

A Path to Incremental Health Care Reform: Improving Affordability, Expanding Coverage, and Containing Costs

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Timely Analysis of Immediate Health Policy Issues

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In Brief

Since the implementation of the Affordable Care Act (ACA) coverage provisions in 2014, health insurance coverage has expanded significantly, but about 32 million people, or 12 percent of nonelderly US residents, are estimated to remain uninsured in 2020, and affordability issues persist for some. As a result, the debate continues over the most attractive next steps, ranging from incremental changes to the current system to widespread overhauls, including everything from ACA repeal with state block grant funding to full federalization of the health insurance system. This analysis focuses on improving the current system through incremental steps that would maintain the structure of the ACA but increase insurance coverage, enhance affordability, and contain costs. The reform package seeks to expand coverage in an efficient and policy-sustainable way.

We estimate the coverage and health care spending effects of four reform scenarios, each building upon the preceding scenario. The policy scenarios are as follows:

- **Scenario 1: Restore 2016 ACA policies.** Reinstate the ACA's individual mandate penalties and cost-sharing reductions and prohibit the expanded availability of short-term, limited-duration (STLD) plans.
- **Scenario 2: Expand Medicaid eligibility in all remaining states.**

Add to scenario 1 full federal financing of the Medicaid expansion for all states and families with incomes up to 138 percent of the federal poverty level (FPL), adding autoenrollment of those receiving Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits.

- **Scenario 3: Improve marketplace financial assistance.** Add to scenario 2 enhancement of the ACA's premium tax credit and cost-sharing subsidy schedules, tie assistance to 80 percent actuarial value ("gold") coverage instead of 70 percent ("silver"), eliminate the tax credit "cliff," and introduce a permanent federal reinsurance program for the nongroup market.
- **Scenario 4: Reduce nongroup market premiums and out-of-pocket costs.** Cap provider payment rates paid by insurers in nongroup insurance markets at levels somewhat above Medicare levels.

Table 1 shows the number of uninsured people and people without minimum essential coverage (i.e., the uninsured plus those with STLD policies), federal government spending, and total national spending on acute care for the nonelderly population in 2020. By implementing all four of our policy scenarios, the number of uninsured would fall by 12.2 million people to 7.3 percent of the nonelderly

population, and the number of people without minimum essential coverage would fall by 16.1 million. Excluding the people eligible but not enrolled for Medicaid/Children's Health Insurance Program (CHIP) (i.e., treating this group more like insured people because of their eligibility status), 8.1 million citizens and other legally present residents, or 3.1 percent of nonelderly legal US residents, would be effectively uninsured under these collective reforms in 2020. These reforms would increase federal spending on acute health care for the nonelderly by \$119.2 billion in 2020, but total health care spending would increase by only \$39.8 billion, or 1.8 percent, that year, because there would be significant savings to state governments (\$7.2 billion), employers (\$25.3 billion), households (\$17.2 billion), and reduced demand for uncompensated care (\$29.7 billion).

With the enhanced financial assistance, many households enrolling in marketplace-based coverage would be eligible for significantly lower premiums, deductibles, and out-of-pocket maximums. A family of four (two 35-year-old parents and two children) with income of 350 percent of FPL (about \$88,500) could save almost \$1,900 on premiums for coverage with a deductible \$3,300 lower than that under current law. Thus, in addition to increased coverage, many families would find substantially more affordable coverage.

Table 1. Insurance Coverage and Health Care Spending on Acute Care for the Nonelderly Population under Current Law and Four Incremental Reform Scenarios, 2020

	Number of uninsured (millions)	Number without minimum essential coverage (millions)	Federal spending on acute care for the nonelderly (\$ billions)	National spending on acute care for the nonelderly (\$ billions)
Current law (ACA)	32.2	36.1	418.9	2,176.0
Scenario 1	30.0	30.0	407.5	2,170.7
Scenario 2	22.8	22.8	487.0	2,196.2
Scenario 3	21.1	21.1	549.9	2,234.9
Scenario 4	20.0	20.0	538.1	2,215.8

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Note: ACA = Affordable Care Act.

Federal spending estimated here does not include spending on nonelderly people with Medicare or military-related coverage. Government spending on these populations would not change under any of the simulated reforms. However, they are included in our estimates of coverage.

Introduction

The ACA substantially improved affordability and access to medical care and reduced the number of uninsured Americans.¹ Between 2013 and 2016, the number of uninsured fell from 45.0 million to 26.5 million people (from 17.0 percent of the nonelderly population to 10.0 percent), according to the American Community Survey (ACS).² However, 26.5 million people remained uninsured. The Trump administration's policy changes (beginning in early 2017) have led to confusion among consumers and large increases in unsubsidized nongroup premiums. These policy changes will also likely lead to significant market instability beginning in 2019, when individual mandate penalties are eliminated and people begin to feel the effects of expanding the availability of STLD policies.³ It is unclear how quickly premiums will fully reflect these changes, so we present estimates for 2020, rather than 2019.⁴ The number of uninsured, high premiums, and cost-sharing requirements relative to some consumers' income, and some evidence that uninsurance may have already begun increasing since 2016 leads analysts and policymakers to consider further health reforms.⁵

Various incremental reforms may reverse recent changes and address the ACA's major shortcomings. In this analysis, we describe the cost and coverage implications of four policy scenarios, each

building upon and shown in comparison with the previous scenario:

- **Scenario 1: Restore 2016 ACA policies.** Reinstate the ACA's individual mandate penalties and cost-sharing reductions and prohibit the expanded availability of STLD plans.
- **Scenario 2: Expand Medicaid eligibility in all remaining states.** Add to Scenario 1 full federal financing of the Medicaid expansion for all states and families with incomes up to 138 percent of FPL, adding autoenrollment of those receiving TANF or SNAP benefits.
- **Scenario 3: Improve marketplace financial assistance.** Add to Scenario 2 enhancement of the ACA's premium tax credit and cost-sharing subsidy schedules, tie assistance to 80 percent actuarial value ("gold") coverage instead of 70 percent ("silver"), eliminate the tax credit "cliff," and introduce a permanent federal reinsurance program for the nongroup market.
- **Scenario 4: Reduce nongroup market premiums and out-of-pocket costs.** Cap provider payment rates paid by insurers in nongroup insurance markets at levels somewhat above Medicare levels.

This analysis relies on the Urban Institute's Health Insurance Policy Simulation Model (HIPSIM), which has

been used extensively to estimate the cost and coverage implications of the ACA, reforms to the ACA, and repeal and replace proposals. We provide 2020 estimates of coverage and costs under current law and each of the four incremental reform steps previously delineated.

Methods

HIPSIM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. HIPSIM is based on two years of the ACS, which provides national and state representative samples. The population is aged to future years using projections from the Urban Institute's Mapping America's Futures program. HIPSIM is designed to incorporate timely, real-world data when they are available. We regularly update the model to reflect published Medicaid and marketplace enrollment and costs in each state. The enrollment experience in each state under current law affects how the model simulates policy alternatives. Here we describe approaches to simulating current law and the specific components of our four proposed policy scenarios. The appendix provides additional detail.

Simulation of Insurance Coverage and Health Care Spending under Current Law, 2020. We begin by estimating health insurance coverage and health care spending by governments, employers,

and households under current law. Our current-law ACA simulations are based on finalized effectuated enrollment in the marketplaces in each state under the 2018 open enrollment period. We capture the collective effect of policy changes implemented by the Trump administration by benchmarking the current-law simulation to 2018 marketplace enrollment, the most recent Medicaid enrollment data, and nongroup market premium changes between 2017 and 2018. We then age these benchmarks to our analysis year of 2020, accounting for estimated premium growth, changing demographics, and anticipated shifts in the income distribution.

Because the individual mandate penalties are still in place but will be set to \$0 under current law in 2019, our 2020 current-law estimates must simulate elimination of these penalties, except in Massachusetts and New Jersey, which have passed legislation enacting their own penalties. In addition, effects of the Trump administration's recently finalized regulations allowing the expansion of sales of STLD policies will not be fully realized until at least 2019. States regulate these policies differently, so we must explicitly estimate the effect of eliminating the individual mandate penalties and expanded sales of STLD policies by state and incorporate these estimates into our simulation of current law in 2020. Then these policy changes will be reversed in our simulations of scenarios 1 through 4.⁶

Our 2020 current-law simulation also assumes that all states would instruct their insurers to add the costs associated with cost-sharing subsidies into their silver-level premiums, consistent with 2019 rules. Beginning with the Scenario 1 simulation, this "silver loading" approach would be reversed, and the federal government would directly reimburse insurers for the costs associated with these out-of-pocket subsidies for low-income people.

