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Statement of

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before the

Committee on the Budget

United States House of Representatives

hearing titled

"The Failures of Obamacare: Harmful Effects and Broken Promises"

Tuesday, January 24, 2017

*The views expressed are my own and should not be attributed to the Urban Institute, its trustees or its funders.

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Chairman Black, Ranking Member Yarmuth, and members of the Committee, I appreciate the opportunity to testify before you on the Affordable Care Act (ACA), the implications of its repeal, and alternative policies for addressing the problems with the law. The views that I express are my own and should not be attributed to the Urban Institute, its trustees, or its funders. My testimony, submitted for the record, is based on two recent papers that I wrote with Urban Institute colleagues. I summarize them here.

The first paper, "Implications of Partial Repeal of the ACA through Reconciliation," written with Matthew Buettgens and John Holahan, compares future health care coverage and government health care spending under the ACA and under passage of a reconciliation bill similar to one vetoed in January 2016. The coverage effects we estimated in this December 2016 analysis are consistent with those released by the Congressional Budget Office on January 17, 2017. Our analysis finds that the key effects of passage of the anticipated reconciliation bill are as follows:

- The number of uninsured people would rise from 28.9 million to 58.7 million in 2019, an increase of 29.8 million people (103 percent). The share of nonelderly people without insurance would increase from 11 percent to 21 percent, a higher rate of uninsurance than before the ACA because of the disruption to the nongroup insurance market.
- Of the 29.8 million newly uninsured, 22.5 million people would become uninsured as a result of eliminating the premium tax credits, the Medicaid expansion, and the individual mandate. The additional 7.3 million people would become uninsured because of the near collapse of the nongroup insurance market.
- Eighty-two percent of the people becoming uninsured would be in working families, 38 percent would be ages 18 to 34, and 56 percent would be non-Hispanic whites. Eighty percent of adults becoming uninsured would not have college degrees.
- There would be 12.9 million fewer people with Medicaid or CHIP coverage in 2019.
- Approximately 9.3 million people who would have received tax credits for private nongroup health coverage in 2019 would no longer receive assistance.
- Federal government spending on health care for the nonelderly would be reduced by $109 billion in 2019 and by $1.3 trillion from 2019 to 2028 because the Medicaid expansion, premium tax credits, and cost-sharing assistance would be eliminated.
- State spending on Medicaid and CHIP would fall by $76 billion between 2019 and 2028. In addition, because of the larger number of uninsured, financial pressures on state and local governments and health care providers (hospitals, physicians, pharmaceutical manufacturers, etc.) would increase dramatically. This financial pressure would result from the newly uninsured seeking an additional $1.1 trillion in uncompensated care between 2019 and 2028.

- The 2016 reconciliation bill increased funding for uncompensated care very little beyond current levels, and this additional federal funding would account for less than 4 percent of the increase in uncompensated care that would be sought. Unless a different action is taken, this approach would place very large increases in demand for uncompensated care on state and local governments and providers. The increase in services sought by the uninsured is unlikely to be fully financed, leading to even greater financial burdens on the uninsured and higher levels of unmet need for health care services.
- If Congress partially repeals the ACA with a reconciliation bill like that vetoed in January 2016 and eliminates the individual and employer mandates immediately, in the midst of an already established plan year, significant market disruption would occur. Some people would stop paying premiums, and insurers would suffer substantial financial losses (about $3 billion); the number of uninsured would increase right away (by 4.3 million people); at least some insurers would leave the nongroup market midyear; and consumers would be harmed financially.
- Many, if not most, insurers are unlikely to participate in Marketplaces in 2018—even with tax credits and cost-sharing reductions still in place—if the individual mandate is not enforced starting in 2017. A precipitous drop in insurer participation is even more likely if the cost-sharing assistance is discontinued (as related to the *House v. Burwell* case) or if some additional financial support to the insurers to offset their increased risk is not provided.

This scenario does not just move the country back to the situation before the ACA. It moves the country to a situation with higher uninsurance rates than before the ACA. To replace the ACA after reconciliation with new policies designed to increase insurance coverage, the federal government would have to raise new taxes, substantially cut spending, or increase the deficit.

