The Healthy America Program, An Update and Additional Options

Linda J. Blumberg, John Holahan, Matthew Buettgens, and Stephen Zuckerman

Timely Analysis of Immediate Health Policy Issues   **SEPTEMBER 2019**

Introduction

In May 2018, we released a paper describing a comprehensive health insurance reform program called Healthy America.[1] Healthy America (HA) is a hybrid reform approach that uses purchasing leverage to reduce health care prices while improving federal subsidies to provide reduced premium and cost-sharing options for many Americans. The combined reforms could bring the United States close to universal coverage while decreasing national health spending over time and are designed to limit health system disruption. This report updates our previous analysis of the coverage and health spending implications of HA and analyzes two additional options.

HA would build on the Affordable Care Act's (ACA's) foundation while making substantial changes to correct for its shortcomings under current law as identified by research and analysis over the last decade of experience:

- The premium tax credits and cost-sharing subsidies offered through the ACA's marketplaces would be enhanced, lowering household premium contributions and reducing out-of-pocket costs when people access medical care.

- The federal government would develop a new public insurance option to be offered through the marketplaces nationwide, offering a lower-cost insurance option to consumers in less competitive

insurer and provider markets. In addition, private insurers in the marketplaces would no longer have to pay the much higher rates charged by health care providers in noncompetitive (often rural) areas, which can drive high premiums. Plus, additional prescription drug rebates would lower drug prices.

- The marketplaces and their improved financial assistance would be made available to more consumers, including workers who prefer subsidized marketplace coverage over their employer-provided insurance plans and nonelderly low-income people currently eligible for Medicaid. Folding people currently eligible for Medicaid (while preserving their current benefits) and some (mostly low-income) workers into the insurance pools would improve systemwide fairness while making the marketplaces larger and thus more attractive to private insurers. As the number of competing insurers increases, premiums tend to decrease.

- State health care spending would be reduced by shifting financial responsibility to the federal government for expenses related to elderly low-income people dually enrolled in Medicaid and Medicare. While the Medicaid/CHIP acute care programs for the nonelderly would be eliminated, states would contribute to HA based initially on their current law spending for those programs.

However, state contributions would grow more slowly than current Medicaid/CHIP program costs, increasing state savings over time.

- Competition in the HA marketplaces would be structured more like that in the Medicare program (i.e., public insurance option and competing private insurers) than that in the ACA's marketplaces. The premium subsidies would be tied to the premium for the public option, as is done in Medicare Advantage, not to the second-lowest silver premium, as is done in the ACA's marketplaces. Consequently, more private insurers will likely participate in the marketplaces, increasing consumer plan choice and lowering premiums over time.

Our original approach, delineated in our 2018 paper, included a redesigned individual responsibility requirement that contained both penalties for remaining uninsured and incentives to obtain and retain coverage. This approach also included limited autoenrollment of people eligible for insurance with $0 premiums. In addition to that base approach, we add two new alternatives, one that would result in somewhat larger numbers of uninsured and one that would result in significantly fewer compared to the base approach. The first alternative eliminates the individual responsibility component, removing any penalties for people remaining uninsured, but maintains autoenrollment for those

eligible for coverage with $0 premiums. The second alternative introduces a policy we call Continuous Autoenrollment with Retroactive Enforcement (CARE), which achieves universal coverage for American citizens and other legal U.S. residents.

Under any of the three approaches, folding the acute care portion of Medicaid for the nonelderly into these reformed markets would eliminate several inequities in the current system, including

- the Medicaid eligibility gap created by 17 states' refusal to expand eligibility under the ACA;

- differences in Medicaid eligibility rules, particularly those related to recent state actions to introduce work requirements and premiums for enrollees below the poverty level, as well as state proposals to introduce time limits and lifetime benefit limits;

- lower Medicaid provider payments that can impede access to care for the lowest-income population; and

- Medicaid enrollees' inability to keep their health insurance plan (and often their health care providers) as their income increases and they are no longer eligible for Medicaid.

Plus, by removing the current-law employer-sponsored insurance "firewall," HA would provide modest-income workers affordable insurance options that currently do not exist for them. This portion of the reform would eliminate

- the "family glitch" that prohibits family members from accessing federal subsidies if even one family member has an employer offer of *single* coverage considered affordable,[2,3] and

- the inability of low-income workers with employer insurance coverage offers to access federal subsidies in the marketplaces even though workers with the same incomes but no employer insurance offers can get them.

We describe HA in detail below, along with our estimates of the program's effects on insurance coverage, health

care spending, and the wages of those moving out of employer-based insurance and into HA coverage. If the program were fully phased in in 2020, we find that the original HA approach (including an individual requirement designed to expand insurance coverage) would

- increase insurance coverage by 17.1 million people, reducing the uninsurance rate to 5.5 percent among the nonelderly population and to 3.2 percent among all U.S. citizens and legally present immigrants;

- increase federal spending by $123.3 billion in 2020 ($1.3 trillion over 10 years), on net, accounting for increased federal subsidies, reduced spending on Medicaid and Medicare prescription drugs, and offsets for increased income tax revenue and state financing contributions;

- decrease state spending by $34.2 billion in 2020, and these savings would increase over time because state financial contributions to the new program would grow more slowly than current trends;

- increase aggregate household spending by $6.2 billion, or 1.1 percent, relative to current law— because more people would enroll in coverage and make some contribution to premiums—but simultaneously decrease household out-of-pocket costs; and

- reduce employer spending on health care by $110.9 billion, or 12.0 percent, relative to current law; this cost reduction would eventually translate into increased employer spending on taxable wages, increasing income tax revenue by $16.3 billion and offsetting some costs associated with the new program.

Eliminating the individual requirement from the original approach would cause the following:

- Decrease HA's health insurance coverage gains by 1.1 million people. The effect of eliminating the penalties is relatively small because of higher coverage levels resulting from more generous financial assistance and

the limited autoenrollment program for those eligible for $0 premiums.

- Increase federal costs relative to the original HA approach by $1.7 billion (an increase of $125.0 billion relative to current law, accounting for income tax offsets in 2020 and $1.3 trillion over 10 years). Most of the coverage decrease from eliminating the individual requirement would be attributable to healthier, higher-income enrollees who would otherwise pay the full insurance premium. Consequently, these "full-pay" enrollees currently effectively subsidize lower-income enrollees, decreasing federal funding necessary to cover lower-income enrollees' care. When not enrolled, that effective subsidy is eliminated, and federal costs increase.

- Decrease state savings modestly compared with the original approach, because the number of uninsured people would be larger and thus demand for state-funded uncompensated care higher.

Adding the CARE provisions to the original approach would

- eliminate uninsurance among the legally present population, decreasing the national number of uninsured people to 6.6 million. All of these remaining uninsured would be immigrants without legal documentation to reside in the United States (approximately 4.4 million immigrants without documentation already have private insurance coverage);

- insure 8.5 million more people than the original HA approach, increasing federal costs by $9.4 billion in 2020 (an increase of $132.7 billion over current law in 2020 and $1.4 trillion over 10 years);

- decrease state spending even further (an additional $5.0 billion in savings in 2020 compared with the original HA approach), with significantly fewer uninsured requiring uncompensated care.

Description of Policy Options: The Building Blocks of Healthy America

This analysis provides three variations of the HA program, starting with the original approach, as detailed in our prior paper, then proceeds to two variations:

1. *HA with an individual requirement:* The original HA concept includes an individual requirement that would incentivize households to obtain and maintain insurance coverage. In addition, we introduced limited autoenrollment of some of the low-income uninsured population, all of whom are eligible for $0 premium coverage through the program.

2. *HA with limited autoenrollment for low-income enrollees only*: This approach includes all components of the first, except it excludes an individual requirement to obtain insurance and any penalties for remaining uninsured.

3. *HA with CARE:* This approach eliminates the individual requirement in the original design but adds what we call Continuous Autoenrollment with Retroactive Enforcement, or CARE. CARE would reach universal coverage for the legally present population, deeming those not actively enrolling in insurance coverage insured through the HA public option. CARE would create a financial obligation for middle- and higher-income people to contribute to their insurance coverage on an income-related basis.

First, we describe the HA components that apply to all three variations. Then we further describe the approaches that vary across the three.

