The Healthy America Program

Building on the Best of Medicare and the Affordable Care Act

Linda J. Blumberg, John Holahan, and Stephen Zuckerman

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Since efforts to "repeal and replace" the Affordable Care Act (ACA) have failed, and bipartisan attempts to improve the law have stalled, some policymakers are now looking beyond incremental fixes. Here, we present a set of policy ideas that would provide universal access to comprehensive coverage but would also allow people to keep their employer-sponsored coverage, would offer a range of insurer options and ensure broad pooling of health care risk, would not have an employer mandate, would provide income-related federal assistance, and would create a more flexible individual incentive to remain insured than that under the ACA. The proposal builds on components of the Medicare program and the ACA Marketplaces. However, it simplifies the current health insurance system by integrating Medicaid acute care for nonelderly people and the Children's Health Insurance Program (CHIP)—while preserving access to their benefits—with coverage for people enrolled in private nongroup insurance and people currently uninsured. This large new Medicare-style marketplace, featuring a public plan and private insurer options, would contain costs by fostering competition among many insurers, capping provider payment rates, and addressing prescription drug pricing. This proposal is less ambitious than a single-payer system (i.e., Medicare for All), but it would get close to universal coverage with much lower increases in federal spending and less disruption for people currently enrolled in employer coverage or Medicare.

The Affordable Care Act has significantly expanded coverage[1] and, until this year, led to reasonable nongroup premiums and premium growth in many markets throughout the nation, particularly those in high-population areas (Holahan, Blumberg, Wengle, et al. 2017). Growth in overall health spending has been slow by historical standards (Council of Economic Advisers 2017, chapter 4; Holahan, Blumberg, Clemans-Cope, et al. 2017).[2] Employer-sponsored insurance has remained stable, and the ACA has had no adverse effects on employment (Garrett, Kaestner, and Gangopadhyaya 2017). But problems remain. Nineteen states have not expanded Medicaid coverage, and some Marketplaces are plagued with low enrollment, high and rising premiums, and low insurer participation. Political opposition has dogged the ACA from the beginning, defeating technical corrections and modifications that could have strengthened the law and helped fill coverage gaps.

Recent efforts to undermine the ACA have exacerbated its problems or caused new ones. Reimbursements to insurers for cost-sharing subsidies have ceased, the open enrollment period has been cut in half, operating hours for the HealthCare.gov enrollment platform have decreased, in-person enrollment assistance has been substantially curtailed, and federal funding for advertising and other outreach efforts has been almost completely eliminated. Other policies in the pipeline, such as the loosening of rules for association health plan coverage and short-term, limited-duration policies beginning in 2018 and the elimination of the ACA's individual mandate penalties in 2019, would hinder the effectiveness of these insurance markets. And some states that expanded Medicaid under the ACA are instituting new work requirements, which risk reducing coverage in those states (Gangopadhyaya and Kenney 2018).

Given the chaos these measures are creating, now is a good time to delineate practical strategies for addressing gaps and weaknesses in the health insurance system. To start, this means reversing efforts to depress enrollment and adopting measures to expand enrollment, improve affordability, and increase Marketplace competition (Blumberg and Holahan 2017). But in response to growing public support for policies approaching universal coverage, we develop a broader structural reform that goes beyond incremental fixes to the ACA but retains a role for employer-sponsored insurance, private nongroup insurance, and Medicare. We outline a program that

- approaches universal coverage, improving affordability while keeping government spending under control;
- recognizes that many Americans are satisfied with employer-sponsored insurance and Medicare and would resist the disruption of that coverage;
- accommodates the strong American preference for having health insurance choices; and
- caps provider payment rates (as Medicare does), thereby reducing per capita costs in areas with limited insurer and/or provider competition.

Because of the deep divisions in today's politics and the larger deficits expected from the recent tax cuts (CBO 2018), the reforms discussed in this brief are unlikely to be adopted in the near term. But we anticipate that public demand for improvements to the health insurance system will grow. In developing this proposal, we drew on the broad set of lessons learned in recent years from both the ACA and the Medicare program, bringing the strengths of each to the design of a more sustainable system.

A Practical Proposal

We propose a new program called Healthy America that would be open to all nonelderly Americans. It would improve income-based assistance for premiums and cost-sharing and reduce costs in less competitive areas. Like Medicare, it would offer a public plan and private insurance plans; like Medicare Advantage, its private options would benefit from caps on provider payment rates.

The Healthy America program would collect enrollees' monthly payments of income-related premiums, and these payments would be reconciled with actual income through tax filings at the end of the year.[3] People who decide to remain uninsured would lose a tax benefit, but they could reverse some of that loss by becoming and remaining insured in the following year.

Employers and private insurers would continue to play key roles. Employers could continue to provide coverage as they do now.[4] The tax exclusion for employer-sponsored insurance would stay in place, providing the financial incentive for most workers to continue obtaining coverage through their workplace. People who choose to enroll in employer-sponsored insurance would not pay income-related premiums for Healthy America. This approach recognizes that large employers use tailored health insurance benefits to recruit and retain workers, that many workers are satisfied with their coverage, and that moving millions of people with employer insurance into a new system would be complex. Preserving employer-based coverage also reduces the new government revenues needed to fund the program.

The acute care portion of Medicaid for the nonelderly and CHIP would be incorporated into the Healthy America program, along with supplemental benefits (e.g., transportation; early and periodic screening, diagnostic, and treatment; access to essential community providers) for low-income children and enrollees with disabilities to ensure that people eligible for Medicaid under current law would have the same benefits under the new program. States would be required to continue contributing what they currently do to Medicaid and CHIP for these populations, and future state spending amounts would be indexed to a five-year rolling average of gross domestic product (GDP) growth. This would keep state obligations for acute care below current projections (Cuckler et al. 2018). Adults and children would no longer have to change insurance plans when family income changes. States would remain responsible for long-term services and supports, with federal matching payments unchanged from today's Medicaid structure.