The second paper, entitled, "Instead of ACA Repeal and Replace, Fix It," was written with John Holahan and was released January 16. This paper describes the challenges of replacing the ACA without reducing insurance coverage, reducing affordability, or impeding access to care for those with health care needs, while identifying new sources of revenue and creating sufficient Congressional consensus for passage. To that end, we propose a range of policies that would address critics' concerns and also strengthen the law, expand coverage, improve affordability, increase market stability, and lower the high premiums that exist in some markets. We propose the following:

- Replace the individual mandate with a modified version of the late enrollment penalties currently used in Medicare Parts B and D.
- End the employer mandate. The limited gains in coverage and the revenue it generates have not been worth the controversy it has caused.
- Replace the Cadillac tax with a cap on the tax exclusion for employer-based insurance while correcting valid concerns that apply to both approaches.
- Improve affordability by reducing premiums, deductibles, and other cost-sharing requirements for modest-income individuals, and extend to higher-income individuals a cap on premiums at 8.5 percent of income.
- With a premium cap at 8.5 percent of income applied to all, relax the 3:1 age rating rule to be more in line with actual differences in spending for younger and older individuals.
- Examine the essential health benefits package, recognizing that eliminating certain benefits would eliminate risk pooling for those services, shifting all costs to individuals needing those services. That is problematic for any service, but particularly so for prescription drugs, mental health, and substance use disorder treatment.
- Stabilize the Marketplaces by taking steps to increase enrollment. This would include investing in additional outreach and enrollment assistance and allowing states to extend Medicaid eligibility to 100 percent of the federal poverty level (FPL) rather than 138 percent of FPL. People with incomes between 100 and 138 percent of FPL would move from Medicaid to Marketplace coverage and thereby benefit from the affordability provisions mentioned above. Further, it should be made easier for working families to be eligible for income-related tax credits.
- Address the impact of insurer and provider concentration on nongroup market premiums by capping provider payments in those plans at Medicare rates or some multiple thereof—an approach currently used by the Medicare Advantage program. This would limit the use of market power by large provider systems and make it easier for insurers to enter new markets.
- Use a broad-based source of revenue (e.g., assessments on all health insurance and stop-loss coverage premiums or general revenues) to permanently protect nongroup insurers from the consequences of enrolling a disproportionate share of very high-cost enrollees, as is done in Medicare Part D and Medicare Advantage.

Most of these steps have had bipartisan support in other contexts and therefore can provide a framework for a bipartisan compromise.

Implications of Partial Repeal of the ACA through Reconciliation

Linda J. Blumberg, Matthew Buettgens, and John Holahan

December 2016

In Brief

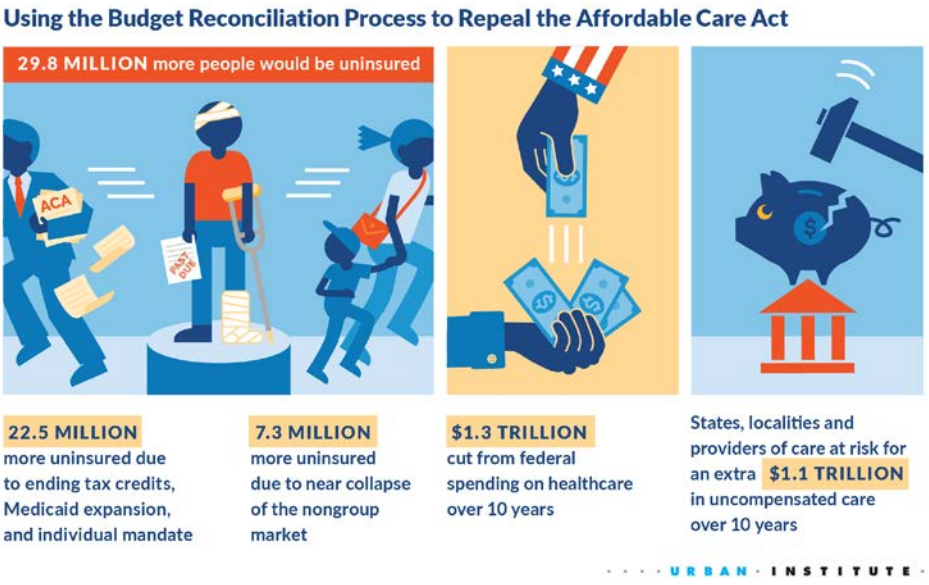
Congress is now considering partial repeal of the Affordable Care Act (ACA) through the budget reconciliation process. Since only components of the law with federal budget implications can be changed through reconciliation, this approach would permit elimination of the Medicaid expansion, the federal financial assistance for Marketplace coverage (premium tax credits and cost-sharing reductions), and the individual and employer mandates; it would leave the insurance market reforms (including the nongroup market's guaranteed issue, prohibition on preexisting condition exclusions, modified community rating, essential health benefit requirements, and actuarial value standards) in place. There is currently no consensus around alternative health policies to enact as the ACA is repealed; consequently, partial repeal via reconciliation without replacement is possible and merits analysis.