Components Included in All Three Healthy America Program Variations

A New Health Insurance Market

Perhaps the most important feature of the HA proposal is the establishment of the new market. It would serve the nonelderly population now enrolled in Medicaid, those now enrolled in the ACA's marketplace and nonmarketplace nongroup health plans, those currently uninsured, and those choosing HA over an employer plan. All HA insurance plans would cover comprehensive benefits and have uniform cost-sharing requirements (deductible, out-of-pocket maximum, etc.) consistent with the ACA's qualified health plans and essential health benefits. HA would offer a government-administered, public, fee-for-service health insurance option, paying at or close to rates in the most competitive nongroup insurance markets today. The public option would operate alongside competing private insurance plans. All plans offered in the program would comply with ACA actuarial value tier requirements.

The current Veterans Affairs health program, TRICARE, the Federal Employees Health Benefits Program, and the Indian Health Service would all remain in place. HA insurance plans would be available to any U.S. resident below age 65,[4] though financial assistance to lower premiums and cost-sharing requirements would only be available to legally present enrollees.[5] New administrative structures would be developed to facilitate enrollment.

To avoid disrupting a popular program, the Medicare program would remain unchanged for all people ages 65 and older and for nonelderly people with disabilities. The current traditional Medicare structure of Parts A, B, and D with different cost-sharing requirements and no out-of-pocket limits could, in principle, be altered to match the HA benefit structure. We do not propose that here because of the complexity of doing so, the additional government costs necessarily associated with such a change, and our intent to limit disruption for populations expressing high levels of satisfaction with their current coverage.[6] Nonelderly people with disabilities could choose to remain enrolled in Medicare or enroll in HA. Those with disabilities choosing HA would be eligible for the same coverage and financial assistance as other HA enrollees with the same income living in the same area.

Premiums and Premium Contributions

Full premiums (before subsidies) in the HA program would be computed based on the actuarial costs of the enrollee population in each state (i.e., like the ACA, premiums assume a statewide risk pool), adjusted for the federally funded reinsurance program which would spread the costs of high-cost cases broadly across the full tax-paying population. However, the excess health

---

Compared with the ACA, HA premium subsidies would require lower household contributions as a percent of income and would be tied to higher actuarial value coverage (i.e., lower cost-sharing plans).

---

costs associated with people with disabilities (those otherwise eligible for Medicaid or choosing HA over Medicare) would be excluded from the premium computations. Premiums would be set based on modified community rating rules (age variation of 3 to 1), and the ACA's medical loss ratio limits for the nongroup market would apply. Substate variation in premiums based on differences in input costs of providing care (but not differences in health care risk) would be permitted, consistent with the ACA's approach. Immigrants without authorized status could enroll in HA plans but would be ineligible for financial assistance.

HA enrollees' premium contributions are structured similarly to those of the ACA, but HA provides more generous subsidies and expands eligibility for those subsidies to higher-income people. The federal subsidies for income-related premiums in HA are structured as premium tax credits tied to the benchmark premium for the 80 percent actuarial value public plan option in each enrollee's area of residence and appropriate for their age (described further below). Premium subsidies decline as income increases. Compared with the ACA, HA premium

subsidies would require lower household contributions as a percent of income and would be tied to higher actuarial value coverage (i.e., lower cost-sharing plans).

- Those with incomes below the tax-filing threshold, and others with incomes below 138 percent of the federal poverty level (FPL), would pay no premiums, assuming they enroll in a plan with premiums no higher than the benchmark plan.

- Those with incomes between 138 and 150 percent of FPL would pay premiums between 0 and 2 percent of their income for the benchmark plan.

- Those with incomes between 150 and 200 percent of FPL would pay premiums ranging from 2 to 4 percent of income for the benchmark plan.

- Those with incomes between 200 and 250 percent of FPL would pay premiums ranging from 4 to 6 percent of income for the benchmark plan.

- Those with incomes between 250 and 300 percent of FPL would pay premiums ranging from 6 to 7 percent of income for the benchmark plan.

- Those with incomes between 300

Systems would be developed to facilitate electronic monthly premium payments for those without employer withholding. The federal government would pay insurers (1) the income-based premiums it collects regularly from households and (2) the federal share of premiums for enrollees receiving subsidies for private HA plans. The federal government may have to pay private insurers upfront to prevent cash flow problems if insurers must pay claims before premiums are collected. The federal government would be reimbursed by enrollees for additional payments at tax time. Household premium payments made throughout the year and the federal premium subsidies paid to HA plans would be reconciled by the income tax process.

Benefits and Cost-Sharing Levels

All HA plans would cover the ACA's essential benefits. Low-income children, pregnant women, and enrollees with disabilities would receive supplemental benefits to ensure those eligible for Medicaid under current law do not receive reduced benefits. However, compared with current law, households would face significantly lower cost-sharing requirements when enrolling in

- People with incomes below 100 percent of FPL could enroll in 100 percent actuarial value plans.

- People with incomes between 100 and 150 percent of FPL could enroll in 94 percent actuarial value plans.

- People with incomes between 150 and 200 percent of FPL could enroll in 90 percent actuarial value plans.

- People with incomes between 200 and 300 percent of FPL could enroll in 85 percent actuarial value plans.

People can still choose to enroll in 60 percent AV actuarial value (bronze), 70 percent AV actuarial value (silver), or 90 percent AV actuarial value (platinum) plans as they do today under the ACA, but the additional cost-sharing assistance would only be available to eligible people enrolling in 80 percent AV actuarial value (gold) tier coverage. Online systems and trained navigators would strongly encourage people eligible for cost-sharing assistance to take it up, clearly demonstrating the financial advantage of doing so. Choosing an insurance option with a higher premium than the benchmark (explained below) would mean additional costs for enrollees. Similarly, savings from a lower- premium option would accrue to the enrollee up to the point until their premium contribution is $0.

Low-income people would be eligible for even higher-value, lower cost-sharing plans than the 80 percent standard under the reform.

and 400 percent of FPL would pay premiums ranging from 7 to 8.5 percent of income for the benchmark plan.

- Those with higher incomes would pay premiums of no more than 8.5 percent of income for the benchmark plan. Those for whom the full premium is less than 8.5 percent of income would pay the full premium.

Employed HA enrollees would have their monthly premium contributions withheld by their employers, who would forward the payments to the HA program to be distributed to the appropriate insurer. Others would be required to pay estimated premiums in the same way that many pay estimated taxes.

standard marketplace coverage. The standard benefit package under HA would have an actuarial value of 80 percent (e.g., single coverage deductible of $1,100, out-of-pocket maximum of $4,000, copays for outpatient physician visits, 20 percent coinsurance for hospital care). This coverage level is equivalent to the ACA's gold-tier plans and roughly comparable with the average employer-sponsored plan.[7] Under current law, the standard marketplace coverage is the silver tier, with 70 percent actuarial value. Consequently, HA would substantially lower consumers' health care financial exposure. Low-income people would be eligible for even higher-value, lower cost-sharing plans than the 80 percent standard under the reform:

Benchmark Premiums

Benchmark premiums determine the level of federal financial assistance available to eligible enrollees. HA benchmark premiums would be set differently than those of the ACA's nongroup insurance marketplaces where premium tax credits are tied to the premium of the second-lowest-cost silver (70 percent actuarial value) plan available to the enrollee. The ACA's premium tax credits cover the portion of that benchmark premium that exceeds a specified percentage of the enrollee's income; that percentage-of-income cap increases as income increases. Anyone choosing a plan with a higher premium than the second-lowest-cost option must pay the full premium difference. Given that the ACA enrollee population tends to be quite price

sensitive, this structure has resulted in intense insurer price competition in many markets. As a consequence, benchmark premiums have been lower than expected in many areas (particularly those with considerable population density), but simultaneously, many insurers unable to price plans among the least expensive options have exited the marketplaces. Particularly in markets with smaller potential enrollee populations, it is difficult for any but the lowest-premium insurers to achieve significant market share. Consequently, there are often few competitors in these areas, and it is becoming unusual for the higher-cost plans with broader provider networks to remain in these markets.

In HA, premium benchmarks would be set at the actuarially determined cost of the public fee-for-service plan (including administrative costs). The public plan provider payment rates would be based on a set of rates approximating the most competitive private nongroup insurance markets today, with adjustments for area input costs, teaching status, uncompensated care, and other factors providers cannot alter in the short run. These rates would generally be higher than Medicaid rates and payments made by or on behalf of the uninsured but would generally be lower than many private commercial insurers' rates. Therefore, on balance, payment rates would be higher for the average HA enrollee than they would be under current law, but a framework would control for rate increases over time.