Estimating the Effect of the Individual Mandate. To simulate the effect of the individual mandate penalties, we

compute eligibility for the most common mandate exemptions (income below the tax-filing threshold, lack of affordability of available premiums, undocumented status) and tax penalties for people without exemptions if they become uninsured. Our estimated number of families paying the tax penalty are similar to published Internal Revenue Service estimates, so the exemptions we cannot model (e.g., individual hardship circumstances and religious conscience objections) do not appear to substantially affect our results. We estimate the size of both the financial and nonfinancial effects of the mandate penalties based on total reported nongroup enrollment in the 2017 National Health Interview Survey and reported marketplace enrollment. This approach is described further in the appendix.

Estimating the Effect of Expanded Availability of Short-Term, Limited-Duration Policies. We assume that full-year STLD coverage would differ markedly from ACA-compliant nongroup coverage, because it has a lower actuarial value (approximately 50 percent); is not guaranteed issue; and permits health status, gender rating, and broad age rating variations. STLD plans do not cover all ACA essential health benefits, but we did not model benefit exclusions given the complexity involved. These differences ensure that those who prefer STLD to ACA-compliant plans, and those who can access the former if desired, will likely have lower health care needs. HIPSM captures the adverse selection behavior of healthier people leaving the ACA-compliant nongroup insurance market for STLD plans by iterating until coverage and premium changes stabilize. STLD plans do not meet the standards of minimum essential coverage; consequently, we categorize STLD purchasers as people without minimum essential coverage and group them with the uninsured. Beginning with the simulation of Scenario 1 (described previously), all states are treated as prohibiting the expansion of STLD plans beyond 2016 Obama administration levels.

Full Federal Funding of the ACA's Medicaid Expansion and Limited Autoenrollment. Under this reform, federal funding for the Medicaid expansion population would increase from its minimum of 90 percent (effective in 2020) to 100 percent. Although states would still administer the program, we assume that all states would take advantage of these federal dollars voluntarily or, alternatively, could be required to do so. Though some states could refuse to enroll the fully federally financed eligible people, we find this unlikely. We also identified people in our model who reported receiving either SNAP or public assistance income on the original ACS survey. If they were simulated to be eligible for Medicaid but would not otherwise enroll, we automatically enrolled them in Medicaid. However, our estimates understate the effect of auto-enrolling this population. Research shows that reporting on the ACS significantly understates SNAP receipt.⁷ Consequently, more people would be auto-enrolled under this approach than we can estimate here.

In this analysis, we do not treat Medicaid expansions that have passed as ballot initiatives but which have yet to be financed and implemented as having expanded under current law. If these initiatives are implemented without further reforms, we will have somewhat over-estimated the government costs associated with Scenarios 2 to 4 here. Uncertainty with the actual political process surrounding these initiatives (Maine is a clear example) led us to treat only expansions legally in place (including Virginia) as part of current law.

Enhanced Financial Assistance for Enrollees in ACA Marketplaces. Elsewhere, we proposed enhanced premium tax credit and cost-sharing schedules to improve insurance affordability and reduce cost-sharing requirements for ACA-compliant nongroup insurance policies.⁸ The changes to both schedules are used in this analysis and shown in Table 2. In addition to increasing financial assistance at all income levels, the approach

Table 2: Enhanced Premium Tax Credit and Cost-Sharing Reduction Schedule

Income (% of FPL)	Premium Tax Credit Schedule		Cost-Sharing Reduction Schedule	
	Household Premium Caps as Percent of Income		AV of Plan Provided to Eligible Enrollees (%)	
	2019 ACA schedule: Pegged to silver (70% AV) premium, indexed	Proposed schedule: Pegged to gold (80% AV) premium, not indexed	2019 ACA schedule: Coverage provided in a silver plan	Proposed schedule: Coverage provided in a gold plan
100–138	2.08	0–1.0	94	94
138–150	3.11–4.15	1.0–2.0	94	94
150–200	4.15–6.54	2.0–4.0	87	90
200–250	6.54–8.36	4.0–6.0	73	85
250–300	8.39–9.86	6.0–7.0	70	85
300–400	9.86	7.0–8.5	70	80
≥ 400	NA	8.5	70	80

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Notes: ACA = Affordable Care Act; AV = actuarial value; FPL = federal poverty level; NA = not applicable.

The ACA premium tax credit schedule can be found at <https://www.irs.gov/pub/irs-drop/rp-18-34.pdf>. Under the ACA, premium tax credits are indexed to change as a function of the increase in health care costs relative to general inflation. Our proposal would eliminate the indexing, keeping the the percent of income caps fixed.

would extend premium tax credits above the current cap of 400 percent of FPL, providing a cap at 8.5 percent of income for all incomes above that level. As income increases, the extended premium tax credit falls to zero as the premium facing individuals and families falls below 8.5 percent of their income. In addition, the percent-of-income caps would no longer be indexed, and they would be tied to the second-lowest-cost gold (80 percent actuarial value plan) instead of silver (70 percent actuarial value) coverage. The approach would also make other components of the system consistent with this new schedule by setting the affordability threshold for exemption from the individual mandate penalties at 8.5 percent of family income (a modest increase from its 2019 level of 8.3 percent) and lowering the employer-sponsored insurance “firewall” to 8.5 percent of family income, a decrease from its current-law 2019 level of 9.86 percent. The latter means workers and their families would be eligible for marketplace financial assistance if the required contribution for worker-only coverage exceeds 8.5 percent of family income.

A Permanent Federal Reinsurance Program. To attract and maintain more insurers to compete in private nongroup insurance markets, we reintroduce a federal reinsurance program into these markets. We assume a gross federal cost of \$10 billion. The effect of this type of reform is to reduce aggregate claims in the private nongroup markets by \$10 billion, thereby lowering premium levels before computing premium tax credits. To put this \$10 billion in perspective, Blewett et al. estimated that a national reinsurance program that reimbursed nongroup insurers for 90 percent of their claims between \$40,000 and \$250,000 per year would have a gross cost of \$9.7 billion in 2019.⁹ With lower premiums resulting from reinsurance, total federal spending on tax credits falls as well. Reinsurance programs under current law (seven states will have them in effect via Section 1332 waivers as of 2019)¹⁰ are financed by federal savings on premium tax credits and state financing. However, under the reforms simulated here that bring in significantly more enrollees with enhanced premium tax credits, cost-sharing reductions, and an individual mandate, the federal savings on premium tax credits would more than pay for the \$10 billion gross investment in the reinsurance program.

Estimating the Effect of Capping ACA-Compliant Nongroup Insurance Payment Rates at Competitive Market Levels. High provider payment rates in areas with limited provider competition and often limited insurer competition lead to higher premiums.¹¹ Increasing competition in these markets, particularly for providers, is extremely difficult because of the high cost of entry. Consequently, we have proposed elsewhere that provider payment rates applying to ACA-compliant nongroup insurers be capped somewhat above Medicare levels.¹² Therefore, monopoly or dominant provider systems could no longer require extremely high rates, leading to lower premiums. These payment rate caps would also lower the barriers to insurance market entry, allowing additional insurers to enter markets without having to effectively negotiate with providers for payment rates that approximate those negotiated by insurers already in those markets with large market shares. The Medicare Advantage program uses a similar approach by capping out-of-network payments at traditional Medicare payment rates. An alternative that achieves roughly the same savings, but could be somewhat more problematic politically, is a public option offered in the marketplaces.

Ideally, these payment rate caps would be set somewhat above Medicare levels. Without information on nongroup insurer provider payment rates, we proxy the ideal levels using those consistent with provider payments rates in the most competitive markets, which have five or more insurers. We estimated the premium effect of these highly competitive marketplaces in prior work and apply those findings here.¹³ We found that benchmark premiums vary by number of insurers in the markets; markets with only one insurer are associated with an additional 35 percent in benchmark premiums, an additional 20 percent for markets with two insurers, an additional 10 percent for three insurers, and an additional 5 percent for four insurers. With provider payment caps in place, we assume these levels of savings relative to current premiums as a function of insurer competition.

These payment rate caps would reduce total premiums in the less competitive and more expensive marketplaces (before premium tax credits), reducing premium tax credits for the federal government and household premiums for enrollees ineligible for tax credits. The payment rate caps would also reduce out-of-pocket spending for nongroup enrollees using medical care before hitting their plans' out-of-pocket maximums. Here, we approximate the household savings on direct medical costs by applying the same percent savings as we apply to the benchmark premium to direct spending by households before reaching the out-of-pocket maximum.

Results

As described in the introduction, each successive reform scenario builds on the previous one by adding components in each scenario. The tables of findings are organized around each policy scenario and include the estimated distribution of health insurance coverage and health care spending. In each table, we compare the findings for the highlighted scenario with the previous scenario. Scenario 1 is compared with current law, and Scenario 4 is compared with both Scenario 3 and current law.

