



Cutting through the Jargon

Health Care Reform Design Issues and Trade-Offs Facing Us Today

Linda J. Blumberg

June 2020

The intersection of the presidential election and the COVID-19 pandemic is likely to make health care reform a frequent subject of conversation in the coming months. Yet for many voters, the proposals and their implications for typical years remain hard to decipher, let alone for years potentially plagued by economic and health crises. Candidates and others describe their plans using such terms as *universal coverage*, *single payer*, *Medicare for All*, *public option*, *market-based reforms*, and *protections for preexisting conditions*. But watching debates, listening to news reports, or attending public forums (virtually or otherwise) can leave people confused about what each plan includes and uncertain about the differences between them. Here, I describe the central issues at the heart of current health care reform proposals, with a focus on understanding that each proposal requires society to make difficult choices and appreciating the trade-offs of each choice. The crux of the debate will always be over defining the goals we want to achieve and deciding who should bear the costs of achieving those goals.

Our current system of paying for health care needs (coverage) is complex, with people holding various forms of insurance coverage: Medicare, Medicaid, the Children's Health Insurance Program (CHIP), employer-sponsored health insurance, insurance purchased by individuals outside of employment (i.e., nongroup, individual, or directly purchased insurance),¹ and other public programs through the US Department of Defense. Other people remain uninsured. Each type of coverage has its own financing system and eligibility rules, all relying on different combinations of public and private funds. Despite expanding coverage for millions of people and improving affordability for many more since 2014, the current system's shortcomings continue to keep health care reform front and center in the political arena. The pandemic only exacerbates those shortcomings. A substantial number of people remain uninsured (with more becoming uninsured during economic crises), health care costs tend to increase faster than incomes, and many people still incur large financial burdens to access coverage.

And the broad patchwork of people's current insurance situations means that any reform will affect different people differently.

Evaluating the trade-offs inherent in the answers to each of the five core questions below is critical to understanding the philosophical underpinnings and general implications of health reform proposals.

1. How broadly should the costs of the sick be shared with the healthy?
2. How important is reaching true universal coverage? How many US residents must be insured?
3. How generous should federally financed subsidies of premiums and cost sharing be?
4. How should reform options be financed?
5. Should there be regulations limiting the prices paid to health care providers of different types (i.e., hospitals, physicians, prescription drug manufacturers, medical device manufacturers), and if so, how broadly should those regulations apply, and how should prices be set?

Below, I address the significance of each of these questions and the trade-offs inherent in different answers.

Exploring the Five Core Questions Necessary to Evaluate the Trade-Offs Inherent in a Health Reform Proposal

Question 1. How Broadly Should the Costs of the Sick Be Shared with the Healthy?

How health care risk is shared speaks to who will pay how much of a population's health care bills. How much should the person receiving the actual care pay, and how much should be shared with others? Should shared costs stay within groups of similarly situated people (e.g., people with high health care needs should share with other people who have serious health problems, and healthy people should share with other healthy people), or should costs be spread more broadly across diverse groups (e.g., currently healthy people sharing in the costs of those who are currently sick)?

Current health insurance arrangements spread health care costs and risk in different ways.² More risk sharing tends to lower the costs associated with obtaining medical care for people with health service needs but tends to increase the costs for people who are healthy. Conversely, separating the risks (e.g., charging the healthy and the sick different premiums, limiting benefits, or blocking some people from getting coverage) tends to increase the costs for people in worse health status and often impedes their access to care while reducing costs for the healthy.

All insurance policies spread risk to some degree but vary in how much is shared. "**Market-based**" approaches generally lie at one end of the spectrum with the least amount of risk sharing. They provide the greatest separation of risk (e.g., healthy young people are grouped with other healthy young people, creating a pool where the risk of insurer payout is low and requires lower premiums). The private

insurance industry extensively used tools to separate risks before 2014, but these tools were limited or prohibited in regulated markets under the Affordable Care Act (ACA). Market-based approaches often advocate reinstating such segmentation policies (as would occur if the ACA was repealed) or otherwise reducing how broadly risk is shared. Proposals include the following:

- **Introducing plans with higher out-of-pocket cost (lower actuarial value³) into the individual and small employer group⁴ markets (i.e., “copper” plans).⁵** These plans place more health care expenses on people using medical services because the insurer pays out a smaller share of expenses.
- **Promoting the use of health savings accounts⁶ by eliminating or lifting limits on them.** These accounts provide financial benefits for high-income enrollees to transfer more resources out of the insurance pool and into tax-preferred individual accounts.
- **Allowing unrestricted sales of insurance across state lines,** which would permit healthy people in states with more regulations to purchase insurance in less regulated states, allowing the healthy to avoid sharing in the costs of the sick in their own state.
- **Eliminating many insurance market regulations** (i.e., guaranteed issue,⁷ modified community rating,⁸ benefit and actuarial value standards,⁹ and preexisting condition exclusion prohibitions) for some or all insurance products, leaving many people with considerable health care needs to rely on high-risk pools, which have historically been underfunded and provided more limited coverage at higher prices than standard coverage.¹⁰
- **Lowering premiums for young adults and raising them for older adults,** by broadening age-rating bands or modifying the premium tax credit schedule. This makes it harder for older adults (who incur a disproportionate share of health problems) to afford coverage.

At the other end of the policy spectrum (i.e., maximization of risk sharing) lies **single-payer or Medicare for All approaches**. Medicare for All is essentially a brand name for particular single-payer proposals.¹¹ These approaches require the full population to have identical coverage through the same government plan and to share in the costs of providing the specified levels of care to that population, regardless of health status or health care risk. The prominent Medicare for All bills include broad benefits, require no (or extremely limited) out-of-pocket costs, and do not charge premiums. Costs of care are fully financed through the tax system. In this way, single payer creates one national risk pool for the entire population, with household costs varying according to the tax rules chosen but not by medical need or actual use of services.