Above average costs associated with enrollees with disabilities would not be included in the calculation of the HA benchmark premiums. In many areas, this approach has been shown to engender higher levels of private plan participation in the Medicare program than in the ACA marketplaces, particularly for national insurers with broader provider networks.[8,9] It also guarantees all enrollees have financial access to the public option at levels considered affordable under the approach.

As shown below, we estimate that more than 100 million people would be covered through the HA program. Together with the program's size, setting the benchmark at the fee-for-service public option premium level would make HA attractive to many insurers. Importantly, we also follow Medicare Advantage's lead in limiting HA provider payment rates by participating private insurers (both in and out of network) to the levels used by the public option, increasing the feasibility of private insurers being able to compete with a public option.[10] People enrolling in a plan with a premium higher than the benchmark would pay the difference in premiums directly to their insurer. People who enroll in a less expensive plan could keep the difference until their premium contribution is $0. Setting the benchmark premiums equal to those of a fee-for-service plan using competitive-level provider payment rates and capping rates for competing private insurers is one of the major differences between HA and the ACA.

Reinsurance and Risk Adjustment

HA would make reinsurance for high-cost cases permanent. Given the more generous premium tax credits under HA than under current law, the cost of the reinsurance program would be completely offset by lower premium tax credit costs. However, we still feel it is important to retain the reinsurance program as a mechanism for increasing insurer confidence in market stability, promoting greater private insurer competition, which can lower premiums over time. In the first year of the HA program, $10 billion would be devoted to the reinsurance program. This amount would grow as the public option's premiums grow.

The program would also employ risk adjustment to spread health care risk across private insurers offering coverage in the new market. Like the current traditional Medicare plan, the HA public plan would not be a part of the risk-adjustment process. Because all enrollees' premiums would be capped as a percent of their income, general revenues would effectively pay for the cost of any adverse selection into the HA public option. If there is considerable adverse selection into the public option, even after adjustments for the permanent reinsurance program, the highest-income enrollees, for whom the unsubsidized premium fell substantially below 8.5 percent of income, would likely opt for one of the competing private insurance options. Adverse selection into the public plan would increase the program's benchmark premiums, but other components of the program (such as premiums capped at fixed percentages of income; limited autoenrollment of low-income, otherwise uninsured people; and reinsurance) would tend to attract healthier-than-average enrollees. Risk

---

This approach would federalize the acute care part of Medicaid for the nonelderly and fold it in to the HA program.

---

adjustment for the private plans offered in HA would be budget neutral. If the private options are selected against, some method of protecting private insurers could be developed, but we believe this to be unlikely. Reinsurance would be funded with general revenues.

Federalizing the Acute Care Part of Medicaid

This approach would federalize the acute care part of Medicaid for the nonelderly and fold it into the HA program. The federalized program would provide supplemental benefits (transportation; early and periodic screening, diagnostic, and treatment services; access to essential community providers) to low-income children, pregnant women, and enrollees with disabilities. This ensures that people eligible for Medicaid under current law have the same benefits under the new program. Federalizing this program, currently funded jointly by the federal government and states but administered by the states, would provide comprehensive, fully subsidized coverage to low-income people in all states, including the 17 that have not expanded Medicaid eligibility under the

ACA, thus eliminating a major inequity in the current system. States would be required to continue contributing what they already spend for Medicaid and the Children's Health Insurance Program for these populations to help finance the new program. Increases in state funding for HA would be indexed to a five-year rolling average of gross domestic product. This indexing approach means future state spending would be lower than currently projected state expenditures on Medicaid and the Children's Health Insurance Program. The federal government would also take

through their workplace. Those who maintain their employer-sponsored insurance would not pay premiums for HA. We recognize that large employers consider health insurance benefits an important part of the compensation package they use to recruit and retain workers. We also recognize that many workers are satisfied with their coverage and appreciate how employers and unions often tailor those benefits to their preferences. Finally, moving over 100 million people with employer insurance into a new system would be highly disruptive and likely unpopular.

Employers could not offer coverage that encourages higher-income workers to maintain employer coverage but low-income workers to leave for HA, nor could they create benefit designs whereby less-healthy workers would choose to enroll in HA while healthier workers would remain in the employer insurance plan. Though we can anticipate some erosion of employer-sponsored insurance, the current tax exclusion for employer-sponsored insurance would provide a strong incentive for most employers to continue to offer coverage to their workers and for most workers to continue enrolling in coverage through their workplace. We assume the new health reimbursement arrangement regulations that would allow employers to make pretax contributions to nongroup insurance on behalf of their workers would be reversed. Thus, because most workers receive a tax benefit for enrolling in their employer plan that is typically greater than the subsidies available in HA, most firms will continue to find it advantageous to provide coverage. However, to avoid subsidizing any worker twice, any worker simultaneously enrolling in employer and HA plans would have the premiums paid by his or her employer to the firm's plan treated as taxable income.[11]

Though we can anticipate some erosion of employer-sponsored insurance, the current tax exclusion for employer-sponsored insurance would provide a strong incentive for most employers to continue to offer coverage to their workers and for most workers to continue enrolling in coverage through their workplace.

over state responsibilities for matching payments for Medicare premiums, cost sharing, and extra benefits for low-income Medicare enrollees.

In addition to covering low-income individuals in nonexpansion states, adults and children would benefit from no longer changing insurance plans or experiencing gaps in coverage when family incomes change. There would be more uniformity in the way lower-income people are treated compared with their higher-income counterparts, including improved equity in provider payment rates and access to providers, and proposals implemented in some states that would create barriers to enrollment (e.g., work requirements) would be eliminated. States would continue providing vital Medicaid long-term services and supports, and they would continue receiving current federal matching payments for doing so.

Employer-Sponsored Insurance

With HA in place, most employers would continue providing insurance coverage. The tax exclusion for employer-sponsored insurance would remain, providing a financial incentive for most workers to continue obtaining coverage

Maintaining employer-based coverage also reduces the size of the program and the new revenue needed to finance it.

The firewall prohibiting employees from taking advantage of ACA marketplace financial assistance would, however, be eliminated under HA. Such firewalls create inequities between otherwise identical workers with differential access to employer insurance; without access to income-related financial assistance to purchase insurance, low-income workers with employer insurance offers may ultimately fare worse than their counterparts without offers (e.g., they may face higher premium contributions and/or cost-sharing requirements for insurance coverage without higher wages to offset these costs). Consequently, HA would allow all workers and/or their legally present family members, regardless of their access to an employer insurance offer, to enroll in an HA plan and obtain the income-related financial assistance for which they are eligible. No penalties would be imposed on workers or employers when workers (and/or their dependents) make such a choice.

Employers would be required to comply with strong antidiscrimination rules.

Noncompliant Plans

Short-term, limited-duration and other private insurance plans not complying with HA standards would be prohibited. This would include any insurance arrangements designed to have more limited benefits and attract healthier people, as these plans would not contribute to the broader pooling of health care risk.

Drug Pricing

The HA program would handle drug prices in two ways. When Medicare began providing drug coverage in 2006, it took over paying for drugs for those dually eligible for Medicare and Medicaid. Before 2006, these dual eligibles benefitted from large Medicaid rebates. HA would extend these full Medicaid rebates (about 50 percent off list prices) to all low-income Medicare

beneficiaries. The Congressional Budget Office has estimated that extending Medicaid rebates to low-income Medicare beneficiaries would reduce Medicare spending by about $15 billion in the first full year of implementation and $154 billion over a 10-year period (2019–28).[12]

We would also limit payments for drugs for any HA-participating insurer (including the new public option) by requiring rebates halfway between current Medicare and Medicaid rebates; this effectively increases prices for the current Medicaid population but decreases them for all others. Private insurance plans offering coverage in the nongroup markets (both in and outside marketplaces) or providing coverage to employer groups receive much smaller rebates today. This policy would reduce HA private insurers' payments for prescription drugs by about 30 percent,[13] as well as households' out-of-pocket costs for prescription drugs.