Current Law

Health Insurance Coverage. We estimate that, under current law, 36.1 million Americans, 13.1 percent of the nonelderly population, will not have minimum essential coverage (i.e., employer-based insurance, ACA-compliant nongroup coverage, Medicare, Medicaid, or other public insurance) in 2020 (Table 3, section A). Of that 36.1 million people, 32.2 million people will have no insurance, and 3.9 million people will have non-ACA compliant nongroup plans (i.e., STLD plans). These noncompliant plans will not cover all ACA essential health benefits, will not be guaranteed issue, and will be permitted to discriminate in benefits and premiums per enrollees' health status.

We estimate that over half of the nonelderly population (148.7 million people) will have employer-based insurance in 2020; 12.7 million people, or 4.6 percent, will have ACA-compliant nongroup insurance (most of those receiving tax credits through the marketplaces); 69.1 million people, or 25.1 percent, will have Medicaid or CHIP coverage; and the remaining 8.6 million people, or 3.1 percent, will have other public insurance coverage, such as Medicare or military coverage.

Health Care Spending. We estimate that, under current law, the federal government will spend \$341.0 billion on Medicaid and CHIP acute care for the nonelderly and \$77.3 billion on marketplace premium tax credits in 2020 (Table 3, section B). State governments will spend \$198.5 billion on Medicaid and CHIP, and the six states (Alaska, Maine, Maryland, Minnesota, Oregon, and Wisconsin) that will have implemented their own reinsurance programs by 2019 under Section 1132 waivers are estimated to spend \$721 million on those programs the same year, assuming no additional waivers are granted for 2020. The federal government will contribute an estimated \$568 million in "pass through" funds to these state reinsurance programs, shifting funds from decreased premium tax credit costs associated with these programs back to the states to help fund the programs. Employers will

spend \$922.4 billion on their workers' premiums, and households will spend \$563.0 billion in premiums and direct out-of-pocket payments at the point of service.

Scenario 1: Restore 2016 ACA policies. Restores the ACA's individual mandate and direct federal funding of cost-sharing reductions and reverses the recent expansion of short-term limited-duration policies.

Health Insurance Coverage. Scenario 1 essentially reverses the central policy changes made to the ACA since early 2017: the individual mandate would be reinstated, direct federal funding of cost-sharing reductions would be restored, and the regulatory change that allows the expansion of non-ACA compliant nongroup plans would be reversed (Table 3, section A). Compared with current law, these changes alone would decrease the number of people without minimum essential coverage by 6.1 million in 2020, from 13.1 percent to 10.9 percent, a 16.9 percent reduction. Approximately 30 million people would remain uninsured, however. The largest changes in coverage would be a 19.2 percent increase in the number of nonelderly people enrolling in nongroup insurance with tax credits (1.6 million more people) and a 64.7 percent increase in the number of people purchasing ACA-compliant nongroup insurance without tax credits (2.9 million more people).

Of the three components of this policy package, reinstating the individual mandate increases the number of people with minimum essential coverage the most. If the mandate were not included here, only 2.4 million people would gain minimum essential coverage (data not shown), instead of 6.1 million people.

Health Care Spending. Reversing these recent policy changes would decrease federal and national health spending. It would increase Medicaid/CHIP spending modestly (\$3.3 billion federally, or 1 percent) compared with current law, largely because of increased enrollment (Table 3, section B). Federal spending on tax credits would decrease by \$14.7

Table 3. Health Insurance Coverage and Health Care Spending for the Nonelderly in 2020 under Current Law and Reform Scenario 1 (thousands of people, millions of dollars)

Scenario 1: Restore 2016 ACA Policies: Individual Mandate, Direct Funding for Cost-Sharing Reductions, Elimination of Short-Term Limited-Duration Policy Extension

A. Health Insurance Coverage						
	Current Law (ACA)		Scenario 1		Difference from Current Law	
	Number	Percent	Number	Percent	Number	Percent
Insured	239,069	86.9%	245,164	89.1%	6,095	2.5%
Employer	148,684	54.0%	149,346	54.3%	663	0.4%
Nongroup (with tax credits)	8,286	3.0%	9,875	3.6%	1,589	19.2%
Nongroup (without tax credits)	4,412	1.6%	7,265	2.6%	2,853	64.7%
Medicaid/CHIP	69,056	25.1%	70,047	25.5%	990	1.4%
Other (including Medicare)	8,632	3.1%	8,632	3.1%	0	0.0%
Lacking minimum essential coverage	36,064	13.1%	29,969	10.9%	-6,095	-16.9%
Uninsured	32,206	11.7%	29,969	10.9%	-2,236	-6.9%
Alternative nongroup market	3,859	1.4%	0	0.0%	-3,859	-100.0%
Total	275,134	100.0%	275,134	100.0%	0	0.0%
B. Acute Care Health Spending						
	Current Law (ACA)		Scenario 1		Difference from Current Law	
	Dollars	Percent	Dollars	Percent	Dollars	Percent
Federal government	\$418,867	19.2%	\$407,501	18.8%	\$(11,365)	-2.7%
Medicaid/CHIP	\$341,012	15.7%	\$344,303	15.9%	\$3,291	1.0%
Marketplace PTCs and CSRs	\$77,288	3.6%	\$62,630	2.9%	\$(14,657)	-19.0%
Reinsurance	\$568	0.0%	\$568	0.0%	\$0	0.1%
State government	\$199,246	9.2%	\$200,771	9.2%	\$1,525	0.8%
Medicaid/CHIP	\$198,525	9.1%	\$200,050	9.2%	\$1,525	0.8%
Reinsurance	\$721	0.0%	\$721	0.0%	\$0	0.0%
Employers	\$922,425	42.4%	\$925,176	42.6%	\$2,750	0.3%
Households	\$563,023	25.9%	\$571,751	26.3%	\$8,728	1.6%
< 138% FPL	\$51,095	2.3%	\$50,931	2.3%	\$(164)	-0.3%
138%–250% FPL	\$95,721	4.4%	\$96,751	4.5%	\$1,030	1.1%
251%–400% FPL	\$139,450	6.4%	\$140,268	6.5%	\$818	0.6%
> 400% FPL	\$276,757	12.7%	\$283,802	13.1%	\$7,045	2.5%
Uncompensated care	\$72,438	3.3%	\$65,517	3.0%	\$(6,921)	-9.6%
Total	\$2,175,999	100.0%	\$2,170,716	100.0%	\$(5,283)	-0.2%

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Notes: PTC = premium tax credit. CSR = cost-sharing reductions. FPL = federal poverty level.

Federal spending estimated here does not include spending on nonelderly people with Medicare or military-related coverage. Government spending on these populations would not change under any of the simulated reforms. However, they are included in our estimates of coverage (under "other").

billion, or 19.0 percent, as healthier people enroll in the private nongroup markets, reducing the average premium tax credit paid out. The savings in tax credits per person would more than offset the tax credits paid to additional enrollees, two-thirds of whom are ineligible for financial assistance. Employer spending would not change significantly, and household spending would increase by \$8.7 billion, 80 percent of which is attributable to people with family income over 400 percent of FPL. The increased spending is clustered in these higher-income families because of higher enrollment in comprehensive health insurance coverage. STLD policies, which would be purchased almost exclusively by people less likely to use health care services and can be denied to people with health problems, tend to have low premiums for those able to purchase them. Households enrolling in comprehensive ACA-compliant coverage, instead of STLDs or going uninsured, would likely face higher premiums, particularly if they are ineligible for marketplace tax credits. Plus, because their out-of-pocket costs would likely be lower and covered benefits broader, some of these people would use more medical services. However, aggregate health spending increases by less than three percent for this income group. As insurance coverage increases, the demand for uncompensated care falls by 9.6 percent.

Scenario 2: Expand Medicaid Eligibility in All Remaining States. Adds to Scenario 1 full federal funding of the ACA's Medicaid expansion for all states and autoenrollment of Medicaid eligibles receiving TANF or SNAP.

Health Insurance Coverage. Scenario 2 addresses the issue that 18 states have thus far declined to expand Medicaid under the ACA, leaving many poor adult residents without access to any financial assistance for health insurance coverage. This step fully funds the cost of expansion in all states plus the District of Columbia, including states that have already voluntarily expanded. If all remaining states agree to enroll the new eligibles, or are required to do so by legislation, this step would reduce

the uninsured by 7.1 million more people than Scenario 1, reducing the number uninsured to 22.8 million people, or 8.3 percent of the nonelderly population in 2020 (Table 4, section A). This change would increase the share of the nonelderly population enrolled in Medicaid or CHIP to 30.2 percent, or 83.1 million people. The most notable other change would be a 22.1 percent decrease in the number of people enrolled in nongroup coverage with tax credits, as people with incomes between 100 and 138 percent of FPL in states that had not previously expanded Medicaid eligibility move from subsidized marketplace coverage into Medicaid.