Nonelderly people with disabilities who are eligible for Medicare could choose between enrolling in coverage with income-related assistance through the Healthy America program or obtaining their coverage through Medicare as under current law. Nonelderly people with disabilities who are ineligible for Medicare would be eligible for coverage through the Healthy America program.

The Medicare program would remain unchanged for all people ages 65 and older and for eligible people with disabilities. The current Medicare cost-sharing structure, including different deductibles for Parts A, B, and D and no out-of-pocket limits, could be changed to match the Healthy America program. We do not propose that here because of the complexities of financing the various components of the Medicare program, the differential impacts on people of different characteristics, and the additional federal revenues required.

The Healthy America Program

Many details must be worked out in a proposal like this—more than we can present in this brief. Here we delineate the most important features of the Healthy America program.

A New Health Insurance Market

A new program for individual and family purchasers called Healthy America would be established, offering an array of insurance options for all legally present[5] US residents younger than 65. The program would replace today's nongroup insurance market as well as Medicaid/CHIP acute care for the nonelderly. The Veterans Administration health care program, TRICARE, the Federal Employees Health Benefits Program (which would be treated like employer-sponsored insurance), and the Indian Health Service would all remain in place.

Healthy America would consist of a government-administered public health insurance plan, operating much like traditional Medicare, alongside private insurance plan options, operating much like Medicare Advantage. But unlike the three-part traditional Medicare option (which is usually combined with private supplemental insurance), the public option in Healthy America would be a consolidated plan covering hospital inpatient and outpatient services, physician care, prescription drugs, and other services with a uniform deductible and out-of-pocket limit.

Any legally present nonelderly US resident could enroll in the Healthy America program. No one would be required to enroll, but the program would offer significant incentives to maintain insurance, and administrative structures would be developed to facilitate enrollment.

Interaction with Employer-Sponsored Insurance

The proposed reforms maintain a central role for employer-sponsored insurance, the market in which most nonelderly Americans purchase insurance coverage today. Unlike under the ACA, this new framework would have no penalties for employers who do not offer coverage and no "firewall" prohibiting workers with offers of insurance from obtaining financial assistance in the Healthy America program. We recognize that

- requiring employers to provide or help finance insurance coverage for their workers leads to increased financial burdens for low-income workers and contributes to employer opposition (Blumberg, Holahan, and Buettgens 2014); and
- firewalls often create inequities where identical workers with different employer offers are treated differently, and low-income workers with offers may ultimately fare worse than their counterparts without offers.

Even with these changes, most workers with employer-sponsored insurance today would keep it. The current tax exclusion for employer-sponsored insurance would remain in place, providing a significant incentive for most workers to seek out employers offering insurance and to enroll in insurance. Employers providing insurance would be required to comply with tight antidiscrimination rules, such that all workers in a firm would be offered identical coverage with identical terms. Without such rules, employers could create conditions under which less healthy workers were sent to Healthy America for coverage while healthier workers were retained in the employer plan. However, employers would be prohibited from offering their workers policies that constituted supplemental coverage for Healthy America. And any worker simultaneously enrolling in an employer plan and a Healthy America plan would have any premiums paid by the employer treated as taxable income.

Benefits

All Healthy America plans would cover the ACA's essential health benefits, along with supplemental benefits for low-income children and for enrollees with disabilities. These supplements would ensure that people eligible for Medicaid under current law would have the same benefits under the new program. The standard plan (used to compute income-related premium assistance) would have an actuarial value (AV) of 80 percent (e.g., deductible of $1,500, out-of-pocket limit of $6,850 in 2018 for a single adult), equivalent to the ACA's gold plans and comparable to the average employer-based plan. Lower-income people could choose from the following higher AV plans, although their premium contributions would be tied to the 80 percent AV benchmark plan:

- 100 percent AV for people with incomes below 100 percent of the federal poverty level (FPL)
- 94 percent AV for people with incomes between 100 and 150 percent of FPL (e.g., $250 deductible, $2,000 out-of-pocket limit for a single adult)
- 90 percent AV for people with incomes between 150 and 200 percent of FPL (e.g., $300 deductible, $2,500 out-of-pocket limit for a single adult)
- 85 percent AV for people with incomes between 200 and 300 percent of FPL (e.g., $500 deductible, $3,250 out-of-pocket limit for a single adult)

People who wish to enroll in the lower-cost-sharing plans would be required to go through an income verification process at the beginning of the year (or at the time of a change in income or special enrollment period), as in the ACA Marketplaces today. Cost-sharing assistance for people with incomes below 300 percent of FPL would not be reconciled with end-of-year income, also as in the Marketplaces. People who forgo cost-sharing assistance for which they are eligible and people ineligible for cost-sharing assistance could choose to enroll in bronze (60 percent AV), silver (70 percent AV), or platinum (90 percent AV) plans, and enrollees would pay any costs above the standard premium. Savings from a lower-premium option would accrue to the enrollee, up to a point. If the computed tax credit exceeds the cost of the plan chosen, the enrollee would pay no out-of-pocket premium but would not receive cash for the remainder of the tax credit.

Premiums

Premiums for Healthy America plans would be income related, with federal subsidies tied to the premium associated with the benchmark 80 percent AV public plan option. Healthy America enrollees who are employed would pay their estimated monthly premium contributions (based on expected family income) through employer withholding; self-employed people would be required to pay estimated premiums along with estimated taxes. Employers would be required to handle such withholding, transferring payments to the program that would then be transferred to the insurers. Systems for facilitating electronic monthly premium payments for unemployed people would be developed. Throughout the year, the federal government would pay insurers (1) the income-based premiums it collects regularly from households and (2) the federal share of premiums for enrollees receiving subsidies for private Healthy America plans. Still, the federal government would likely have to front some funds to private insurers to prevent cash flow problems when they pay claims (if significant shares of enrollees are not making monthly premium contributions). The federal government would be reimbursed by enrollees for those additional payments at tax time. Households' premium payments throughout the year and advanced federal premium subsidies paid to Healthy America plans would be reconciled with actual income through the income tax process.

