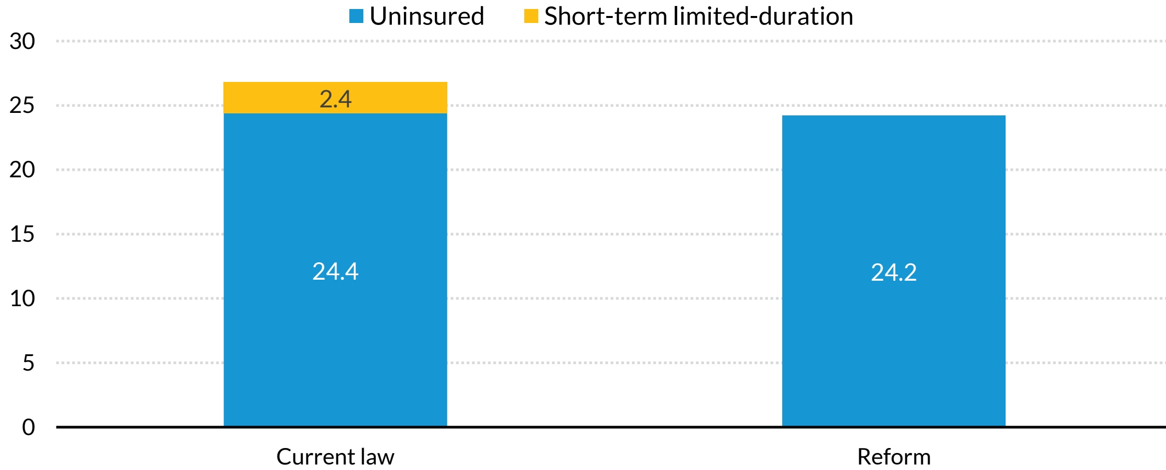
Employer spending falls by $44.5 billion, primarily because people drop employer coverage and enroll in marketplace plans when the firewall provision allows people with income below 300 percent of FPL to receive PTCs and CSRs.

National health spending falls by $3.2 billion compared with current law, primarily because Marketplace coverage is less expensive than employer coverage.

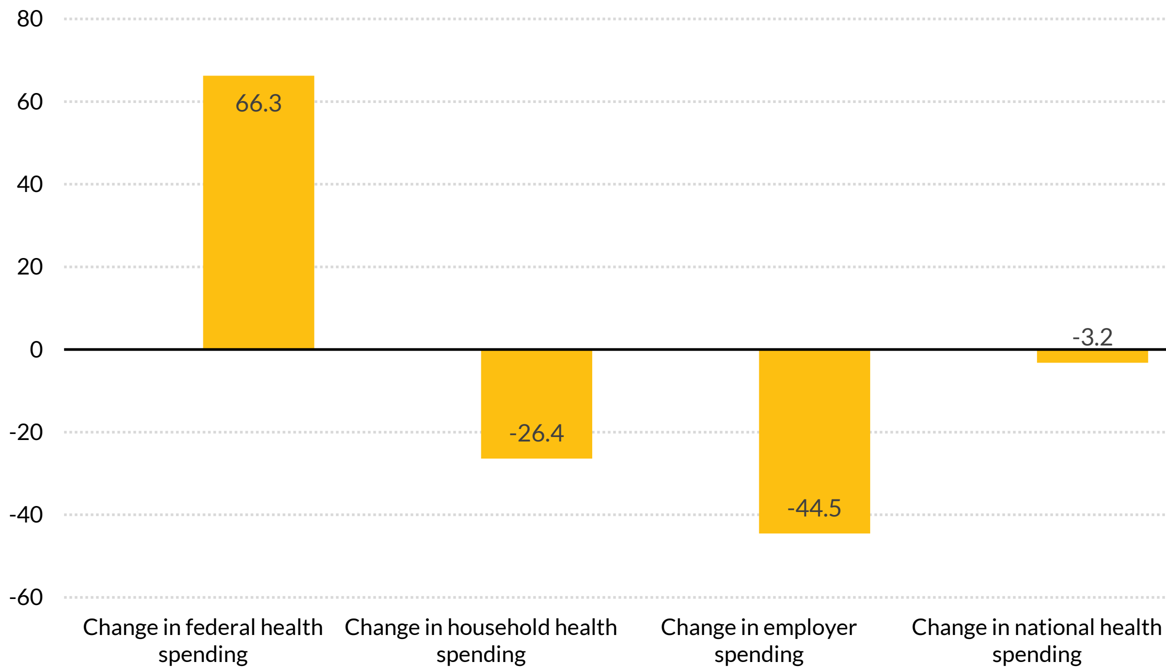
FIGURE 2

Coverage and Changes in Spending under Reform 2, Other Low-Income Reforms, and Prior Reform Compared with Current Law, 2025

Millions of people



Billions of dollars



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Source: Urban Institute Health Policy Simulation Model, 2024.

Notes: Because of the decline in employer spending on health care, wages and income tax revenues would increase, and the change in the federal deficit, $51.4 billion, would be smaller than the change in federal spending.

Reform 3. Filling the Medicaid Gap

POLICY

This adds to previous reforms by filling the Medicaid gap by allowing people with income below 100 percent of FPL to receive Marketplace subsidies. In the 10 nonexpansion states, this population can choose nongroup coverage with PTCs and CSRs. In expansion states, this population is covered by Medicaid; this reform therefore fully federally funds Medicaid expansion in these states by increasing the federal matching rate for the expansion population from 90 to 100 percent.

COVERAGE

Filling the Medicaid gap reduces the uninsured by 4.3 million compared with current law and by an additional 1.8 million people compared with reform 2. Employer coverage falls somewhat because many low-income people in nonexpansion states give up employer plans and enroll in subsidized Marketplace plans. Subsidized private nongroup coverage increases by 2.3 million over reform 2 as newly eligible people take up coverage; 11.7 million more people would have this coverage than under current law.

SPENDING

Federal government spending increases by $93.7 billion, including $27.4 billion to fill the Medicaid gap (up from $66.3 billion without the gap fill; figure 3). Compared with current law, Marketplace PTCs are $50 billion greater, and cost-sharing subsidies are $21.5 billion greater, largely because of new enrollment (not shown). Federal Medicaid spending is $15.6 billion greater than under current law, of which most is the result of the federal matching rate for the expansion population increasing from 90 percent to 100 percent. At the same time, states spend $11.0 billion less on Medicaid, mostly because of the 100 percent match (not shown).

Household spending is $29.9 billion below current law because newly enrolled people save on premiums and cost sharing.

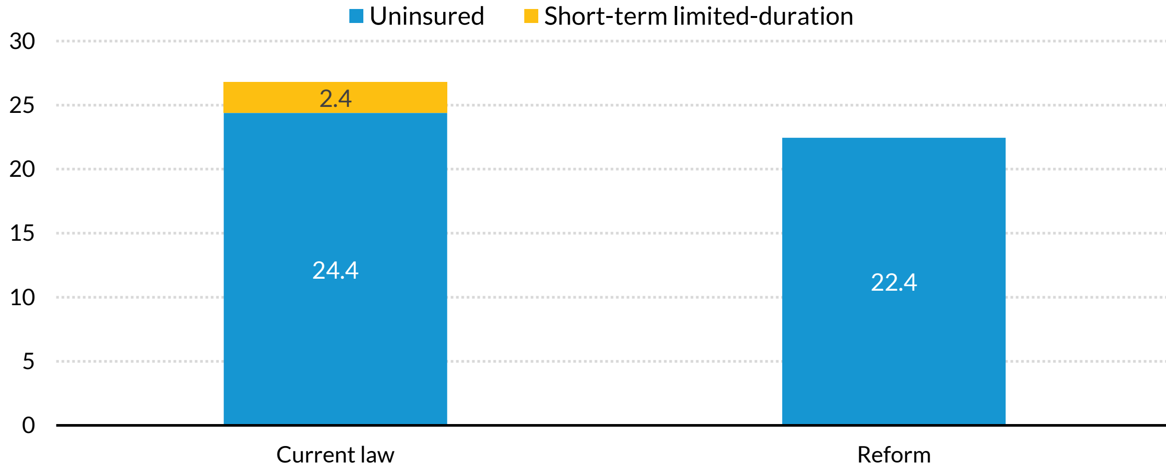
Employer spending is $47.3 billion below current law, as many low-income people in nonexpansion states who maintained coverage through their employers give that up to enroll in very low-premium Marketplace coverage.

National health spending increases by $4.7 billion because of the combined reforms.

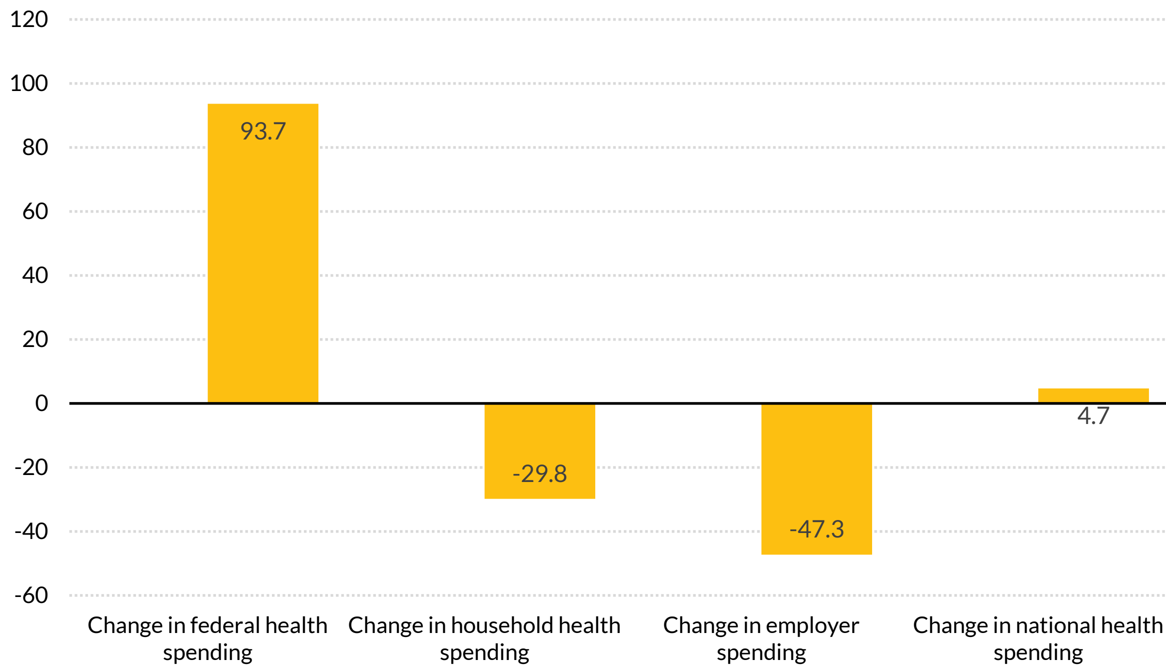
FIGURE 3

Coverage and Changes in Spending under Reform 3, Filling the Medicaid Gap, and Prior Reforms, Compared with Current Law, 2025

Millions of people



Billions of dollars



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Source: Urban Institute Health Policy Simulation Model, 2024.