Health Care Spending. Compared with Scenario 1, the biggest changes in spending under Scenario 2 are increased federal government spending because of current-law Medicaid expansion costs shifting from states to the federal government and because of new federal spending on states that have not expanded Medicaid under current law (Table 4, section B). Federal spending increases further because administrative TANF and SNAP program data are used to identify and autoenroll some Medicaid eligibles. State spending on Medicaid/CHIP would be 4.5 percent lower (-\$8.9 billion), and federal Medicaid/CHIP spending would be 27.7 percent higher (\$95.5 billion). The significantly larger number of people insured in states that had not expanded Medicaid previously would also decrease demand for uncompensated care by 20.9 percent nationally (\$13.7 billion). Newly eligible for Medicaid under the federal expansion, families with income at or below 138 percent of FPL would save \$13.6 billion (26.8 percent nationally) on health care compared with Scenario 1.

Alternatively, offering states newly expanding Medicaid eligibility the same three years of full federal financing and subsequent phase-down to the 90 percent federal funding offered states in 2014 would be less costly for the federal government.¹⁴ This approach would encourage states to contain program costs and would lower federal costs; however, the trade-off is likely lower participation by states and thus

lower insurance coverage, at least in the foreseeable future.

Scenario 3: Improve Marketplace Financial Assistance. Adds to Scenario 2 enhanced premium tax credits and cost-sharing assistance plus federal reinsurance; standardizes affordability; and makes the employer-based insurance firewall threshold consistent with the highest percent-of-income cap in the tax credit schedule.

Health Insurance Coverage. This step improves coverage affordability and reduces the direct consumer cost of covered services by increasing the financial assistance provided to eligible marketplace enrollees at all income levels, including extending an 8.5 percent of income premium tax credit cap to all incomes of 400 percent of FPL or higher. As income increases, the extended premium tax credit falls to zero as the premium facing individuals and families falls below 8.5 percent of their income. We delineate the enhanced tax credit and cost-sharing assistance schedules in the methods section. This step also creates consistency between the exemption from the individual mandate penalty, the employer-sponsored insurance firewall, and the premium tax credits. We also add a permanent federal reinsurance program that would make nongroup market participation more attractive to insurers and would lower premiums for higher-income people paying the full premium (i.e., those for whom even the enhanced premium tax credits are not binding). In the nongroup insurance market, enrollees are likely to always be at somewhat higher health care risk than the larger population in the employer-sponsored insurance market. A permanent reinsurance program would spread this additional risk in a small percentage of the population more broadly across the population of taxpayers, further stabilizing this market.

These changes would increase the number of people purchasing nongroup insurance with a premium tax credit by 5.8 million people, or 75.6 percent, compared with Scenario 2 (Table 5, section A). The number of people buying

Table 4. Health Insurance Coverage and Health Care Spending for the Nonelderly in 2020 under Reform Scenarios 1 and 2 (thousands of people, millions of dollars)

Scenario 1: Restore 2016 ACA Policies: Individual Mandate, Direct Funding for Cost-Sharing Reductions, Elimination of Short-Term Limited-Duration Policy Extension

Scenario 2: Expand Medicaid Eligibility in All Remaining States: Scenario 1 Plus Full Federal Funding of Medicaid Expansion and Limited Autoenrollment

A. Health Insurance Coverage						
	Scenario 1		Scenario 2		Difference from Scenario 1	
	Number	Percent	Number	Percent	Number	Percent
Insured	245,164	89.1%	252,285	91.7%	7,121	2.9%
Employer	149,346	54.3%	145,804	53.0%	-3,542	-2.4%
Nongroup (with tax credits)	9,875	3.6%	7,693	2.8%	-2,182	-22.1%
Nongroup (without tax credits)	7,265	2.6%	7,028	2.6%	-237	-3.3%
Medicaid/CHIP	70,047	25.5%	83,129	30.2%	13,082	18.7%
Other (including Medicare)	8,632	3.1%	8,632	3.1%	0	0.0%
Lacking minimum essential coverage	29,969	10.9%	22,849	8.3%	-7,121	-23.8%
Uninsured	29,969	10.9%	22,849	8.3%	-7,121	-23.8%
Alternative nongroup market	0	0.0%	0	0.0%	0	n.a.
Total	275,134	100.0%	275,134	100.0%	0	0.0%
B. Acute Care Health Spending						
	Scenario 1		Scenario 2		Difference from Scenario 1	
	Dollars	Percent	Dollars	Percent	Dollars	Percent
Federal government	\$407,501	18.8%	\$486,970	22.2%	\$79,469	19.5%
Medicaid/CHIP	\$344,303	15.9%	\$439,807	20.0%	\$95,504	27.7%
Marketplace PTCs and CSRs	\$62,630	2.9%	\$46,595	2.1%	\$(16,035)	-25.6%
Reinsurance	\$568	0.0%	\$568	0.0%	\$0	0.0%
State government	\$200,771	9.2%	\$191,852	8.7%	\$(8,919)	-4.4%
Medicaid/CHIP	\$200,050	9.2%	\$191,131	8.7%	\$(8,919)	-4.5%
Reinsurance	\$721	0.0%	\$721	0.0%	\$0	0.0%
Employers	\$925,176	42.6%	\$909,953	41.4%	\$(15,222)	-1.6%
Households	\$571,751	26.3%	\$555,587	25.3%	\$(16,164)	-2.8%
< 138% FPL	\$50,931	2.3%	\$37,295	1.7%	\$(13,635)	-26.8%
138%–250% FPL	\$96,751	4.5%	\$95,311	4.3%	\$(1,439)	-1.5%
251%–400% FPL	\$140,268	6.5%	\$139,493	6.4%	\$(775)	-0.6%
> 400% FPL	\$283,802	13.1%	\$283,487	12.9%	\$(315)	-0.1%
Uncompensated care	\$65,517	3.0%	\$51,819	2.4%	\$(13,698)	-20.9%
Total	\$2,170,716	100.0%	\$2,196,181	100.0%	\$25,465	1.2%

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Notes: PTC = premium tax credit. CSR = cost-sharing reductions. FPL = federal poverty level.

Federal spending estimated here does not include spending on nonelderly people with Medicare or military-related coverage. Government spending on these populations would not change under any of the simulated reforms. However, they are included in our estimates of coverage (under "other").

Table 5. Health Insurance Coverage and Health Care Spending for the Nonelderly in 2020 under Reform Scenarios 2 and 3 (thousands of people, millions of dollars)

Scenario 2: Expand Medicaid Eligibility in All Remaining States: Scenario 1 Plus Full Federal Funding of Medicaid Expansion and Limited Autoenrollment

Scenario 3: Improve Marketplace Financial Assistance: Scenario 2 Plus Enhanced Marketplace Subsidies; Federal Reinsurance Program; and Additional Changes to Create Consistency between the Premium Tax Credit Schedule, the Affordability Standard, and the Employer-Sponsored Insurance Firewall

A. Health Insurance Coverage						
	Scenario 2		Scenario 3		Difference from Scenario 2	
	Number	Percent	Number	Percent	Number	Percent
Insured	252,285	91.7%	254,012	92.3%	1,727	0.7%
Employer	145,804	53.0%	144,058	52.4%	-1,746	-1.2%
Nongroup (with tax credits)	7,693	2.8%	13,508	4.9%	5,815	75.6%
Nongroup (without tax credits)	7,028	2.6%	4,262	1.5%	-2,766	-39.4%
Medicaid/CHIP	83,129	30.2%	83,553	30.4%	424	0.5%
Other (including Medicare)	8,632	3.1%	8,632	3.1%	0	0.0%
Lacking minimum essential coverage	22,849	8.3%	21,122	7.7%	-1,727	-7.6%
Uninsured	22,849	8.3%	21,122	7.7%	-1,727	-7.6%
Alternative nongroup market	0	0.0%	0	0.0%	0	n.a.
Total	275,134	100.0%	275,134	100.0%	0	0.0%
B. Acute Care Health Spending						
	Scenario 2		Scenario 3		Difference from Scenario 2	
	Dollars	Percent	Dollars	Percent	Dollars	Percent
Federal government	\$486,970	22.2%	\$549,916	24.6%	\$62,946	12.9%
Medicaid/CHIP	\$439,807	20.0%	\$441,777	19.8%	\$1,970	0.4%
Marketplace PTCs and CSRs	\$46,595	2.1%	\$98,139	4.4%	\$51,544	110.6%
Reinsurance	\$568	0.0%	\$10,000	0.4%	\$9,432	1660.4%
State government	\$191,852	8.7%	\$191,620	8.6%	\$(232)	-0.1%
Medicaid/CHIP	\$191,131	8.7%	\$191,620	8.6%	\$489	0.3%
Reinsurance	\$721	0.0%	\$0	0.0%	\$(721)	-100.0%
Employers	\$909,953	41.4%	\$899,805	40.3%	\$(10,149)	-1.1%
Households	\$555,587	25.3%	\$547,571	24.5%	\$(8,016)	-1.4%
< 138% FPL	\$37,295	1.7%	\$36,831	1.6%	\$(464)	-1.2%
138%–250% FPL	\$95,311	4.3%	\$91,676	4.1%	\$(3,636)	-3.8%
251%–400% FPL	\$139,493	6.4%	\$137,026	6.1%	\$(2,467)	-1.8%
> 400% FPL	\$283,487	12.9%	\$282,037	12.6%	\$(1,450)	-0.5%
Uncompensated care	\$51,819	2.4%	\$45,998	2.1%	\$(5,821)	-11.2%
Total	\$2,196,181	100.0%	\$2,234,909	100.0%	\$38,728	1.8%