- People with incomes below the tax-filing threshold and others with incomes below 138 percent of FPL would not be charged premiums if they enroll in a plan with premiums no higher than the benchmark plan.
- People with incomes between 138 and 150 percent of FPL would pay premiums ranging from 0 to 2 percent of income for the benchmark plan.
- People with incomes between 150 and 200 percent of FPL would pay premiums ranging from 2 to 4 percent of income for the benchmark plan.
- People with incomes between 200 and 250 percent of FPL would pay premiums ranging from 4 to 6 percent of income for the benchmark plan.
- People with incomes between 250 and 300 percent of FPL would pay premiums ranging from 6 to 7 percent of income for the benchmark plan.
- People with incomes between 300 and 400 percent of FPL would pay premiums ranging from 7 to 8.5 percent of income for the benchmark plan.
- People with higher incomes would pay premiums of no more than 8.5 percent of income for the benchmark plan.

At all incomes, household premium contributions for the benchmark plan would never exceed the total benchmark premium for that person or family. Premiums would be subject to modified community rating rules as under the ACA, with age rating limited to a ratio of 3 to 1, as in the ACA-compliant nongroup and small-group insurance markets today.

Benchmark Premiums

The benchmark premium would be set much like it is in the Medicare program. The actuarially determined average cost of the public plan (including claims and administrative costs) would be the benchmark based on Medicare provider payment rates, with some adjustments in areas with very low or very high input costs to encourage plan availability in all markets. More than 100 million people would be covered through the Healthy America program (estimates presented in a later section), so the market would be attractive to many insurers. Costs associated with enrollees with disabilities would not be included in the calculation of Healthy America's benchmark premium. As in Medicare Advantage, out-of-network providers could not charge enrollees more than traditional Medicare rates. Healthy America would extend that policy by explicitly capping provider payment rates for in-network or out-of-network care at traditional Medicare rates. People who enroll in a plan with a premium higher than the benchmark would pay the difference in premiums directly to their insurer. People who enroll in a less expensive plan could keep the difference up to the point where they owe no premium contribution.

Incentives to Insure

People who remain uninsured would be responsible for paying their own medical bills and dealing directly with providers. Uninsured people and people with employer-based insurance could enroll in insurance through the Healthy America program at standard rates during the annual open enrollment period, as under the ACA. Limited special enrollment periods would also be available for circumstances such as birth, adoption, and loss of employer coverage. To limit adverse selection, uninsured people would lose a percentage of their standard deduction (or the equivalent for the itemized deduction) when they pay income taxes. The percentage of the standard deduction they would lose would increase with income, making the penalty progressive. By design, people with incomes below the tax-filing threshold would owe no penalty because they would not owe premiums. People with incomes of $1 million or more would lose the entire standard deduction. The lost tax benefit for a single tax filer losing half the standard deduction ($12,000) would depend on the person's marginal tax rate.[6] The effective penalty for losing a portion of the standard deduction increases with a taxpayer's income because people with higher marginal tax rates get a higher value from the deduction and would lose a higher percentage of it. People who itemize their deductions would lose equivalent amounts, and the losses of deductions would be prorated for the number of months uninsured. Half the lost deduction amount could be refunded the following year if the person enrolls in coverage and maintains it for the next full plan year.

Table 1 shows that the average tax filer with adjusted gross income of $25,000 to $50,000[7] who remains uninsured for a full year would lose a tax benefit worth $935 under this approach, compared with a tax penalty of $1,058 under the full ACA approach. Because the Healthy America approach ensures access to affordable coverage for all legally resident Americans, the lost tax benefit would not require affordability exemptions. Premium contributions for the 80 percent AV plan could not exceed 8.5 percent of income, and lower-income people would contribute less because they would receive more generous assistance. Of course, people who are not required to pay income taxes would have no deduction to lose. The value of the lost deduction would increase with income, reaching a maximum of nearly $8,900 for a person with income of $1 million or more in 2019. Penalties would be capped at the premium for a 60 percent actuarial value (bronze) plan.

TABLE 1

Average Tax Penalties under the ACA and Healthy America, by Income Group, 2019

Adjusted gross income	ACA	Healthy America
Below tax-filing threshold	$0	$0
Above tax-filing threshold, below 138% of FPL	N/A	$0
<$10,000	$695	$602
$10,000–25,000	$815	$770
$25,000–50,000	$1,058	$935
$50,000–75,000	$1,832	$1,625
$75,000–100,000	$2,882	$1,953
$100,000–200,000	$4,287	$2,630
$200,000–500,000	$4,045	$3,979
$500,000–1,000,000	$3,901	$4,643
≥$1,000,000	$5,728	$8,877

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.
Notes: ACA = Affordable Care Act; FPL = federal poverty level; N/A = not applicable.

We propose replacing the ACA's tax penalty for remaining uninsured with this restructured penalty for two reasons:

1. We recognize the need for significant incentives to encourage insurance coverage—regardless of health status—to create and maintain stable insurance risk pools (i.e., to prevent adverse selection).

2. We believe the loss of a tax benefit that people already have (particularly the doubled standard deduction under the 2017 tax law) would be better received politically than the additional tax penalty assessed under the ACA. And the opportunity to have a substantial portion of that lost benefit reimbursed, if the person enrolls in and maintains coverage later, should also help increase support.

People who enroll in coverage that meets essential health benefits requirements and has an actuarial value of at least 60 percent (i.e., bronze coverage) would not lose any of their tax benefit.

Reinsurance and Risk Adjustment

Reinsurance for high-cost cases and risk adjustment for risk-sharing across private nongroup insurers would be permanent in Healthy America. Like traditional Medicare within the Medicare program, the public plan within the Healthy America program would not be part of the risk adjustment process, so the costs of adverse selection into that plan would effectively be absorbed by all taxpayers, not only program enrollees. The public plan's premiums would reflect the actuarial value of benchmark coverage provided to its enrollees. Adverse selection into the public plan would increase the program's benchmark premium, but enrollees' premium contributions would be protected by the structure of the premium subsidies because all contributions would be capped at a percentage of family income. Risk adjustment for the private plans offered in Healthy America would be budget neutral. However, in the unlikely event that private insurance options are selected against as a group, an alternative risk-adjustment approach that is not budget neutral (i.e., that subsidized the higher average risk enrolling in private plans with government dollars) must be considered. The program must also combat the type of private insurer upcoding seen in Medicare Advantage to avoid overpayments to some private plans.