Notes: Because of the decline in employer spending on health care, wages and income tax revenues would increase, and the change in the federal deficit, $78.6 billion, would be smaller than the change in federal spending.

Reform 4. Autoenrollment of Low-Income People

POLICY

Adds to previous reforms by adding limited automatic enrollment of selected low-income people eligible for zero-premium coverage as identified through their receipt of SNAP, TANF, unemployment insurance, or through tax filing (box 1).

COVERAGE

Adding this reform would reduce the number of uninsured people by 9.8 million compared with the current law and 5.4 million compared with reform 3. The primary effect of this reform is on Medicaid coverage, which increases to 5.4 million people compared with current law because of limited autoenrollment. Compared with current law, employer coverage is 7.5 million lower, and subsidized nongroup coverage is 12.4 million higher.

SPENDING

Federal government spending now increases by $127.2 billion compared with current law, up from $93.7 billion in the previous reform (figure 4). Most of the effect of this reform is on Medicaid spending because the reform primarily affects a low-income population. Spending on Medicaid increases by $48.6 billion compared with current law.

Household spending is $4.9 billion lower than without automatic enrollment because of lower out-of-pocket spending by the newly covered. With all provisions in place, household spending is $34.7 billion below current law.

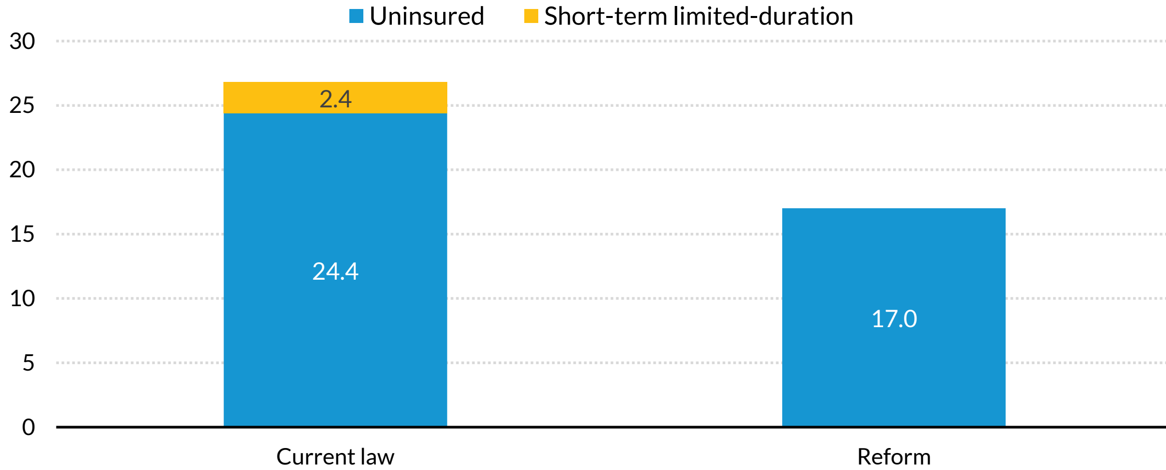
Employer spending falls by $47.6 billion compared with current law, little changed from the previous reform.

National health spending increases by $36.3 billion compared with current law, up from $4.7 billion in the previous reform, reflecting the cost of care for 5.4 million newly insured, largely low-income people.

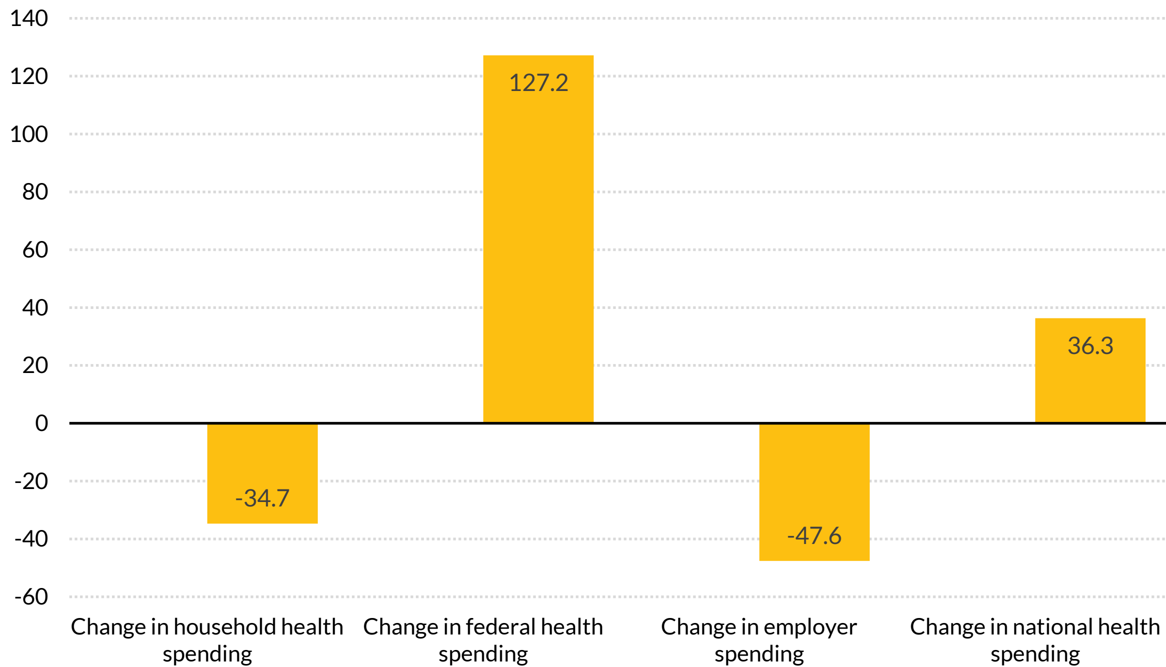
FIGURE 4

Coverage and Changes in Spending under Reform 4, Autoenrollment of Low-Income People, and Prior Reforms, Compared with Current Law, 2025

Millions of people



Billions of dollars



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Source: Urban Institute Health Policy Simulation Model, 2024.

Notes: Because of the decline in employer spending on health care, wages and income tax revenues would increase, and the change in the federal deficit, $112.1 billion, would be smaller than the change in federal spending.

BOX 1

Autoenrollment

These proposals outline two forms of autoenrollment: (1) autoenrollment of people identified through program participation and (2) of people with provider contact.[a] Reforms 3, 7, and 8 apply one or both of these to three distinct populations.

Limited Autoenrollment of People Eligible for Coverage without Premiums (Reform 4)

This policy would auto-enroll anyone eligible for zero-premium coverage in Medicaid or the ACA Marketplace who is identified because of receipt of SNAP benefits, unemployment insurance, Social Security, or through income tax filing. Those identified, or flagged, will be autoenrolled into Medicaid if eligible or into a Marketplace plan if they are eligible for PTCs and have incomes at or below 150 percent of FPL, so their PTC covers the entire premium. In Medicaid, states would choose whether to cover them on a fee-for-service basis or how to assign them to a managed care plan. For Marketplace coverage, states would also be expected to develop policies on assigning individuals to plans. They could limit enrollment to one of the two lowest-cost gold plans or make all plans, as a condition of participation, cover those who were autoenrolled and agree to be paid the premium for the benchmark plan.

Full Autoenrollment (Reforms 7 and 8)

Under this policy in Reform 7, all lawfully present Americans would be deemed covered. Individuals would be enrolled through flags for the four programs listed above. People who remained without a plan would be enrolled by a provider who, if they use a significant amount of medical care, e.g., $250. To be paid, providers would contact a designated state agency that would then enroll the patient in a plan. The designated agency would also inform the federal government that an individual has been autoenrolled and assist in obtaining information on which to base premium contributions and tax obligations at the end of the year. Those not enrolled through flags or provider contact would be contingently covered; that is, they would be insured if they had a serious episode despite not being identified in our data as having such an episode. Contingently covered people who do not incur significant costs would utilize health care as if they were uninsured. Reform 8 would make undocumented people eligible for Marketplace coverage and extend the full autoenrollment policy to them, both through flags and provider contact.

Notes: [a] For additional information on automatic enrollment, including issues and estimates of proposals, see Blumberg, Holahan, and Levitis (2021) and Holahan, Simpson, and Levitis (2024).

Reform 5. Capped Rates in Nongroup and Small-Group Insurance Markets

POLICY

Adds to previous reforms by capping provider payment rates in both the nongroup and small-group markets (box 2).

COVERAGE

This reform would primarily reduce the costs of nongroup and small-group insurance. It will result in a slight reduction in the uninsured relative to the previous reforms. Many people who would have switched away from small-group ESI without this provision would now choose to keep their ESI, which is now less expensive. The number of people with nongroup insurance (29.9 million) is therefore lower than under the previous reform (36.8 million). This decline is more than offset by greater ESI coverage, 146.7 million with limited capped rates versus 139.6 million without.

SPENDING

Federal government spending now increases by $79.5 billion over current law, $47.7 billion less than the increase of $127.2 billion under the previous option (figure 5). Spending is lower because of caps on payment rates in the nongroup market and because fewer people are subsidized. The cost of Marketplace PTCs and cost-sharing subsidies falls significantly from the prior reform, now amounting to increases from current law of $12.7 billion for PTCs and $15.3 billion for cost-sharing subsidies (data not shown).

Household spending is lower than current law by $41.5 billion because of the reduced payment rates in the nongroup and small-group ESI markets. Both household premiums and out-of-pocket spending are lower than under the previous reform.