In this brief, we compare future health care coverage and government health care spending under the ACA and under passage of a reconciliation bill similar to one vetoed in January 2016. The key effects of passage of the anticipated reconciliation bill are as follows:

- The number of uninsured people would rise from 28.9 million to 58.7 million in 2019, an increase of 29.8 million people (103 percent). The share of nonelderly people without insurance would increase from 11 percent to 21 percent, a higher rate of uninsurance than before the ACA because of the disruption to the nongroup insurance market.
- Of the 29.8 million newly uninsured, 22.5 million people would become uninsured as a result of eliminating the premium tax credits, the Medicaid expansion, and the individual mandate. The additional 7.3 million people would become uninsured because of the near collapse of the nongroup insurance market.
- Eighty-two percent of the people becoming uninsured would be in working families, 38 percent would be ages 18 to 34, and 56 percent would be non-Hispanic whites. Eighty percent of adults becoming uninsured would not have college degrees.
- There would be 12.9 million fewer people with Medicaid or CHIP coverage in 2019.
- Approximately 9.3 million people who would have received tax credits for private nongroup health coverage in 2019 would no longer receive assistance.

- Federal government spending on health care for the nonelderly would be reduced by $109 billion in 2019 and by $1.3 trillion from 2019 to 2028 because the Medicaid expansion, premium tax credits, and cost-sharing assistance would be eliminated.
- State spending on Medicaid and CHIP would fall by $76 billion between 2019 and 2028. In addition, because of the larger number of uninsured, financial pressures on state and local governments and health care providers (hospitals, physicians, pharmaceutical manufacturers, etc.) would increase dramatically. This financial pressure would result from the newly uninsured seeking an additional $1.1 trillion in uncompensated care between 2019 and 2028.
- The 2016 reconciliation bill did not increase funding for uncompensated care beyond current levels. Unless a different action is taken, this approach would place very large increases in demand for uncompensated care on state and local governments and providers. The increase in services sought by the uninsured is unlikely to be fully financed, leading to even greater financial burdens on the uninsured and higher levels of unmet need for health care services.
- If Congress partially repeals the ACA with a reconciliation bill like that vetoed in January 2016 and eliminates the individual and employer mandates immediately, in the midst of an already established plan year, significant market disruption would occur. Some people would stop paying premiums, and insurers would suffer substantial financial losses (about $3 billion); the number of uninsured would increase right away (by 4.3 million people); at least some insurers would leave the nongroup market midyear; and consumers would be harmed financially.
- Many, if not most, insurers are unlikely to participate in Marketplaces in 2018—even with tax credits and cost-sharing reductions still in place—if the individual mandate is not enforced starting in 2017. A precipitous drop in insurer participation is even more likely if the cost-sharing assistance is discontinued (as related to the *House v. Burwell* case) or if some additional financial support to the insurers to offset their increased risk is not provided.

This scenario does not just move the country back to the situation before the ACA. It moves the country to a situation with higher uninsurance rates than before the ACA. To replace the ACA after reconciliation with new policies designed to increase insurance coverage, the federal government would have to raise new taxes, substantially cut spending, or increase the deficit.



