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Filling the Medicaid Gap with a Public Option

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As of July 2021, 12 states have not yet expanded Medicaid as permitted by the Affordable Care Act (ACA). These states, hereafter called "nonexpansion states," have 14.6 million uninsured residents, including 5.8 million with incomes below the federal poverty level (FPL).[1] Adults in these states with incomes below the FPL are generally ineligible for any financial assistance in obtaining health insurance. Policymakers are interested in filling this "Medicaid gap" by extending the ACA Marketplace subsidies to this group. Here we present three reform options for filling the Medicaid gap by expanding Marketplace subsidies to people with incomes below the FPL using different subsidy schedules. We explore how the effects of these reforms differ when they are based on Marketplace benchmarks versus when they are available through a public option. The public option would be a government-sponsored plan paying Medicare rates for hospital and other provider services and reduced (negotiated) prices for prescription drugs.

Filling the Medicaid gap could significantly affect broader efforts to reduce uninsurance, because nonexpansion states have large numbers of uninsured people, their residents generally have lower incomes than people in expansion states, and several of them have large populations (e.g., Florida, Georgia, North Carolina, and Texas). The federal government would bear most of costs of filling the gap, but because benchmark premiums are high in many nonexpansion states, a public option could potentially provide the same coverage at a lower cost to the federal government.

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute has undertaken US Health Reform—Monitoring and Impact, a comprehensive monitoring and tracking project examining the implementation and effects of health reforms. Since May 2011, Urban Institute researchers have documented changes to the implementation of national health reforms to help states, researchers, and policymakers learn from the process as it unfolds. The publications developed as part of this ongoing project can be found on both the Robert Wood Johnson Foundation's and Urban Institute Health Policy Center's websites.

If Marketplace subsidies were used to fill the Medicaid gap, eligible people would be able to choose from among all Marketplace plans offered in a rating region. The federal government would pay for subsidies, specifically the difference between the percentage-of-income cap on consumers' health insurance costs laid out in the subsidy schedule and the premium for each rating region's Marketplace benchmark plan. However, filling the Medicaid gap with a Marketplace expansion will still leave some people ineligible for assistance. People with an affordable offer of insurance from an employer cannot receive help with premiums under the ACA (although they could receive Medicaid if their state were to choose to expand). And people who are not legally present in the US are not eligible for any sort of federal assistance. On the other hand, many people with incomes below the FPL in nonexpansion states already have health insurance—either through an employer, purchased on the nongroup market without subsidies, or through the existing Medicaid program. Some of these people could benefit from extended subsidies, but others will not. To capture all people who could potentially be affected by reform, we present results of filling Medicaid gap for all people with incomes below the FPL in the 12 nonexpansion states.

If a public option were established by the federal government and offered in the Marketplaces specifically to those in the Medicaid gap, it would not be available to those with incomes above the FPL, and those with incomes below the FPL would not have access to private Marketplace plans. In general, a public option paying Medicare rates would result in significant reductions in providers' payment rates. However, a public option offered only to people in the Medicaid gap would have limited impacts on providers; the public option would be limited only to people with incomes below the FPL, and many of those who would become eligible are currently uninsured. Thus, a public option plan paying Medicare rates would generally be an improvement over current payments to providers, and federal subsidy costs with the public option in place would be lower than federal costs using Marketplace benchmarks.

In other work, we examined Marketplace options for filling the Medicaid gap using existing or improved subsidies for people with ACA nongroup coverage.[2] In that work, subsidies would be tied to Marketplace benchmark premiums, which are based on the second-lowest-cost silver plan in each rating region. Subsidy estimates in that work, as well as in this paper, are only for nonexpansion states. Increasing subsidies would affect all states and would cost considerably more than shown here. In that work, we examined the following reform options for filling the Medicaid gap:

- **Marketplace expansion using the pre–American Rescue Plan Act (ARPA) subsidy schedule.** If a policy using the ACA subsidy schedule that was in place before ARPA's enactment in March 2021 were in place in 2022, it would cover 3.0 million people at a federal cost of $15.1 billion in nonexpansion states ($181 billion over 10 years).
- **Marketplace expansion using the ARPA subsidy schedule.** This policy would increase premium subsidies at all incomes to match the ARPA's subsidy schedule. If implemented in 2022, it would cover 4.6 million people at a federal cost of $22.5 billion in nonexpansion states ($270 billion over 10 years).
- **Marketplace expansion using an enhanced subsidy schedule.** This policy would increase both premiums and cost-sharing subsidies. If implemented in 2022, it would cover 5.0 million people at a cost to the federal government of $27.9 billion in nonexpansion states ($335 billion over 10 years).

In this paper, we build on these reforms by introducing a public option that would be the plan available to the Medicaid gap population. We compare spending on and coverage among the gap population under each of the three reforms using either Marketplace benchmark premiums or a public option. This paper focuses on the Medicaid gap population but has effects outside that population, too. In the coverage changes shown above, 2.8 million, 3.2 million, and 3.2 million people gaining coverage under these reforms would be in the Medicaid gap population, and $16.6 billion, $17.2 billion, and $18.1 billion of the increases in federal spending would go to this group.

Under all three options, we also project the federal government would spend $12.1 billion in 2022 (or $145 billion over 10 years) to increase the federal match rate for the Medicaid expansion population in states that have already expanded Medicaid. Without this increase, Medicaid expansion states would bear a greater share of the costs of caring for their low-income populations than would nonexpansion states. This would be inequitable and could lead states to drop Medicaid expansion.