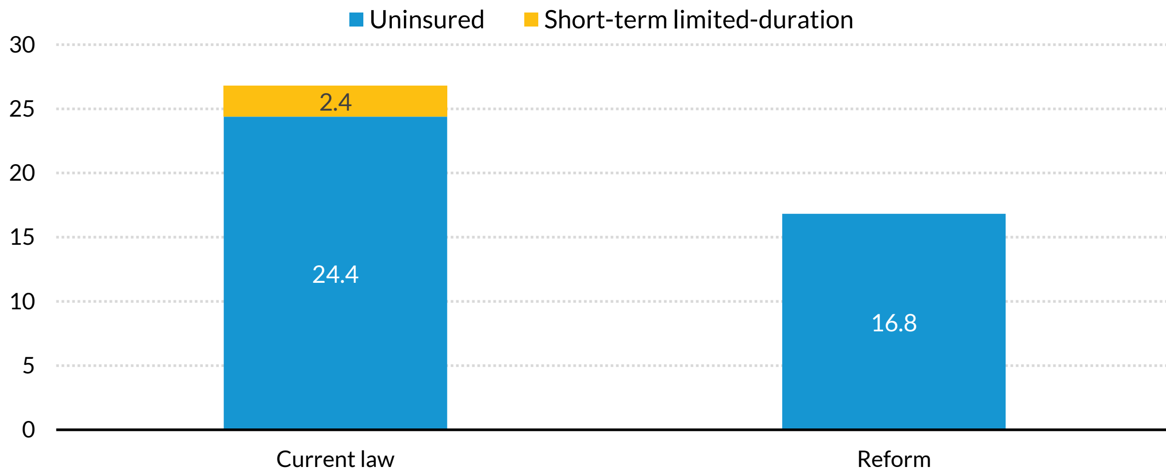
Employer spending is now $18.0 billion below current law, which is higher than in the previous option because more people choose employer plans in the small group market.

National health spending increases by only $11.0 billion over current law. This is lower than with the previous reforms by $25.3 billion, because the caps on provider payment rates reduce spending in the nongroup and small-group markets.

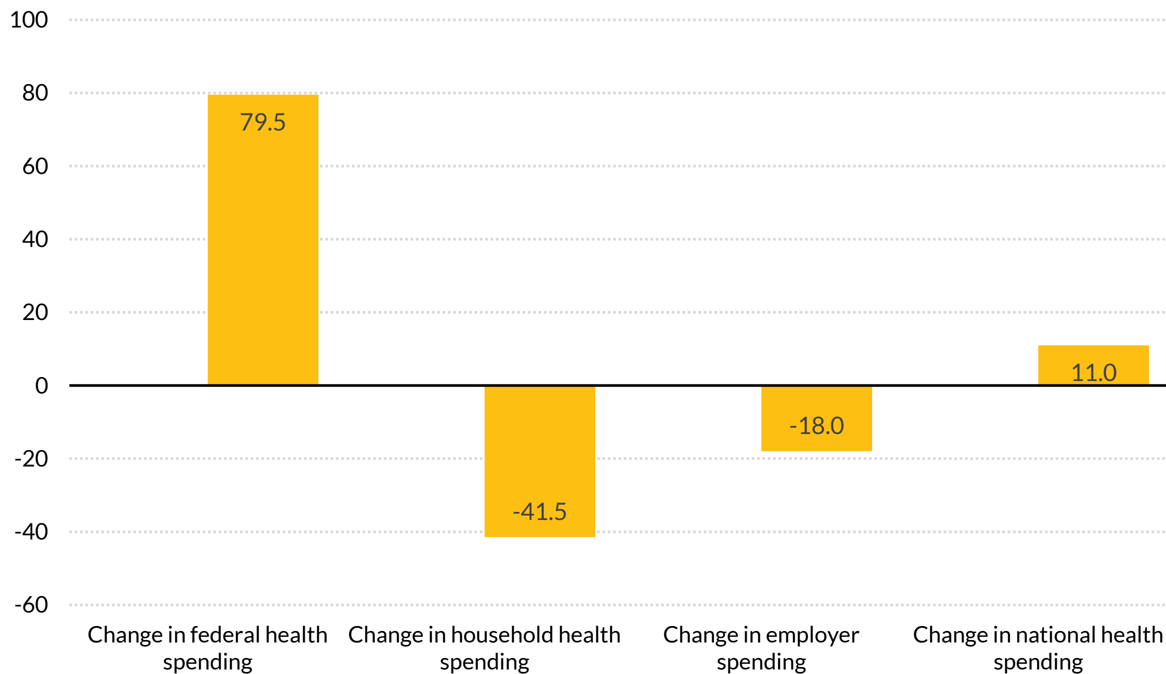
FIGURE 5

Coverage and Changes in Spending under Reform 5, Capped Rates in Nongroup and Small-Group Insurance Markets, and Prior Reforms, Compared with Current Law, 2025

Millions of people



Billions of dollars



URBAN INSTITUTE

Source: Urban Institute Health Policy Simulation Model, 2024.

Notes: Because of the decline in employer spending on health care, wages and income tax revenues would increase, and the change in the federal deficit, $74.9 billion, would be smaller than the change in federal spending.

BOX 2

Capping Provider Payment Rates

Two broad regulatory approaches are proposed for reducing provider payment rates. The first would be to employ a public option—a government-sponsored insurance plan that would pay providers (hospitals, doctors, and other providers) according to a fee schedule that would be lower than those typical of private insurance.[a] A public option would require households or employers to enroll in the new plan to maximize the full cost savings.

An alternative is to cap payment rates paid to all providers by all insurers. This is the approach that we follow in this paper. Providers would be required to accept payment rates no higher than those specified, as Medicare does with Medicare Advantage. Capped rates would allow households and employers to take advantage of the full cost savings while still enrolling with their preferred insurers (or their employer's self-insured plan). Capping rates would likely result in more private insurers entering a market and/or staying in markets because a large number of enrollees is not needed as leverage in negotiating competitive payment rates with providers.

In this analysis, we assume that rates for physicians and other professionals would be set at 15 percent above Medicare, and payment rates for hospital inpatient and outpatient care would be set at 60 percent above Medicare. They could be higher or lower. We assume prescription drugs would not be covered, primarily because it would be hard to model. Capping payment rates could apply to insurers in (1) the nongroup and small-group ESI markets, and (2) nongroup plus all employer plans. We show the effects of both.

There could be serious opposition by providers to capped rates. The rate levels assumed here would pay providers more than they currently are in Medicaid and Medicare, but rates would typically be less than those currently paid by most commercial insurers. We show that the effects on provider incomes/revenues from the reduction in payment rates we assume are relatively small overall, but the reductions would not affect providers uniformly, so they could lead to financial stress for some hospitals or other providers.

Notes:[a] For additional information on public option and capped rate reforms, including issues and estimates of proposals, see Simpson and Holahan (2024) and Blumberg (2021).

Reform 6. Capped Rates in All Private Insurance Markets

POLICY

Adds capped rates on provider payment rates in the large-group ESI market to the previous reforms.

COVERAGE

Under extension of capped rates to the large-group ESI market, there is a small reduction in the number of uninsured, less than 100,000, because of the reduction in ESI premiums. The number with ESI increases by a relatively small amount, just over 200,000, because ESI is less expensive. This accounts for the small reduction in the uninsured.

SPENDING

Federal government spending is virtually unchanged from the previous reform because extending coverage to the ESI market has little effect on coverage in federally subsidized insurance. The reduction in employer spending on premiums, however, increases wages and income tax revenues, so the net effect on the federal deficit is an increase of $40.2 billion, considerably less than the increase of $74.9 billion under the prior reform.

Household savings increased to $88.1 billion over current law because of a reduction in both premiums and other health spending now paid for employer plans (figure 6).

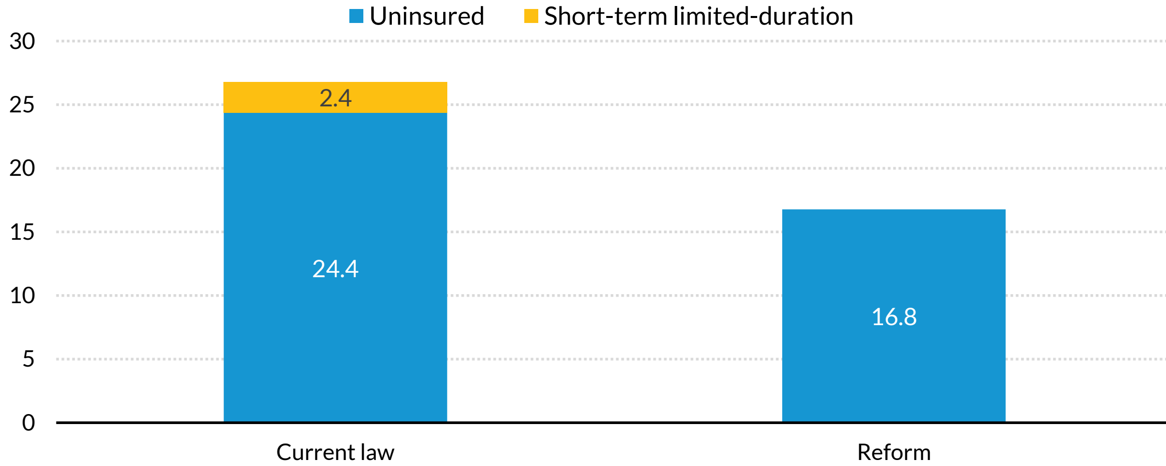
Employer spending on premiums falls to $113.5 billion below current law because of the reduction in provider payments under capped rates.