Introduction

Congress passed a reconciliation bill repealing substantial portions of the Affordable Care Act (ACA) in January 2016; however, the bill was vetoed by President Obama.[1] Congress is now poised to pass a similar bill in early 2017.[2] The bill Congress passed did not contain policies intended to replace the ACA, presumably because a consensus did not exist on what form such an alternative should take. It is unlikely that supporters of ACA repeal will have agreed on an alternative before voting on repeal. In the absence of agreement on an alternative to the ACA, Congress is likely to delay the repeal of most, if not all, provisions in the bill for two or three years, giving members time to try developing an alternative set of policies. This was the approach taken by Congress last year.

Under Senate rules, reconciliation bills can only make legislative changes that affect the federal budget.[3] In the context of the ACA, rules permit repeal of the Medicaid expansion; the premium tax credits and cost-sharing assistance provided to people with modest income through the Marketplaces; the tax on some people who do not carry minimum creditable health insurance (a.k.a. the individual mandate); and the employer responsibility requirement (a.k.a. the employer mandate), which assesses a penalty on some employers whose workers obtain subsidized coverage through the Marketplaces. Because provisions that do not directly affect spending or revenues cannot be included in reconciliation bills, the 2016 bill did not eliminate the insurance market reforms, which include the extension of family coverage for adult children up to age 26, prohibitions on preexisting condition exclusions, and requirements for modified community rating, essential health benefits, and actuarial value standards. An attempt to repeal these provisions through normal legislative channels would be subject to a filibuster. For that reason, we assume that these provisions would remain in effect, at least in the near term.

This brief considers the effect of partial repeal of the ACA in the context of reconciliation. Since the 2016 reconciliation bill delayed its repeal of most budget-related components of the ACA for two years, we simulate the cost and coverage implications of a similar 2017 reconciliation bill in 2019. We also provide 10-year estimates for 2019 to 2028. However, even with most components delayed two years, such a reconciliation bill would substantially alter the nation's private nongroup insurance markets during 2017, with even larger effects on the 2018 plan year. Insurers could decide to stop offering insurance through the ACA-compliant nongroup insurance markets for 2018, knowing that enrollment will drop and the markets will soon be disassembled. A substantial drop in insurer participation is even more likely if Marketplace cost-sharing assistance is discontinued in 2017 or 2018 (as related to the *House v. Burwell* case) or if some additional financial support to insurers is not provided to offset their increased risk. A delay of the repeal provisions for three years instead of two would delay our estimated effects an additional year, changing the size of the estimated effects somewhat over 10 years.

The 2016 reconciliation bill would have eliminated the individual and employer mandates immediately upon passage.[4] If, under a 2017 reconciliation bill, the individual mandate penalties are not enforced beginning in 2017, people would have less incentive to pay premiums (especially people who are healthy and not eligible for premium tax credits); nongroup coverage would decline as enrollment falls almost immediately; the average health care costs of enrollees in the market would increase; and

these increased costs would create financial issues for insurers participating in 2017. As the number of uninsured people increases, providers would face increasing financial pressures because of higher demand for uncompensated care. Changes like these implemented *during a plan year* would seriously disrupt insurance markets for consumers, insurers, and providers. Thus, in addition to providing 2019 estimates for the reconciliation bill, we provide separate estimates of the immediate consequences of repealing the individual and employer mandates in 2017.

Results

We estimate insurance coverage in 2019 under the ACA and under the partial repeal expected to be included in a January 2017 reconciliation bill. We present coverage estimates for the nation as a whole and changes in the number of people uninsured for each state. We also provide detailed socioeconomic characteristics of those losing insurance coverage. We estimate the change in federal spending under each scenario in the same year, breaking out the total decrease in federal spending by Medicaid/CHIP and Marketplace financial assistance, nationally and by state. We provide estimates of the effects of elimination of the Medicaid expansion on state spending. We also show the implications of the increase in uncompensated care that would be sought as the number of uninsured increases. Finally, we estimate the financial losses of insurers if the 2017 bill, like that passed in 2016, eliminates the individual and employer mandates immediately, affecting enrollment decisions during 2017 once nongroup health insurance premiums are already fixed. Additional state-by-state detail on changes in federal and state spending in 2019 and over the 2019 to 2028 period is provided in appendix tables.