Enrollment Variations across the Three Healthy America Approaches

Across the three HA options, we include different levels of autoenrollment and individual requirements to obtain coverage. Autoenrollment poses very significant challenges. Most prominently, no existing records list uninsured people, and autoenrolling people in insurance plans requires particular plans in which

to enroll them. In addition, collecting premiums from those autoenrolled will not be straightforward, both programmatically and politically. As a result, we present three separate options:

1. A replacement of the ACA's now-eliminated financial penalty for not obtaining coverage, redesigned to encourage future coverage, with limited autoenrollment of more easily identifiable people eligible for HA coverage with a $0 premium

2. Limited autoenrollment without the new financial penalty

3. Eliminate the new financial penalty and instead deem all those not actively choosing insurance coverage enrolled in the HA public option and collect appropriate income-related premiums through the tax system retroactively, if necessary

As several states have shown,[14] Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) receipt can be used to facilitate auto- or reenrollment in Medicaid coverage. Because all SNAP and TANF recipients with incomes below the poverty level would be eligible for $0 premiums under HA, HA would build upon state experiences using these programs to identify and enroll those eligible people not indicating other coverage into the program. We assume that recent administrative actions designed to reduce SNAP rolls would be reversed prior to implementation of this reform. Autoenrollees would be notified of their autoenrollment and given an opportunity to opt out (if, for example, they had enrolled in employer-based coverage or simply wished to remain uninsured) or choose an HA private plan option. Though the government's ability to contact autoenrollees is imperfect, those not responding to requests for action would be autoenrolled in the HA public

option and subsequently sent coverage information.[15] In addition, any individual remaining uninsured but sufficiently low income to be eligible for $0 premium coverage would be enrolled in the HA public option when they seek care, even if they do so outside the open enrollment period. Consequently, we deem this population to be effectively insured under each HA option.

This population deemed insured would be enrolled in the public option to ensure

they would not incur premium costs, for example, from being enrolled in a plan with a premium exceeding the benchmark. In addition, enrolling this population in the public fee-for-service option avoids the complexity associated with risk selection into any private managed-care plan for a population primarily enrolling in coverage when seeking medical care. During the next annual open enrollment period, those autoenrolled using their SNAP/TANF data or when seeking medical care would be contacted and offered direct assistance to actively enroll in the HA program plan of their choice, and absent any action, they would be reenrolled in the public option for the next year.[16]

The first HA option, called the "individual requirement" below, closely reflects HA as originally conceived,[1] and it includes limited low-income autoenrollment plus a financial penalty for people remaining uninsured during the prior calendar year. Structured differently than the ACA's individual responsibility requirement, the penalty for remaining uninsured under this option would be the loss of half of the taxpayer's income tax standard deduction. Nontaxpayers would owe no penalty, just as they would owe no premium if they had enrolled in the benchmark plan. Those paying the penalty but demonstrating they obtained and retained insurance coverage for the following 12 months would be refunded half of their lost deduction.

The second HA option, called "limited autoenrollment only" below, would autoenroll low-income SNAP and TANF recipients but excludes a financial penalty for remaining uninsured.

The third approach, HA with CARE, could effectively eliminate uninsurance among the population legally residing in the US. A broad public relations campaign using various strategies would be used to notify the population that if they do not actively enroll in health insurance coverage through an employer or HA, they will be deemed covered through the public option. In this way, any eligible person seeking coverage from a health care provider during the year who had not yet actively enrolled in insurance

> *In this way, any eligible person seeking coverage from a health care provider during the year who had not yet actively enrolled in insurance coverage would be considered enrolled in the public option.*

coverage would be considered enrolled in the public option. These late-identified enrollees would be strongly encouraged to pay premiums regularly via federally established enrollment offices and an online system. However, if they fail to pay income-related premiums during the year, the premiums they owe *for the full plan year* (less any months otherwise insured) would be added to their tax bill. Anyone not obtaining health care during the year and not actively enrolling in a plan would also be assessed the appropriate income-related premium via the tax system.

For many taxpayers, this would mean reduced tax refunds, but for others, this would mean an increase in their end-of-year tax payments. The individual requirement approach assesses a financial tax penalty but does not use the funds to enroll the person in coverage; the CARE approach does not apply any noncompliance penalties but instead provides insurance coverage and collects the premium the person could otherwise have paid during the year. Those deemed insured through the HA public option would be insured for any care they would need but would still be subject to premium payments at the end of the year.

The CARE approach includes an inherent trade-off similar to that associated with single-payer proposals: achieving universal coverage requires implementation of a system that collects funds (premiums or other designated tax revenue) and enrolls people in insurance coverage who would not enroll and contribute to the system voluntarily.

Methodology

We estimate the coverage and health care spending implications of the HA approaches using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). HIPSM, a detailed microsimulation model of the U.S. health insurance system designed to estimate the cost and coverage effects of policy options, has been used extensively to model implications of health reforms at the national and state levels. Analyses using HIPSM have been widely cited,

including in the Supreme Court's majority opinion in *King v. Burwell*.[17]

HIPSM uses responses from two years of the American Community Survey. The population is aged to future years using projections from the Urban Institute's Mapping America's Futures program.[18] 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 the Centers for Medicare & Medicaid Services monthly enrollment snapshots. As of this publication, no 2019 data were available on off-marketplace nongroup or non–ACA compliant nongroup coverage. Therefore, we simulate baseline enrollment in these coverage types using available 2018 and 2019 information on those and other coverage sources.

The simulations account for relevant state regulations, such as banning short-term, limited-duration plans.[19] Our current-law estimates account for the federal individual mandate penalties being set to $0 beginning in plan year 2019, as well as California, the District of Columbia, Massachusetts, and New Jersey having established individual mandate penalties. We treat states in which the ACA Medicaid expansion has been approved by ballot initiative but not yet implemented as nonexpansion states (Idaho, Nebraska, and Utah).

As described above, the HA program is envisioned to include a public insurance

option and private insurance options. We assume the public option would reimburse providers at rates similar to those in the most competitive nongroup insurance markets today, and HA private insurers' provider payment rates (both in and out of network) would be capped at the same rates. 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).

We assume the public option would reimburse providers at rates similar to those in the most competitive nongroup insurance markets today, and HA private insurers' provider payment rates (both in and out of network) would be capped at the same rates.

As has been shown in other work,[20] 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 desirable rates in the HA markets.

Our estimates of current state spending on Medicare premiums and cost-sharing assistance for the low-income elderly population are inflated to 2020 based on data from the 2014 Medicaid Statistical Information System. Uncompensated care spending by the federal government, state governments, and providers is based on Coughlin and colleagues' findings.[21] Those estimates are adjusted under reform options as a function of changes in the number of uninsured people and the expected health care costs of those remaining uninsured.

Consistent with empirical economic research,[22] we assume decreases in employer contributions to workers' health insurance would, in equilibrium, be passed back to all workers in the firm via

higher wages. These additional wages are taxable, whereas health insurance contributions are not, and therefore this shift in compensation type increases income tax revenues. The shift would also increase payroll tax revenues, but we do not count those here as offsets to the federal costs associated with HA. We assume employers' decreased spending on inactive workers are not passed onto workers via higher wages; they simply constitute savings to employers.

We estimate the prescription drug savings from requiring manufacturers to pay rebates to insurers on behalf of HA program enrollees using forthcoming work by Kesselheim and Hwang.[23] We identify those receiving SNAP and TANF by reported receipt on the American Community Survey data underlying our model. Receipt of these programs is underreported, so we likely undercount those eligible for SNAP or TANF. [24]

Results

All results are simulated as if the HA policy options were fully implemented and phased in in 2020.

Effects on the Uninsured by Legal Resident Status

Table 1 shows the effect of the three HA options on the number of uninsured people and the share of the nonelderly population uninsured compared with current law. We break the estimates out for (1) U.S. citizens and other legally

present U.S. residents (the population eligible for financial assistance under HA) and (2) undocumented immigrants (the population eligible to purchase coverage at full cost but ineligible for financial assistance).

The original conception of HA, which includes limited autoenrollment and an individual requirement to obtain insurance or pay a penalty, would increase insurance coverage by 17.1 million people, reducing the number of uninsured people to 15.1 million, or 5.5 percent of the nonelderly population. Approximately 8.5 million U.S. citizens and other legally present residents would remain uninsured, or 3.2 percent of this population. Uninsurance among nonelderly undocumented immigrants is currently very high, with 6.6 million uninsured (or about 60 percent of that population), and would remain high without further assistance.