Other policies fall in between these extremes, increasing current risk sharing but not spreading costs as broadly as single-payer approaches. Examples include

- reversing the current administration’s policy changes, which have decreased enrollment in Marketplace and Medicaid coverage (Trump administration executive actions include expanded access to short-term limited-duration plans, elimination of outreach funding, cuts in enrollment assistance, and shortening of the annual enrollment period);

- increasing subsidies to lower cost sharing faced by consumers;
- providing additional federal funding to lower household contributions for insurance premiums as a share of income and enhancing low-income cost-sharing subsidies;
- using additional federal funding to fill in the Medicaid “gap” for poor adults living in states that have refused to expand Medicaid eligibility under the ACA;¹²
- expanding minimum benefit standards (e.g., adult dental, vision, and hearing); and
- requiring people to enroll in a defined minimum level of insurance coverage (actual insurance enrollment could be required, or, alternatively, people could be assessed a penalty for not enrolling).

Increasing the number of people with insurance coverage, a goal that can be accomplished through one of several strategies (some noted above), usually will increase the sharing of health care costs. But, more directly, how much health care costs are shared depends on how much people of different health statuses share in the population’s total health care costs. For example, many people enrolled in an insurance plan that covers few benefits or requires lots of out-of-pocket spending when accessing care does not spread health care risk much. Large numbers of people contributing to a comprehensive insurance plan does. Large numbers of enrollees with low health care risk in their own separate insurance plan do not spread costs broadly, while large numbers of people of diverse health care risk do.

SUMMARY OF THE TRADE-OFFS INHERENT IN MORE

SHARING VERSUS LESS SHARING OF HEALTH CARE RISK

Lower premiums for healthy people at a given point can be achieved with more benefit limits or exclusions, higher cost-sharing requirements, and a reversal of various consumer protections, such as guaranteed issue, community rating, and prohibitions on preexisting condition exclusions. All these strategies reduce risk sharing across the population. The resulting trade-off is that people seeking health care services, especially those with significant health care needs, face higher costs and reduced access to care. And although people save money while they are healthy, they could face higher costs and reduced access to care when they need health care services in the future. Conversely, as covered benefits increase, cost-sharing requirements fall, regulatory reforms are strengthened, and risk sharing increases, premiums for the currently healthy and the need for injections of government dollars to keep coverage affordable will increase as well. Affordability for the sick and access to necessary care increase as risk sharing increases.

Question 2. How Important Is Reaching True Universal Coverage?

Strong evidence shows that, regardless of how generously insurance coverage is subsidized, some people will not voluntarily enroll. We see this in the Medicaid program, the state-administered insurance program for low-income people for whom premiums and cost-sharing requirements are zero or near zero. Participation rates among eligible people vary by state and between children, parents, and nonparents, but they average 89 percent for parents and 96 percent for children (Haley et al. 2018) and

tend to be lowest for nonparents. Financial assistance through the ACA Marketplaces has improved insurance affordability markedly for many people, yet enrollment rates among people eligible for premium tax credits range from 74 percent among people with incomes below 200 percent of the federal poverty level (FPL) to 48 percent among people with incomes between 200 and 400 percent of the FPL.¹³ Some people do not believe they need insurance coverage, some object to insurance on religious grounds, some do not use traditional medical care, some feel coverage remains unaffordable or the “hassle factor” of enrolling is too high, some remain unaware that they can access coverage, and others simply prefer not to contribute to the cost of their own care or that of others.

Therefore, **to reach true universal coverage** (i.e., an entire specified population insured with no exceptions), people must be required to participate, and **there must be some enforcement mechanism** for those who would otherwise choose not to. This compelled participation will mean a financial contribution for some, either through premiums or increased taxes.¹⁴ For others who have very low incomes and may not be asked to contribute financially but who still resist participation, this may mean some type of autoenrollment mechanism that evades their objections. This is true for single-payer programs or other approaches designed to achieve universal coverage. Requiring participation among the unwilling creates a political challenge. Yet, an automatic transfer of coverage -- for example, from employer-based insurance to publicly subsidized insurance during the 2020 economic crisis -- can prevent workers who lose their jobs from becoming uninsured.

If we accept that some people will remain uninsured, we must assess the acceptable number of uninsured people. Absent the pandemic, we estimate that repealing the ACA in its entirety would increase the number of uninsured by 19.9 million, leaving 50.3 million people nationwide uninsured (more than 15 percent of the US population) (Banthin et al. 2019). Policymakers advocating repeal implicitly find this level of uninsurance acceptable. For policymakers designing policies to increase coverage, is a 2 to 5 percent uninsurance rate still too high? Should a program cover undocumented immigrants, or is covering all legal residents sufficient? Are acceptable coverage rates during a public health crisis different from those during more typical periods?

SUMMARY OF THE TRADE-OFFS INHERENT IN EXPANDING COVERAGE VERSUS ACHIEVING TRUE UNIVERSAL COVERAGE

Providing additional financial assistance and improving cost-containment can increase voluntary enrollment by making insurance coverage more affordable, but voluntary measures alone will not lead to universal coverage. The trade-offs become political backlash associated with compelling full participation and requiring households to contribute to the costs either through premiums (e.g., some hybrid public-private approaches) or taxes (e.g., single payer) versus leaving some people uninsured, along with the resulting uncompensated care and unmet medical need. Effective auto-enrollment systems, while admittedly challenging to design, would reduce uninsurance resulting from lack of information and administrative barriers, allowing for coverage consistency during crises and typical times.

Question 3. How Generous Should Federally Financed Subsidies of Premiums and Cost Sharing Be?

Not everyone can equally afford premiums. If coverage and affordability are a priority, the federal government, through tax dollars, can subsidize or contribute to premiums for at least some people, with subsidization of coverage for low-income people particularly critical. The government can also subsidize out-of-pocket costs. Doing so requires the government to set some standards as to what type of coverage to subsidize. Four main parameters determine the generosity of health insurance premium and cost-sharing subsidies: the number and characteristics of people eligible for them, the amount people are expected to contribute themselves in the form of premiums, the benefits covered, and the level of cost-sharing requirements.