Insurance Coverage

The anticipated reconciliation bill would dramatically affect public insurance and private nongroup insurance for people covered through the Medicaid expansions, the ACA's Marketplaces, and ACA-compliant plans outside the Marketplaces. We estimate that the partial ACA repeal would increase the number of uninsured people by 29.8 million by 2019 (table 1, figure 1), raising the total number of uninsured to 58.7 million people—21 percent of the nonelderly population—compared with 28.9 million people uninsured if the ACA remains in effect. More people would be uninsured in 2019 than the 50.0 million who were uninsured in 2009, just before passage of the ACA (Holahan 2011).

The market for nongroup coverage would virtually collapse, causing 7.3 million of the additional 29.8 million people to become uninsured. Full repeal of all components of the ACA, including the insurance market reforms, would increase the number of uninsured by 22.5 million by 2019 (data not shown). The nongroup market would unravel because of three factors:

- Eliminating premium tax credits and cost-sharing assistance would make coverage unaffordable for many of the people currently enrolled, causing them to drop coverage. Those with the fewest health problems would drop their coverage fastest.

- Eliminating the individual mandate penalty would reduce the incentive to enroll for healthy people who can afford coverage.
- Insurers would remain subject to the requirement to sell coverage that meets adequacy standards to all would-be purchasers, and they would remain subject to the prohibition against charging higher premiums or offering reduced benefits to those with health care needs.

TABLE 1

Health Insurance Coverage Distribution of the Nonelderly with the ACA and an Anticipated Reconciliation Bill, 2019

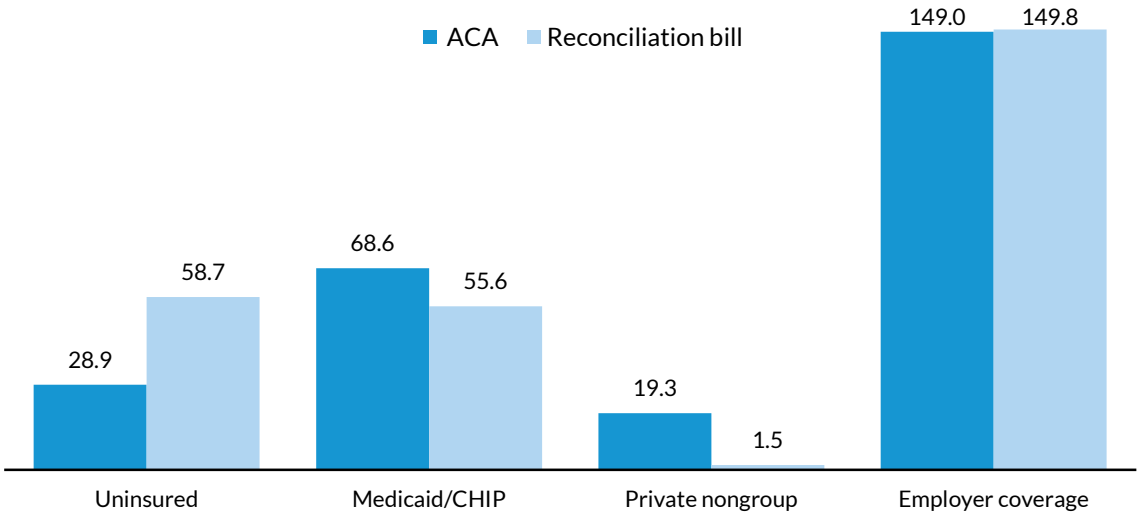
	ACA (current law)		Reconciliation Bill		
	People (thousands)	Share of US total (%)	People (thousands)	Share of US total (%)	Difference (thousands)
Insured	*245,380*	***89***	*215,598*	***79***	*-29,782*
Employer	148,974	54	149,832	55	858
Nongroup (eligible for tax credit)	9,322	3	0	0	-9,322
Nongroup (other)	9,955	4	1,560	1	-8,395
Medicaid/CHIP	68,556	25	55,632	20	-12,924
Other (including Medicare)	8,574	3	8,574	3	0
Uninsured	*28,936*	***11***	*58,718*	***21***	*29,782*
Total	**274,316**	**100**	**274,316**	**100**	**0**

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program. Columns may not sum to totals because of rounding.