Reinsurance would be funded with general revenues, and payments would not be included in calculating premiums.

Autoenrollment of Low-Income People

Most people would need to take direct action to enroll in the Healthy America program. Higher federal investment (compared with that under the ACA) in outreach and enrollment assistance during open enrollment periods and throughout the year would increase awareness and lead to higher coverage rates. But to boost enrollment in Healthy America and increase the size and diversity of its health insurance risk pools, people receiving SNAP and TANF payments would be automatically enrolled. This population would be eligible for coverage with no premium in a Healthy America plan. These families would be contacted and given the opportunity to choose an insurance plan or opt out of coverage (e.g., if they prefer to enroll in employer coverage). Individuals and families who neither opt out nor choose a plan would be enrolled in the benchmark public plan. People who opt out would be required to acknowledge with a signature that if they seek health care services during the year, they are fully responsible for the costs charged by the providers they use. Opt-out rates should be very low. Each year, individuals receiving SNAP or TANF would be auto-reenrolled or newly enrolled with the same process.

Noncompliant Plans

Short-term and other private insurance plans that do not comply with Healthy America regulations (consistent with the ACA's regulatory framework) would be prohibited. Prohibited types of plans include short-term, limited-duration policies and association health plans. These plans attract healthier people and work against the goal of broader pooling of health care risk.

Drug Prices

The cost of prescription drugs is much higher in the US than in other nations, and many have called for limits on prescription drug prices. Analysts have argued for strategies such as reference pricing, direct negotiation between the Department of Health and Human Services and drug manufacturers, and expanded use of rebates (Kesselheim, Avorn, and Sarpatwari 2016). Deciding on the best approach is beyond the scope of this brief, but for the Healthy America program, we would draw on some of the available options to generate significant savings. For example, the Congressional Budget Office has provided cost estimates on a proposal for extending the Medicaid rebate on drugs covered under Part D of Medicare for low-income beneficiaries (CBO 2016, 255–56). CBO argues that these beneficiaries cost the government less before the introduction of the Medicare drug benefit because of the Medicaid rebate. The Medicaid rebate was extended in 2010 from 15.1 percent to 23.1 percent of the average manufacturer price, and there are inflation-based rebates if price increases exceed the rate of inflation. The combined Medicaid rebates can become quite large.

Extending these rebates to Medicare's low-income subsidy population (mostly people who are now dually eligible for Medicaid and Medicare) would yield considerable savings. Pharmaceutical manufacturers already give rebates to pharmacy benefit managers. Thus, the savings from the Medicaid rebate policy would be the difference between the overall rebate and the preexisting Medicare rebate agreed to by pharmacy benefit managers and pharmaceutical manufacturers.

The Congressional Budget Office estimates that this would save $15 billion in the first year of implementation and $145 billion between 2019 and 2026. These rebates apply to all drugs, whether single-source or multiple-source, with smaller rebates for generics. These rebates could also be applied to drugs purchased for low-income Healthy America beneficiaries. We estimate that, at a minimum, an additional $10 billion of savings could be achieved by extending the additional rebates in the first year of implementation and by a larger amount over 10 years.

People with Disabilities

Nonelderly people with disabilities who are identified through their receipt of cash assistance and who are not eligible for Medicare would be eligible to enroll in Healthy America plans for coverage of acute care services; those who are eligible for Medicare could enroll in Healthy America or Medicare. People with disabilities who enroll in Healthy America plans would be eligible for the same income-related financial assistance as other enrollees, but their benefit package would be established separately from the rest of the nonelderly population. The separate benefits would include supplemental services currently available through the Medicaid program (e.g., transportation services). Costs for people with disabilities in excess of the average costs for the rest of the enrolled population would not be counted in the calculation of Healthy America premiums. In other words, the higher expected costs of the population with disabilities would not affect premiums for the program; the excess would be financed with government dollars. Low-income people with disabilities who are currently eligible for both Medicare and Medicaid and choose to enroll in Medicare instead of Healthy America would still receive the acute-care benefits currently paid for by Medicaid, financed through state "maintenance of effort" requirements and federal funding.[8]

Government Costs and Financing

The government cost of this program would depend upon how many people enroll in Healthy America instead of keeping employer coverage and how many people choose to be uninsured. Adverse selection into the program would increase federal costs. But competition among plans, caps on provider payment rates, and negotiation of prescription drug prices would help restrain program costs. Payment and delivery system reforms that have been successful in the Medicare program could also be applied to Healthy America.

The reform plan would be financed largely by the required income-related premiums paid through the tax system, as well as through the redirection of a substantial amount of current government spending on health programs. The federal government would pay the share of costs not covered by premiums, including the extra costs for people with disabilities and the costs of reinsurance. Current federal spending on Medicaid acute care for the nonelderly and CHIP would be repurposed for this program. Because states would no longer pay for these two programs, they would instead be required to make maintenance-of-effort payments equal to current spending indexed to a rolling five-year average of GDP growth. Funds used for current Marketplace subsidies (premium tax credits and cost-sharing reductions), reduced spending on uncompensated care, and savings on prescription drug costs would also partially offset the costs. And as fewer people enroll in employer-based insurance, pretax premium payments would be converted into taxable wages, increasing tax revenues. Still, some new tax financing would be needed: approximately $98 billion in the first full year of implementation (estimated here in 2019). This could come from increases in payroll, income, and sin taxes (e.g., on alcohol and tobacco). Reinsurance would be financed separately with general revenues. States would be responsible for funding long-term services and supports with federal matching funds, as under current law.

Healthy America would substantially reduce, but not zero out, the number of uninsured people. Most of the remaining uninsured would be undocumented immigrants. Providers would be expected to collect payments for care directly from the uninsured. States could support providers serving the most uninsured people with their current Medicaid disproportionate share hospital (DSH) payments. Federal Medicare DSH payments would continue, as would federal funding for community health centers. The federal share of Medicaid DSH payments, approximately $12 billion annually, would be repurposed to help finance Healthy America.