The larger **the eligible population** and the greater the inclusiveness for people with high health care needs, the larger the government subsidy bill will be because the costs the insurer pays out will be higher. Excluding more people from eligibility for assistance will reduce government costs but can create unfairness. For example, subsidizing people below an arbitrary income cutoff (current law terminates premium tax credits at 400 percent of the FPL) can leave people with slightly higher incomes facing much higher costs, making them less likely to enroll in coverage. Extending tax credits above 400 percent of the FPL could eliminate the inequitable subsidy “cliff” but would require additional government funding.¹⁵ The larger **the share of premiums and out-of-pocket costs a government subsidy covers** and the extent to which the assistance offered is income-related also has substantial implications for costs and household affordability. If subsidy levels are higher, more people will enroll under a voluntary system and there will be less unmet medical need and demand for uncompensated care.¹⁶ At the same time, greater government subsidization increases public costs and the need for revenue sources. Relatedly, a given amount of government funding can either be concentrated on low- or middle-income people or be spread among people of all incomes. The former approach has a larger effect on affordability and likelihood of voluntary enrollment, but political support for reform may broaden among high-income voters if they too can expect to receive assistance.

As with premiums, **out-of-pocket health care costs** (e.g., deductibles, coinsurance, copayments, and out-of-pocket maximums) can be subsidized at different levels. The lower the household contributions required when using services, the more affordable the access to care, with the greatest implications for people with substantial health problems and people with low incomes who may not be able to cover even modest cost-sharing requirements. But the lower the cost-sharing requirements, the higher the government subsidy costs because people will use more care and the government will cover a higher share of the bills.

A broader **set of covered benefits in subsidized plans** increases access to care for people needing the covered services but also increases government costs and premiums for people ineligible for subsidies. Of course, premiums would be less expensive if plans excluded prescription drug coverage, maternity care, and mental health care (like many policies did before 2014), but then affordability, and thus access to those services, would be compromised for the people who need them. Expanding benefits beyond those that are typical today will increase use of those services, increasing costs and premiums.

SUMMARY OF THE TRADE-OFFS INHERENT IN MORE GENEROUS VERSUS LESS GENEROUS SUBSIDIZATION OF HEALTH INSURANCE AND OUT-OF-POCKET COSTS

More generous subsidies, resulting from subsidizing more people, lowering the amount households are expected to contribute to premiums or out-of-pocket costs, increasing the benefits covered in subsidized programs, or some combination of those actions will increase the government's costs of subsidizing insurance while improving affordable access to medical care. Reducing the comprehensiveness of coverage being subsidized or increasing the share of premiums some enrollees pay (e.g., older enrollees) would have the opposite effect. Improved generosity is likely to most favor people with modest incomes and people with substantial health care needs. Reducing generosity is most likely to disadvantage those same groups. Excluding particular benefits from subsidized coverage is likely to deny access to that type of care for people who need it, particularly if those benefits carry a high price.

Question 4. How Should Reform Options Be Financed?

Most policymakers agree that if health insurance and necessary medical care is going to be accessible to everyone, at a minimum, premiums and cost-sharing requirements must be income-related, with after-subsidy premiums and out-of-pocket costs increasing as income rises. In other words, a household's health care costs should reflect the household's ability to pay, given its income. This is part of the design of the ACA and related reforms that would build upon it. It was also part of the design of many of the 2017 market-oriented repeal-and-replace bills Congress considered, albeit with lower subsidy levels. Income-related assistance requires a combination of government and private financing. Single-payer bills do not generally include premiums. All the costs associated with such programs would be raised through the tax system and would provide people of all incomes identical benefits. They require more taxes to fully finance them.

Premium contributions are familiar to many people, particularly those who have or have had private insurance coverage. Premiums support the notion that everyone should contribute to the insurance system, perhaps with the exception of people with the lowest incomes. Premiums lower the amount of program funding that needs to be financed with taxes, but they require households (and sometimes employers) to make tangible payments to be enrolled in and maintain insurance coverage. Premium payments can be fixed, as is the case in some systems in other countries, or they can increase with income as they do in the US Marketplaces. For people who have means but do not pay premiums, the premiums must be collected in a different way (e.g., through the tax system¹⁷), or some people will remain uninsured. It is not credible, however, to rely solely on premiums to finance a reform, if coverage is to be made affordable for people with low and modest incomes.

To provide the necessary financial support to make coverage affordable for financially vulnerable people, taxes will have to be raised. Taxes can be politically unpopular, so using premiums to reduce the amount of additional taxes required to finance a reform may increase support. Premiums also appeal to people who value personal responsibility in health insurance.

Tax financing requires identifying taxation options and determining how the revenue will be raised across the revenue options. Possible revenue sources include income taxes, payroll taxes, sales taxes, value-added taxes, and corporate taxes. Depending on the amount of additional tax revenue needed, one or several new revenue sources might be used. Each revenue source has implications for how people of different incomes and circumstances will be affected.

Theoretically, carefully designed tax financing provides an avenue for explicitly allocating the costs of health reforms across people and entities by income and other characteristics. But challenges remain in ensuring these costs are borne as intended. For example, raising shares of needed revenue from high-income people reduces financial burdens on people with modest incomes. But depending on how the taxes are assessed and how big they are, they could change investment and other behavior if people who are assessed attempt to avoid them and identify mechanisms for doing so. Taxes also may be perceived as unfairly concentrating the financial burdens in a small share of the population, potentially hampering long-term political sustainability of reforms.

In another example, taxing employers who do not provide health insurance to their workers may be considered fair because many employers already contribute to the health insurance costs of their workers while others do not. But workers without offers of employer coverage generally are low-paid and low-income employees, and their employers, if taxed, are likely to reduce their workers' wages to offset the new taxes. Thus, this approach has the potential to place a significant new financing burden on some low- and middle-income workers.

Using a mix of revenue sources may add to the complexity of financing systems but would likely spread the costs of reforms more broadly across a population, lowering the perception that any group is carrying a disproportionate share of the financing weight.