Eliminating the individual requirement but retaining limited low-income autoenrollment only (i.e., without any penalties for remaining uninsured) would decrease the number of uninsured people by 16.0 million compared with current law; 16.2 million people would remain uninsured under the reform, or 5.9 percent of the U.S. nonelderly population. Approximately 9.6 million U.S. citizens and other legally present residents would remain uninsured, or 3.6 percent of that nonelderly population. Compared with the option without the

individual requirement, the option with the individual requirement results in 1.1 million more insured people. The effect of eliminating the penalties is relatively small compared with earlier estimates of the effect of the ACA's individual mandate because of HA's more generous financial assistance and autoenrollment of low-income people eligible for $0 premiums. This low-income autoenrollment would be in place under all the HA options and would significantly reduce the number of people affected by imposing an individual requirement policy.

Adding the CARE option to HA would eliminate uninsurance among U.S. citizens and others legally residing in the United States. The 6.6 million remaining uninsured would all be undocumented immigrants, comprising 2.4 percent of the total nonelderly population.

Additional government funding for providers caring for large numbers of undocumented immigrants via uncompensated care provided by hospitals and community health centers would likely more effectively address the basic health care needs for this population than making them eligible for HA.[25] We have, however, included estimates for such programs here beyond acknowledging that some government funding for uncompensated care (both state and federal) would remain in the system, along with some in-kind care provision.

Table 1. Breakout of Number of Nonelderly Uninsured and Uninsured Rate by Documented Status under Current Law and Reform Options, 2020

Counts only include those completely uninsured, excluding those with short-term, limited-duration policies

	Current Law		Healthy America & Individual Requirement		Healthy America with Low-Income Autoenrollment Only		Healthy America & CARE	
	Millions of People	Uninsured Rate	Millions of People	Uninsured Rate	Millions of People	Uninsured Rate	Millions of people	Uninsured Rate
Total	32.2	11.7%	15.1	5.5%	16.2	5.9%	6.6	2.4%
US Citizens and Other Residents Legally Present	24.0	9.1%	8.5	3.2%	9.6	3.6%	—	0.0%
Undocumented Immigrants	6.6	59.7%	6.6	59.9%	6.6	59.9%	6.6	59.9%

Source: The Urban Institute, Health Insurance Policy Simulation Model, 2019.

Note: CARE = Continuous Autoenrollment with Retroactive Enforcement.

Effects on the Distribution of Health Insurance Coverage

Table 2 shows the three HA options' effects on the distribution of health insurance for the nonelderly. The table includes all U.S. residents below age 65. The HA approach with an individual requirement would decrease employer-sponsored insurance by 18.9 million people (12.8 percent), a consequence of more generous premium and cost-sharing assistance and elimination of the employer-sponsored insurance firewall. The decrease in employer-based coverage would be of similar size under all simulated HA policy options.

The size of the HA markets would be much larger than the current-law private nongroup insurance markets; we estimate more than 120 million enrollees under each policy design, compared with 15.5 million people in nongroup coverage under current law. Approximately 68.8

million people in the HA plans would be low income and enrolled in Medicaid under current law. As noted above, 18.5 to 18.9 million people (depending on the option) would move from employer-based coverage to HA. Coverage through short-term, limited-duration policies would be eliminated, leading to an additional shift of 2.4 million people into HA.

Uninsurance is the coverage dynamic varying most across the HA policy options. In the first approach with an individual requirement, uninsurance falls by 17.1 million people. That figure drops to 16.0 million people when the penalty for remaining uninsured is removed. The difference, 1.1 million more insured with the individual requirement, as noted in the previous section, is relatively small because of HA's more generous financial assistance than that in the ACA's nongroup market, as well as

its low-income autoenrollment, which stays constant across the options. The third option, HA plus CARE, decreases uninsurance the most, by 25.6 million people, because legally present residents not actively enrolling are deemed enrolled in the public option during the year, regardless of whether they seek medical care. Postsubsidy premiums for late enrollees and those not accessing medical care during the plan year would be collected via the income tax system. Under HA and CARE, the program would enroll 130.6 million people.

Comparison of Households' Direct Spending in Healthy America Versus ACA Marketplaces

Compared with current law, HA would reduce direct spending on premiums and out-of-pocket costs for two groups of people. First, many of those currently enrolled in ACA marketplaces would be eligible for new or additional financial

Table 2. Health Insurance Coverage Distribution of the Nonelderly Population (under Age 65) under Current Law and Healthy America, 2020

	Current Law		Healthy America & Individual Requirement			Healthy America with Low-Income Autoenrollment Only			Healthy America & CARE		
	1000s	Percent	1000s	Percent	Diff. from Current Law	1000s	Percent	Diff. from Current Law	1000s	Percent	Diff. from Current Law
With Minimum Essential Coverage (Excludes STLD Coverage)	**240,508**	**87.4%**	**260,080**	**94.5%**	**19,572**	**258,955**	**94.1%**	**18,446**	**268,535**	**97.6%**	**28,027**
Employer-Sponsored Insurance	**147,570**	**53.6%**	**128,674**	**46.8%**	**(18,896)**	**129,042**	**46.9%**	**(18,529)**	**128,674**	**46.8%**	**(18,896)**
Private Nongroup Insurance	**15,467**	**5.6%**	**122,775**	**44.6%**	**107,308**	**121,282**	**44.1%**	**105,815**	**131,229**	**47.7%**	**115,763**
Basic Health Program	790	0.3%	0	0.0%	(790)	0	0.0%	(790)	0	0.0%	(790)
Marketplace with PTC	8,328	3.0%	0	0.0%	(8,328)	0	0.0%	(8,328)	0	0.0%	(8,328)
Full-Pay Nongroup	6,348	2.3%	656	0.2%	(5,692)	655	0.2%	(5,693)	656	0.2%	(5,692)
Healthy America	0	0.0%	122,119	44.4%	122,119	120,626	43.8%	120,626	130,573	47.5%	130,573
Medicaid/CHIP Acute Care	**68,840**	**25.0%**	**0**	**0.0%**	**(68,840)**	**0**	**0.0%**	**(68,840)**	**0**	**0.0%**	**(68,840)**
Other Public	**8,632**	**3.1%**	**8,632**	**3.1%**	**0**	**8,632**	**3.1%**	**0**	**8,632**	**3.1%**	**0**
Without Minimum Essential Coverage	**34,625**	**12.6%**	**15,053**	**5.5%**	**(19,572)**	**16,179**	**5.9%**	**(18,446)**	**6,599**	**2.4%**	**(28,027)**
Uninsured	32,183	11.7%	15,053	5.5%	(17,130)	16,179	5.9%	(16,004)	6,599	2.4%	(25,584)
Short-Term, Limited-Duration Policies	2,442	0.9%	0	0.0%	(2,442)	0	0.0%	(2,442)	0	0.0%	(2,442)
Total	**275,134**	**100.0%**	**275,134**	**100.0%**	**0**	**275,134**	**100.0%**	**0**	**275,134**	**100.0%**	**0**

Source: The Urban Institute, Health Insurance Policy Simulation Model, 2019.

Notes: CARE = Continuous Autoenrollment with Retroactive Enforcement. STLD = short-term, limited-druation. PTC = premium tax credits. CHIP = Children's Health Insurance Program.

assistance. Second, people choosing to move from employer-sponsored insurance to HA would tend to do so because the change would reduce their health care costs.

Table 3 provides examples of how coverage affordability under HA could compare with affordability under the ACA's marketplaces for people of different ages, incomes, and family structure. The cost-sharing levels used in the table are examples based on median options offered in the ACA marketplaces, with minor modifications made using the Centers for Medicare & Medicaid Services actuarial value calculator for 2020 to hit target actuarial value levels in that year. Plans of any given actuarial value could take many forms, so these represent only examples of possible coverage structures at each level. Household premium savings would be largest for older single adults and families with incomes slightly higher than the ACA's subsidy cutoff of 400 percent of FPL. Premium savings would exceed $11,000 for singles age 64 and our example family of four (two adults age 35 and two children) with incomes of 450 percent of FPL. Savings would still be significant, but smaller, for younger adults, singles, and families at each income level. Premiums savings for lower-income singles would not vary with age because their premium contributions are capped under both the ACA and HA as a percent of income.