FIGURE 1

Health Insurance of the Nonelderly in 2019, under the ACA and an Anticipated Reconciliation Bill

Millions of people



Source: Urban Institute analysis using HIPSM 2016.
Note: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

As increasing numbers of people continued to drop their insurance (with healthier people leaving coverage fastest), the situation would threaten the nongroup insurers both inside and outside the Marketplaces with insupportable losses, would force insurers to raise premiums by increasingly large amounts, and would drive many insurers out of the nongroup market entirely. That is why the increase in the number of uninsured due to a reconciliation bill would exceed the gains in insurance coverage achieved under the ACA.

Table 2 gives a state-by-state breakdown of where the losses of insurance coverage would occur. The effects are uneven. The hardest hit, on average, would be states that expanded Medicaid, as those states averaged the largest coverage gains under reform. In those states, the number of people uninsured would more than double, from 14.0 to 32.5 million people, an increase of 18.5 million people. The number of uninsured would increase by 11.3 million people, from 14.9 to 26.2 million, in the states that did not expand Medicaid eligibility. In California, 4.9 million people would become uninsured; over 1 million people in Illinois and New York each would also become uninsured. Over 2 million people in Florida and 2.6 million people in Texas would become uninsured, as would over 1 million people in Georgia and North Carolina each.

TABLE 2

Uninsured under the ACA and an Anticipated Reconciliation Bill and Their Eligibility for Financial Assistance, by State and Medicaid Expansion Status, 2019

	ACA		Reconciliation Bill		Difference	
State	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Percentage change in uninsured
National total	**28,936**	**42%**	**58,718**	**15%**	**29,782**	**103%**
Expansion states						
Alaska	117	78%	178	12%	62	53%
Arizona	750	53%	1,459	18%	709	95%
Arkansas	211	58%	572	12%	361	171%
California	3,349	33%	8,236	14%	4,887	146%
Colorado	438	54%	1,026	13%	588	134%
Connecticut	200	47%	448	25%	248	124%
Delaware	60	58%	113	32%	52	86%
District of Columbia	31	56%	63	33%	32	103%
Hawaii	88	70%	174	12%	86	99%
Illinois	896	48%	2,046	14%	1,150	128%
Indiana	552	70%	1,119	16%	566	103%
Iowa	153	63%	383	14%	230	150%
Kentucky	244	66%	730	16%	486	200%
Louisiana	363	62%	921	12%	558	154%
Maryland	385	37%	861	10%	476	123%
Massachusetts	135	43%	504	8%	369	273%
Michigan	508	70%	1,394	13%	887	175%
Minnesota	309	67%	690	31%	380	123%
Montana	85	79%	227	15%	142	168%
Nevada	391	51%	762	18%	371	95%

	ACA		Reconciliation Bill		Difference	
State	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Percentage change in uninsured
New Hampshire	62	63%	180	9%	118	190%
New Jersey	644	37%	1,443	14%	799	124%
New Mexico	196	50%	462	15%	266	136%
New York	1,524	55%	2,662	31%	1,139	75%
North Dakota	45	69%	114	10%	69	154%
Ohio	621	71%	1,585	14%	964	155%
Oregon	256	50%	731	11%	475	186%
Pennsylvania	711	73%	1,667	13%	956	134%
Rhode Island	57	44%	153	15%	96	170%
Vermont	27	68%	62	35%	35	129%
Washington	508	51%	1,283	12%	775	153%
West Virginia	88	71%	272	13%	184	208%
Expansion states total	***14,002***	***51%***	***32,519***	***16%***	***18,516***	***132%***
Nonexpansion states						
Alabama	484	32%	841	14%	357	74%
Florida	2,482	26%	4,711	12%	2,230	90%
Georgia	1,427	31%	2,433	15%	1,006	71%
Idaho	183	36%	366	11%	184	101%
Kansas	289	39%	508	12%	219	76%
Maine	78	40%	173	12%	95	122%
Mississippi	351	40%	580	16%	229	65%
Missouri	544	38%	1,048	15%	504	93%
Nebraska	149	36%	314	12%	165	111%
North Carolina	1,140	27%	2,166	12%	1,025	90%
Oklahoma	529	43%	842	16%	313	59%
South Carolina	606	42%	959	17%	353	58%
South Dakota	81	55%	155	12%	74	92%
Tennessee	664	37%	1,190	15%	526	79%
Texas	4,377	32%	6,927	13%	2,550	58%
Utah	328	45%	601	15%	273	83%
Virginia	863	35%	1,548	9%	685	79%
Wisconsin	299	63%	731	17%	431	144%
Wyoming	61	49%	108	10%	47	76%
Nonexpansion states total	***14,933***	***33%***	***26,199***	***13%***	***11,266***	***75%***