SUMMARY OF THE TRADE-OFFS INHERENT IN FINANCING HEALTH INSURANCE REFORMS

Premium financing spreads the costs of insurance coverage broadly across enrollees, implicitly conveying a message of personal responsibility in financing one's care and reducing the need for politically unpopular tax increases. But premiums alone cannot develop systems that provide adequate and affordable coverage to low- and middle-income people. Using highly progressive taxes to finance reforms reduces health care cost burdens on financially vulnerable people and places the burdens much more heavily on people with the greatest ability to pay. But concentrating the financing burdens for a reform that carries substantial government costs on a small segment of the population may lead to tax avoidance and perceptions of unfairness that could impede the reform's long-term sustainability. Using a mix of financing mechanisms increases complexity but spreads the costs of a program more broadly across the population than would relying solely on taxes directed at the wealthy.

Question 5. Should there be regulations limiting the prices paid to health care providers of different types

Current law regulates the provider (e.g., hospitals, physicians, other medical professionals, prescription drug manufacturers, and device manufacturers) prices paid in certain public programs, including

Medicare and Medicaid. Physicians and hospitals are also paid under government programs for veterans and active-duty military personnel and their family members. **Provider payment rates** (the prices paid to those delivering health care services or products) under these programs tend to be significantly lower than those paid by typical commercial insurers. Supporters of market-based approaches generally do not support expanding the number of people enrolled in markets that regulate provider prices, and they generally do not support lowering prices in current programs by government dictate.

Yet **unregulated health care markets** are seldom competitive in the economic sense. Lack of competition results from barriers to entry in provider and insurance markets,¹⁸ information asymmetries,¹⁹ differences in services provided across providers,²⁰ and positive externalities of medical care.²¹ Because of these combined factors, unregulated health care markets lead to market distortions, not efficiency. In many circumstances, left unregulated, prices are higher than would be the case in competitive conditions.

Those interested in reducing total health care spending increasingly recognize that **provider price regulation** (i.e., setting or capping the prices that public and private insurers pay to hospitals, physicians, and prescription drug manufacturers) is the most promising policy option. Provider groups tend to disagree with this approach, however, arguing that it would decrease the quality of care and supply of providers and that it could decrease investments in research and development for new prescription drugs and treatments.²² Without price regulation, and as the costs of care and insurance premiums have increased, advocates of market-based solutions tend to rely on higher levels of household cost-sharing requirements (e.g., higher deductibles, coinsurance, or copayments and reductions in covered benefits). As household out-of-pocket costs increase, use of care tends to decrease. Lower use of care and reductions in the share of expenses an insurance policy covers yield lower premiums. Although this approach can lower spending by insurers, it places higher costs directly on people needing care and increases unmet medical need among people who cannot afford to pay those higher costs. Consequently, it does not necessarily lower total health spending, or, if it does, it can reduce it in a way that harms health. For people who believe that provider price regulation is warranted, at least in some circumstances, design issues remain.

A public option, capped provider payment rates, and a single-payer program are points on a continuum regarding how many people should have access to price-regulated plans. A **public option** provides a government-designed and government-administered insurance plan as an option in one or more insurance markets (e.g., in the nongroup insurance market alone or perhaps also as an option for employers offering coverage to their workers). Such a plan would pay health care providers according to a specified price schedule set at levels below those commercial insurers typically pay. **Capping provider payment rates** limits the prices providers can charge to *any* insurer in a particular market, so this approach could lower premiums for more people.²³ A **single-payer plan** (also known as Medicare for All) would apply regulated prices to an entire population through a single government insurance plan, with no option for consumers to choose a plan that pays providers at higher rates.

The lower the provider prices are set, the greater the reduction in health care costs, but the lower is the income of health care providers. We do not know what level of pricing would best balance cost

containment, access to care, and quality of care. Ideal prices across providers and geographic areas may differ (e.g., rural versus urban areas). Plus, the more people to whom the regulated prices apply, the higher the prices may need to be to reduce access and quality concerns.

In addition, the greater the desired reduction in prices paid to providers and the more consumers to whom the regulated prices apply, the longer the time likely required to move from current to target prices while avoiding significant disruptions to the delivery of care.

The COVID-19 pandemic has led to substantially reduced revenue and layoffs in many US hospitals. The financial pressures on hospitals and independent physician practices created by the crisis likely make it more difficult to engage policymakers in a near-term discussion of limiting provider prices. However, the public health crisis does not negate the long-term concerns with overall system costs and pricing at inefficient levels. Effective short-term policy strategies to help providers weather unusual circumstances, such as the pandemic, can and should be separated from policy initiatives geared toward efforts to move the broader health care system in the direction of efficient pricing and lower overall costs for the longer term.

SUMMARY OF THE TRADE-OFFS INHERENT IN GREATER VERSUS LESS REGULATION OF PROVIDER PRICES

Public options, capped payment rate reforms, and single-payer approaches can lower the prices paid for the health care delivered to at least some people. As more households enroll in insurance plans using regulated prices, prices are set lower, prices increase more slowly over time, and overall health system spending is likely to be lower. But large price reductions, applied to large swaths of people, particularly if implemented quickly, could significantly disrupt the delivery of medical care. Implementing changes more slowly would allow hospitals and other providers time to lower their underlying costs and for governments to implement systems to measure changes in access and quality as prices decrease. But moving slower means system-wide savings also would be lower, at least over an extended period.

Answers to These Five Central Questions Frame Policy Proposals

Each fully developed health reform proposal explicitly or implicitly responds to the five central questions delineated above, and the choices made relay the philosophical values and objectives of those who designed the proposal. Open and honest discussion of a policy approach's intent and implications should begin by identifying the answers to these questions.

To illustrate how this five-decision framework clarifies the reforms most frequently discussed, I use three policy examples:

- Full repeal of the ACA
- Build upon the ACA with additional financial assistance and a public option

- Replace the current system with an enhanced single-payer program

Full Repeal of the ACA

This policy has been the one most consistently supported by the Trump administration and most Republican members of Congress. The policy began as a legislative effort and is being advocated via the *Texas v. US* litigation, which the Supreme Court will hear in fall 2020.