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Notes: PTC = premium tax credit. CSR = cost-sharing reductions. FPL = federal poverty level.

Federal spending estimated here does not include spending on nonelderly people with Medicare or military-related coverage. Government spending on these populations would not change under any of the simulated reforms. However, they are included in our estimates of coverage (under "other").

nongroup insurance without a tax credit would decrease by 2.8 million people, or 39.4 percent compared with Scenario 2, and the number of uninsured would fall by an additional 1.7 million people, or 7.6 percent. Compared with Scenario 2, employer-sponsored insurance would decrease by 1.2 percent under this scenario, because modestly more people with employer-sponsored insurance offers would be eligible for marketplace financial assistance (because the employer-sponsored insurance firewall decreases to 8.5 percent from the current-law 2019 level of 9.86 percent).

Health Care Spending. Federal spending increases as the marketplace premium tax credit and cost-sharing assistance generosity increase in Scenario 3. In addition, state-specific reinsurance programs in Alaska, Maine, Maryland, Minnesota, Oregon, and Wisconsin would be replaced by a permanent, nationwide federally financed reinsurance program in the nongroup market. We assume this program would provide \$10 billion in reinsurance funds. Given the increased number of people enrolled with premium tax credits in this scenario, the gross \$10 billion cost of the reinsurance program is more than offset by lower aggregate federal spending on premium tax credits than would be the case absent the reinsurance (data not shown). Lower nongroup premiums from reinsurance translate into lower premium tax credits; the effect on premium tax credits is large here because of significantly higher enrollment under a scenario with enhanced subsidies.

In this scenario, federal government spending would be \$62.9 billion, or 12.9 percent, higher than in Scenario 2 (Table 5, section B). With greater marketplace assistance, household spending for nongroup insurance enrollees in each of our four income groups would be lower. We estimate that household spending for people in families with incomes between 138 and 400 percent of FPL would be \$6.1 billion lower, and spending by people in higher-income families would be \$1.5 billion lower compared with Scenario 2. The change for the lowest-income group (incomes below 138

percent of FPL) is smallest because they are generally ineligible for marketplace financial assistance. The demand for uncompensated care would be even lower than in Scenario 2 (decreased by \$5.8 billion or 11.2 percent) as uninsurance declines further.

Household Spending by Income and Age. The enhanced premium tax credits and cost-sharing assistance provided in this and the subsequent scenario have substantial implications for household premium affordability and direct out-of-pocket medical costs. Table 6 shows the household premium contributions required by different households under the ACA and Scenario 3. As noted before, the benchmark premium under the ACA is for a silver (70 percent actuarial value) plan, and the benchmark premium under Scenario 3 is for a gold (80 percent actuarial value) plan. Under the ACA, additional cost-sharing subsidies are provided for those with incomes up to 250 percent of FPL, and under Scenario 3, additional assistance is provided to this income group and then extended to people with incomes up to 300 percent of FPL.

We show the premium contributions and illustrative deductibles and out-of-pocket maximums for single adults at ages 25, 45, and 64 and at four income levels, 138, 250, 350, and 450 percent of FPL under the ACA and Scenario 3. We also show illustrative deductibles and out-of-pocket maximums for a family of four (two adults both age 35 and two children) at the same income levels.¹⁵

Compared with the ACA, single adults with incomes just over the Medicaid expansion eligibility threshold (138 percent of FPL) would save \$356 in premiums when purchasing the standard marketplace insurance package in 2020 under Scenario 3. The premium contributions are the same at all ages within the ACA and within Scenario 3 because enrollees' shares are capped at fixed income shares. The example low-income family would save \$736 in premiums. Larger families would have larger premium contributions because the federal poverty level is higher for

larger families than smaller families. The cost-sharing assistance would be comparable for these low-income households under both approaches.

As income increases to 250 percent, 350 percent, and 450 percent of poverty, and ACA premium contributions as a percent of income increase, enrollees will generate more household savings under the Scenario 3 premium tax credit schedule. The largest household premium savings from the Scenario 3 approach are seen for 64-year-old single adults and the family unit with income of 450 percent of FPL. Over 400 percent of FPL, no households are eligible for financial assistance under the ACA, but that assistance "cliff" is eliminated under Scenario 3. Sixty-four-year-olds face the highest premiums in the marketplace because of age rating and thus gain the most from this approach (almost \$9,500), though significant premium savings would accrue to younger adults as well. Family premiums are essentially the sum of the premiums for the individuals in the unit (although the premium does not increase for families with more than two children), and the financial assistance extended to them under Scenario 3 results in savings of \$9,000 in 2020 for the example family. The youngest adults at 450 percent of FPL gain less under Scenario 3 because the capped share of their income is close to the full unsubsidized premium, because age rating lowers their premiums.

The additional cost-sharing assistance and tying the premium tax credits to gold- rather than silver-level coverage also decreases out-of-pocket costs for these households. Cost-sharing subsidies for those at 250 percent of FPL are improved under Scenario 3 compared with the ACA; a typical deductible decreases by \$1,650, and a typical out-of-pocket maximum falls by \$3,800 for a single adult (and double that for a family). Though the Scenario 3 cost-sharing reductions would stop at 300 percent of FPL, cost-sharing savings would still accrue to higher-income enrollees because the premium tax credits are tied to gold instead of silver coverage. Thus, even without extra cost-

Table 6. Enrollee Portion of Annual Premium and Out-of-Pocket Structure, ACA versus Scenario 3, 2020

	138% of FPL			250% of FPL			350% of FPL			450% of FPL		
	ACA (94% AV)	Scenario 3 (94% AV)	Difference	ACA (73% AV)	Scenario 3 (85% AV)	Difference	ACA (70% AV)	Scenario 3 (80% AV)	Difference	ACA (70% AV)	Scenario 3 (80% AV)	Difference
Enrollee portion of premiums												
Single												
Age												
25	\$524	\$169	-\$356	\$2,554	\$1,833	-\$721	\$4,217	\$3,315	-\$902	\$4,722	\$4,674	-\$47
45	\$524	\$169	-\$356	\$2,554	\$1,833	-\$721	\$4,217	\$3,315	-\$902	\$6,791	\$4,674	-\$2,117
64	\$524	\$169	-\$356	\$2,554	\$1,833	-\$721	\$4,217	\$3,315	-\$902	\$14,108	\$4,674	-\$9,434
Family of four (two age 35, two children)	\$1,085	\$349	-\$736	\$5,281	\$3,791	-\$1,491	\$8,721	\$6,854	-\$1,866	\$18,689	\$9,666	-\$9,023
Out-of-pocket structure												
Single												
Deductible	\$200	\$200	\$0	\$2,650	\$1,000	-\$1,650	\$3,150	\$1,500	-\$1,650	\$3,150	\$1,500	-\$1,650
Out-of-pocket maximum	\$700	\$700	\$0	\$6,500	\$2,700	-\$3,800	\$7,450	\$7,200	-\$250	\$7,450	\$7,200	-\$250
Family												
Deductible	\$400	\$400	\$0	\$5,300	\$2,000	-\$3,300	\$6,300	\$3,000	-\$3,300	\$6,300	\$3,000	-\$3,300
Out-of-pocket maximum	\$1,400	\$1,400	\$0	\$13,000	\$5,400	-\$7,600	\$14,900	\$14,400	-\$500	\$14,900	\$14,400	-\$500

Notes: ACA = Affordable Care Act, current law. AV = actuarial value. FPL = federal poverty level. Plan data shown is the national median 2019 second-lowest-cost silver (and the associated cost-sharing reduction variations) and median second-lowest-cost gold plan among rating regions in states using the healthcare.gov platform, aged to 2020.

sharing subsidies, deductibles for people enrolling in the standard gold plan under Scenario 3 would be \$1,650 lower than under the standard ACA plan, and the typical out-of-pocket maximum would be \$250 lower.