Results

Subsidy schedules. As in our previous work, we examine policies that would fill the Medicaid gap using three alternative subsidy schedules. The first option would use the subsidy schedule in place under the ACA, before the ARPA took effect in March 2021 (table 1).[3] People with incomes below 138 percent of FPL would pay premiums of 2.07 percent of their income, whereas those with incomes above 400 percent of FPL would receive no premium assistance. The second option would use the ARPA's premium subsidies. Those with incomes below 150 percent of FPL would not pay premiums, and no one would have to pay premiums greater than 8.5 percent of their income. Both the first and second reform options link premium subsidies to the silver metal tier. The third option would improve premium assistance and cost-sharing subsidies. Its subsidy schedule would be identical to the ARPA's, but the premium subsidies would be tied to the gold metal tier; the more comprehensive cost-sharing subsidies used have been proposed by Senator Shaheen (D-NH) and other members of Congress.[4]

TABLE 1

Pre–American Rescue Plan and Reform Option Subsidy Schedules

Premium tax credit percentage-of-income limits for benchmark coverage (%)

	Pre-ARPA law	Marketplace expansion, pre-ARPA subsidy schedule	Marketplace expansion, ARPA subsidy schedule	Marketplace expansion, enhanced subsidy schedule
Income (% of FPL)				
<138	2.07	2.07	0.0	0.0
138–150	3.10–4.14	3.10–4.14	0.0	0.0
150–200	4.14–6.52	4.14–6.52	0.0–2.0	0.0–2.0
200–250	6.52–8.33	6.52–8.33	2.0–4.0	2.0–4.0
250–300	8.33–9.83	8.33–9.83	4.0–6.0	4.0–6.0
300–400	9.83	9.83	6.0–8.5	6.0–8.5
400–500	n/a	n/a	8.5–8.5	8.5–8.5
500–600	n/a	n/a	8.5–8.5	8.5–8.5
600+	n/a	n/a	8.5–8.5	8.5–8.5
Benchmark plan	**Silver**	**Silver**	**Silver**	**Gold**

Cost-sharing reductions: Actuarial value of plan provided to eligible enrollees (%)

	Pre-ARPA law	Marketplace expansion, pre-ARPA subsidy schedule	Marketplace expansion, ARPA subsidy schedule	Marketplace expansion, enhanced subsidy schedule
Income (% of FPL)				
<138	94	94	94	95
138–150	94	94	94	95
150–200	87	87	87	95
200–250	73	73	73	90
250–300	70	70	70	90
300–400	70	70	70	85
400–500	70	70	70	80
500–600	70	70	70	80
600+	70	70	70	80

Sources: Data on premium tax credit percentage-of-income limits are from Examination of Returns and Claims for Refund, Credit, or Abatement; Determination of Correct Tax Liability, CFR 601.105, (2020); American Rescue Plan Act of 2021, Pub. L. No. 117-2; and the Improving Health Insurance Affordability Act of 2021, S.499 117th Cong. (2021–22). Data on cost-sharing reductions are from "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans," 85 Fed. Reg. 29164, May 14, 2020, and the Improving Health Insurance Affordability Act of 2021.

Notes: ARPA = American Rescue Plan Act. FPL = federal poverty level. n/a = not applicable, because no subsidies are available at this income level. Percentage-of-income caps applied in 2022, though the pre–American Rescue Plan Act caps are for 2021 and are indexed each year. Alternative schedules are not intended to be indexed.

Pre-ARPA subsidy schedule. In table 2 and figure 1, we show how filling the Medicaid gap using a Marketplace expansion with pre-ARPA subsides would affect coverage for people in the gap in 2022. Under this reform, the number of people with nongroup coverage would increase by 3.0 million relative to pre-ARPA law, with 3.2 million people gaining Marketplace subsidies. About 267,000 people would leave employer coverage (presumably people who bought employer coverage and paid more than is

considered affordable under ACA rules). Another 119,000 would leave other nongroup coverage. The net result would be an increase of 2.8 million people with comprehensive health insurance; of those, 113,000 would have left ACA-noncompliant nongroup plans.

If the Medicaid gap were instead filled by a public option, coverage would not increase more than under expansion tied to Marketplace benchmarks. People in the Medicaid gap who would gain subsidized coverage would pay a fixed percentage of their income for coverage, which would not change with the addition of the public option. Therefore, these people would not change their coverage type. Savings from the public option's lower payment rates would instead result in lower federal costs for subsidies.[5] People would, however, leave the private Marketplace coverage they would have had and would instead enroll in the public option. Under the public option, no one with income above the FPL would be able to enroll in the public option, and no one with income below the FPL would be able to choose a private Marketplace plan.

TABLE 2

Coverage Distribution of the Nonelderly Population in the Medicaid Gap under Pre-ARPA Law and under Marketplace Expansion Using the Pre-ARPA Subsidy Schedule with and without a Public Option, 2022

Thousands of people

	Pre-ARPA law	Marketplace expansion, pre-ARPA subsidy schedule	Change	Marketplace expansion, pre-ARPA subsidy schedule and a public option	Change
Insured (MEC)	**13,856**	**16,649**	**2,793**	**16,649**	**2,793**
Employer	2,154	1,887	-267	1,887	-267
Nongroup	394	3,438	3,044	3,438	3,044
Public option	0	0	0	3,203	3,203
Private Marketplace with PTC	41	3,203	3,163	0	-41
Other private nongroup	353	234	-119	234	-119
Medicaid/CHIP	10,666	10,681	16	10,681	16
Other public coverage	642	642	0	642	0
Uninsured (no MEC)	**5,764**	**2,971**	**-2,793**	**2,971**	**-2,793**
Uninsured	5,503	2,823	-2,681	2,823	-2,681
Noncompliant nongroup	260	148	-113	148	-113
Total	**19,619**	**19,619**	**0**	**19,619**	**0**