1. **How broadly should the health care costs of the sick be shared with the healthy?** The ACA significantly increased the sharing of health care risk, particularly through reforms to the nongroup and small-group insurance markets and the expansion of public program eligibility in Medicaid. Repealing or overturning the ACA would reverse these changes, returning the system to a situation of greater separation of health care costs between people who are healthy and those projected to need significant medical care. ACA repeal would increase costs for people with current or past health problems and lower them for people who are very healthy.
2. **How important is reaching true universal coverage?** This approach would reverse the recent gains made toward universal coverage. Prior to the pandemic, we estimated that an additional 19.9 million people would be uninsured, a 65 percent increase compared with current law (Banthin et al. 2019). Given the largest job losses in generations and the consequent loss of employer-based insurance for millions of people due to the pandemic, overturning the ACA now would lead to even larger numbers of uninsured people.
3. **How generous should federally financed subsidies of premiums and cost sharing be?** Full ACA repeal would significantly reduce federal investment in health care, eliminating the subsidization of private nongroup insurance through the Marketplaces, rolling back Medicaid eligibility to pre-2014 levels,²⁴ and reintroducing the Medicare prescription drug “doughnut hole” for seniors.²⁵ Thus, the approach indicates that the current levels of subsidization are too high and should be reduced. Prior to the pandemic, my colleagues and I estimated that full ACA repeal would have reduced federal spending on health care by \$134.7 billion in 2019, a 35 percent decrease compared with current law spending on Medicaid/CHIP acute care for the nonelderly and Marketplace subsidies (Banthin et al. 2019). As job losses ballooned due to the pandemic, reliance on the ACA’s Medicaid expansion and subsidized marketplace coverage has grown. Thus, the drop in federal spending on health care would be even larger than those estimates indicated should the law be overturned.
4. **How should the reform option be financed?** Because this approach would reduce both federal and state government spending on health care, no new financing mechanisms are required.
5. **Should there be regulation of the prices paid to health care providers?** With fewer people enrolled in Medicaid under ACA repeal, a smaller share of people would be enrolled in insurance coverage where government regulates the prices paid to providers. Implicitly, then, this approach would reduce the reach of health care provider price regulation. In addition, if the ACA is overturned, monopoly and duopoly nongroup insurer pricing and market power may

once again become the norm in areas where the law increased market competition and lowered premiums.

Build upon the ACA with Additional Financial Assistance and a Public Option

Joe Biden, the presumptive Democratic presidential nominee as well as other Democratic presidential candidates have presented such policies, and my colleagues and I have included a similar construct in our recent quantitative analysis of a spectrum of health reform proposals (Blumberg, Holahan, Buettgens, Gangopadhyaya, et al. 2019). This type of proposal would increase premium and cost-sharing subsidies for people currently eligible and extend them to additional people currently ineligible. It would fill in the Medicaid eligibility gap, allow workers with employer offers to opt into the Marketplaces and access subsidies if they prefer that to their employer's plan, and provide a public option in the nongroup market that pays providers at prices roughly equivalent to those paid by Medicare. In addition, the approach we modeled as reform 5 in the cited analysis would use an autoenrollment backup to enroll anyone not voluntarily enrolling in coverage into either Medicaid or the public option, collecting any income-related premiums as appropriate through the tax system.²⁶ Notably, such a policy would ensure that those losing their employer-based insurance due to a crisis like the current one would not experience a gap in insurance coverage.

1. **How broadly should the health care costs of the sick be shared with the healthy?** By increasing government subsidies for private insurance coverage, lowering cost-sharing requirements for people in the nongroup insurance market, and increasing Medicaid enrollment, this approach would share the health care costs of the sick more broadly than is the case under current law.²⁷ Not all health care risk would be combined into one insurance pool, because some people remain in employer-based coverage and some care is paid for specifically by those who use medical services, but a larger share of care would be collectively financed compared with today. These reforms would lower costs for people when they are having health problems and increase them when they are healthy.
2. **How important is reaching true universal coverage?** The approach we modeled is designed to ensure coverage for all legally present US residents. Approximately 6.6 million undocumented immigrants would remain uninsured (another 4.2 million undocumented residents are estimated to have private coverage), leaving 2 percent of US residents uninsured (all of them undocumented residents).
3. **How generous should federally financed subsidies of premiums and cost sharing be?** This approach increases the generosity of subsidies offered to consumers buying coverage in the nongroup Marketplaces. It would lower out-of-pocket costs and premiums for people already eligible for premium tax credits and would extend them to more people.²⁸ Very low-income people would pay no premium and face very low out-of-pocket costs. Premiums would increase on a sliding scale with income, but no one need pay premiums of more than 8.5 percent of their income.

4. **How should the reform option be financed?** Prior to the pandemic, we estimated that this reform would increase federal government spending by \$122.1 billion in 2020 or \$1.5 trillion between 2020 and 2029, if fully implemented and phased in in 2020. At this time, a particular financing mechanism for the approach has not been proposed. With larger Medicaid and subsidized Marketplace enrollment due to pandemic-related job losses, federal costs prior to economic recovery would be higher than those estimated previously.
5. **Should there be regulation of the prices paid to health care providers?** This reform option's Marketplace includes a public option, a plan with provider payment rates set at approximately the levels used by the current Medicare program. Other private insurers offering nongroup coverage would have the rates they pay providers capped at the same levels. Under this reform, my colleagues and I estimated an additional 30.8 million nongroup insurance enrollees compared with current law, increasing the total to 46.2 million people (Blumberg, Holahan, Buettgens, Gangopadhyaya, et al. 2019). These people, representing 14 percent of the US population, would be enrolled in plans using regulated rates for the first time. These estimates correspond with the pre-pandemic reality; with larger Medicaid and public option enrollment during a crisis, a larger share of the US population would be enrolled in plans using regulated rates than these estimates indicate, at least until the rate of employer-based insurance rebounds.