Preliminary Coverage and Cost Estimates

Table 2 shows our preliminary estimates[9] of changes in the distribution of health insurance coverage under Healthy America if it were fully implemented in 2018. We estimate that Healthy America would cover roughly 117.1 million nonelderly people. Employer coverage would fall by 18.3 million people because some people would choose Healthy America over their employer plans; these enrollees would make up 16 percent of Healthy America's enrollment.

TABLE 2

Distribution of Health Coverage, 2019

	Affordable Care Act		Healthy America		Difference	
	Number (thousands)	Share of coverage	Number (thousands)	Share of coverage	Change (thousands)	Percentage-point change
Insured	**239,988**	**89.1%**	**255,893**	**93.3%**	**15,905**	**4.2%**
Employer	148,580	54.5%	130,251	47.5%	-18,329	-7.0%
Nongroup with tax credits	7,990	3.3%	0	0.0%	-7,990	-3.3%
Nongroup without tax credits	6,002	2.9%	0	0.0%	-6,002	-2.9%
Medicaid/CHIP	68,842	25.3%	0	0.0%	-68,842	-25.3%
Healthy America	N/A	N/A	117,068	42.7%	117,068	42.7%
Other (including Medicare)	8,574	3.1%	8,574	3.1%	0	0.0%
Uninsured	**34,328**	**10.9%**	**18,423**	**6.7%**	**-15,905**	**-4.2%**
Legal residents	26,266	9.6%	10,390	3.8%	-15,876	-5.8%
Undocumented residents	8,062	2.9%	8,033	2.9%	-29	0.0%
Total	**274,316**	**100.0%**	**274,316**	**100.0%**	**0**	**0.0%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Note: CHIP = Children's Health Insurance Program; N/A = not applicable.

In our estimates, employer-sponsored insurance decreases about 12 percent but stays in place. Employer-sponsored insurance has been essentially constant since the implementation of the coverage components of the ACA, but the Healthy America program increases financial assistance and eliminates the ACA's "firewall" between employer-sponsored insurance offers and the purchase of subsidized nongroup insurance. Employers, particularly large employers, would continue to use tailored insurance benefits to attract and retain workers. And the value of the tax exemption for employer-sponsored insurance (which remains in place under Healthy America) increases with income and is greater than the value of premium subsidies for people at higher incomes. These conditions, combined with antidiscrimination rules requiring that workers of all wages be offered the same employer insurance coverage on the same terms, would keep offers of employer-sponsored insurance from declining substantially. Enrollment in employer-sponsored insurance would be lower than now but still high under the reforms, at 47.5 percent of the nonelderly population.

Most Healthy America enrollees (59 percent) would be people currently covered by Medicaid and CHIP. The rest would be people who currently have nongroup coverage (12 percent) and people who are newly insured (14 percent). We estimate that the number of uninsured people would fall by 15.9 million and that 10.4 million legal residents would remain uninsured, along with 8.0 million undocumented residents. This would leave 4 percent of nonelderly legal US residents uninsured and 63 percent of undocumented nonelderly US residents uninsured (data not shown).

Table 3 shows our preliminary estimates of changes in health care spending by payer (employers, households, federal government, state governments, and providers), all in 2019 dollars. Employer spending would fall by $110.6 billion because some workers and their dependents would opt out of employer insurance plans and into Healthy America. Household expenditures would increase by $31.4 billion because premiums would increase by $36.3 billion (as more people became insured), but out-of-pocket expenses would fall by $5.0 billion. The federal government's health care spending would increase by $97.9 billion because the number of people receiving federal assistance to purchase insurance would increase and Medicaid/CHIP and subsidized Marketplace enrollees would shift into Healthy America. However, state spending would decrease by $32.4 billion, meaning that overall government spending would increase by $65.5 billion. To put these government costs into perspective, in 2019, national health expenditures are expected to be $3.9 trillion under current law,[10] and GDP is expected to total $21.4 trillion.[11] We estimate that over 10 years of the Healthy America program, federal spending would increase by $1.2 trillion and state government spending would decrease by $422 billion, resulting in a net increase in total government spending of $790 billion, or roughly 0.025 percent of GDP (not shown).

TABLE 3

Summary of Health Care Spending by Payer in 2019

Millions of dollars

Payer	Current spending	Healthy America spending	Difference
Employer	**865,798**	**755,188**	**-110,610**
Household	**537,397**	**568,769**	**31,372**
Premiums	327,073	363,421	36,348
Out-of-pocket spending	210,324	205,348	-4,976
Government	**649,931**	**715,413**	**65,482**
Federal	*423,583*	*521,459*	*97,876*
Subsidies and reinsurance	65,247	713,453	648,206
Medicare premiums and Medicaid acute care for elderly people	0	21,560	21,560
Medicaid acute care for nonelderly people	326,859	0	-326,859
State Medicaid maintenance-of-effort payments	0	-185,116	-185,116
Uncompensated care	31,477	14,141	-17,335
Prescription drug savings	0	-25,000	-25,000
Increased income tax revenue because of lower rates of employer insurance	0	-17,580	-17,580
State	*226,348*	*193,954*	*-32,395*
Medicaid acute care for nonelderly people	185,116	0	-185,116
State Medicaid maintenance-of-effort payments	0	185,116	185,116
Medicare premiums and Medicaid acute care for elderly people	21,560	0	-21,560
Uncompensated care	19,673	8,838	-10,835
Provider	**27,542**	**12,374**	**-15,169**
Uncompensated care	27,542	12,374	-15,169
Total	**2,080,667**	**2,051,742**	**-28,925**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Note: Lower spending on employer insurance would increase payroll tax revenue, but we did not include it here as a funding source for Healthy America.