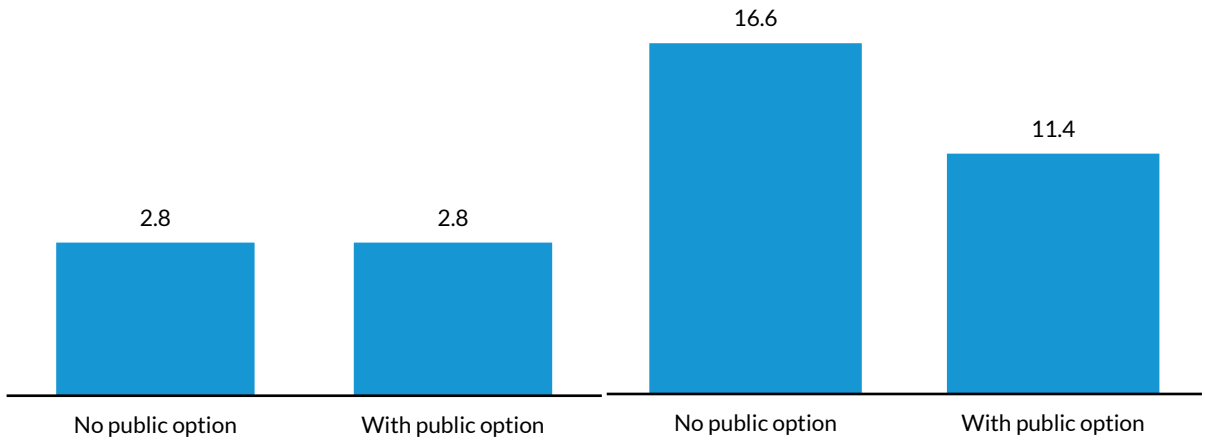
Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: ARPA = American Rescue Plan Act. MEC = minimum essential coverage. PTC = premium tax credit. CHIP = Children's Health Insurance Program. People with Medicaid/CHIP have coverage under the traditional rules for these programs. People in the Medicaid gap have incomes below the federal poverty level and live in the 12 nonexpansion states (Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming).

FIGURE 1

Increases in Coverage and Federal Spending for Nonelderly People in the Medicaid Gap under Medicaid Expansion Using the Pre-ARPA Subsidy Schedule with and without a Public Option, Relative to Pre-ARPA Law, 2022

Change in coverage (millions of people) *Change in federal spending (billions of dollars)*



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: ARPA = American Rescue Plan Act. People in the Medicaid gap have incomes below the federal poverty level and live in the 12 Medicaid nonexpansion states (Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming).

Table 3 shows how using pre-ARPA subsidies based on Marketplace benchmarks to fill the Medicaid gap affects health spending on people in the gap. In 2022, premium tax credits would increase by $18.1 billion relative to pre-ARPA law. Uncompensated care costs would decline by $1.6 billion.[6] The net increase in federal government spending would be $16.6 billion. Households would pay $2.1 billion less in premiums; for example, those leaving employer coverage would likely pay lower premiums once Marketplace premium subsidies are available to them. Other household health care spending would increase by $4.2 billion as newly covered people consume more care. The overall increase in household health care spending would be $2.1 billion. Employers would spend $1.9 billion less on premiums because fewer people would stay with employer coverage. Overall health care spending on the Medicaid gap population would increase by $14.4 billion.

If instead the gap were filled by a Marketplace expansion using the pre-ARPA subsidy schedule and a public option, government spending on tax credits would increase by $12.9 billion in 2022. This is $5.2 billion, or 28 percent, less than under a reform using Marketplace benchmarks. Total federal spending would increase by $11.4 billion, a reduction of $5.2 billion relative to using Marketplace benchmarks. Households would also save money both in premiums and cost sharing because of the public option's lower premiums. Employers' premium contributions would not fall further under the public option, because no additional workers would leave employer coverage. National health spending would increase by $8.1 billion, down from $14.4 billion with Marketplace benchmarks.

TABLE 3

Health Spending on the Nonelderly Population in the Medicaid Gap under Pre-ARPA Law and under Marketplace Expansion Using the Pre-ARPA Subsidy Schedule with and without a Public Option, 2022

Billions of dollars

	Pre-ARPA law	Marketplace expansion, pre-ARPA subsidy schedule	Change	Marketplace expansion, pre-ARPA subsidy schedule and a public option	Change
Household					
Premiums	5,814	3,744	-2,070	3,617	-2,197
Other health care spending	7,685	11,841	4,156	10,880	3,195
Subtotal	*13,498*	*15,585*	*2,087*	*14,497*	*999*
Federal government					
Medicaid	56,723	56,778	56	56,778	56
Marketplace PTC	303	18,373	18,070	13,158	12,855
Marketplace CSR	0	63	63	57	57
Reinsurance	2	2	1	2	0
Uncompensated care[a]	3,988	2,374	-1,614	2,374	-1,614
Subtotal	*61,016*	*77,591*	*16,575*	*72,369*	*11,353*
State government					
Medicaid	31,448	31,482	34	31,482	34
Marketplace PTC	0	0	0	0	0
Marketplace CSR	0	0	0	0	0
Reinsurance	0	0	0	0	0
Uncompensated care	2,493	1,484	-1,009	1,484	-1,009
Subtotal	*33,941*	*32,966*	*-975*	*32,966*	*-975*
Employers					
Premium contributions	13,069	11,178	-1,891	11,178	-1,891
Providers					
Uncompensated care	3,490	2,077	-1,412	2,077	-1,412
Total, all payers	**125,013**	**139,397**	**14,384**	**133,087**	**8,074**

Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: ARPA = American Rescue Plan Act. PTC = premium tax credit. CSR = cost-sharing reduction. People in the Medicaid gap have incomes below the federal poverty level and live in the 12 nonexpansion states (Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming).

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

ARPA subsidy schedule. With a Marketplace expansion based on the ARPA subsidy schedule and Marketplace benchmarks, nongroup coverage would increase by 3.4 million in 2022 relative to pre-ARPA law (table 4 and figure 2); 3.3 million people would get new Marketplace subsidies. The number of people with employer coverage would fall by 228,000. About 3.2 million people would gain comprehensive coverage, 116,000 of whom would have left noncompliant nongroup coverage. Once again, using this reform and a public option to fill the Medicaid gap would have no additional change in coverage; 3.2 million people fewer people would be uninsured than under pre-ARPA law.