Replace the Current System with an Enhanced Single-Payer Program

Some legislative proposals would, if enacted, replace the current private-public hybrid insurance system with a purely public system enrolling the entire population in a government-organized and government-administered plan.²⁹ Some Democratic presidential candidates support this type of reform. These approaches, often referred to as Medicare for All, include benefits beyond those in typical private plans, eliminate household out-of-pocket costs and premiums, and would be financed entirely with government revenues. Private insurance plans would be prohibited. In the same work mentioned above, Urban Institute researchers estimated the cost and coverage implications of one such approach: enhanced single payer, which is reform 8 in Blumberg, Holahan, Buettgens, Gangopadhyaya, et al. (2019).

1. **How broadly should the health care costs of the sick be shared with the healthy?** A single-payer program like this one spreads the health care costs for all residents as broadly as possible. Virtually all health care costs are shared across all taxpayers, with the users of medical services contributing no more to financing than those who do not. It would increase the sharing of health care risk substantially beyond current law, essentially eliminating all premiums, out-of-pocket costs, and benefit limits. By removing financial barriers to accessing care, sudden changes in household income, such as job loss due to a pandemic, would not reduce access to care.
2. **How important is reaching true universal coverage?** This approach is designed to eliminate uninsurance in the US. It would include coverage for all US residents, regardless of legal

residency status. Since the coverage is completely unrelated to employment status, no changes or gaps in coverage would result due to crises like the current one.

3. **How generous should federally financed subsidies of premiums and cost sharing be?** With no premiums or cost sharing, this approach is essentially as generous a design as is possible to construct. The intent is that there be no financial barriers to accessing coverage when people need services.
4. **How should the reform option be financed?** We estimate that this reform would increase federal government spending by \$2.8 trillion in 2020 or \$34.0 trillion between 2020 and 2029, if fully implemented and phased in in 2020, a federal budget increase of more than 70 percent.³⁰ Senator Elizabeth Warren has proposed an array of revenue sources to finance this type of reform,³¹ and one of the single-payer bills active in Congress includes a list of potential funding sources, although it has not designated specific ones or a particular structure for covering the full estimated government costs.
5. **Should there be regulation of the prices paid to health care providers?** Every US resident would be in the same insurance plan under this approach, and all providers would be paid according to a regulated schedule of federally determined prices. In our estimates, we assume these would be at approximately Medicare levels.³² As a result, the number of services for which prices would be regulated by the federal government would increase dramatically.

Conclusion

Advocates of various health care reform proposals are quick to extoll the virtues of their preferred reforms. But advocates should acknowledge the trade-offs inherent in their respective approaches. An educated consumer of public policy ideas should be aware that there is no perfect solution. All reforms will yield advantages and disadvantages, gains and losses. The challenge is finding a policy that represents a broadly accepted set of trade-offs. Any one person's preferred trade-offs will hinge on their individual values and preferences. This brief is designed to help people understand the inherent consequences of different options so readers can make more informed choices about the types of reforms they support.

The five questions delineated here, when explored honestly and thoroughly, will expose the central trade-offs inherent in any specified reform proposal. Developing policy approaches that fit the needs of a critical mass of the American people and can engender sufficient support for sustained political viability after implementation necessitates an acknowledgement of, and open dialogue on, the country's priorities and the reform's trade-offs, measured as carefully and transparently as possible.

Notes

- ¹ Marketplaces (also known as exchanges) are organized health insurance markets for consumers to purchase private nongroup insurance policies that meet standards defined under the Affordable Care Act (ACA). The Marketplaces (some run by state governments, others run by the federal government) contract with private insurers to offer coverage, determine applicant eligibility for income-related subsidies, and provide enrollment assistance. Nongroup insurance policies can be purchased through the Marketplaces or outside them, but income-related subsidies to lower premiums and cost-sharing requirements (i.e., deductibles, copayments, and coinsurance) can be provided only for the purchase of coverage through the Marketplaces. Nongroup insurance, sometimes called individual insurance or directly purchased insurance, is private health insurance coverage available for purchase independent of employers. It is the market in which regulatory rules changed the most under the ACA.
- ² Large employer plans share the risk of workers and their dependents among others in the same firm. Small employer plans generally share risk with other small employers buying coverage. Like workers enrolled in employer plans, Medicare enrollees contribute toward their own costs through premiums and out-of-pocket payments, but a large share of Medicare enrollees' health care costs are spread across all federal taxpayers. Virtually all the health care costs of Medicaid enrollees are spread across state and federal government taxpayers, since the beneficiaries are very low income, their coverage is comprehensive, and they are asked to contribute very little to their care out-of-pocket. The private nongroup market is the insurance market for which health care costs were traditionally shared the least, although that has changed significantly under the ACA. Health care costs of nongroup insurance enrollees are largely shared across the population of nongroup enrollees in a state, although federal premium and cost-sharing subsidies pay for some. Depending upon their income and the plan chosen, households may shoulder substantial directly paid premiums, and those who use care may face large out-of-pocket costs. Some additional plans are exempt from the ACA's risk-sharing rules, such as grandmothers plans, health care sharing ministries, and short-term limited duration plans. Consequently, risk sharing has increased significantly because of the ACA, particularly within the individual insurance market, but a significant degree of risk segmentation continues.
- ³ Actuarial value is one measure of a health insurance plan's generosity. It measures the share of insured health care costs the insurance plan pays, as opposed to the share the enrollees pay through deductibles, copayments, and coinsurance. Actuarial value reflects an average over a population of enrollees.
- ⁴ Small-group insurance is sold to employers with fewer than 50 employees (including full-time equivalents).
- ⁵ Higher cost-sharing (lower-actuarial-value) plans have larger deductibles, copayments, coinsurance, or out-of-pocket maximums. Proposed "copper" plans introduce lower-value plans into the nongroup market. These plans would have an actuarial value of 50 percent compared with the standard 70 percent for Marketplace benchmark "silver" plans or 60 percent for "bronze" plans, the current lowest-value plans open to all purchasers. By one estimate, a copper plan in 2019 would have a deductible for a single adult of \$12,000 to \$13,000, with an out-of-pocket maximum of the same amount. See David Anderson, "Why Current Copper Plan Proposals Won't Work," Health Affairs blog, August 9, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180803.744146/full/>. This compares with the median deductible bronze plan the same year that had a deductible of \$6,650 with an out-of-pocket maximum of the same amount.
- ⁶ Health savings accounts (HSAs) are tax-exempt savings accounts that are used with high-deductible health plans; the funds deposited in the accounts can be used to pay for qualifying medical expenses. Although supporters hope HSAs will make individuals more prudent purchasers of medical care, the tax structure and incentives built into HSAs make them most attractive to the high-income and healthy people who are already advantaged by the current system. Funds deposited into the accounts are deducted from income for tax purposes, and any earnings on the funds accrue tax-free and are not subject to tax or penalty as long as they are withdrawn to cover medical costs.
- ⁷ Guaranteed issue requires insurers to sell a policy to any applicant, regardless of their health status or health risk.
- ⁸ Pure community rating prohibits insurers from selling the same insurance policy to different people at a different price, usually within a defined geographic area. Modified community rating prohibits the use of health status or