All current Medicaid acute care expenditures for the nonelderly and all spending on the ACA's premium tax credits would be repurposed to fund Healthy America. Estimated costs for federal subsidies include wraparound benefits for low-income children and nonelderly people with disabilities. The federal government's income tax revenues would increase by $17.6 billion because some workers would choose Healthy America over their employer plans. Reduced spending on pretax employer-sponsored insurance premiums would be converted into taxable increases in wages and salaries as a result (Blumberg 1999; Gruber 1994; Kolstad and Kowalski 2016). Payroll tax revenues would also increase by almost $16 billion, but we do not include that here as a source of program funding.

States, relieved of their expenditures on Medicaid acute care for the nonelderly, would be required to make maintenance-of-effort payments of $185.1 billion in total, and these funds would offset some of the new federal spending. Our estimate of state maintenance-of-effort payments is based on states' current share of Medicaid and CHIP spending. State government spending would decrease by $32.4 billion because of lower spending on uncompensated care and care for elderly people. We have also proposed that the federal government take over the funding of payments currently made by state Medicaid programs for Medicare premiums and acute-care wraparound services used by low-income elderly Medicare beneficiaries; these costs amount to $8.0 billion and $13.6 billion, respectively, shown as a total of $21.6 billion in table 3. This change would give states some fiscal relief and simplify the elderly low-income population's access to benefits.

Prescription drug savings would total $25 billion—or more, depending upon how many people the rebates are applied to. We use rebates as a placeholder policy because cost estimates are available for them, but other approaches are possible.

We assume that federal DSH payments for uncompensated care would end, but about $9.8 billion per year in federal funds (e.g., Veterans Administration, community health centers) would still be available to support uncompensated care under Healthy America. Total federal spending on uncompensated care, including DSH, would fall by $17.3 billion, and state uncompensated care spending would fall by $10.8 billion. Providers' in-kind contributions for uncompensated care would fall by $15.2 billion.

In sum, even though more people would be insured under this approach, overall health care spending would fall by $28.9 billion a year. This modest 1.4 percent decrease is attributable to the significant numbers of people moving out of more expensive employer-sponsored and nongroup health insurance plans and into Healthy America coverage; savings would exceed the increase in costs resulting from nonelderly Medicaid acute care enrollees shifting into the new program. Premiums in Healthy America would be held down by competition between private insurance plans and caps on provider payment rates in less competitive areas. Healthy America's large enrollee pool should make it attractive to most insurers, as seen in Medicare Advantage. Additional savings would come from extending prescription drug rebates to at least some Medicare and Healthy America enrollees. The increase in federal spending on health care would be modest compared with comprehensive single-payer proposals that do not require premium contributions or enrollee cost-sharing because (1) the system provides incentives for the continuation of employer-sponsored insurance, (2) most households would continue to pay directly toward the costs of their care, and (3) the Medicare program and Medicaid long-term services and supports would remain essentially unchanged.

The additional federal costs associated with Healthy America could be financed in several ways. For example, the Congressional Budget Office recently estimated that increasing the Medicare Hospital Insurance payroll tax by 1.0 percentage point (0.5 percentage point for both employers and employees) would increase federal revenues by $823.2 billion between 2017 and 2026 (CBO 2016). This would cover a large share of the revenue we estimate would be needed to fund the additional federal government costs under Healthy America. Other adjustments to excise and income taxes would be needed.

The net federal costs of the program could be lower than what we have estimated here. For example, the Medicare program makes large adjustments to payment rates for Medicare Advantage plans operating in geographic areas where traditional Medicare plan costs are low. These adjustments encourage private plan participation, but the current amounts are likely too large and could be reduced; doing so in the Medicare program and in the Healthy America structure would reduce federal costs.

Healthy America Compared with Other Proposals

Several other proposals to enhance or replace the ACA have been developed, most borrowing from aspects of the Medicare program. These other proposals all have some similarities and some differences with the Healthy America proposal presented here. Any proposal must lay out who will be eligible to enroll and whether it will be mandatory to do so, what benefits will be covered, how the program will be paid for, what cost controls might be used, and how much private health insurance and the major public programs (Medicare and Medicaid) would change. In table 4, we summarize the key components of each proposal for comparison with Healthy America. We have ordered the following proposals from least to most comprehensive in their changes to the current health care system:

- Medicare-X, introduced by Senators Tim Kaine and Michael F. Bennet;[12]
- the Consumer Health Insurance Protection Act, introduced by Senator Elizabeth Warren;[13]
- Healthy America, described here;
- Medicare Part E, developed by Jacob S. Hacker;[14]
- Medicare Extra, developed by the Center for American Progress (CAP 2018); and
- Medicare for All, introduced by Senator Bernie Sanders.[15]

The Warren and Kaine-Bennet proposals are expansions of the ACA, more modest in scope than Healthy America. Medicare Part E would autoenroll all legal residents and thus would achieve somewhat higher coverage than Healthy America. It would impose a strong employer mandate. Medicare Extra also has autoenrollment for legal residents, offers more benefits, and places substantial requirements on employers. The Sanders plan is the most comprehensive in coverage and benefits without cost-sharing, and it would have by far the greatest role for government.

TABLE 4

Health Reform Proposals Compared

	Medicare-X (Kaine-Bennet)	Consumer Health Insurance Protection Act (Warren)	Healthy America	Medicare Part E (Hacker)	Medicare Extra (Center for American Progress)	Medicare for All (Sanders)
Who is eligible for the new program?	ACA Marketplace–eligible individuals and small groups	No new program; enhancements to existing programs	All lawfully present people younger than 65	All people lawfully present in the US	All people lawfully present in the US	All US residents
What's in the program?	New public plan option offered on ACA Marketplaces as an alternative to participating private plans	Enhancements to the ACA, including increased premium and cost-sharing subsidies, limits on prescription drug cost-sharing, "family glitch" fix, and strengthened private insurance regulations	New public plan option, restructured private nongroup insurance market, enhanced premium and cost-sharing subsidies, new incentive to remain insured	New public plan option available to all people lawfully present in the US	New public program with broad benefits and income-related premiums and cost-sharing; all are autoenrolled with no opt-out option	Single-payer system enrolling all US residents in a single plan
Does the separate Medicaid program continue?	Yes	Yes	Medicaid acute care program ends, with enrollees folded into other programs; long-term services and supports program continues as under current law	Yes, but with some increased reimbursement rates	No	No
Are states required to make maintenance-of-effort contributions?	Not applicable	Not applicable	Yes, but only for spending on acute care for the nonelderly	No	Yes, for all spending, including care for the elderly and long-term services and supports	No
Does the separate Medicare program continue?	Yes	Yes	Yes	Yes	Yes, people can stay in Medicare or switch to Medicare Extra for superior benefits, out-of-pocket limits	No
Does the private insurance market remain?	Yes	Yes, with strengthened regulations in nongroup and small-group markets	Yes, for group and nongroup private insurers; no firewall between employer coverage and new program	Yes; employer insurance and Medicare Advantage plans continue to be offered	Employer market remains; employers can choose to enroll their workers in Medicare Extra	No