Table 3. Example Premium and Out-of-Pocket Cost Comparison, ACA Marketplaces and Healthy America, 2020

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

	138% of FPL			250% of FPL			350% of FPL			450% of FPL		
	ACA	Healthy America	Difference	ACA	Healthy America	Difference	ACA	Healthy America	Difference	ACA	Healthy America	Difference
	(94% AV)	(94% AV)		(73% AV)	(85% AV)		(70% AV)	(80% AV)		(70% AV)	(80% AV)	
Premiums												
Single Coverage												
Age of Enrollee:												
25	$536	$0	-$536	$2,610	$1,874	-$737	$4,310	$3,388	-$922	$5,375	$4,777	-$598
45	$536	$0	-$536	$2,610	$1,874	-$737	$4,310	$3,388	-$922	$7,731	$4,777	-$2,953
64	$536	$0	-$536	$2,610	$1,874	-$737	$4,310	$3,388	-$922	$16,061	$4,777	-$11,284
Family of 4 (2 Parents Age 35, 2 Children)	$1,105	$0	-$1,105	$5,382	$3,863	-$1,519	$8,886	$6,985	-$1,902	$21,276	$9,849	-$11,427
Out-of-Pocket Requirements												
Coinsurance on Inpatient Care	10%	10%	0%	20%	10%	-10%	25%	20%	-5%	25%	20%	-5%
Single Coverage												
Deductible	$200	$200	$0	$2,400	$1,150	-$1,250	$2,500	$1,100	-$1,400	$2,500	$1,100	-$1,400
Out-of-Pocket Maximum	$700	$700	$0	$5,000	$2,100	-$2,900	$6,000	$4,000	-$2,000	$6,000	$4,000	-$2,000
Family Coverage												
Deductible	$400	$400	$0	$4,800	$2,300	-$2,500	$5,000	$2,200	-$2,800	$5,000	$2,200	-$2,800
Out-of-Pocket Maximum	$1,400	$1,400	$0	$10,000	$4,200	-$5,800	$12,000	$8,000	-$4,000	$12,000	$8,000	-$4,000

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

Additional cost sharing details for each option:

- 94% AV Plan: $10 primary care physician visit copay; $30 specialist visit copay; $7 generic drug copay; $30 preferred brand drug copay; $100 nonpreferred drug copay; 10% coinsurance after deductible for specialty drugs.
- 85% AV Plan: $10 primary care physician visit copay; $30 specialist visit copay; $7 generic drug copay; $30 preferred brand; 10% coinsurance after deductible nonpreferred drugs; 10% coinsurance after deductible for specialty drugs.
- 80% AV Plan: $20 primary care physician visit copay; $40 specialist visit copay; $15 generic drug copay; $50 preferred brand; $150 nonpreferred drugs; 50% coinsurance after deductible for specialty drugs.
- 73% AV Plan: $10 primary care physician visit copay; $50 specialist visit copay; $7 generic drug copay; $30 preferred brand; $100 nonpreferred drugs; 20% coinsurance after deductible for specialty drugs.
- 70% AV Plan: $25 primary care physician visit copay; $55 specialist visit copay; $7 generic drug copay; $45 preferred brand; $150 nonpreferred drugs; 25% coinsurance after deductible for specialty drugs.

Source: Urban Institute analysis of CMS marketplace data and the CMS actuarial value calculator.

Table 4. Average Household Direct Spending on Premiums and OOP Health Costs per Covered Life Switching from ESI to Healthy America, 2020

	Current Law	Healthy America & Individual Requirement	Difference
Premiums	$1,971	$1,298	-$673
OOP Health Costs	$1,218	$744	-$473
Total	$3,189	$2,042	-$1,147

Source: The Urban Institute, Health Insurance Policy Simulation Model, 2019.

Notes: OOP = out-of-pocket. ESI = employer-sponsored insurance.

At these premium levels, households would also be eligible for coverage with lower cost-sharing requirements under HA than under current law. 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 coinsurance for inpatient care. By comparison, an example of an 80 percent actuarial value plan associated with the HA premium tax credits has a deductible $1,400 lower, an out-of-pocket maximum $2,000 lower, and lower coinsurance and outpatient care copayments. Lower-income people would also reap savings from additional cost-sharing subsidies under HA. For example, single adults with income of 250 percent of FPL in typical plans would have a $1,250 lower deductible, a $2,900 lower out-of-pocket maximum, a 10 percent inpatient coinsurance instead of 20 percent, and lower copayments for outpatient care.

Table 4 shows the average change in households' premium and out-of-pocket spending for those choosing to move from employer-based insurance to HA under the first option with the individual requirement (i.e., the original HA formation). Employer-based coverage does not differ appreciably under the three options. Households choosing to move from employer coverage to HA would, on average, save $673 per year in direct spending on premiums and an average of $473 per year in out-of-pocket spending when accessing care, for a total average savings of $1,147 per year on health care costs.

Effects on Health Care Spending for Acute Care for the Nonelderly

Table 5 compares health care spending by payer (employers, households, government, health care providers) under each HA option and current law. Spending in this table includes

- employer-paid premiums;[26]

- premiums and direct out-of-pocket payments made by households;

- federal government spending on premium and cost-sharing assistance for those buying coverage through the current-law nongroup market or HA (reform), reinsurance (current law and reform), Medicaid acute care for the nonelderly (current law), premiums and cost-sharing assistance for low-income Medicare enrollees (reform), and uncompensated care (current law and reform);

- state government spending on reinsurance programs (current law in 9 states as of 2020), Medicaid acute care for the nonelderly (current law), Medicaid maintenance-of-effort payments (reform), premiums and cost-sharing assistance for low-income Medicare enrollees (current law), and uncompensated care (current law and reform); and

- offsets to increased federal spending under reform, including state Medicaid maintenance-of-effort payments made to the federal government, increased income tax revenue because of lower enrollment in employer-sponsored insurance, and prescription drug savings from

requiring Medicaid-level rebates on behalf of Medicare-Medicaid dual eligibles.

Employer spending on health care. Under each HA approach, employer spending on health insurance would decrease by approximately 12 percent, or $109.2 to $110.9 billion. These decreases correspond to decreases in employer-sponsored insurance coverage of roughly 13 percent.

Household spending on health care. Household spending on premiums would increase modestly compared with current law, because more people would have affordable access to coverage and make some premium contribution to newly gained coverage. Simultaneously, out-of-pocket care costs would decrease compared with current law, reflecting the lower cost-sharing available to many enrollees with HA coverage. Under the original HA approach, household spending would increase by $6.2 billion, or 1.1 percent. In the alternative without the individual requirement, household spending would increase by $3.4 billion, or 0.6 percent, compared with current law. In the HA plus CARE approach, 8.5 million more people would enroll in insurance coverage, most with some premium contribution, therefore increasing overall household spending on health care by $16.0 billion in 2020, or 2.9 percent.

Federal and state government spending on health care. Federal government spending would increase under all three HA approaches because of the additional financial assistance

Table 5. Acute Health Care Spending for the Nonelderly under Current Law and Reform Options, 2020

Payer	Current Law	Healthy America & Individual Requirement		Healthy America with Low-Income Autoenrollment Only		Healthy America & CARE	
	$ Millions	$ Millions	Diff. from Current Law	$ Millions	Diff. from Current Law	$ Millions	Diff. from Current Law
Employer	**924,280**	**813,359**	**(110,921)**	**815,079**	**(109,200)**	**813,359**	**(110,921)**
Household	**560,313**	**566,489**	**6,175**	**563,715**	**3,401**	**576,331**	**16,017**
Premiums	340,248	348,105	7,856	345,157	4,909	360,118	19,870
Out-of-Pocket	220,065	218,384	(1,681)	218,557	(1,508)	216,212	(3,853)
Government	**637,431**	**742,821**	**105,390**	**744,947**	**107,516**	**747,263**	**109,832**
Federal	*435,525*	*575,108*	*139,583*	*576,518*	*140,993*	*584,537*	*149,012*
Subsidies & Reinsurance (Including BHP)	60,450	740,666	680,216	740,932	680,482	758,075	697,625
Medicaid Acute Care for Nonelderly	347,553	0	(347,553)	0	(347,553)	0	(347,553)
State Medicaid Maintenance-of-Effort Payments	0	(184,115)	(184,115)	(184,115)	(184,115)	(184,115)	(184,115)
Uncompensated Care	27,523	10,557	(16,966)	11,702	(15,821)	2,577	(24,946)
Prescription Drug Savings on Dual Eligibles	0	(15,000)	(15,000)	(15,000)	(15,000)	(15,000)	(15,000)
Medicare Premiums and Medicaid Acute Care for Low-Income Elderly	0	23,000	23,000	23,000	23,000	23,000	23,000
State	*201,906*	*167,713*	*(34,193)*	*168,428*	*(33,477)*	*162,726*	*(39,180)*
Reinsurance and State Subsidies	589	0	(589)	0	(589)	0	(589)
Medicaid Acute Care for Nonelderly	184,115	0	(184,115)	0	(184,115)	0	(184,115)
State Medicaid Maintenance-of-Effort Payments	0	184,115	184,115	184,115	184,115	184,115	184,115
Medicare Premiums and Medicaid Acute Care for Low-Income Elderly	0	(23,000)	(23,000)	(23,000)	(23,000)	(23,000)	(23,000)
Uncompensated Care	17,202	6,598	(10,604)	7,313	(9,888)	1,611	(15,591)
Providers (Uncompensated Care)	**24,082**	**9,237**	**(14,845)**	**10,239**	**(13,844)**	**2,255**	**(21,827)**
Total	**2,146,106**	**2,131,905**	**(14,201)**	**2,133,980**	**(12,126)**	**2,139,207**	**(6,899)**
Federal Spending Change from Current Law			139,583		140,993		149,012
Income Tax Increases from Lower ESI			16,307		16,010		16,307
Additional Federal Revenues Needed Net of Increased Income Tax Receipts			**123,275**		**124,983**		**132,704**

Source: The Urban Institute, Health Insurance Policy Simulation Model, 2019.