TABLE 4

Coverage Distribution of the Nonelderly Population in the Medicaid Gap under Pre-ARPA Law and under Marketplace Expansion Using the ARPA Subsidy Schedule with and without a Public Option, 2022

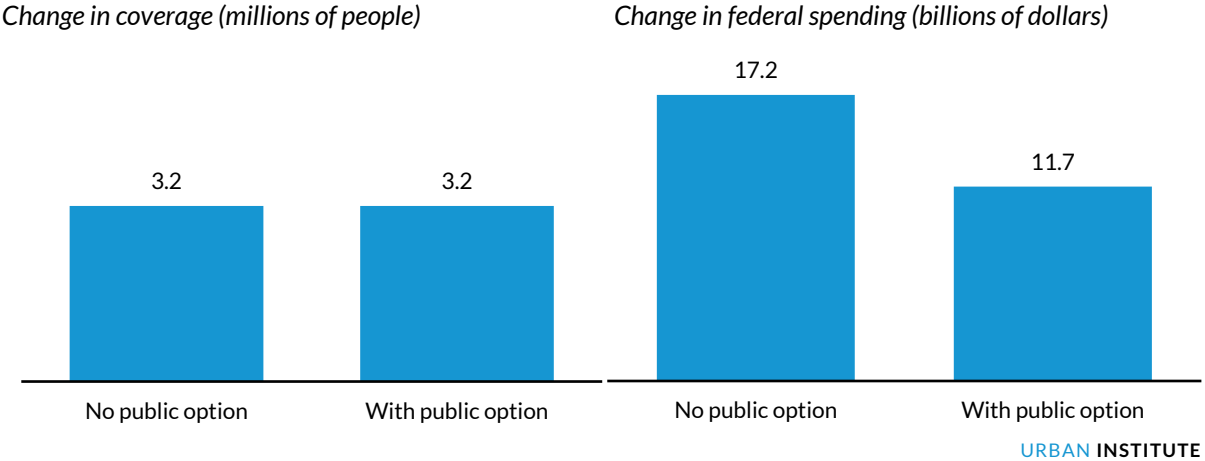
Thousands of people

	Pre-ARPA law	Marketplace expansion, ARPA subsidy schedule	Change	Marketplace expansion, ARPA subsidy schedule and a public option	Change
Insured (MEC)	**13,856**	**17,025**	**3,169**	**17,025**	**3,169**
Employer	2,154	1,926	-228	1,926	-228
Nongroup	394	3,769	3,376	3,769	3,376
Public option	0	0	0	3,296	3,296
Private Marketplace with PTC	41	3,296	3,255	0	-41
Other private nongroup	353	473	121	473	121
Medicaid/CHIP	10,666	10,687	21	10,687	21
Other public coverage	642	642	0	642	0
Uninsured (no MEC)	**5,764**	**2,595**	**-3,169**	**2,595**	**-3,169**
Uninsured	5,503	2,451	-3,053	2,451	-3,053
Noncompliant nongroup	260	144	-116	144	-116
Total	**19,619**	**19,619**	**0**	**19,619**	**0**

Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: ARPA = American Rescue Plan Act. MEC = minimum essential coverage. PTC = premium tax credit. CHIP = Children's Health Insurance Program. People with Medicaid/CHIP have coverage under the traditional rules for these programs. People in the Medicaid gap have incomes below the federal poverty level and live in the 12 nonexpansion states (Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming).

FIGURE 2

Increases in Coverage and Federal Spending for Nonelderly People in the Medicaid Gap under Medicaid Expansion Using the ARPA Subsidy Schedule with and without a Public Option, Relative to Pre-ARPA Law, 2022



Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: ARPA = American Rescue Plan Act. People in the Medicaid gap have incomes below the federal poverty level and live in the 12 nonexpansion states (Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming).

Filling the Medicaid gap with a Marketplace expansion based on the ARPA subsidy schedule and Marketplace benchmarks would increase federal spending on people in the gap by $19.2 billion relative to pre-ARPA law (table 5). Household spending would increase by $2.9 million, because premium savings would be offset by expanded coverage and cost sharing for additional health services used. Accounting for the reduction in uncompensated care, net federal spending would increase by $17.2 billion. Employers' premium payments would decline by $1.7 billion because of the number of employees leaving their employer-sponsored plans. Overall health expenditures on the Medicaid gap population would increase by $15.3 billion.

If a public option with the same ARPA subsidy schedule were used to fill the gap, government spending on premium tax credits would increase by $13.7 billion relative to pre-ARPA law, which is $5.5 billion less than using Marketplace benchmarks. Again, this is more than a 28 percent reduction in the costs of premium tax credits for people in the gap. Total federal spending would increase by $11.7 billion, also $5.5 billion less than under this reform with Marketplace benchmarks. Households would save $1.2 billion because of lower cost sharing owing to lower provider payments in the public option. Employer coverage would not decline more than under the Marketplace benchmarks.