past health status or health experience in setting insurance prices but permits limited variation in premiums (e.g., adjustments for age or tobacco use).

- ⁹ Benefit standards define the minimum benefits that must be covered by a policy (e.g., hospital care, physician care, prescription drugs, maternity care, and preventive care). Actuarial value standards define the minimum share of covered expenses for the average enrollee that the policy must reimburse. For example, a policy must reimburse enrollees for at least 70 percent of the cost of covered benefits, on average, across the population of enrollees. The actuarial value standards effectively limit the out-of-pocket costs associated with an insurance policy.
- ¹⁰ High-risk pools are an explicit approach to separate the costs of people with high medical needs from others. Experience with high-risk pools before 2014 demonstrated that providing affordable, adequate coverage to a separated, high-need population required larger investments of public dollars than allocated. The funding required is well beyond levels proponents have suggested, given the large share of total health expenditures attributable to the highest-need population and the income constraints many face. See Blumberg (2011).
- ¹¹ Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019); Medicare for All Act of 2019, S. 1129, 116th Cong. (2019).
- ¹² Because of a Supreme Court decision in *National Federation of Independent Business v. Sebelius*, the ACA's Medicaid expansion of eligibility to almost all adults and children with incomes up to 138 percent of the federal poverty level was made voluntary to states. As of January 1, 2020, 14 states had not yet adopted the expansion, and another (Nebraska) had adopted it by ballot initiative but had not yet implemented it. Because the ACA stipulated that only people with incomes between 100 and 400 percent of the federal poverty level are eligible for Marketplace subsidies, people with low incomes who are not eligible for their state's traditional Medicaid or CHIP program (adults) are not eligible for any financial assistance to purchase coverage under the ACA. In essence, they are too poor to qualify for help under current law.
- ¹³ Calculation from the Urban Institute's Health Insurance Policy Simulation Model in 2019.
- ¹⁴ See, for example, the description of Continuous Autoenrollment with Retroactive Enforcement (CARE) as described in Blumberg, Holahan, Buettgens, Gangopadhyaya, et al. (2019). CARE would reach universal coverage for the legally present population, deeming those not actively enrolling in insurance coverage insured through either Medicaid or a public option, depending on their income. CARE would create a financial obligation for middle- and high-income people to contribute to their insurance coverage on an income-related basis. Those not enrolling in coverage voluntarily during the year would be required to pay income-related premiums for any months they were uninsured through the tax system at the end of the year. The lowest-income people, eligible for Medicaid or \$0 premium Marketplace coverage, would owe no premium.
- ¹⁵ If Marketplace subsidies had no upper income limit, the value of a person's subsidy would smoothly decrease to zero as the full premium they faced fell below the share-of-income cap as their income increased.
- ¹⁶ Uncompensated care refers to delivered medical services that the patient, insurer, or other third party does not directly pay for. This type of care is financed through a combination of sources, including federal and state government programs and providers' in-kind contributions. As the number of uninsured people increases, the demand for uncompensated care increases. Similarly, some people may have insurance, but because their cost-sharing responsibilities (e.g., deductibles and coinsurance) are large, they may be unable to pay their full portion of their medical bill.
- ¹⁷ For examples of reforms that would work in this way, see Blumberg, Holahan, Buettgens, and Zuckerman (2019) and reforms 5 and 6 in Blumberg, Holahan, Buettgens, Gangopadhyaya, et al. (2019).
- ¹⁸ High levels of concentration in insurer and provider markets are common, as are monopolies and duopolies.
- ¹⁹ Information asymmetries mean that consumers cannot make their own decisions about what services to consume. Providers are generally making the decisions for them.
- ²⁰ Providers deliver services in different ways, so in some respects, they are not selling the same services, another necessary condition of competitive markets.
- ²¹ Good health care provides positive externalities (e.g., workers are more productive, and thus economic conditions improve, and general population health is better when the broad population receives appropriate health care services).