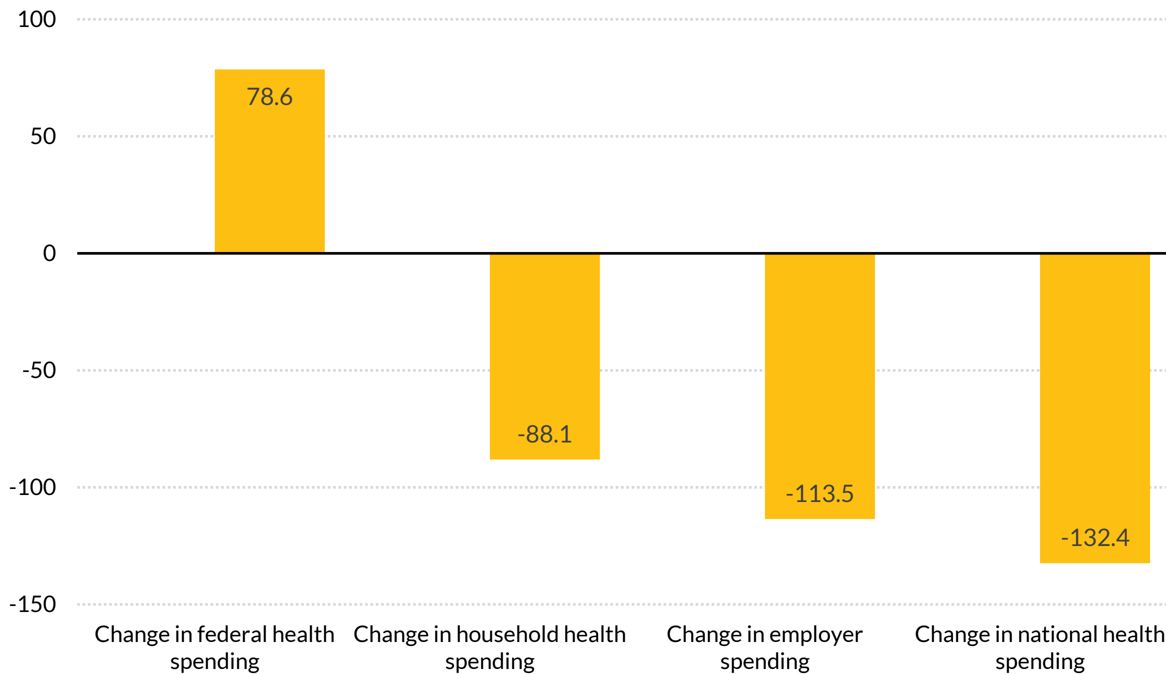
National health spending falls to $132.4 billion below current law, substantially more than in the previous reform. This is because lower provider payment rates now apply to the entire private insurance market. The decline in national health spending is despite the increased coverage of 17.1 million people.

FIGURE 6

Coverage and Changes in Spending under Reform 6, Capped Rates in All Private Insurance Markets, and Prior Reforms, Compared with Current Law, 2025

Millions of people





Source: Urban Institute Health Policy Simulation Model, 2024.

Notes: Because of the decline in employer spending on health care, wages and income tax revenues would increase, and the change in the federal deficit, $40.2 billion, would be smaller than the change in federal spending.

Reform 7. Automatic Enrollment of All Lawfully Present Residents

POLICY

Adds to the previous reforms by eliminating the firewall for the remaining workers and automatically or contingently enrolling all lawfully present individuals.

COVERAGE

This reform results in a reduction in the uninsured of 20.2 million from current law, and 10.2 million compared with the previous reforms. The only remaining uninsured are 6.6 million undocumented immigrants. The number of people with employer coverage falls by 3.3 million over the prior reform because of the elimination of the remaining firewall (above 300 percent of FPL). The number with nongroup coverage, primarily subsidized coverage, increases because of automatic enrollment. There are 1.4 million lawfully present people who are not actively enrolled in coverage and are considered contingently covered. They are protected from bills if they were to become ill, but use care and incur costs as if they were uninsured. Autoenrollment accounts for most of the effect on the uninsured in this reform.

SPENDING

Federal government spending increases to $98.1 billion above current law, up from $78.6 billion in the previous reform (figure 7). This is primarily because of the increase in PTCs received by those who are now autoenrolled.

Household savings decreases by $29.1 billion from the prior reform, largely because of new premiums paid by people automatically enrolled in coverage. Household spending is $59.0 billion less than under current law.

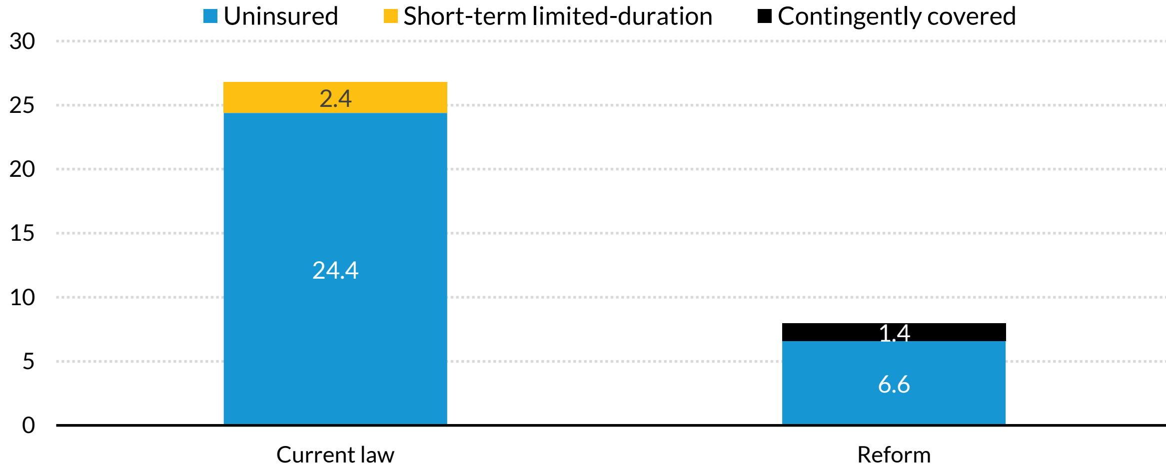
Employer spending is $130.3 billion below current law and lower than under the previous reform because the elimination of the firewall reduces ESI take-up.

National health spending is $116.2 billion lower than current law despite the coverage of all lawfully present individuals. National health spending falls by less than in the previous reform, reflecting the costs of new coverage, mostly in subsidized nongroup plans, for over 10 million people.

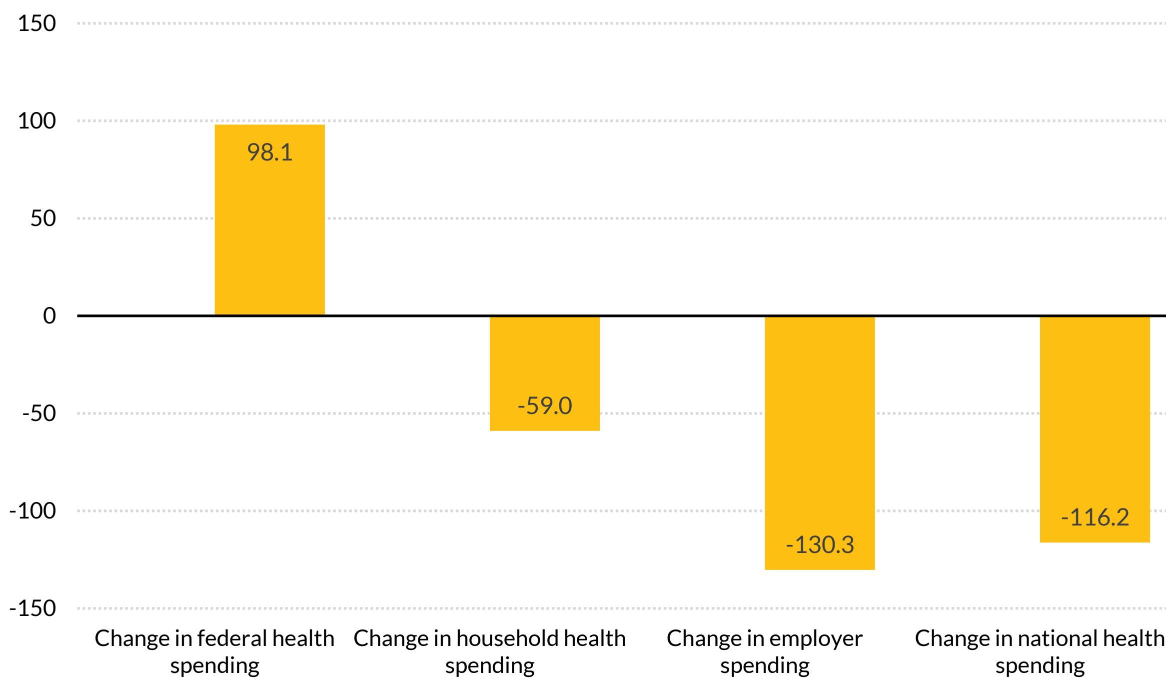
FIGURE 7

Coverage and Changes in Spending under Reform 7, Automatic Enrollment of All Lawfully Present Residents, and Prior Reforms, Compared with Current Law, 2025

Millions of people



Billions of dollars



URBAN INSTITUTE

Source: Urban Institute Health Policy Simulation Model, 2024.

Notes: Because of the decline in employer spending on health care, wages and income tax revenues would increase, and the change in the federal deficit, $54.8 billion, would be smaller than the change in federal spending.

Reform 8. Coverage of Undocumented Residents to Reach Universal Coverage

POLICY

Combined, the first seven reforms leave 6.6 million people uninsured. Reform 8 adds to the previous reforms by extending PTC eligibility to undocumented residents and automatically or contingently enrolling all US residents (box 3).

COVERAGE

This reform results in all US residents, regardless of immigration status, having explicit or contingent coverage. All 6.6 million undocumented residents are now covered, with 3.5 million having contingent coverage and protected from bills if they were to become ill (figure 8). There are 276.9 million nonelderly people insured with comprehensive coverage, an increase of 23.3 million over current law.

SPENDING

Federal spending increases by an additional $19.5 billion over the $98.1 billion increase in the previous reform, to $117.6 billion above current law. This is primarily because of the increase in PTCs received by newly eligible undocumented residents.

Household spending is $52.1 billion less than under current law, less than in the previous reform, because of premium payments for the newly covered.