TABLE 5

Health Spending on the Nonelderly Population in the Medicaid Gap under Pre-ARPA Law and under Marketplace Expansion Using the ARPA Subsidy Schedule with and without a Public Option, 2022

Billions of dollars

	Pre-ARPA law	Marketplace expansion, ARPA subsidy schedule	Change	Marketplace expansion, ARPA subsidy schedule and a public option	Change
Household					
Premiums	5,814	3,878	-1,936	3,731	-2,083
Other health spending	7,685	12,490	4,805	11,405	3,720
Subtotal	*13,498*	*16,367*	*2,869*	*15,136*	*1,638*
Federal government					
Medicaid	56,723	56,802	80	56,802	80
Marketplace PTC	303	19,527	19,224	14,011	13,708
Marketplace CSR	0	74	74	65	65
Reinsurance	2	2	0	2	0
Uncompensated care[a]	3,988	1,847	-2,141	1,847	-2,141
Subtotal	*61,016*	*78,252*	*17,237*	*72,728*	*11,712*
State government					
Medicaid	31,448	31,496	48	31,496	48
Marketplace PTC	0	0	0	0	0
Marketplace CSR	0	0	0	0	0
Reinsurance	0	0	0	0	0
Uncompensated care	2,493	1,154	-1,338	1,154	-1,338
Subtotal	*33,941*	*32,651*	*-1,290*	*32,651*	*-1,290*
Employers					
Premium contributions	13,069	11,402	-1,666	11,402	-1,666
Providers					
Uncompensated care	3,490	1,616	-1,873	1,616	-1,873
Total, all payers	**125,013**	**140,289**	**15,276**	**133,533**	**8,520**

Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: ARPA = American Rescue Plan Act. PTC = premium tax credit. CSR = cost-sharing reduction. People in the Medicaid gap have incomes below the federal poverty level and live in the 12 nonexpansion states (Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming).
[a] Uncompensated care represents the demand for care for the uninsured. At the federal level, about half the change in demand resulting from a decrease in uninsurance would automatically be realized as federal savings to Medicare disproportionate share hospitals. Reinsurance savings would be uncertain.

Enhanced subsidy schedule. Further enhancing subsidies beyond the ARPA would have a minimal effect on coverage for people with incomes below the FPL relative to the ARPA based reform; it would affect coverage for people with higher incomes, however. Both reforms have $0 premiums for coverage and very similar cost-sharing subsidies. Under the enhanced subsidy schedule in 2022, nongroup coverage for people in the Medicaid gap would increase by 3.4 million relative to pre-ARPA law (table 6 and figure 3). Of these, 3.3 million people would have new Marketplace subsidies, nearly all of whom would have been previously uninsured, and 116,000 would have left noncompliant nongroup coverage. Employer coverage would decline by 229,000 people.

Using a public option with the enhanced subsidy schedule would result in no changes to overall coverage relative to using Marketplace benchmarks, because the public option would not change peoples' percentage-of-income caps (i.e., premiums are $0 with or without the public option). Rather than enrolling in private Marketplace plans, 3.3 million people would be in the public option.

Under the enhanced subsidy schedule using Marketplace benchmarks, federal government spending on premium tax credits would increase by $19.2 billion in 2022 relative to pre-ARPA law (table 7). Total federal spending would increase by $18.1 billion. With the enhanced subsidy schedule and a public option, spending on premium tax credits would increase by $13.6 billion, or by $5.6 billion (28 percent) less than with Marketplace benchmarks. Federal government spending on people in the gap would rise by $12.3 billion, a reduction of $5.6 billion relative to this reform with Marketplace benchmarks. Households would also spend less ($1.2 billion) because of the lower payment rates in the public option. Overall health spending would increase by $9.0 billion with the public option, rather than $15.9 billion with the Marketplace benchmarks.

TABLE 6

Coverage Distribution of the Nonelderly Population in the Medicaid Gap under Pre-ARPA Law and under Marketplace Expansion Using the Enhanced Subsidy Schedule with and without a Public Option, 2022

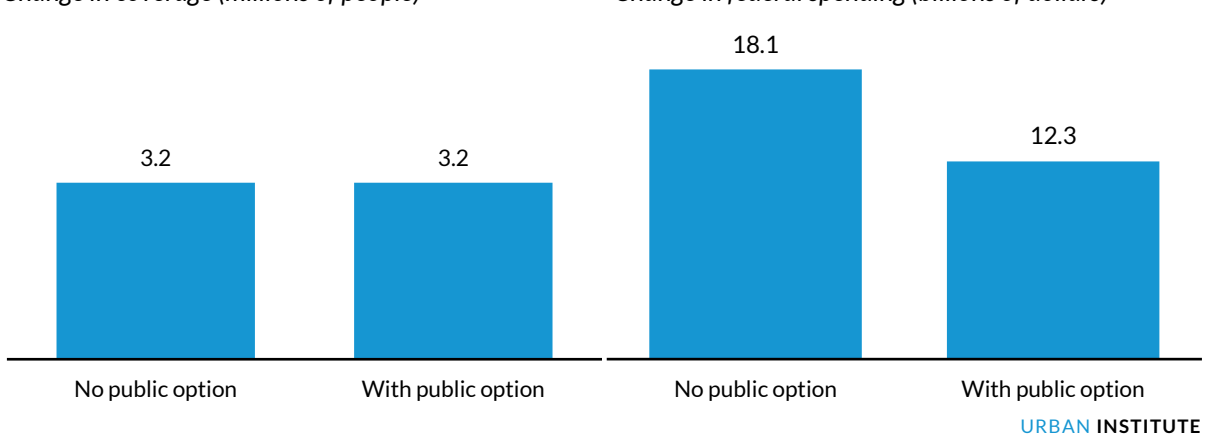
Thousands of people

	Pre-ARPA law	Marketplace expansion, enhanced subsidy schedule	Change	Marketplace expansion, enhanced subsidy schedule and a public option	Change
Insured (MEC)	**13,856**	**17,025**	**3,170**	**17,025**	**3,170**
Employer	2,154	1,925	-229	1,925	-229
Nongroup	394	3,771	3,378	3,771	3,378
Public option	0	0	0	3,297	3,297
Private Marketplace with PTC	41	3,297	3,256	0	-41
Other private nongroup	353	475	122	475	122
Medicaid/CHIP	10,666	10,687	21	10,687	21
Other public coverage	642	642	0	642	0
Uninsured (no MEC)	**5,764**	**2,594**	**-3,170**	**2,594**	**-3,170**
Uninsured	5,503	2,450	-3,053	2,450	-3,053
Noncompliant nongroup	260	144	-116	144	-116
Total	**19,619**	**19,619**	**0**	**19,619**	**0**

Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: ARPA = American Rescue Plan Act. MEC = minimum essential coverage. PTC = premium tax credit. CHIP = Children's Health Insurance Program. People with Medicaid/CHIP have coverage under the traditional rules for these programs. People in the Medicaid gap have incomes below the federal poverty level and live in the 12 nonexpansion states (Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming).