	Medicare-X (Kaine-Bennet)	Consumer Health Insurance Protection Act (Warren)	Healthy America	Medicare Part E (Hacker)	Medicare Extra (Center for American Progress)	Medicare for All (Sanders)
What benefits are offered?	ACA essential health benefits	ACA essential health benefits	ACA essential health benefits	ACA essential health benefits	ACA essential health benefits plus dental, vision, and hearing care and long-term services and supports	All medically necessary acute care and dental, vision, and hearing care; long-term services and supports stay the same as under current Medicaid program
How much are household premiums?	Same as under current law	Marketplace premiums range from 0 to 8.5% of income; premium subsidies are tied to 80% actuarial value plan	Premiums range from 0 to 8.5% of income; premium subsidies are tied to 80% actuarial value plan	Related to income	Premiums range from 0 to 10% of income	None
What are the cost-sharing requirements?	Same as under current law	Cost-sharing subsidies increase Marketplace plan actuarial value above 80% for people with incomes up to 400% of FPL	Cost-sharing subsidies increase actuarial value above 80% for people with incomes up to 300% of FPL; cost-sharing options with actuarial value below 80% also available	Similar to ACA	Deductibles, copayments, and out-of-pocket limits vary with income, but none are below 80% actuarial value	None
Are people automatically enrolled?	No	No	Only SNAP and TANF enrollees, who face no premiums, are autoenrolled; others without premiums can enroll in public plan at any time	Yes, all are enrolled and required to pay premiums; no open enrollment period	Yes, premiums are collected through the tax system so no one can avoid premium payments	Yes
Do individuals face a penalty for remaining uninsured?	Current law	Current law	Yes, structured as loss of a tax benefit, which can be partially refunded if people enroll in coverage later	No, all are enrolled	No; all are autoenrolled in Medicare Extra unless they choose an employer plan	No, all are enrolled in a single plan
Are there limits on provider payment rates?	Yes, for public plan	Prohibits balance billing for emergency room services	Yes, for nongroup insurance markets	Yes	Yes, for Medicare Extra and employer plans	Yes
Do employers face a penalty for not insuring workers?	Current law	Current law	No	Yes, varies with firm's average wage	Yes, "play or pay" requirements	No

	Medicare-X (Kaine-Bennet)	Consumer Health Insurance Protection Act (Warren)	Healthy America	Medicare Part E (Hacker)	Medicare Extra (Center for American Progress)	Medicare for All (Sanders)
Are there minimum standards for employer coverage?	Current law	Current law	No	Yes	Yes	Not applicable; employer insurance eliminated
Does the program provide universal coverage?	No, but it will increase coverage	No, but it will increase coverage	Close to universal for legal residents (not for undocumented people)	Yes, for legal residents (not for undocumented people)	Yes, for legal residents (not for undocumented people)	Yes

Sources: Medicare-X Choice Act of 2017, S. 1970, 115th Cong. (2017); Consumer Health Insurance Protection Act of 2018, S. 2582, 115th Cong. (2018); Jacob S. Hacker, "The Road to Medicare for Everyone," *American Prospect*, January 3, 2018, http://prospect.org/article/road-medicare-everyone; Center for American Progress, *Medicare Extra for All: A Plan to Guarantee Universal Health Coverage in the United States* (Washington, DC: Center for American Progress, 2018), https://www.americanprogress.org/issues/healthcare/reports/2018/02/22/447095/medicare-extra-for-all/; Medicare for All Act of 2017, S. 1804, 115th Cong. (2017).

Note: ACA = Affordable Care Act; FPL = federal poverty level; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance for Needy Families.

Discussion

Healthy America would address most of the problems in the Affordable Care Act and would move the country close to universal coverage. The ACA's most important innovations and its largest sources of controversy reside in the nongroup Marketplaces. Before the new obstacles created through executive actions in 2017 and 2018, the Marketplaces had performed unevenly: some (particularly those in high-population-density areas) saw strong insurer competition and low premiums, but others saw little to no insurer competition and escalating premiums (Holahan, Blumberg, and Wengle 2017). Medicaid has provided affordable, comprehensive access to medical care for low-income people in states that adopted the ACA expansion, but coverage disparities have widened between states that expanded and those that did not. Another common complaint with the ACA is that cost-sharing requirements and premium contributions can still be too high for some people in the Marketplaces, particularly those ineligible for cost-sharing assistance. There was also persistent political opposition to the ACA's individual mandate, which was essentially repealed (effective 2019) in the Tax Cuts and Jobs Act of 2017.

Our approach would address many of the shortcomings of the ACA and come close to universal coverage through a combination of improved financial assistance, an improved public program with a broad provider network, provider payment rate caps to boost insurer participation and counteract the monopoly power of health systems in some areas, autoenrollment for very low–income people, and a new tax penalty for uninsured people. We restructured the incentive to obtain and retain insurance as the loss of a tax benefit instead of a tax surcharge, and we give households the opportunity to reverse a portion of the benefit loss by obtaining and maintaining coverage in the following year.