- ²² See Rick Pollack, “Perspective: New Study Shows the Perils of a ‘Medicare for All’ Plan,” American Hospital Association blog, March 15, 2019, <https://www.aha.org/news/perspective/2019-03-15-perspective-new-study-shows-perils-medicare-all-plan>; and Pharmaceutical Research and Manufacturers of America, “Speaker Pelosi’s Drug Pricing Plan Could Result in 56 Fewer New Medicines over 10 Years,” press release, November 21, 2019, <https://phrma.org/Press-Release/Speaker-Pelosis-Drug-Pricing-Plan-Could-Result-in-56-Fewer-New-Medicines-Over-10-Years>.
- ²³ Capped rates can be implemented independently or in conjunction with a public option, the latter similar to the current Medicare market.
- ²⁴ It is possible that Medicaid eligibility levels in at least some of the seven states that had expanded eligibility before 2014 through coverage waivers would be set back even further. This is because not all those waivers are still active and it is unclear whether they would be resubmitted and reapproved.
- ²⁵ Medicare Part D prescription drug coverage plans typically pay for a share of an enrollee’s prescription drug costs up to a threshold. After the enrollee and the insurer spend the threshold amount, the enrollee must pay all additional prescription drug costs out of pocket, up to another threshold. Once that higher threshold is met, the Part D plan kicks in again and begins to help pay for additional prescription drug costs incurred. The range of spending where the insurer stops sharing in costs is referred to as the “doughnut hole.” The ACA includes a provision that eliminates the doughnut hole, requiring insurers to provide coverage all along the range of prescription drug spending.
- ²⁶ For more explanation, see the description of reform 5 in Blumberg, Holahan, Buettgens, Gangopadhyaya, et al. (2019).
- ²⁷ A public option implemented in the nongroup market would not affect risk pooling significantly. The ACA-compliant nongroup market in each state is already treated as a single risk pool under current law. The public option would simply provide another insurance option (at a lower price in many areas) into that single risk pool. But the other policies grouped together with the public option in most proposals would increase the sharing of health care risk.
- ²⁸ The premium tax credits are tied to an 80 percent actuarial value (gold) plan (as opposed to a 70 percent—silver—plan under current law), with people earning below 300 percent of the FPL offered even higher-value plans. Premium tax credits in the nongroup market limit household premium contributions for benchmark coverage to no more than 8.5 percent of income, with share-of-income caps decreasing from there for people with incomes below 400 percent of the FPL. The lowest-income enrollees in the Marketplaces pay no premium and are eligible for 95 percent actuarial value coverage. People choosing a plan more expensive than the second-lowest-cost gold plan would have to pay the full premium difference between the two themselves.
- ²⁹ Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019); Medicare for All Act of 2019, S. 1129, 116th Cong. (2019).
- ³⁰ Relative increase in the federal budget calculation is based on the Congressional Budget Office’s estimate of the federal budget between 2020 and 2029. See CBO (2020).
- ³¹ “Plans: Ending the Stranglehold of Health Care Costs on American Families,” Warren for President, accessed March 10, 2020, <https://elizabethwarren.com/plans/paying-for-m4a>
- ³² The Urban Institute analysis assumes that professionals would be paid at Medicare rates, hospitals would be paid at 15 percent above Medicare rates, and prescription drug prices would be set halfway between current Medicare and Medicaid prices. But, as explained previously, setting the payment and growth rate levels and delineating a path for moving from current levels to target levels poses significant practical challenges, particularly when the new rates apply to the entire population.

References

- Banthin, Jessica, Linda J. Blumberg, Matthew Buettgens, John Holahan, Clare Wang Pan, and Robin Wang. 2019. "Implications of the Fifth Circuit Court Decision in *Texas v. United States*: Losses of Coverage, Federal Health Spending, and Provider Revenue." Washington, DC: Urban Institute.
- Blumberg, Linda J. 2011. "High-Risk Pools—Merely a Stopgap Reform." *New England Journal of Medicine* 364: e39. <https://doi.org/10.1056/NEJMp1100112>.
- Blumberg, Linda J., John Holahan, Matthew Buettgens, Anug Gangopadhyaya, Bowen Garrett, Adele Shartzter, et al. 2019. *From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs*. Washington, DC: Urban Institute.
- Blumberg, Linda J., John Holahan, Matthew Buettgens, and Stephen Zuckerman. 2019. "The Healthy America Program, an Update and Additional Options." Washington, DC: Urban Institute.
- CBO (Congressional Budget Office). 2020. *The Budget and Economic Outlook: 2020 to 2030*. Washington, DC: CBO.
- Haley, Jennifer, Genevieve M. Kenney, Robin Wang, Clare Pan, Victoria Lynch, and Matthew Buettgens. 2018. "Uninsurance and Medicaid/CHIP Participation among Children and Parents: Variation in 2016 and Recent Trends." Washington, DC: Urban Institute.

About the Author

Linda J. Blumberg is an Institute Fellow in the Health Policy Center at the Urban Institute. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation at the state and federal levels, and interpreting and analyzing the implications of particular policies. Examples of her work include analyses of the implications of congressional proposals to repeal and replace the ACA, delineation of strategies to fix problems associated with the ACA, estimation of the cost and coverage potential of a broad array of health insurance system reforms, including public option and single payer approaches, analysis of the implications of the *Texas v US* and *King v. Burwell* cases, and several studies of competition in ACA Marketplaces. In addition, Blumberg led the quantitative analysis supporting the development of a “Road Map to Universal Coverage” in Massachusetts, a project with her Urban colleagues that informed that state’s comprehensive health reforms in 2006. Blumberg frequently testifies before Congress and is quoted in major media outlets on health reform topics. She serves on the Cancer Policy Institute’s advisory board and has served on the *Health Affairs* editorial board. From 1993 through 1994, she was a health policy adviser to the Clinton administration during its health care reform effort, and she was a 1996 Ian Axford Fellow in Public Policy. Blumberg received her PhD in economics from the University of Michigan.

Acknowledgments

This brief was funded by the Bernard and Anne Spitzer Charitable Trust. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the author and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute’s funding principles is available at urban.org/fundingprinciples.

The author is grateful for comments and suggestions from Jessica Banthin, Mary Beech, Mark Blumberg, John Holahan, Jean Ross, and Stephen Turow and for editorial assistance from David Hinson.



500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is a leading research organization dedicated to developing evidence-based insights that improve people’s lives and strengthen communities. For 50 years, Urban has been the trusted source for rigorous analysis of complex social and economic issues; strategic advice to policymakers, philanthropists, and practitioners; and new, promising ideas that expand opportunities for all. Our work inspires effective decisions that advance fairness and enhance the well-being of people and places.

Copyright © March 2020. Urban Institute. Permission is granted for reproduction of this file, with attribution to the Urban Institute.