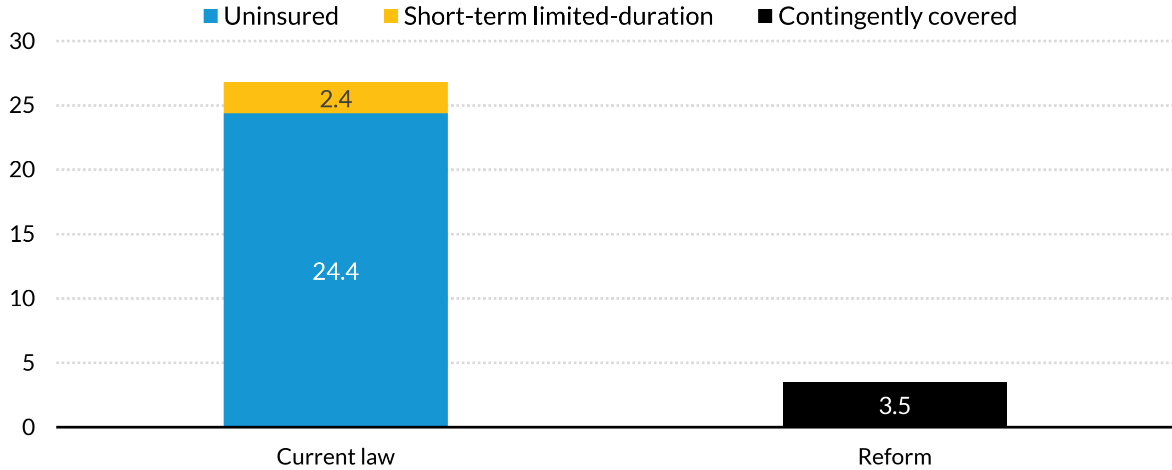
Employer spending is $133.2 billion lower than under current law and little changed from the previous reform.

National health spending is $93.6 billion smaller than under current law, despite coverage of all US residents.

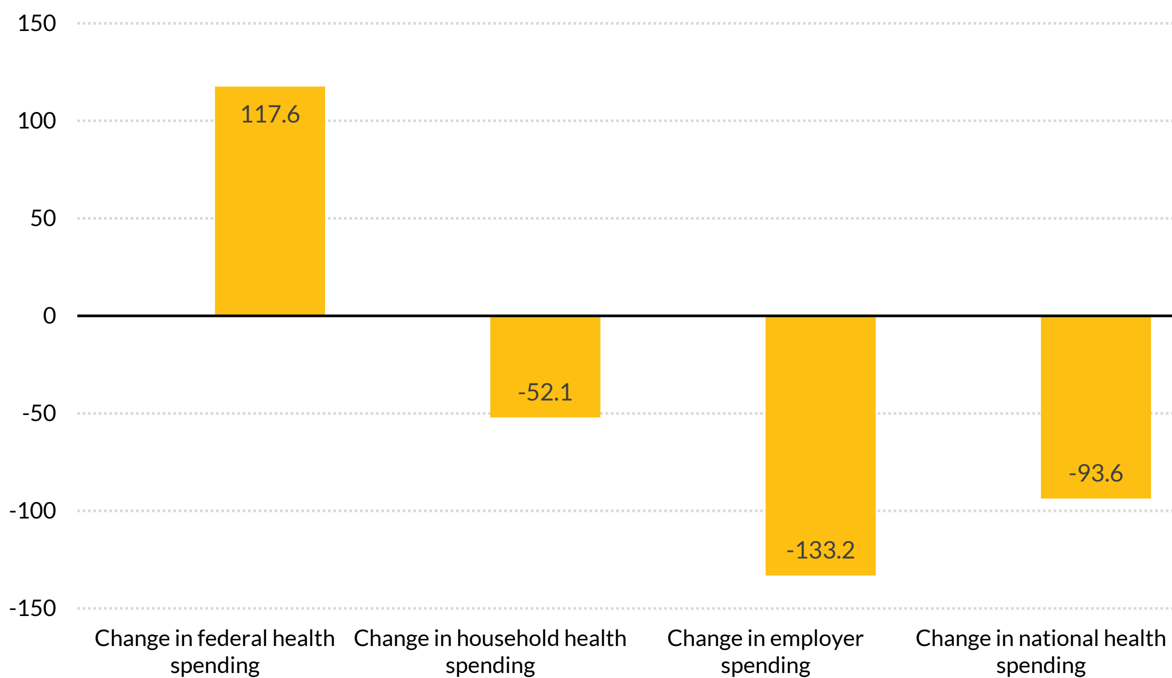
FIGURE 8

Coverage and Changes in Spending under Reform 8, Coverage of Undocumented Residents to Reach Universal Coverage, and Prior Reforms, Compared with Current Law, 2025

Millions of people



Billions of dollars



URBAN INSTITUTE

Source: Urban Institute Health Policy Simulation Model, 2024.

Notes: Because of the decline in employer spending on health care, wages and income tax revenues would increase, and the change in the federal deficit, $74.3 billion, would be smaller than the change in federal spending.

BOX 3

Covering Undocumented People

People without a federal immigration status—referred to as “undocumented” in this report, as opposed to “lawfully present” for those with federal status—are generally not eligible for Medicaid or the Children’s Health Insurance Program and cannot buy coverage through the ACA Marketplaces. Unless they have coverage through an employer (or an employed family member), they are often uninsured. Around 11 million undocumented people live in the US, and about half of them will be uninsured, compared with less than 9 percent of nonelderly people in general.[a]

Reform 8 would require a change in federal law to extend eligibility for Marketplace participation, including receipt of PTCs and CRSs, to undocumented immigrants. Although this would be politically controversial, no feasible path to universal health insurance exists without it. And there is precedent at the state level, as some states already have programs extending care to undocumented people. In 2024, 13 states funded Medicaid-like coverage for at least some undocumented children; adults, with restrictions on age, income, and participation, are covered in a small number of other states. In reform 8, we assume that eligibility for the Marketplaces has been extended to undocumented immigrants nationwide, and that the eligibility extends below 100 percent of FPL, as it currently does for lawfully present immigrants who are ineligible for Medicaid because of immigration status and for US citizens in nonexpansion states beginning in reform 4 (filling the Medicaid gap). We assume that the take-up of Marketplace coverage among undocumented people would be robust, as it is among the lawfully present and as it has been for state programs extending coverage to the undocumented.[b]

Notes: [a] Jeffrey S. Passel and Jens Manuel Krogstad, “What We Know About Unauthorized Immigrants Living in the US,” *Pew Research Center*, July 22, 2024, https://www.pewresearch.org/short-reads/2024/07/22/what-we-know-about-unauthorized-immigrants-living-in-the-us/; and “Key Facts on Health Coverage of Immigrants,” KFF, January 15, 2025, https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/.
b Passel and Krogstad, “What We Know About Unauthorized Immigrants Living in the US.”

Summary

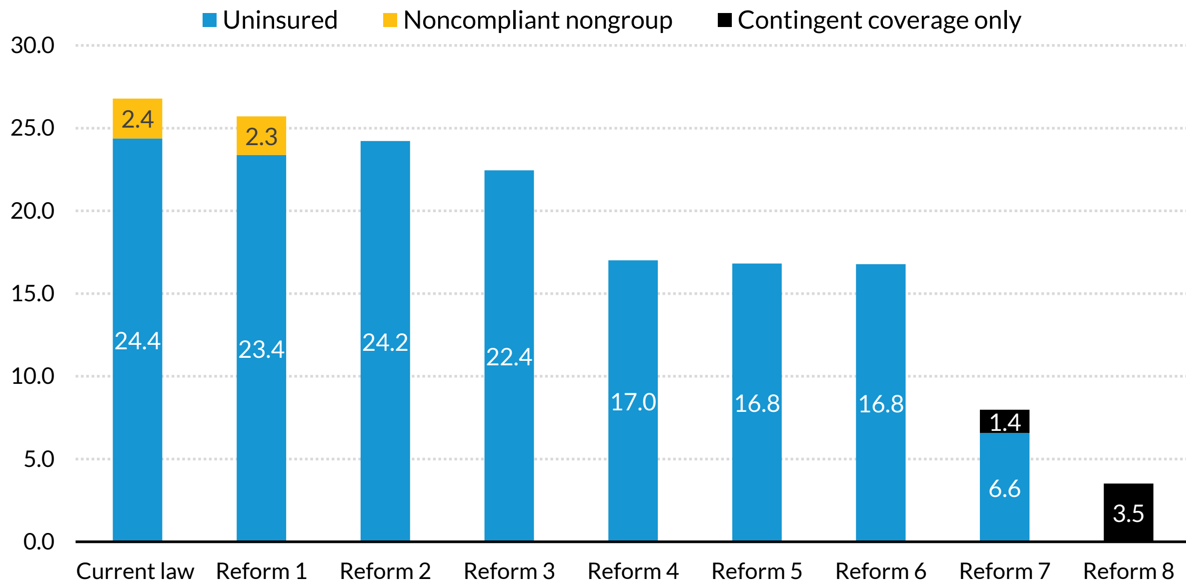
Figures 9 and 10 summarize the impacts of the eight reforms. Figure 9 shows that the number of uninsured falls by 17 percent, from 26.8 million to 22.4 million, in the first three reforms. These reforms largely increase eligibility for, and affordability of, ACA Marketplace insurance. Reform 4 introduces limited autoenrollment of people eligible for zero-premium coverage; it affects mainly low-income people and reduces the number of uninsured to 17.0 million. Reforms 5 and 6 cap provider payments in private coverage and have small effects on the number of uninsured. Reform 7 eliminates the remaining firewall and adds autoenrollment for the lawfully present population; the number of uninsured falls to

6.6 million, all undocumented. Reform 8 extends Marketplace eligibility and automatic enrollment to undocumented immigrants; uninsurance is eliminated.

FIGURE 9

Uninsurance under Current Law and Reform, 2025

Millions of people



Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.
Notes: People with contingent coverage would only be protected if they were to incur major medical costs, but use care as if uninsured, and have spending as if uninsured.

Figure 10 shows the changes in household, federal, employer, and national health spending. Household health spending is lower with each of the first four reforms, each of which adds provisions affecting lower-income people. Such spending then shrinks more when provider payment rates are capped in private insurance markets, first by an additional 1 percent in when capped rates are applied to the nongroup and small-group ESI markets, then by 7 percent more when rates are applied to the large-group ESI market, which has the largest share of enrollees under 65 years old. The total amount spent by households increases (so savings from the current baseline shrink) in the final two reforms, which largely reflects increased spending by the newly insured, who can now access health care more easily, as opposed to higher spending by already insured people.