Scenario 4: Reduce Nongroup Market Provider Payment Rates and Premiums. Adds to Scenario 3 provider payment rate caps for private nongroup insurers.

Health Insurance Coverage. This scenario adds in a new cost-containment feature: provider payment rate caps that would apply to private nongroup insurance plans for both in- and out-of-network coverage. These caps are intended to approximate rates somewhat higher than Medicare levels and reflect levels in the most competitive nongroup insurance markets (those with five or more insurers). We estimate that this

policy would reduce nongroup market premiums in 430 out of 499 US rating regions. We estimate that this approach, added to the affordability enhancements included in previous scenarios, will not greatly affect coverage. The most noticeable coverage effects are an estimated 9.2 percent increase (392,000 more enrollees) in nongroup coverage purchased without tax credits and an estimated 6.7 percent increase (902,000 more enrollees) in nongroup coverage purchased with tax credits (Table 7, section A). The capped provider payment rates decrease nongroup insurance premiums for those ineligible for premium tax credits, and they decrease out-of-pocket costs for those covered by subsidized or unsubsidized nongroup coverage. Both changes would make nongroup insurance coverage more attractive to potential consumers, reducing the number of uninsured by an

additional 1.1 million people, down to 7.3 percent of the nonelderly population.

Health Care Spending. The biggest effect of the provider payment rate caps introduced in Scenario 4 is to lower health care spending for services received by people enrolled in private nongroup insurance coverage. In nongroup market areas that are less competitive under current law, the provider payment rate caps would lower the costs of medical care the most. With lower health care costs, premiums and out-of-pocket payments for medical care decrease. This in turn decreases federal health care spending and household spending for those purchasing nongroup insurance coverage. We estimate that, with these caps, federal spending would decrease by \$11.8 billion compared with Scenario 3, and household spending would decrease by \$1.7 billion, almost

Table 7. Health Insurance Coverage and Health Care Spending for the Nonelderly in 2020 under Reform Scenarios 3 and 4 (thousands of people, millions of dollars)

Scenario 3: Improve Marketplace Financial Assistance: Scenario 2 Plus Enhanced Marketplace Subsidies; Federal Reinsurance Program; and Additional Changes to Create Consistency between the Premium Tax Credit Schedule, the Affordability Standard, and the Employer-Sponsored Insurance Firewall

Scenario 4: Reduce Nongroup Market Premiums and Out-of-Pocket Costs: Scenario 3 Plus Cap on Provider Payment Rates in Nongroup Market

A. Health Insurance Coverage								
	Scenario 3		Scenario 4		Difference from Scenario 3		Difference between Scenario 4 and Current Law	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Insured	254,012	92.3%	255,129	92.7%	1,117	0.4%	16,059	6.7%
Employer	144,058	52.4%	143,528	52.2%	-530	-0.4%	-5,155	-3.5%
Nongroup (with tax credits)	13,508	4.9%	14,409	5.2%	902	6.7%	6,124	73.9%
Nongroup (without tax credits)	4,262	1.5%	4,654	1.7%	392	9.2%	242	5.5%
Medicaid/CHIP	83,553	30.4%	83,905	30.5%	353	0.4%	14,849	21.5%
Other (including Medicare)	8,632	3.1%	8,632	3.1%	0	0.0%	0	0.0%
Lacking minimum essential coverage	21,122	7.7%	20,005	7.3%	-1,117	-5.3%	-16,059	-44.5%
Uninsured	21,122	7.7%	20,005	7.3%	-1,117	-5.3%	-12,201	-37.9%
Alternative nongroup market	0	0.0%	0	0.0%	0	n.a.	-3,859	-100.0%
Total	275,134	100.0%	275,134	100.0%	0	0.0%	0	0.0%
B. Acute Care Health Spending								
	Scenario 3		Scenario 4		Difference from Scenario 3		Difference between Scenario 4 and Current Law	
	Dollars	Percent	Dollars	Percent	Dollars	Percent	Dollars	Percent
Federal government	\$549,916	24.6%	\$538,113	24.3%	\$(11,803)	-2.1%	\$119,246	28.5%
Medicaid/CHIP	\$441,777	19.8%	\$443,388	20.0%	\$1,611	0.4%	\$102,376	30.0%
Marketplace PTCs and CSRs	\$98,139	4.4%	\$84,726	3.8%	\$(13,414)	-13.7%	\$7,438	9.6%
Reinsurance	\$10,000	0.4%	\$10,000	0.5%	\$0	0.0%	\$9,432	1661.7%
State government	\$191,620	8.6%	\$192,041	8.7%	\$421	0.2%	\$(7,205)	-3.6%
Medicaid/CHIP	\$191,620	8.6%	\$192,041	8.7%	\$421	0.2%	\$(6,484)	-3.3%
Reinsurance	\$0	0.0%	\$0	0.0%	\$0	n.a.	\$(721)	-100.0%
Employers	\$899,805	40.3%	\$897,104	40.5%	\$(2,701)	-0.3%	\$(25,322)	-2.7%
Households	\$547,571	24.5%	\$545,847	24.6%	\$(1,724)	-0.3%	\$(17,176)	-3.1%
< 138% FPL	\$36,831	1.6%	\$36,474	1.6%	\$(357)	-1.0%	\$(14,621)	-28.6%
138%–250% FPL	\$91,676	4.1%	\$91,279	4.1%	\$(397)	-0.4%	\$(4,442)	-4.6%
251%–400% FPL	\$137,026	6.1%	\$136,762	6.2%	\$(264)	-0.2%	\$(2,688)	-1.9%
> 400% FPL	\$282,037	12.6%	\$281,332	12.7%	\$(705)	-0.2%	\$4,575	1.7%
Uncompensated care	\$45,998	2.1%	\$42,703	1.9%	\$(3,295)	-7.2%	\$(29,735)	-41.0%
Total	\$2,234,909	100.0%	\$2,215,808	100.0%	\$(19,101)	-0.9%	\$39,809	1.8%

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Notes: PTC = premium tax credit. CSR = cost-sharing reductions. FPL = federal poverty level.

Federal spending estimated here does not include spending on nonelderly people with Medicare or military-related coverage. Government spending on these populations would not change under any of the simulated reforms. However, they are included in our estimates of coverage (under "other").

entirely because of lower spending in the nongroup insurance market (Table 7, section B).

All Policies Combined: Scenario 4 Compared with Current Law.

Health Insurance Coverage. We estimate that the collective steps included in Scenario 4 would decrease the number of people without minimum essential coverage by 16.1 million people in 2020 compared with the estimated 36.1 million people under current law, a decrease of 44.5 percent (Table 7, Section A). An additional 6.4 million people would have private nongroup insurance, a 50 percent increase (summing nongroup coverage with and without tax credits). Medicaid and CHIP coverage would be 21.5 percent higher than under current law, and employer-sponsored insurance would be 3.5 percent lower.

Of the estimated 20.0 million remaining uninsured under this scenario in 2020, 32.8 percent, or 6.6 million people, are undocumented immigrants and are thus ineligible for any financial assistance; 26.8 percent, or 5.4 million people, are eligible for Medicaid or CHIP at no or very low cost; and 19.7 percent, or 3.9 million people, are eligible for subsidized marketplace coverage (Figure 1). Broader outreach and enrollment assistance efforts could increase coverage among those who remain uninsured but are eligible for financial assistance. Providing program eligibility to undocumented immigrants could even further reduce uninsurance, but participation in public programs that may require sharing personal information has the potential to jeopardize their continued residence in the US. These 6.6 million undocumented uninsured people equal 50.9 percent of the estimated nonelderly undocumented population in the US (data not shown).

Those eligible for Medicaid or CHIP can enroll in coverage at any time during the year because these programs do not have limited open enrollment periods. Thus, those eligible for the programs can be enrolled at virtually no cost when they need medical care (although they may not seek medical care at the same rate as insured persons when not already

enrolled). Thus, excluding those eligible for but not enrolled in Medicaid/CHIP (i.e., treating them more like insured people because of their eligibility status), our Scenario 4 estimates indicate that 8.1 million citizens and other legally present residents, or 3.1 percent of nonelderly legal US residents, would be effectively uninsured under these collective reforms in 2020 (data not shown).