FIGURE 3

Increases in Coverage and Federal Spending for Nonelderly People in the Medicaid Gap under Medicaid Expansion Using the Enhanced Subsidy Schedule with and without a Public Option, Relative to Pre-ARPA Law, 2022



Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: ARPA = American Rescue Plan Act. People in the Medicaid gap have incomes below the federal poverty level and live in the 12 nonexpansion states (Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming).

TABLE 7

Health Spending on the Nonelderly Population in the Medicaid Gap under Pre-ARPA Law and under Marketplace Expansion Using the Enhanced Subsidy Schedule with and without a Public Option, 2022

Billions of dollars

	Pre-ARPA law	Marketplace expansion, enhanced subsidy schedule	Change	Marketplace expansion, enhanced subsidy schedule and a public option	Change
Household					
Premiums	5,814	3,641	-2,173	3,548	-2,265
Other health care spending	7,685	12,502	4,817	11,415	3,731
Subtotal	*13,498*	*16,143*	*2,645*	*14,964*	*1,466*
Federal government					
Medicaid	56,723	56,802	80	56,802	80
Marketplace PTC	303	19,484	19,181	13,932	13,629
Marketplace CSR	0	53	53	46	46
Reinsurance	2	913	912	733	732
Uncompensated care[a]	3,988	1,846	-2,142	1,846	-2,142
Subtotal	*61,016*	*79,099*	*18,083*	*73,360*	*12,344*
State government					
Medicaid	31,448	31,496	48	31,496	48
Marketplace PTC	0	0	0	0	0
Marketplace CSR	0	0	0	0	0
Reinsurance	0	0	0	0	0
Uncompensated care	2,493	1,154	-1,339	1,154	-1,339
Subtotal	*33,941*	*32,649*	*-1,291*	*32,649*	*-1,291*
Employers					
Premium contributions	13,069	11,392	-1,677	11,392	-1,677
Providers					
Uncompensated care	3,490	1,615	-1,875	1,615	-1,875
Total, all payers	**125,013**	**140,898**	**15,885**	**133,980**	**8,967**

Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: ARPA = American Rescue Plan Act. PTC = premium tax credit. CSR = cost-sharing reduction. People in the Medicaid gap have incomes below the federal poverty level and live in the 12 nonexpansion states (Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming).

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

Increases in coverage outside the Medicaid gap. Expanding coverage in the Medicaid gap and increasing subsidies will also affect people with incomes above the FPL. This happens for two reasons. First, in the ARPA-based and enhanced subsidy reforms, more generous assistance would be available to people who are outside the Medicaid gap and eligible for nongroup subsidies, which lowers the cost of purchasing insurance and increases coverage. Second, the additional people who would be covered because of the more generous subsidies (both among people in the gap and, in reforms 2 and 3, outside the gap) would add a relatively healthy population to the risk pool, which reduces total premiums for

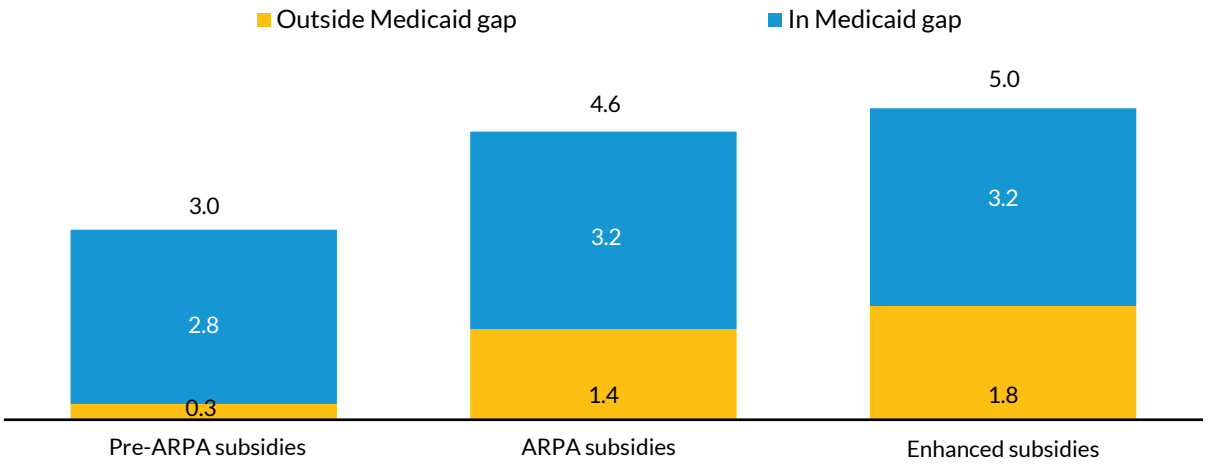
everyone in the Marketplace. Lower premiums would also make coverage more affordable for people ineligible for subsidies or whose subsidies are limited by income.

Figure 4 shows how the three reform options affect overall coverage independent of a public option; results in this section are only for nonexpansion states but are not limited to the Medicaid gap population. Under a Marketplace expansion with pre-ARPA subsidies, 3.0 million people would be newly covered in 2022 relative to pre-ARPA law. Of these, 2.8 million would have been in the Medicaid gap, and about 300,000 would enroll in coverage because premiums would have been reduced by the improved risk pool.[7] Under Marketplace expansion with ARPA subsidies, 3.2 million people in the gap would be newly covered and 1.4 million people outside the gap would enroll in coverage because of the improved subsidies and lower household premiums. Thus, coverage would expand by 4.6 million people under this reform. With enhanced subsidies, 3.2 million people in the Medicaid gap again obtain new coverage, and 1.8 million with incomes above the FPL would gain coverage because of the improved subsidies and lower premiums. Thus, coverage would increase by 5.0 million people.