Federal government health spending for the nonelderly grows with each of the first four reforms, each of which increases the generosity of or eligibility for federally funded care for low-income people. The increase in federal spending falls when provider payments are capped in the nongroup and small-

group markets because PTCs are smaller for people with nongroup coverage, and more people choose now less expensive small-group ESI and do not receive PTCs. Federal spending increases again in the final two reforms as more people receive subsidies with increased eligibility for Marketplace coverage and autoenrollment. With all reforms in place, federal spending would be $118 billion greater than under current law in 2025.

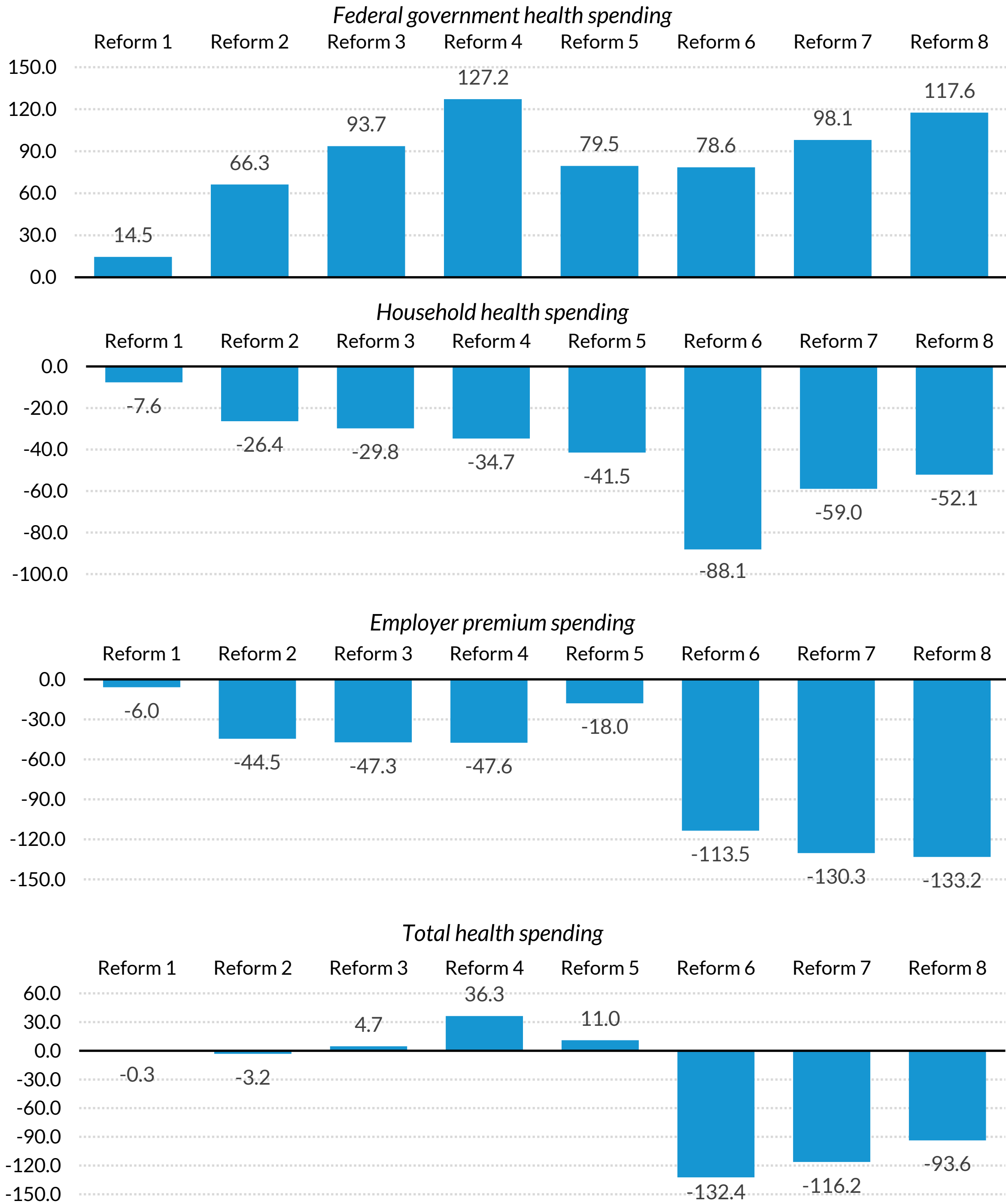
Employer spending for health premiums under the first four reforms would decrease with decreasing ESI coverage. With the firewall lifted in reform 2, roughly 5 percent of people would leave ESI for subsidized nongroup coverage. Employer spending on premiums would also fall by roughly 5 percent; this change would persist through reforms 3 and 4 as well. Under capped rates in reform 5, total employer premiums would be smaller than under current law, despite many people choosing to keep small-group ESI, because small employers would benefit from lower payments to providers. Under reform 6, when provider rate caps are extended to the large-group ESI market, employer spending on premiums falls by 13 percent compared with current law, as lower payments are reflected in smaller premiums. This lower spending would be expected to be returned to workers as higher wages, which would increase federal tax revenues and offset some of the additional federal spending under reform. This revenue offset would total over $38 billion under reform 6. Reforms 7 and 8 further decrease employer spending as more people become eligible for and choose subsidized nongroup coverage.

National health spending is largely unaffected by the first three reforms. Introducing limited autoenrollment in reform 4 increases total national spending by $32 billion, but covers an additional 5.4 million people. Introducing capped rates in the nongroup and small group markets reduces the increase in national health spending to $10.5 billion. The largest drop comes under reform 6, which extends caps rates to the entire private insurance market; the substantial premium savings reduce national health spending to $132 billion below current law. With autoenrollment for the full population, national spending is reduced by $116 billion. Even adding undocumented immigrants still results in a reduction in national health spending by $94 billion.

FIGURE 10

Changes in Health Spending for the Nonelderly under Reform, 2025

Billions of dollars



Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Discussion

We have outlined eight steps that would get the US to universal coverage and contain costs without moving to a single-payer or Medicare for All system. These reforms would build on the current private insurance system and public programs, including the ACA's Marketplaces and Medicaid. With the reforms we develop, everyone would have coverage, there would be less disruption of current institutions, and the need for new taxes would be considerably less than in a single-payer system, such as Medicare for All.

These reforms, modeled in 2025, are built on a baseline that includes the enhanced PTCs in place through that year. If the enhanced PTCs are not extended and the required contribution percentages of income revert to their original levels, we project that baseline federal spending on health care for the nonelderly will decrease by over $45 billion, but at the cost of 4 million more people uninsured. The baseline also omits the effects of the March 2025 proposed rules for the Marketplaces and the effects of the OBBBA, both of which lower spending at the expense of coverage. The restoration of enhanced PTCs, reversal of the Marketplace rule changes, and reversal of OBBBA policies would then be another necessary reform, serving as a base for these reforms, if universal coverage is to be achieved.

The analysis shows that some controversial measures would have to be taken to reach universal coverage. One would be autoenrollment of individuals who would otherwise not sign up for coverage. Some may welcome the coverage, but some, especially those needing to pay premiums, may strongly oppose being enrolled. Household premiums from automatically enrolled people total almost $23 billion (an average of $2750 per person paying), representing money people have chosen to use elsewhere and would now be compelled to spend on insurance they may not value. While an opt-out provision may be necessary, that would leave the nation short of universal coverage.

The second is the enrollment of the undocumented immigrant population. Providing federal assistance to this population is likely to face political opposition, with concern that it could incentivize further immigration. However, it would be a necessary step to fully achieve universal coverage and provide financial relief to providers who currently care for these populations. The magnet effect would create a waiting period of some length.

We have also shown that the cost of expanding coverage, when coupled with modest rate setting, is not great. And new spending by the federal government is more than offset by savings to employers and households. With all reforms, federal spending will increase by $118 billion in the base year and $1.5 trillion over 10 years (table 2). Because of the new revenues resulting from taxation of higher wages

when employer spending on premiums falls, the effect on the deficit would be less than the increase in federal spending, $895 billion over 10 years.

TABLE 2

Cumulative Effects on Federal Health Spending and Federal Deficit under Reforms, 2025–34

Billions of dollars

	Change	
Reform	**Federal spending**	**Federal deficit**
1. Enhanced Cost-Sharing Subsidies	181	154
2. Other Low-Income Reforms	809	612
3. Filling the Medicaid Gap	1,149	951
4. Autoenrollment of Low-Income People	1,572	1,373
5. Capped Rates in the Nongroup and Small-Group Insurance Markets	984	922
6. Capped Rates in All Private Insurance Markets	972	466
7. Automatic Enrollment of All Lawfully Present Residents	1,223	652
8. Coverage of Undocumented Residents to Reach Universal Coverage	1,465	895

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

We have also shown that national health spending would be a bit lower under the assumptions we have laid out. The results presented assume immediate full implementation. Serious reforms of this nature would have to be phased in. The 10-year cost would be somewhat over or understated because not everything could occur immediately. Some provisions, such as those in reforms 1–3, could be implemented relatively quickly. Provisions that rely on autoenrollment could take longer because of the need to develop the data system infrastructure to support the policies. Caps on provider payment rates could take several years to phase in to ease the burdens on providers; during this period, spending would be higher because rates would not have fallen to the levels that would be seen in equilibrium. The increased coverage and improved cost sharing would increase demand for services, but it could take a while for supply to expand to meet the needs. During this phase in period, spending would be lower.

We assume provider payment rates would be Medicare plus 15 percent for physicians and other professionals and Medicare plus 60 percent for hospitals. These are typically lower than current commercial rates, which average 124 percent of Medicare rates for professional services (Medicare plus 24 percent) and 246 percent of Medicare for hospitals (Medicare plus 146 percent), so there could be significant provider opposition.[9] But these rates are higher than current payment rates in Medicaid

and Medicare, which account for about half of US health spending. Most providers accept the rates that those programs pay. What would happen if those payment rates were extended to the entire population is unknown. If payment rates are set higher, there would be less provider opposition, but it would increase the costs of these reforms. If rates were closer to Medicare, on the other hand, it would result in more savings, but could cause significant harm in some places and generate even more intense provider opposition.

Households would save considerably because of the added coverage or reduced cost sharing. We estimate household savings for the entire population to be about 9 percent compared with current law. Employer spending would also fall, and we assume that the reductions in employer spending on health care are eventually passed back to workers through higher wages. This would add to household well-being. But on the other hand, this analysis does not account for the higher taxes necessary to pay for the higher federal spending. If these new federal costs were financed somewhat progressively, the outcome would be that low- and middle-income households would receive more benefits than they would pay in new taxes; the reverse would be true for those at the highest income levels.