This plan should encourage most insurers to participate. The market for the Healthy America program would be substantially larger than the current ACA-compliant nongroup insurance market, and provider payment rate caps would allow insurers to enter new markets and set reasonable premiums without needing any market share to negotiate with providers. The insurer competition structure would be much more like that in the Medicare program than that in the Marketplaces. Regardless of private insurer participation in a geographic area, a public plan option administered by the federal government would be available. Providers would be paid higher rates for patients enrolled in employer coverage, as they are now.

Employers would still have the option to purchase coverage independently, self-insure their employees, or provide no coverage at all. No penalties would be imposed on employers that do not offer a health plan. The tax advantages for employers who continue to provide coverage would remain in place, and the standard plans offered through Healthy America would be comparable to typical employer plans. Because of the value of the tax advantages for many workers and the value employers place on using health benefits to attract and maintain their workforce, most large and medium-size employers could be expected to continue to offer coverage. Firms that stop offering coverage would eventually experience pressure to increase wages to attract workers.

We leave Medicare untouched to limit the new federal revenues needed and to limit disruption of coverage for people satisfied with their current plans. However, the uniform cost-sharing provisions we suggest could be adapted for the Medicare population as well.

The Healthy America program would be financed largely through premiums, but also through the repurposing of current Medicaid financing and Marketplace subsidies. Some additional revenue sources would be needed, but a substantial share of the government funding is already within the current system.

Two issues we do not address here warrant further consideration: the role for states and a cap on the tax exclusion of employer coverage. First, several states have considerable administrative expertise and political support for implementing health insurance system reforms. Policymakers should consider ways to take advantage of state-level expertise where available and appropriate. Second, we do not propose a cap on the employer tax exclusion because we want to maintain robust levels of employer-based insurance. However, modest caps may yield needed tax revenue with little impact on employer-based coverage.

Several proposals are being put forward to fix the ACA or to fundamentally reshape the US health insurance system. Proposals of significant restructuring are necessarily more complex than those focused on making the ACA work better. In Healthy America, we try to strike a balance by retaining Medicare and employer-sponsored insurance while significantly changing Medicaid and nongroup health insurance. Our goals are to keep what people like, change what is not working, and limit the increase in new federal costs.

Notes

1 See Blumberg, Garrett, and Holahan (2016); Council of Economic Advisers (2017), chapter 4; Garrett and Gangopadhyaya (2016); Karpman and Kenney (2017); Long et al. (2017); and Uberoi, Finegold, and Gee (2016).

2 See also Douglas W. Elmendorf (director, Congressional Budget Office), letter to Honorable Nancy Pelosi, (speaker, US House of Representatives), estimate of the direct spending and revenue effects of an amendment in the nature of a substitute to H.R. 4872, the Reconciliation Act of 2010, March 20, 2010, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf.

3 Investments in improved data matching and one-on-one assistance would be made to significantly reduce cancellations of coverage and financial assistance that occur within the ACA's marketplaces today. Although we acknowledge that estimating income for the year and reconciling it with taxable income is burdensome for some households, we believe it is a necessary component of a program mindful of the political necessity of limiting increases in federal spending.

4 To prevent the undermining of employer-sponsored insurance, employers would not be allowed to fund a worker's Healthy America premiums with pretax compensation through health reimbursement arrangements.

5 Undocumented people could purchase insurance, but they would be ineligible for federal financial assistance. States could choose to provide subsidies with their own funds to help undocumented people buy coverage through the program.

[6] The doubling of the standard deduction, a component of the Tax Cuts and Jobs Act of 2017, is set to expire after 10 years. The larger standard deduction may be extended beyond those 10 years, but if it is not, this formula would have to be revisited.

[7] For reference, average adjusted gross income for single filers in 2014 was about $35,000. See Matthew Frankel, "Here's the Average American Household Income -- How Do You Compare?," *Motley Fool*, October 30, 2016, updated September 20, 2017, https://www.fool.com/retirement/2016/10/30/heres-the-average-american-household-income-how-do.aspx.

[8] We assume that many people with disabilities eligible for Medicare would continue to enroll in that program. However, lower Medicare costs from those who choose Healthy America instead would be used to offset Healthy America costs. Because the two programs would use the same provider payment rates and have comparable covered benefits, the difference in costs between the two options would be attributable to cost-sharing differences. Depending upon enrollees and their needs, both programs would have advantages and disadvantages in that respect, and it is difficult to assess whether there would be an overall difference in government costs as a result of providing the choice to eligible people. Here, we assume that aggregate federal costs would not differ significantly from the costs associated with giving this population a choice of insurance programs.

[9] These preliminary estimates of the Healthy America program's coverage and costs were developed by the authors and Matthew Buettgens, using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).

[10] Centers for Medicare & Medicaid Services, "National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar Years 2010-2026," NHE Projections 2017–26, table 1, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

[11] Congressional Budget Office, "April 2018 Baseline Forecast—Data Release (Calendar Year)," 10-Year Economic Projections, April 2018, table 2, https://www.cbo.gov/about/products/budget-economic-data#4.

[12] Medicare-X Choice Act of 2017, S. 1970, 115th Cong. (2017).

[13] Consumer Health Insurance Protection Act of 2018, S. 2582, 115th Cong. (2018).

[14] Jacob S. Hacker, "The Road to Medicare for Everyone," *American Prospect*, January 3, 2018, http://prospect.org/article/road-medicare-everyone.

[15] Medicare for All Act of 2017, S. 1804, 115th Cong. (2017).

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About the Authors

Linda J. Blumberg is an Institute fellow in the Health Policy Center at the Urban Institute, having joined in 1992. 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 efforts 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, analysis of the implications of the *King v. Burwell* Supreme Court case, and a number of studies of competition in ACA marketplaces.

John Holahan is an Institute fellow in the Health Policy Center, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, and on developing proposals for health system reform, most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act, including the costs of Medicaid expansion and 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.

Stephen Zuckerman is a senior fellow and vice president for health policy at Urban. He has studied health economics and health policy for 30 years and is a national expert on Medicare and Medicaid physician payment, including how payments affect enrollee access to care and the volume of services they receive. He is currently examining how payment and delivery system reforms can affect the availability of primary care services and studying the implementation and impact of the Affordable Care Act.

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