FIGURE 4

Increases in Coverage among the Nonelderly Population in Nonexpansion States in and outside the Medicaid Gap under the Reforms, Relative to Pre-ARPA Law, 2022

Millions of people



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: ARPA = American Rescue Plan Act. People in the Medicaid gap have incomes below the federal poverty level and live in the 12 nonexpansion states (Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming).

Figure 5 shows changes in federal spending in 2022 under reforms with and without the public option. Under the pre-ARPA subsidy schedule and Marketplace benchmarks, federal expenditures would increase by $27.2 billion relative to pre-ARPA law. This includes $16.6 billion spent on people in the Medicaid gap. Spending on those outside the gap would fall by $1.5 billion relative to pre-ARPA law because of the reduction in premiums resulting from the improved risk pool. An additional $12.1 billion would be used to increase the federal matching rate in expansion states to preserve equity and prevent states from dropping their Medicaid expansions. If a public option were implemented alongside these subsidies, federal spending would instead increase by $22.0 billion relative to pre-ARPA law. Federal spending on the gap population would fall to $11.4 billion, a reduction of $5.2 billion relative to the same policy using Marketplace benchmarks. Spending on subsidies for those with incomes above the FPL would still fall by $1.5 billion because of the premium reductions due to the improved risk pool. Again, the federal government would spend an additional $12.1 billion on increased matching rates. Thus, total spending under a public option with pre-ARPA subsidies would be $22.0 billion, or $5.2 billion less than pre-ARPA subsidies with Marketplace benchmarks.

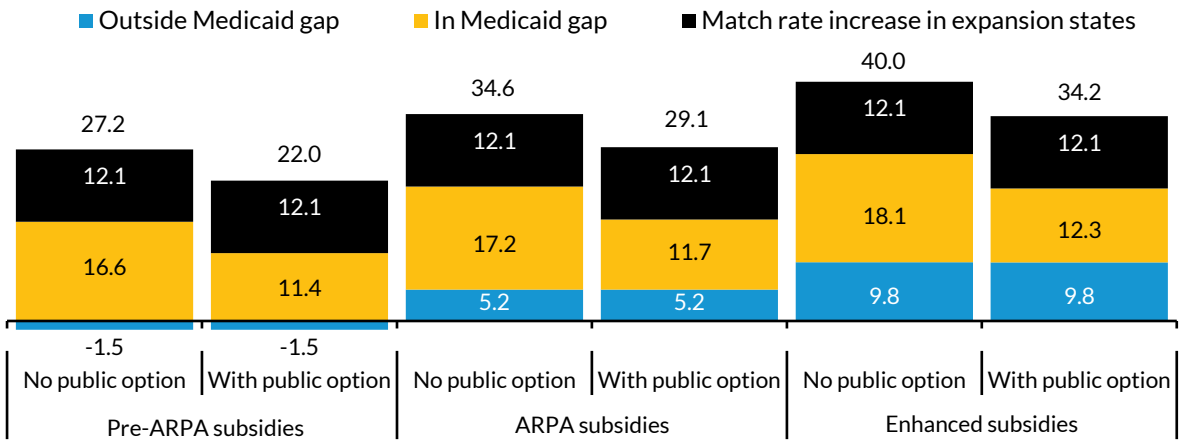
Under a Marketplace expansion using the ARPA subsidy schedule and Marketplace benchmarks, federal spending would increase by $34.6 billion relative to pre-ARPA law. The federal government would spend $17.2 billion on people in the Medicaid gap; it would also spend $5.2 billion on people with incomes above the FPL because of expanded coverage and the cost of improved subsidies. Again, the federal government would spend $12.1 billion to increase matching rates in expansion states. With the ARPA subsidy schedule and a public option, federal spending for those in the gap would be $11.7 billion, $5.5 billion less than under this reform using Marketplace benchmarks. Thus, overall spending with a public option would increase by $29.1 billion, a reduction of $5.5 billion relative to using Marketplace benchmarks.

Under the final reform, Marketplace expansion with an enhanced subsidy schedule for both premium tax credits and cost sharing, spending would increase relative to pre-ARPA law by $40.0 billion using Marketplace benchmarks and by $34.2 billion with the public option. Using Marketplace benchmarks, federal spending would be $18.1 billion for those in the Medicaid gap under this reform; under a public option for this reform, federal spending for this group would be $12.3 billion, or $5.8 billion less than under Marketplace benchmarks. Another $9.8 billion would be spent on people with incomes above the FPL because of both increased coverage and the higher costs of subsidies. Adding in the $12.1 billion for increasing the federal matching rate, total spending for this reform would be $40.0 billion using Marketplace benchmarks and $34.2 billion with the public option.

FIGURE 5

Changes in Federal Spending under Marketplace Expansion Reforms to Fill the Medicaid Gap with and without the Public Option, Relative to Pre-ARPA Law, 2022

Billions of dollars



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: ARPA = American Rescue Plan Act. Includes federal health spending in nonexpansion states and increased Medicaid spending in expansion states. Nonexpansion states are Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

Ten-year spending estimates. Figure 6 presents 10-year estimates (2022–31) of federal spending under the reforms with and without a public option. Under a Marketplace expansion using the pre-ARPA subsidy schedule and Marketplace benchmarks, federal spending would increase by $327 billion over 10 years. Of this, $199 billion would be spent on people in the Medicaid gap. Spending on those outside the gap in nonexpansion states would fall by $18 billion over 10 years because of the premium reduction. Increasing the federal matching rate for Medicaid expansion would increase spending by $145 billion. Under the reform with the pre-ARPA subsidy schedule and a public option, total spending would be $264 billion. Spending on people outside the gap and the cost of increasing the matching rate in expansion states would be the same. But spending on those in Medicaid gap would increase by $136 billion, a reduction of $63 billion compared with using Marketplace benchmarks under this reform.