Appendix Tables

TABLE A.1

Schedules for Original ACA, Current Law (ARPA/IRA), and Reform Proposal

Income (percent of FPL)	Original subsidy schedule	Current law (ARPA/IRA) subsidy schedule	Reform subsidy schedule
Premium Tax Credit Percentage of Income Limits for Benchmark Coverage			
<138	2.07	0.0	0.0
138–150	3.10-4.14	0.0	0.0
150–200	4.14-6.52	0.0-2.0	0.0-2.0
200–250	6.52-8.33	2.0-4.0	2.0-4.0
250–300	8.33-9.83	4.0-6.0	4.0-6.0
300–400	9.83	6.0-8.5	6.0-8.5
400–500	n/a	8.5	8.5
500–600	n/a	8.5	8.5
600+	n/a	8.5	8.5
Benchmark plan	Silver	Silver	Silver
Cost-Sharing Reductions: AV of Plan Provided to Eligible Enrollees (%)			
<138	94	94	95
138–150	94	94	95
150–200	87	87	95
200–250	73	73	90
250–300	70	70	90
300–400	70	70	85
400–500	70	70	80
500–600	70	70	80
600+	70	70	80

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: ARPA = American Rescue Plan Act (ARPA); IRS = Inflation Reduction Act; AV = Actuarial Value; FPL = federal poverty level; n/a = not applicable because no subsidies are available at this income level.

TABLE A.2

Coverage and Spending for the Nonelderly Population under Reform 1: Enhanced and Federally Funded CSRs

	Current law (ARPA/IRA Subsidies)	Reform 1	Change
Coverage in 2025 (thousands of people)			
Insured (MEC)	**253,614**	**254,693**	**1,078**
Employer	147,152	145,993	-1,158
Private nongroup	24,930	27,103	2,173
Subsidized	*18,875*	*20,084*	*1,209*
Unsubsidized	*6,055*	*7,019*	*964*
Medicaid/CHIP	72,799	72,862	63
Other public	8,734	8,734	0
Uninsured (No MEC)	**26,790**	**25,712**	**-1,078**
Uninsured	24,380	23,383	-997
Noncompliant nongroup	2,410	2,329	-81
Total	**280,405**	**280,405**	**0**
Spending in 2025 (billions of dollars)			
Household	658.3	650.6	-7.6
Federal government	593.5	608.1	14.5
Medicaid	*436.1*	*436.4*	*0.3*
Marketplace	*129.2*	*144.1*	*14.8*
Uncompensated care [a]	*28.2*	*27.6*	*-0.6*
State government	259.7	259.4	-0.3
Employers premium contributions	898.1	892.1	-6.0
Providers uncompensated care	23.0	22.0	-1.0
Total, all payers	**2,432.6**	**2,432.2**	**-0.3**
Change in federal deficit	n/a	n/a	12.5

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: CSR = cost-sharing reduction; MEC = minimum essential coverage; CHIP = Children's Health Insurance Program; ARPA = American Rescue Plan Act (ARPA); IRS = Inflation Reduction Act; n/a = not applicable. HIPSM computes only changes for revenues and deficits.

* = less than +/- $50 million.

[a] Uncompensated care represents the demand for care for the uninsured. At the federal level, about half the change in demand resulting from a decrease in uninsurance would automatically be realized as federal savings to Medicare disproportionate share hospitals.

TABLE A.3

Coverage and Spending for the Nonelderly Population under Reform 2: Enhanced and Federally Funded CSRs, Federal Reinsurance, Elimination of STLDs, and Removal of the Employer Firewall for People with Incomes below 300 Percent of FPL

	Current law (ARPA/IRA Subsidies)	Reform 2	Change
	Coverage in 2025 (thousands of people)		
Insured (MEC)	**253,614**	**256,180**	**2,565**
Employer	147,152	140,059	-7,092
Private nongroup	24,930	34,165	9,235
Subsidized	18,875	28,325	9,450
Unsubsidized	6,055	5,840	-215
Medicaid/CHIP	72,799	73,222	423
Other public	8,734	8,734	0
Uninsured (No MEC)	**26,790**	**24,225**	**-2,565**
Uninsured	24,380	24,225	-156
Noncompliant nongroup	2,410	0	-2,410
Total	**280,405**	**280,405**	**0**
	Spending in 2025 (billions of dollars)		
Household	658.3	631.9	-26.4
Federal government	593.5	659.8	66.3
Medicaid	436.1	438.8	2.8
Marketplace	129.2	192.5	63.3
Uncompensated care[a]	28.2	28.4	0.2
State government	259.7	260.8	1.1
Employers premium contributions	898.1	853.6	-44.5
Providers uncompensated care	23.0	23.4	0.3
Total, all payers	**2,432.6**	**2,429.4**	**-3.2**
Change in federal deficit	n/a	n/a	51.4

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: MEC = minimum essential coverage; CHIP = Children's Health Insurance Program; CSR = cost-sharing reductions; STLD = short-term limited duration nongroup insurance; FPL = federal poverty level; ARPA = American Rescue Plan Act (ARPA); IRS = Inflation Reduction Act; n/a = not applicable. HIPSM computes only changes for revenues and deficits.

* = less than +/- $50 million.

[a] Uncompensated care represents the demand for care for the uninsured. At the federal level, about half the change in demand resulting from a decrease in uninsurance would automatically be realized as federal savings to Medicare disproportionate share hospitals.

TABLE A.4

Coverage and Spending for the Nonelderly Population under Reform 3: Enhanced and Federally Funded CSRs, Federal Reinsurance, Elimination of STLDs, Removal of the Employer Firewall for People with Incomes below 300 Percent of FPL, and Filled Medicare Gap

	Current law (ARPA/IRA Subsidies)	Reform 3	Change
	Coverage in 2025 (thousands of people)		
Insured (MEC)	**253,614**	**257,955**	**4,341**
Employer	147,152	139,667	-7,484
Private nongroup	24,930	36,126	11,196
Subsidized	18,875	30,592	11,717
Unsubsidized	6,055	5,534	-521
Medicaid/CHIP	72,799	73,428	629
Other public	8,734	8,734	0
Uninsured (No MEC)	**26,790**	**22,449**	**-4,341**
Total	**280,405**	**280,405**	**0**
	Spending in 2025 (billions of dollars)		
Household	658.3	628.4	-29.8
Federal government	593.5	687.2	93.7
Medicaid	436.1	451.7	15.6
Marketplace	129.2	207.8	78.5
Uncompensated care[a]	28.2	27.7	-0.5
State government	259.7	248.7	-11.0
Employers premium contributions	898.1	850.8	-47.3
Providers uncompensated care	23.0	22.2	-0.9
Total, all payers	**2,432.6**	**2,437.2**	**4.7**
Change in federal deficit	n/a	n/a	78.6

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: MEC = minimum essential coverage; CHIP = Children's Health Insurance Program; CSR = cost-sharing reductions; STLD = short-term limited duration nongroup insurance; FPL = federal poverty level; ARPA = American Rescue Plan Act (ARPA); IRS = Inflation Reduction Act; n/a = not applicable. HIPSM computes only changes for revenues and deficits.

* = less than +/- $50 million.

[a] Uncompensated care represents the demand for care for the uninsured. At the federal level, about half the change in demand resulting from a decrease in uninsurance would automatically be realized as federal savings to Medicare disproportionate share hospitals.

TABLE A.5

Coverage and Spending for the Nonelderly Population under Reform 4: Enhanced and Federally Funded CSRs, Federal Reinsurance, Elimination of STLDs, Removal of the Employer Firewall for People with Incomes below 300 Percent of FPL, Filled Medicare Gap, and Automatic Enrollment of People Eligible for Zero Premium Coverage Who Get Other Benefits

	Current law (ARPA/IRA Subsidies)	Reform 4	Change
Coverage in 2025 (thousands of people)			
Insured (MEC)	**253,614**	**263,390**	**9,776**
Employer	147,152	139,615	-7,536
Private nongroup	24,930	36,806	11,876
Subsidized	18,875	31,266	12,391
Unsubsidized	6,055	5,540	-514
Medicaid/CHIP	72,799	78,234	5,435
Other public	8,734	8,734	0
Uninsured (No MEC)	**26,790**	**17,015**	**-9,776**
Total	**280,405**	**280,405**	**0**
Spending in 2025 (billions of dollars)			
Household	658.3	623.6	-34.7
Federal government	593.5	720.7	127.2
Medicaid	436.1	484.6	48.6
Marketplace	129.2	211.7	82.4
Uncompensated care[a]	28.2	24.5	-3.8
State government	259.7	257.6	-2.0
Employers premium contributions	898.1	850.5	-47.6
Providers uncompensated care	23.0	16.4	-6.6
Total, all payers	**2,432.6**	**2,468.9**	**36.3**
Change in federal deficit	n/a	n/a	112.1

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: MEC = minimum essential coverage; CHIP = Children's Health Insurance Program; CSR = cost-sharing reductions; STLD = short-term limited duration nongroup insurance; FPL = federal poverty level; ARPA = American Rescue Plan Act (ARPA); IRS = Inflation Reduction Act; n/a = not applicable. HIPSM computes only changes for revenues and deficits.

* = less than +/- $50 million.

[a] Uncompensated care represents the demand for care for the uninsured. At the federal level, about half the change in demand resulting from a decrease in uninsurance would automatically be realized as federal savings to Medicare disproportionate share hospitals.