Notes: BHP = basic health plan. CARE = Continuous Autoenrollment with Retroactive Enforcement. ESI = employer-sponsored insurance.

provided, the larger numbers of covered lives, and the shift of enrollees from the Medicaid program into the new HA program. Additional federal revenues needed to finance the program would range from $123.3 billion under the individual requirement option to $132.7 billion under the CARE option, if fully phased in 2020 (bottom row of Table 5).

Estimating 10-year federal costs is inherently difficult because all programs would require a phase-in period designed to accommodate the implementation of a new program, and other unforeseen changes in the economy and health care system can have significant effects. However, assuming cost growth within the HA program structure could be constrained to 0.5 percentage points below recent trends in the commercial insurance market, and accounting for population growth, we estimate net federal government costs of $1.3 to $1.4 trillion over 10 years for each of the three HA approaches (not shown). With an appropriate phase-in schedule, and accounting for the lag in people's behavior changes, the 10-year net costs would be somewhat lower.

The alternative with only autoenrollment for the low-income population would have only modestly higher net federal government costs than the option with the individual requirement, because the latter brings in additional enrollees facing the full unsubsidized premium (because the premium would amount to less than 8.5 percent of their family income). Thus, premiums paid by these reasonably healthy, higher-income enrollees would effectively offset a small percentage of federal subsidies paid on behalf of the lower-income enrollees in the HA program under either option. Federal premium and cost-sharing subsidies are highest in the CARE approach because of the significantly larger enrollee population.

The federal government would absorb $23.0 billion in spending devoted to lowering premium and cost-sharing for low-income Medicare enrollees; these costs are savings for state governments. Both the federal government and state

governments would no longer spend money on Medicaid acute care for the nonelderly, constituting savings for both. State governments would, however, be required to contribute to the federal costs associated with HA by making maintenance-of-effort contributions. These contributions would be based on current-law Medicaid spending but would grow more slowly than Medicaid program spending has typically grown, creating additional savings for state governments over time. As the number of uninsured people decreases, state and federal spending on uncompensated care would also decrease.

The federal government's costs for HA would also be offset by a new requirement that prescription drug manufacturers pay rebates on prescription drugs purchased on behalf of Medicare and Medicaid dual eligibles, saving $15.0 billion in 2020, according to the Congressional Budget Office.[12] In addition, as fewer workers enroll in employer-based insurance, we estimate that compensation via contributions to health insurance would convert into an additional $78.9 to $80.4 billion in wages, taxable as income (data not shown). Consequently, income tax revenue would increase by $16.0 to $16.3 billion, offsetting a portion of the increase in federal government health care spending. Payroll tax revenue would

also increase for the same reason (we estimate additional revenues of roughly $10.6 billion), but we do not assume here that those revenues would be used to offset costs of the new program.

A portion of uncompensated care is funded directly by physicians, hospitals, and pharmaceutical manufacturers through in-kind care. With significant decreases in the number of uninsured people, each HA option would reduce the costs associated with providing free or reduced-priced care. We estimate that providers would save $13.8 to $21.8 billion as a result, depending on the option implemented.

Under the HA options, overall spending on health care, accounting for all of these sources of spending, is estimated to decrease modestly, by $6.9 to $14.2 billion, or less than 1 percent, in 2020.

Discussion

Approximately 32 million people are expected to be uninsured in 2020, despite advances brought by the ACA. Health insurance affordability remains a high-ranking concern in America.[27] The three HA program options presented here are designed to address the continuously large number of uninsured Americans; lack of affordability of coverage for many, regardless of whether they are shopping for insurance on their own or have coverage offers from an employer; and the high costs of coverage in noncompetitive insurer and/or provider markets. The approaches are intended to limit disruption of insurance coverage with high rates of satisfaction (i.e., employer-based insurance and Medicare) while using federal dollars effectively and efficiently.

No large-scale expansion of coverage and affordability can be accomplished without increasing government spending. However, any of the HA approaches delineated here could be implemented at a net federal cost of approximately

We estimate net federal government costs of $1.3 to $1.4 trillion over 10 years for each of the three HA approaches.

$1.3 to $1.4 trillion over 10 years, a substantially lower federal cost than proposed single-payer approaches.[28,29,30] Health care spending would also be reduced for employers, state governments, health care providers, and many families. Depending on the approach, the uninsurance rate could drop to as low as 2.4 percent of the nonelderly population (all Americans insured except 6.6 million undocumented immigrants), greatly expanding not only coverage but financial access to care for millions of Americans. Obviously, if provider payment rates approximating the most competitive levels could not be achieved for political reasons, or if rates

in some areas (e.g., rural areas) are too low to sufficiently support existing or needed provider supply, then payment rates would have to be set higher, and the federal costs for HA would be higher than shown here. Net federal costs would also be higher without a commitment of Medicaid maintenance-of-effort funding

As we show, there are trade-offs with designing an approach like HA to achieve universal coverage (for the legally present population) versus designing it to reach near-universal coverage (in which approximately 3 percent of the nonelderly legally present population remains uninsured). The increased

choose to do. This trade-off is one of the same fundamental questions facing policymakers considering a single-payer approach, in which some Americans would be required to enroll in coverage and pay for it via higher taxes.

Regardless of the ultimate choice about how much coverage is considered sufficient politically, our analysis of HA alternatives demonstrates that there are options for

The size of the HA markets would be much loarger than the current-law private nongroup insurance markets; we estimate more than 120 million enrollees under each policy design, compared with 15.5 million people in nongroup coverage under current law.

from the states. However, setting HA provider payment rates at competitive levels would signify increased payment rates on behalf of current-law Medicaid enrollees and the uninsured, populations that would make up most Health America enrollees. Plus, even with a maintenance of effort by states based on current Medicaid/the Children's Health Insurance Plan acute care spending for the nonelderly, states would achieve budgetary savings that would increase with time.

net federal cost per additional person insured under the universal approach, HA plus CARE, would be quite low (less than $1,200 in 2020). However, covering an additional 8.5 million people would require a system that retroactively collects income-related premium payments from those not actively enrolling in coverage. Such an approach would ensure all Americans have affordable access to necessary medical care but would also require this segment of the population to contribute to the costs of insurance in a way they otherwise would not

- improving household affordability and thus access to medical care,

- improving equity of coverage availability across people of different incomes and states,

- increasing competition in insurance markets while simultaneously addressing the disproportionate pricing power of hospitals in noncompetitive areas, and

- providing savings to state governments while minimizing disruption of existing insurance systems and using federal dollars efficiently.

NOTES

1. Blumberg LJ, Holahan J, Zuckerman S. The Healthy America Program: Building on the Best of Medicare and the Affordable Care Act. Washington: Urban Institute; 2018. https://www.urban.org/research/publication/healthy-america-program. Accessed July 30, 2019.

2. Brooks T. The family glitch. Health Affairs; 2014. https://www.healthaffairs.org/do/10.1377/hpb20141110.62257/full/. Accessed July 30, 2019.

3. Buettgens M, Dubay L, Kenney GM. Marketplace subsidies: Changing the 'family glitch' reduces family health spending but increases government costs. Health Affairs 2016;35(7):1167–75. https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1491. Accessed July 30, 2019.