Under the Marketplace expansion with the ARPA subsidy schedule, total spending would increase by $415 billion using Marketplace benchmarks and by $349 billion with the public option over 10 years. Spending on people in the Medicaid gap would increase by $207 billion with the Marketplace benchmarks and by $141 billion with the public option. Spending on those outside the Medicaid gap in nonexpansion states would increase by $63 billion. Again, the 10-year cost of increasing the federal matching rate in expansion states would be $145 billion.

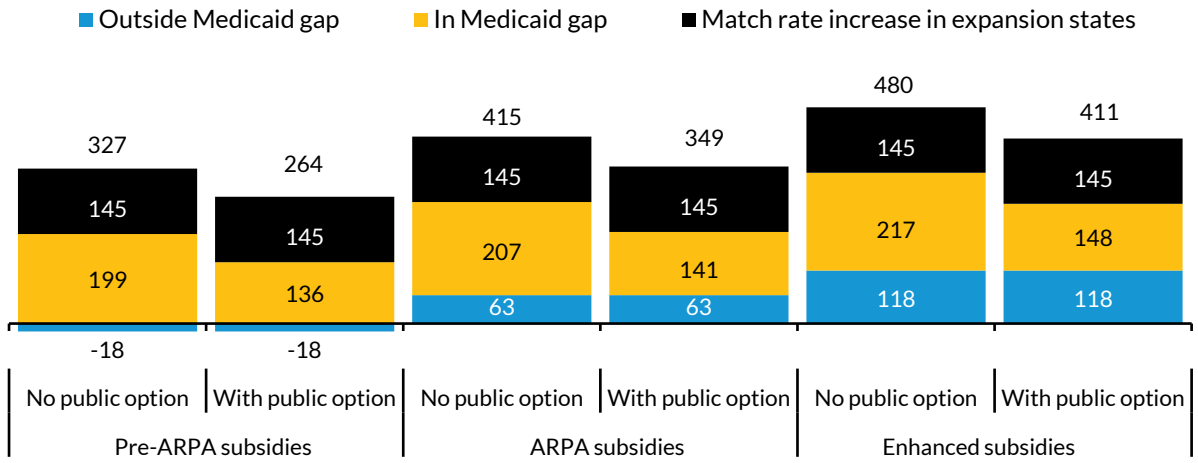
Under Marketplace expansion with the enhanced subsidy schedule, overall spending would increase by $480 billion with Marketplace benchmarks and $411 billion with the public option over 10 years. Spending on those in the Medicaid the gap would be $217 billion with Marketplace benchmarks

and $148 billion with the public option. With or without the public option, spending on those outside the gap in nonexpansion states would be $118 billion and the cost of expanding the Medicaid matching rate would be $145 billion.

FIGURE 6

Changes in Federal Spending under Marketplace Expansion Reforms to Fill the Medicaid Gap with and without the Public Option, Relative to Pre-ARPA Law, 2022–31

Billions of dollars



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: ARPA = American Rescue Plan Act. Includes federal health spending in nonexpansion states and increased Medicaid spending in expansion states. Nonexpansion states are Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

Conclusion

This paper shows that a public option that typically pays reduced rates to providers would considerably reduce the costs of filling the Medicaid gap. Using a public option instead of Marketplace benchmark premiums would reduce federal premium tax credits for people in the Medicaid gap by about 28 percent. Because premiums paid by households would be limited under each reform to a percentage of income that is unchanged by the public option, the public option would result in the same changes in coverage as using Marketplace benchmarks. Savings from the public option would mainly lower federal subsidy spending. Federal spending for people in the Medicaid gap would range from $16.6 to $18.1 billion in 2022 with Marketplace benchmarks, compared with $11.4 to $12.3 billion with the public option, depending on the subsidy schedule. Ten-year estimates of federal spending range from $199 to $217 billion with Marketplace benchmarks, compared with $136 to $148 billion with the public option. Under the reforms examined, the federal government could also increase federal matching rates for expansion states, which would further increase federal spending.

Notes

[1] Though Missouri and Oklahoma passed ballot initiatives to expand Medicaid but have not yet implemented them, we classify them as expansion states in this analysis. We do this to keep our national baseline projections more in line with those of the Congressional Budget Office for the purposes of 10-year cost estimates.

[2] John Holahan, Matthew Buettgens, Jessica Banthin, and Michael Simpson, "Filling the Gap in States That Have Not Expanded Medicaid Eligibility" (Washington, DC: Urban Institute, 2021).

[3] Under current law, the ACA Marketplace will revert to this subsidy schedule in 2023.

[4] Improving Health Insurance Affordability Act of 2021, S. 499, 117th Cong. (2021–22).

[5] Because of the public option's lower provider payment rates and prescription drug prices, people with such coverage would also spend less out of pocket than what they would spend under private Marketplace coverage. This change is not projected to be large enough to change coverage decisions.

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

[7] Throughout the paper, numbers may not add up to the sums shown because of rounding.

About the Authors

John Holahan is an Institute fellow in the Health Policy Center at Urban, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA. Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

Michael Simpson is a principal research associate in the Health Policy Center with 25 years of experience developing economic models and using survey and administrative data. His current work focuses on using Urban's Health Insurance Policy Simulation Model to project health insurance coverage and spending both in the baseline and under policy alternatives. Before joining Urban, Simpson developed the Congressional Budget Office's long-term dynamic microsimulation model. He analyzed numerous policy reform proposals, investigated differences between various projections of Social Security finances and benefits, quantified the importance of Monte Carlo variation in model results, and created multiple methods to demonstrate uncertainty in projections.

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