Health Care Spending. Combining all four reform scenarios, we estimate that federal government health spending would be \$119.2 billion, or 28.5 percent, higher than under current law; state government spending would be \$7.2 billion, or 3.6 percent, lower; employer spending would be \$25.3 billion, or 2.7 percent, lower; and household spending would be \$17.2 billion, or 3.1 percent lower, with the lowest-income group's health spending 28.6 percent lower (Table 7, section B). Because of the substantial decrease in the number of uninsured people, the demand for uncompensated care would be \$29.7 billion lower (41.0 percent) in 2020 than under current law. Accounting for all sources of payment, aggregate health spending for acute care for the nonelderly would increase by 1.8 percent.

The increased federal government cost over 10 years would be approximately \$1.4 trillion (data not shown). This is compared with a 10-year estimated increase in federal costs of more than \$30 trillion under the Sanders single-payer approach.¹⁶

Discussion

The ACA has significantly increased health insurance coverage, yet the nature of the law and decisions by 18 states not to expand Medicaid eligibility have still left many people uninsured. These issues have been exacerbated by policy changes since early 2017, such as the elimination of the individual mandate and expansion of STLD policies. Policymakers differ on the appropriate way to expand insurance coverage and the attractiveness of comprehensive system overhauls, such as single-payer-type proposals. Our analysis demonstrates the coverage and

cost implications of various incremental approaches designed to expand coverage, improve affordability, and lower increases in government spending, while remaining consistent with the ACA framework. We provide estimates in steps, with each scenario building on the last, as one possible policy path. Obviously, there are an infinite number of policies and policy orderings that could be implemented, and thus the policy path presented here is illustrative.

Compared with current law, we find that the following policies combined would reduce the number of nonelderly uninsured people in the US by 37.9 percent and would reduce the number of nonelderly people in the US without minimum essential coverage by 44.5 percent:

- restoring the individual mandate and direct federal funding of cost-sharing reductions,
- reversing the expansion of STLD policies,
- fully federally funding the ACA's Medicaid expansion while instituting limited autoenrollment,
- enhancing marketplace financial assistance while creating more consistency in affordability thresholds and tax credit eligibility rules,
- creating a permanent nongroup market reinsurance program, and
- capping provider payment rates for nongroup insurers.

The number of nonelderly people without minimum essential coverage would fall from 36.1 million under current law to 20.0 million. Approximately 94 percent of legally present US residents would be insured. Household and employer spending would be 3 percent lower than under current law. For families with incomes at or below 400 percent of FPL, household health care costs would decrease by 7.6 percent (and would increase by 1.7 percent for those with incomes above 400 percent of FPL), with lower-income people receiving the most savings. Savings to the households benefiting from the expansion in Medicaid eligibility and greater marketplace financial assistance

would be substantial. The demand for uncompensated care would fall by \$29.7 billion, or 41.0 percent, compared with current law.

Achieving these gains would require increasing government spending (federal and state combined) by about 18 percent. The federal cost of these reforms would be \$119.2 billion in 2020, an increase

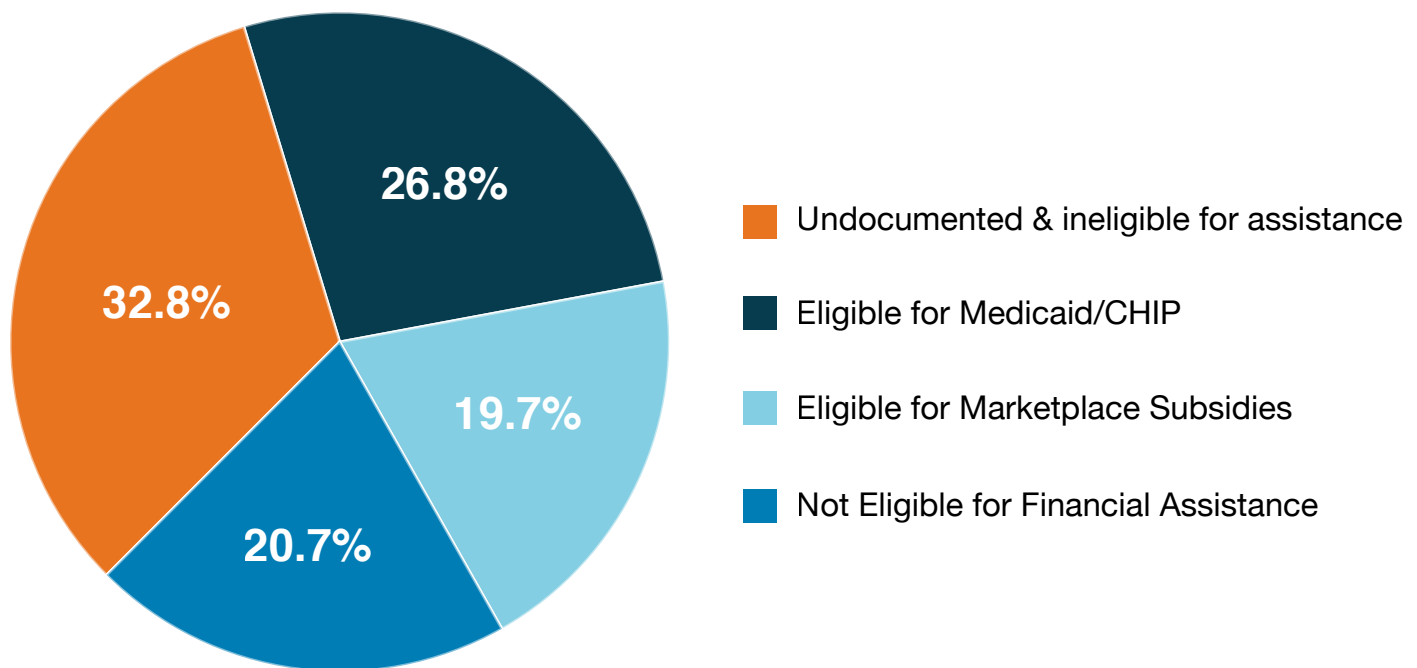
of 28.5 percent over current law acute health care spending for the nonelderly, but state government spending would decrease by \$7.2 billion (3.6 percent).

As such, this approach provides an option for policymakers interested in increasing insurance coverage, improving affordability, and introducing a

new cost-containment approach without overhauling the entire system. It offers significant improvements in coverage and affordability at a lower federal cost without dramatic changes to the entire health care system, making it a sustainable policy.

Because of the political challenges of reinstating the ACA's individual mandate, we also estimated the implications of the full set of reforms in Scenario 4, except for the individual mandate. With all the other policy changes in place, 2.4 million additional people would be uninsured without the individual mandate for a total of 22.4 million people (8.1 percent of the nonelderly population; data not shown). The savings to the federal government in 2020 would be \$5.7 billion, a reduction in government costs of just over 1 percent of our Scenario 4 estimate (data not shown). The effect on government spending would be small relative to the increase in the uninsured, because the healthiest people and those receiving the least financial assistance would be most likely to drop their coverage without a mandate.

Figure 1. Remaining Uninsured Under Scenario 4, in 2020



Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Appendix: Additional Information on Methods

Nongroup Insurance Coverage Outside Marketplaces. As of November 2018, no nationwide state-specific data are available on nongroup enrollment outside the marketplaces in 2018, so this was simulated in HIPSM based on premium increases between 2017 and 2018. This estimate was then updated using anticipated premium increases for 2019 and 2020.

Individual Mandate. Recent research using ACA data confirms the experience under the 2006 Massachusetts reforms, that the individual mandate's impacts on coverage are larger than penalties' dollar amount would suggest (Salzman 2017). To estimate the nonfinancial effect of the mandate and the size of the nongroup market outside the marketplaces, we use the total reported nongroup enrollment in the 2017 National Health Interview Survey (generally considered the most reliable national measure of enrollment in major health coverage) combined with reported marketplace enrollment. We simulate health insurance coverage based on financial factors (premiums, expected out-of-pocket costs, a measure of risk aversion, individual mandate penalties) and other factors known to affect individual and family coverage, and we compare the resulting coverage levels with benchmarks based on marketplace enrollment and the National Health Interview Survey. The difference between coverage levels based on financial factors and the benchmark is attributed to the nonfinancial effect of the individual mandate, and the model's simulated coverage is calibrated to hit those benchmarks in 2017. This enrollment from nonfinancial factors is aged to 2020, eliminated for the current-law scenario, and replaced under the Scenario 1, which reinstates the mandate penalties.