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program. Financial assistance under the ACA includes Medicaid/CHIP and Marketplace premium tax credits and cost-sharing reductions. Financial assistance under the anticipated reconciliation bill consists of Medicaid/CHIP. Columns may not sum to totals because of rounding.

Overall, the elimination of the Medicaid expansion would decrease coverage through that program by 12.9 million people in 2019 as people lose eligibility for the program. The near "death spiral" in the private nongroup market described earlier is likely to occur immediately after the reconciliation bill's provisions take effect. Insurers would recognize the unsustainable financial dynamics of broad-based pooling policies (e.g., guaranteed issue, no preexisting condition exclusions, essential health benefits,

modified community rating) combined with no individual mandate and no financial assistance to spur enrollment. Similar near market collapse has occurred in the past under similar conditions. When New York's and New Jersey's state governments implemented community rating and guaranteed issue in their private nongroup markets without also providing for an individual requirement to obtain coverage or financial assistance to make coverage affordable for people with modest incomes, the nongroup markets unwound (Monheit et al. 2004).

We estimate that the number of people with nongroup insurance would drop from 19.3 million people to 1.6 million by the beginning of the 2019 plan year, concurrent with elimination of the premium tax credits. A small number of people otherwise covered by this market—fewer than 1 million—would obtain employer-sponsored insurance. Some insurers, such as Blue Cross-affiliated insurers, may continue to offer ACA-compliant plans at much higher premiums in the nongroup market, but without federal financial assistance, relatively few people—we estimate approximately 8 percent of those who have such coverage now—would enroll.

After the large increase in uninsured people that would result from a reconciliation bill, a much smaller share of the uninsured would be eligible for any financial assistance compared with the share eligible under the ACA (table 3). In the reconciliation bill scenario, only 15 percent of the 58.7 million uninsured would be eligible for any financial assistance (all under Medicaid or CHIP), given the elimination of both the Marketplace tax credits and the Medicaid eligibility expansion. As a consequence, there would be a much higher number of uninsured and very little room to significantly reduce that number absent substantial policy initiatives. In contrast, under the ACA, 42 percent of the remaining 28.9 million uninsured would be eligible for either Medicaid/CHIP or tax credits through the ACA's Marketplaces in 2019. That high rate of eligibility means that additional outreach and enrollment assistance could significantly increase the number of uninsured obtaining coverage under the ACA.

TABLE 3

Uninsured Eligible for Financial Assistance to Obtain Coverage, Nationally and by State Medicaid Expansion Status, 2019

	ACA		Reconciliation Bill		Difference	
	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Percentage change
National total	**28,936**	**42%**	**58,718**	**15%**	**29,782**	**103%**
Expansion states	14,002	51%	32,519	16%	18,516	132%
Nonexpansion states	14,933	33%	26,199	13%	11,266	75%

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act. Under the ACA, assistance can take the form of Medicaid, CHIP, or Marketplace tax credits; under reconciliation, assistance can take the form of Medicaid or CHIP. Columns may not sum to totals because of rounding.

Characteristics of Those Becoming Uninsured

Table 4 provides income, age, employment, race/ethnicity, and educational attainment characteristics of the 29.8 million people becoming uninsured under the anticipated reconciliation bill. We find that approximately 53 percent of those becoming uninsured would be people with family income between 100 and 400 percent of the federal poverty level (FPL). The remaining increase in the number of uninsured would be almost evenly split between those with lower and higher incomes, 25 percent with income below 100 percent of FPL and 23 percent with income over 400 percent of FPL. These newly uninsured people would be spread broadly through the age distribution: 13 percent children under age 18, 38 percent young adults ages 18 to 34, and 49 percent adults ages 35 to 64.

The vast majority of those becoming uninsured would be members of working families (82 percent), and more than half (56 percent) would be non-Hispanic whites. The vast majority of adults becoming uninsured would lack college degrees (80 percent).