TABLE A.6

Coverage and Spending for the Nonelderly Population under Reform 5: Enhanced and Federally Funded CSRs, Federal Reinsurance, Elimination of STLDs, Removal of the Employer Firewall for People with Income below 300 Percent of FPL, Filled Medicare Gap, Automatic Enrollment of People Eligible for Zero Premium Coverage Who Get Other Benefits, and Capped Rates in Nongroup and Small-Group ESI

	Current law (ARPA/IRA Subsidies)	Reform 5	Change
	Coverage in 2025 (thousands of people)		
Insured (MEC)	**253,614**	**263,583**	**9,968**
Employer	147,152	146,680	-472
Private nongroup	24,930	29,949	5,019
Subsidized	18,875	25,028	6,153
Unsubsidized	6,055	4,921	-1,133
Medicaid/CHIP	72,799	78,220	5,421
Other public	8,734	8,734	0
Uninsured (No MEC)	**26,790**	**16,822**	**-9,968**
Total	**280,405**	**280,405**	**0**
	Spending in 2025 (billions of dollars)		
Household	658.3	616.8	-41.5
Federal government	593.5	673.0	79.5
Medicaid	436.1	484.5	48.5
Marketplace	129.2	164.2	35.0
Uncompensated care[a]	28.2	24.3	-3.9
State government	259.7	257.5	-2.2
Employers premium contributions	898.1	880.1	-18.0
Providers uncompensated care	23.0	16.1	-6.9
Total, all payers	**2,432.6**	**2,443.6**	**11.0**
Change in federal deficit	n/a	n/a	74.9

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: MEC = minimum essential coverage; CHIP = Children's Health Insurance Program; CSR = cost-sharing reductions; STLD = short-term limited duration nongroup insurance; FPL = federal poverty level; ESI = employer-sponsored insurance; ARPA = American Rescue Plan Act (ARPA); IRS = Inflation Reduction Act; n/a = not applicable. HIPSM computes only changes for revenues and deficits.

* = less than +/- $50 million.

[a] Uncompensated care represents the demand for care for the uninsured. At the federal level, about half the change in demand resulting from a decrease in uninsurance would automatically be realized as federal savings to Medicare disproportionate share hospitals.

TABLE A.7

Coverage and Spending for the Nonelderly Population under Reform 6: Enhanced and Federally Funded CSRs, Federal Reinsurance, Elimination of STLDs, Removal of the Employer Firewall for People with Income below 300 Percent of FPL, Filled Medicare Gap, Automatic Enrollment of People Eligible for Zero Premium Coverage Who Get Other Benefits, and Capped Rates in Nongroup and All ESI Markets

	Current law (ARPA/IRA Subsidies)	Reform 6	Change
Coverage in 2025 (thousands of people)			
Insured (MEC)	**253,614**	**263,629**	**10,014**
Employer	147,152	146,914	-237
Private nongroup	24,930	29,886	4,956
Subsidized	18,875	24,981	6,106
Unsubsidized	6,055	4,905	-1,149
Medicaid/CHIP	72,799	78,094	5,295
Other public	8,734	8,734	0
Uninsured (No MEC)	**26,790**	**16,776**	**-10,014**
Total	**280,405**	**280,405**	**0**
Spending in 2025 (billions of dollars)			
Household	658.3	570.2	-88.1
Federal government	593.5	672.1	78.6
Medicaid	436.1	484.0	47.9
Marketplace	129.2	163.9	34.6
Uncompensated care[a]	28.2	24.3	-4.0
State government	259.7	257.3	-2.4
Employers premium contributions	898.1	784.5	-113.5
Providers uncompensated care	23.0	16.1	-6.9
Total, all payers	**2,432.6**	**2,300.2**	**-132.4**
Change in federal deficit	n/a	n/a	40.2

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: MEC = minimum essential coverage; CHIP = Children's Health Insurance Program; CSR = cost-sharing reductions; STLD = short-term limited duration nongroup insurance; FPL = federal poverty level; ESI = employer-sponsored insurance; ARPA = American Rescue Plan Act (ARPA); IRS = Inflation Reduction Act; n/a = not applicable. HIPSM computes only changes for revenues and deficits.

* = less than +/- $50 million.

[a] Uncompensated care represents the demand for care for the uninsured. At the federal level, about half the change in demand resulting from a decrease in uninsurance would automatically be realized as federal savings to Medicare disproportionate share hospitals.

TABLE A.8

Coverage and Spending for the Nonelderly Population under Reform 7: Enhanced and Federally Funded CSRs, Federal Reinsurance, Elimination of STLDs, Removal of the Employer Firewall for People with Income below 300 Percent of FPL, Filled Medicare Gap, Automatic Enrollment of People Eligible for Zero Premium Coverage Who Get Other Benefits, Capped Rates in Nongroup and All ESI Markets, and Automatic Enrollment of All Legally Present People (firewall eliminated)

	Current law (ARPA/IRA Subsidies)	Reform 7	Change
	Coverage in 2025 (thousands of people)		
Insured (MEC)	**253,614**	**272,425**	**18,810**
Employer	147,152	143,590	-3,561
Private nongroup	24,930	41,789	16,859
Subsidized	18,875	31,258	12,383
Unsubsidized	6,055	10,531	4,477
Medicaid/CHIP	72,799	78,311	5,512
Other public	8,734	8,734	0
Contingently Covered	**0**	**1,400**	**1,400**
Uninsured (No MEC)	**26,790**	**6,580**	**-20,210**
Total	**280,405**	**280,405**	**0**
	Spending in 2025 (billions of dollars)		
Household	658.3	599.3	-59.0
Federal government	593.5	691.6	98.1
Medicaid	436.1	486.1	50.0
Marketplace	129.2	188.0	58.7
Uncompensated care[a]	28.2	17.5	-10.7
State government	259.7	253.3	-6.4
Employers premium contributions	898.1	767.8	-130.3
Providers uncompensated care	23.0	4.4	-18.7
Total, all payers	**2,432.6**	**2,316.4**	**-116.2**
Change in federal deficit	n/a	n/a	54.8

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: MEC = minimum essential coverage; CHIP = Children's Health Insurance Program; CSR = cost-sharing reductions; STLD = short-term limited duration nongroup insurance; FPL = federal poverty level; ESI = employer-sponsored insurance; ARPA = American Rescue Plan Act (ARPA); IRS = Inflation Reduction Act; n/a = not applicable. HIPSM computes only changes for revenues and deficits.

* = less than +/- $50 million.

[a] Uncompensated care represents the demand for care for the uninsured. At the federal level, about half the change in demand resulting from a decrease

TABLE A.9

Coverage and Spending for the Nonelderly Population under Reform 8: Enhanced and Federally Funded CSRs, Federal Reinsurance, Elimination of STLDs, Removal of the Employer Firewall for People with Income below 300 Percent of FPL, Filled Medicare Gap, Automatic Enrollment of People Eligible for Zero Premium Coverage Who Get Other Benefits, Capped Rates in Nongroup and All ESI Markets, Automatic Enrollment of All Legally Present People (firewall eliminated), and Marketplace Eligibility for Undocumented with Automatic Enrollment

	Current law (ARPA/IRA Subsidies)	Reform 8	Change
	Coverage in 2025 (thousands of people)		
Insured (MEC)	**253,614**	**276,889**	**23,275**
Employer	147,152	143,216	-3,935
Private nongroup	24,930	46,295	21,366
Subsidized	18,875	35,630	16,755
Unsubsidized	6,055	10,665	4,610
Medicaid/CHIP	72,799	78,643	5,844
Other public	8,734	8,734	0
Contingently Covered	**0**	**3,515**	**3,515**
Uninsured (No MEC)	**26,790**	**0**	**-26,790**
Total	**280,405**	**280,405**	**0**
	Spending in 2025 (billions of dollars)		
Household	658.3	606.2	-52.1
Federal government	593.5	711.1	117.6
Medicaid	436.1	487.3	51.2
Marketplace	129.2	207.1	77.9
Uncompensated care[a]	28.2	16.7	-11.5
State government	259.7	254.0	-5.7
Employers premium contributions	898.1	764.9	-133.2
Providers uncompensated care	23.0	2.8	-20.2
Total, all payers	**2,432.6**	**2,338.9**	**-93.6**
Change in federal deficit	n/a	n/a	74.3

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: MEC = minimum essential coverage; CHIP = Children's Health Insurance Program; CSR = cost-sharing reductions; STLD = short-term limited duration nongroup insurance; FPL = federal poverty level; ESI = employer-sponsored insurance; ARPA = American Rescue Plan Act (ARPA); IRS = Inflation Reduction Act; n/a = not applicable. HIPSM computes only changes for revenues and deficits.

* = less than +/- $50 million.

[a] Uncompensated care represents the demand for care for the uninsured. At the federal level, about half the change in demand resulting from a decrease

Notes

[1] "45 CFR Parts 147, 155, and 156," CMS, accessed June 16, 2025.

For more details of the provisions, see Katie Keith and Jason Levitis, "HHS Proposes to Restrict Marketplace Eligibility, Enrollment, and Affordability in First Major Rule under Trump Administration (Part 1)," *Health Affairs Forefront* (blog), March 12, 2025, https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-and-affordability-first-major; and Jason Levitis and Katie Keith, "HHS Proposes to Restrict Marketplace Eligibility, Enrollment, and Affordability in First Major Rule under Trump Administration (Part 2)," *Health Affairs Forefront* (blog), March 13, 2025, https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-affordability-part-two.

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[2] US Congress, House, *One Big Beautiful Bill Act*, H.R. 1, 119th Congress, passed in House May 22, 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text.

[3] "Hawley Introduces Legislation to Prevent Future Medicaid Cuts, Invest in Rural Hospitals," Josh Hawley U.S. Senator for Missouri, July 15, 2025, https://www.hawley.senate.gov/hawley-introduces-legislation-to-prevent-future-medicaid-cuts-invest-in-rural-hospitals/; and Ben Leonard, Democrats Take Aim at GOP's Medicaid Work Requirements," *Politico*, May 14, 2025.

[4] "Smucker Leads Bipartisan Legislation Expanding Primary Care Access," Congressman Lloyd Smucker, February 5, 2025, https://smucker.house.gov/media/press-releases/smucker-leads-bipartisan-legislation-expanding-primary-care-access.

[5] Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act, 2025. Congressional Budget Office, https://www.cbo.gov/publication/61463; Estimated Budgetary Effects of H.R. 1, the One Big Beautiful Bill Act. 2025, Congressional Budget Office, https://www.cbo.gov/publication/61461.

[6] *American Rescue Plan Act of 2021*, Public Law 117-2; and *Inflation Reduction Act of 2022*, Public Law 169, *U.S. Statute at Large* 136 Stat. 1818.

[7] US Congress, Senate, *Improving Health Insurance Affordability Act of 2021*, S 499, 117th Cong., 1st sess., introduced in Senate March 1, 2021, https://www.congress.gov/bill/117th-congress/senate-bill/499.

[8] Comprehensive insurance provides at least minimum essential coverage as defined by the ACA.

[9] For additional information on estimated ratios of commercial to Medicare payment rates, see Blavin and Holahan (2025).

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