Expansion of Short-Term Limited Duration Policies. Our current law characterization of state regulations is based upon an analysis of state regulations by Georgetown University's Center on Health Insurance Reforms.¹⁷ Per their detailed analysis, we categorize states into three groups based on any current legislation that would prohibit or limit the expansion of STLD plans beginning in late 2018 under Trump administration regulations. The recently finalized regulations would permit STLD policies to be issued for a maximum one-year plan period, as opposed to the previous three-month limit. Our three groups of states are: (1) those with regulations that would effectively prohibit the expansion of STLD policies; (2) those that would significantly reduce, but not prohibit, the expansion of STLD policies; and (3) those where the new regulations will effectively allow STLD policies to compete with ACA-compliant policies. These categories and our approach are consistent with our prior analysis of the effect of the regulations, but some states have increased their regulation of these plans since that analysis was released.¹⁸ Our second and third categories are primarily based on duration limits of contract length and renewals. Many states have limits, but our categorization is based on people's ability to enroll in and extend or renew an STLD plan for up to 12 months. The states included in our first category, the most restrictive group, are California, Hawaii, Massachusetts, New Jersey, New York, Oregon, Vermont, and Washington. The states included in our second category are Michigan and Nevada. All other states and the District of Columbia fall into the third, least effectively regulated category.

NOTES

- 1 See Antonisse L, Garfield R, Rudowitz R, et al. The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review. Washington: Henry J. Kaiser Family Foundation; 2018. <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review>. McMorro S and Polsky D. Insurance Coverage and Access to Care under the Affordable Care Act. Philadelphia: University of Pennsylvania, Leonard Davis Institute; 2016. <https://ldi.upenn.edu/brief/insurance-coverage-and-access-care-under-affordable-care-act>.
- 2 Skopec L, Holahan J, Elmendorf C. Changes in Health Insurance Coverage 2013–2016: Medicaid Expansion States Lead the Way. Washington: Urban Institute; 2018. <https://www.urban.org/research/publication/changes-health-insurance-coverage-2013-2016-medicaid-expansion-states-lead-way>.
- 3 Blumberg LJ, Buettgens M, Wang R. Updated Estimates of the Potential Impact of Short-Term Limited Duration Policies. Washington: Urban Institute; 2018. https://www.urban.org/sites/default/files/updated_estimates_of_the_potential_impact_of_std_policies_final.pdf.
- 4 Recent studies showing declines in some average premiums from 2018 to 2019 do not necessarily mean policy changes will not affect premiums. First, it is unlikely that the full impact will happen immediately, particularly because STLD regulations were only finalized this summer. Second, it is unclear how insurers factored these changes into their 2019 premiums, so we do not know what 2019 premiums would have been without the changes. Third, some evidence shows insurers may have reacted to the policy uncertainty in 2017 by setting overly high 2018 premiums. Fourth, several states were granted reinsurance waivers, which would reduce premiums from last year.
- 5 Changes in the number of uninsured between 2016 and 2017 varied across the major census surveys. The ACS showed a statistically significant increase, but the Current Population Survey and National Health Interview Survey showed small, statistically insignificant increases. See Berchick E, Hood E, Barnett J. Health Insurance Coverage in the United States: 2017. Suitland, MD: Census Bureau; 2018. <https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf>. Cohen R, Martinez M, Zammiti E. Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–March 2018. Washington: National Center for Health Statistics; 2018. <https://www.cdc.gov/nchs/data/nhis/earlyrelease/Insur201808.pdf>.
- 6 We did not model the impact of the administration’s final rule on expanding Association Health Plans because of uncertainty about the rule’s implementation and the extent to which organizations will choose to form such plans. For a summary of the major legal issues raised by the final Association Health Plans regulation, see Keith K. (2018). *Final Rule Rapidly Eases Restrictions On Non-ACA-Compliant Association Health Plans*. *Health Affairs Blog*. <https://www.healthaffairs.org/doi/10.1377/hblog.20180621.671483/full/>. Accessed November 30, 2018. Some organizations that have been vocal advocates of Association Health Plans do not intend to set up their own plans under the new regulation; see Cancryn A. Trump promised them better, cheaper health care. It’s not happening. *Politico*. July 19, 2018. <https://www.politico.com/story/2018/07/19/trump-health-care-better-cheaper-693362>. Accessed November 30, 2018. However, this rule could eventually increase the gap in health coverage and costs between current law and the four incremental reforms we simulated.
- 7 Wheaton L, Giannarelli L, Morton J. Methods for Estimating SNAP Policy Impacts with an ACS-Based Simulation Model. Washington: Urban Institute; 2018. https://www.urban.org/sites/default/files/publication/98454/methods_for_estimating_snap_policy_impacts_with_an_acs-based_simulation_model_0.pdf.
- 8 Blumberg LJ, Holahan J. After King v. Burwell: Next Steps for the Affordable Care Act. Washington: Urban Institute; 2015. https://www.urban.org/sites/default/files/publication/98432/2001826_2018.05.11_healthy_america_final_9.pdf. Blumberg LJ, Holahan J. Stabilizing and Strengthening ACA Nongroup Markets. Washington: Urban Institute; 2017. https://www.urban.org/sites/default/files/publication/93576/2001527_qs_stabilizing_and_strengthening_aca_nongroup_markets_final_4.pdf. Holahan J, Blumberg LJ. Instead of ACA Repeal and Replace, Fix It. Washington: Urban Institute; 2017. https://www.urban.org/sites/default/files/publication/87076/2001054-repeal-and-replace-aca-fix-it_2.pdf.
- 9 Blewett L, Drake C, Fried B. Estimated costs of a reinsurance program to stabilize the individual health insurance market: National and state estimates. Minneapolis: University of Minnesota, State Health Access Data Assistance Center. Under review.
- 10 The Commonwealth Fund. What Is Your State Doing to Affect Access to Adequate Health Insurance? <https://www.commonwealthfund.org/publications/interactive/2018/oct/what-your-state-doing-affect-access-adequate-health-insurance>. Published November 15, 2018. Accessed November 30, 2018.
- 11 Scheffler R and Arnold DR. Insurer Market Power Lowers Prices in Numerous Concentrated Provider Markets. *Health Affairs*. 2017;36(9): 1539–46. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0552>. Published September 1. Accessed December 3, 2018.
- 12 Blumberg LJ and Holahan J. Stabilizing and Strengthening the ACA Nongroup Markets. Washington: Urban Institute; 2017. https://www.urban.org/sites/default/files/publication/93576/2001527_qs_stabilizing_and_strengthening_aca_nongroup_markets_final_3.pdf. Blumberg LJ and Holahan J. Strengthening the ACA for the Long Term. *New England Journal of Medicine*. 2017, 377:2105-2107. <https://www.nejm.org/doi/full/10.1056/NEJMp1713247>. Accessed November 30, 2018. Blumberg LJ and Holahan J. High Premiums in Nongroup Insurance Markets: Identifying Causes and Possible Remedies. Washington: Urban Institute; 2017. <https://www.urban.org/research/publication/high-premiums-nongroup-insurance-markets-identifying-causes-and-possible-remedies>. Holahan J and Blumberg, LJ. Instead of ACA Repeal and Replace, Fix It. Washington: Urban Institute; https://www.urban.org/sites/default/files/publication/87076/2001054-repeal-and-replace-aca-fix-it_2.pdf.
- 13 Holahan J, Blumberg LJ, Wengle E, et al. What Explains the 21 Percent Increase in 2017 Marketplace Premiums, and Why Do Increases Vary Across the Country? Washington: Urban Institute; 2017. <https://www.urban.org/research/publication/what-explains-21-percent-increase-2017-marketplace-premiums-and-why-do-increases-vary-across-country>.
- 14 Office of Management and Budget. Budget of the US Government: Fiscal Year 2017. Washington: Office of US Government Printing Office; 2016. <https://obamawhitehouse.archives.gov/sites/default/files/omb/budget/fy2017/assets/budget.pdf>.
- 15 The premiums, deductibles, and out-of-pocket maximums used in these ACA examples are all projected to 2020 based on the 2019 national median benchmark (second-lowest cost) silver plan across all rating regions in states using the healthcare.gov platform. The Scenario 3 examples are projected to 2020 based on the 2019 national median of the second-lowest cost gold plans across all rating regions in states using the health care.gov platform.
- 16 Holahan J and Blumberg LJ. Estimating the Cost of a Single-Payer Plan. Washington: Urban Institute; 2018. <https://www.urban.org/research/publication/estimating-cost-single-payer-plan>.
- 17 The Commonwealth Fund. What Is Your State Doing to Affect Access to Adequate Health Insurance? <https://www.commonwealthfund.org/publications/interactive/2018/oct/what-your-state-doing-affect-access-adequate-health-insurance>. Published November 15, 2018. Accessed December 3, 2018.
- 18 Blumberg LJ, Buettgens M, Wang R. Updated: The Potential Impacts of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending. Washington: Urban Institute; 2018. https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf.

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