4. In addition, the small number of people ages 65 and over ineligible for Medicare can also enroll in Healthy America.

5. Legally present residents ages 65 and over who do not have enough quarters of work to qualify for Medicare would also be eligible to purchase coverage in an HA plan and may be eligible for financial assistance, depending upon their income.

6. For an analysis of government, household, and private insurance cost implications of providing traditional Medicare plan enrollees with combined Parts A, B, and D cost-sharing requirements, see Garrett B, Gangopadhyaya A, Shartzer A, Arnos D. A Unified Cost-Sharing Design for Medicare: Effects on Beneficiary and Program Spending. Washington: Urban Institute; 2019. https://www.urban.org/research/publication/unified-cost-sharing-design-medicare-effects-beneficiary-and-program-spending. Accessed July 30, 2019.

7. Actuarial Research Corporation. Final Report: Analysis of Actuarial Values and Plan Funding Using Plans from the National Compensation Survey. Washington: US Department of Labor; 2017. https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/health-and-welfare/analysis-of-actuarial-values-and-plan-funding-using-plans-from-the-national-compensation-survey.pdf. Accessed July 30, 2019.

8. Holahan J, Skopec L, Wengle E, Blumberg LJ. Why Does Medicare Advantage Work Better Than Marketplaces? Washington: Urban Institute; 2018. https://www.urban.org/research/publication/why-does-medicare-advantage-work-better-marketplaces. Accessed July 30, 2019.

9. Corlette S, Hoadley J. Strategies to Stabilize the Affordable Care Act Marketplaces. Princeton, NJ: Robert Wood Johnson Foundation; 2016. https://www.rwjf.org/en/library/research/2016/08/strategies-to-stabilize-the-affordable-care-act-marketplaces.html. Accessed August 1, 2019.

10. In Medicare Advantage, out-of-network provider payment rates are capped at traditional Medicare rates, but in-network provider payment rates are not. It is commonly understood that capping out-of-network rates gives insurers the leverage necessary to set in-network payment rates at the same or similar levels to Medicare Advantage. We propose extending the capping policy to in-network providers explicitly for consistency and completeness.

11. Based on experience with the Affordability Care Act and the 2006 reforms in Massachusetts, employer-based insurance has been shown to be very stable, even in the presence of generous financial assistance in the private nongroup market. Though the more generous financial assistance and larger market created by Healthy America would lead more employers to drop health insurance than has been seen under either program, the bulk of employer-based insurance should remain stable. If, however, the Healthy America program's insurance options prove to be more attractive than those provided by typical employers, there could be more movement from employer-based insurance to Healthy America coverage. Such a transition would increase federal government subsidy costs but would also increase income and payroll tax revenue because nontaxable employer health insurance benefits would convert into taxable wages.

12. Congressional Budget Office. Options for Reducing the Deficit: 2019 to 2028. Washington: Congressional Budget Office; 2018. https://www.cbo.gov/publication/54667. Accessed August 1, 2019.

13. Hwang TJ, Kesselheim AS. Reducing Prescription Drug Costs: Policy Options for a Public Plan. PORTAL Report for the Urban Institute and Arnold Ventures, forthcoming, 2019.

14. Wagner J, Huguelet A. Opportunities for States to Coordinate Medicaid and SNAP Renewals. Washington: Center on Budget and Policy Priorities; 2016. https://www.cbpp.org/research/health/opportunities-for-states-to-coordinate-medicaid-and-snap-renewals. Accessed July 30, 2019.

15. A broad-based outreach and enrollment campaign would inform low-income populations about the autoenrollment effort, letting them to know to look for coverage information.

16. That a single unified system of outreach and autoenrollment can be designed and implemented nationwide by the federal government and made easily accessible to health care providers sets this effort and its effect on coverage apart from the Medicaid program, where eligibility rules and barriers to enrollment vary geographically. Though some autoenrollees may not use care because they do not know they are insured, this should be a short-term phenomenon as information about the program disperses in the early years of the reform.

17. King v. Burwell, 576 U.S. __ (2015).

18. Mapping America's futures. Urban Institute website. http://apps.urban.org/features/mapping-americas-futures/. Accessed July 30, 2019.

19. What is your state doing to affect access to health insurance? Commonwealth Fund website. https://www.commonwealthfund.org/publications/maps-and-interactives/2019/may/what-your-state-doing-affect-access-adequate-health. Accessed July 30, 2019.

20. Wengle E, Blumberg LJ, Holahan J. Are Marketplace Premiums Higher in Rural Than in Urban Areas? Washington: Urban Institute; 2018. https://www.urban.org/sites/default/files/publication/99341/moni-ruralurban_-_final_0.pdf. Accessed July 30, 2019.

21. Coughlin T, Holahan J, Caswell K, McGrath M. Uncompensated Care for the Uninsured in 2013: A Detailed Examination. Menlo Park, CA: Henry J. Kaiser Family Foundation. https://www.kff.org/wp-content/uploads/2014/05/8596-uncompensated-care-for-the-uninsured-in-2013.pdf. Accessed July 31, 2019.

22. Gruber J. Health insurance and the labor market. In: Joseph Newhouse and Anthony Culyer. The Handbook of Health Economics. Amsterdam: Elsevier; 2001:645–706.

23. Hwang TJ, Kesselheim AS. Reducing Prescription Drug Costs: Policy Options for a Public Plan. PORTAL Report for the Urban Institute and Arnold Ventures, forthcoming, 2019.

24. Lynch V, Loprest PJ, Wheaton L. Joint Eligibility and Participation in SNAP and Medicaid/CHIP, 2011, 2013, and 2015. Washington: Urban Institute; 2017. https://www.urban.org/research/publication/joint-eligibility-and-participation-snap-and-medicaidchip-2011-2013-and-2015. Accessed July 31, 2019.

25. Theoretically, HA financial assistance could be extended to undocumented immigrants, as called for in some Medicare for All proposals. However, we do not believe this is feasible as a practical matter. If enrollment required no legal documentation of permanent residence, it would be difficult for an eligibility determination system to differentiate between permanent residents and those simply visiting from other countries. In addition, reported income (necessary for determining financial assistance eligibility) could not be verified without social security numbers, and though some undocumented residents have social security numbers, many do not. Without income verification requirements, legally present people who might otherwise be required to make income-based contributions toward the cost of their coverage could enroll and receive coverage without appropriate premium contributions. This could put the federal government at risk for additional public costs. Further, undocumented immigrants would likely be reticent to enroll in a program that would require providing the federal government with detailed information about their families and residences for fear that it might be shared with immigration officials. Due to these types of issues as well as other complexities involved, it is uncommon for developed countries to provide undocumented immigrants eligibility for national health programs. See Gray BH, van Ginneken E. Health Care for Undocumented Migrants: European Approaches. New

York: The Commonwealth Fund; 2012. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2012_dec_1650_gray_hlt_care_undocumented_migrants_intl_brief.pdf. Accessed July 31, 2019.

26 Reductions in employer spending on health care resulting from decreased enrollment in employer-based insurance are not equivalent to overall employer savings. As noted in the methods section, we assume, consistent with the economic empirical literature, that reductions in health insurance compensation would be turned into roughly equivalent increases in other forms of compensation (i.e., taxable wages).

27 Goldstein A. Voters have big health-care worries, but not the ones Democrats are talking about. New York Times. June 21, 2019. https://www.washingtonpost.com/health/voters-have-big-health-care-worries-but-not-the-ones-democrats-are-talking-about/2019/06/21/5c4a353e-8d22-11e9-adf3-f70f78c156e8_story.html?utm_term=.66d881b59ee9. Accessed July 31, 2019.

28 Holahan J, Buettgens M, Clemans-Cope L, Favreault M, Blumberg LJ, Ndwandwe S. The Sanders Single-Payer Health Care Plan: The Effect on National health Expenditures and Federal Private Spending. Washington: Urban Institute; 2016. https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private-spending. Accessed August 1, 2019.

29 Blahous C. The Costs of a National Single-Payer Healthcare System. Arlington, VA: George Mason University Mercatus Center; 2018. https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf. Accessed July 31, 2019.

30 Liu JL, Eibner C. National Health Spending Estimates under Medicare for All. New York: RAND Corporation; 2019. https://www.rand.org/pubs/research_reports/RR3106.html. Accessed July 31, 2019.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector. For more information specific to the Urban Institute's Health Policy Center, its staff, and its recent research, visit http://www.urban.org/policy-centers/health-policy-center.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.