Uninsurance rates for people of all characteristics measured would increase by at least 50 percent under the reconciliation approach. For example, 10 percent of those with family income from 150 to 200 percent of the FPL are uninsured under the ACA, but that rate would increase to 26 percent under the reconciliation approach. Under the ACA, 7 percent of white, non-Hispanic people would be uninsured in 2019, but 18 percent would be uninsured under the reconciliation approach. Uninsurance rates for adults with a high school diploma would increase from 16 percent under the ACA to 30 percent.

TABLE 4

Characteristics of Those Losing Coverage under an Anticipated Reconciliation Bill and Uninsurance Rates under the ACA and an Anticipated Reconciliation Bill, 2019

	Thousands of people	Share losing coverage	Uninsurance rate under ACA	Uninsurance rate under reconciliation bill
Income level				
< 100% of FPL	7,357	25%	14%	27%
100–150% of FPL	5,004	17%	8%	28%
150–200% of FPL	3,792	13%	10%	26%
200–300% of FPL	4,059	14%	10%	20%
300–400% of FPL	2,836	10%	6%	15%
> 400% of FPL	6,733	23%	11%	18%
Total	***29,782***	***100%***	***11%***	***21%***
Age group (years)				
< 18	3,998	13%	4%	9%
18–24	4,842	16%	14%	31%
25–34	6,341	21%	18%	32%
35–44	4,967	17%	14%	26%
45–54	5,103	17%	11%	23%
55–64	4,532	15%	8%	19%
Total	***29,782***	***100%***	***11%***	***21%***

	Thousands of people	Share losing coverage	Uninsurance rate under ACA	Uninsurance rate under reconciliation bill
Family employment status				
No worker	5,400	18%	16%	29%
Part-time only	4,690	16%	16%	33%
At least one full-time worker	19,692	66%	9%	18%
Total	***29,782***	***100%***	***11%***	***21%***
Race and ethnicity				
White, non-Hispanic	16,623	56%	7%	18%
Black, non-Hispanic	3,497	12%	11%	20%
Hispanic	6,501	22%	21%	32%
Asian	2,033	7%	9%	22%
American Indian/Alaska Native	654	2%	14%	26%
Other, non-Hispanic	475	2%	7%	16%
Total	***29,782***	***100%***	***11%***	***21%***
Educational attainment				
Less than high school	3,493	14%	31%	47%
High school	10,222	40%	16%	30%
Some college	6,906	27%	11%	24%
College	3,665	14%	7%	17%
Graduate school	1,497	6%	4%	12%
Total	***25,785***	***100%***	***13%***	***26%***

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act; FPL = federal poverty level. Columns may not sum to totals because of rounding.

Government Spending on Health Care and Uncompensated Care

Under reconciliation, the federal government would spend $67 billion less on Medicaid/CHIP for the nonelderly and $42 billion less on Marketplace financial assistance (premium tax credits and cost-sharing reductions) in 2019.[5] This reduces spending on these programs by $109 billion that year (table 5 and figure 2) and by $1.3 trillion from 2019 to 2028 (table 5). State governments would reduce their spending on Medicaid/CHIP by $4 billion in 2019 (table 5 and figure 3) and by $76 billion from 2019 to 2028 (table 5). Total government spending on these programs would therefore be $1.4 trillion below the levels estimated under the ACA.

Table 6 shows state-specific estimates for 2019 to 2028 changes in federal spending on Medicaid/CHIP and Marketplace financial assistance. States that expanded Medicaid and enrolled larger numbers of residents in the Marketplaces would lose the most federal funding under the reconciliation bill. For example, California would lose $160 billion in federal funding over the 10 years, and New York would lose $57 billion. Although they had not expanded Medicaid eligibility, Florida and Texas would lose $87 and $62 billion in federal funding for health care, respectively, because of their large populations and high rates of Marketplace enrollment. (State-by-state 2019 federal spending estimates and 2019–28 state Medicaid/CHIP spending estimates are provided in appendix tables.)

TABLE 5

Government Spending on Medicaid/CHIP for the Nonelderly and Marketplace Financial Assistance, 2019 and 2019–28

Billions of dollars

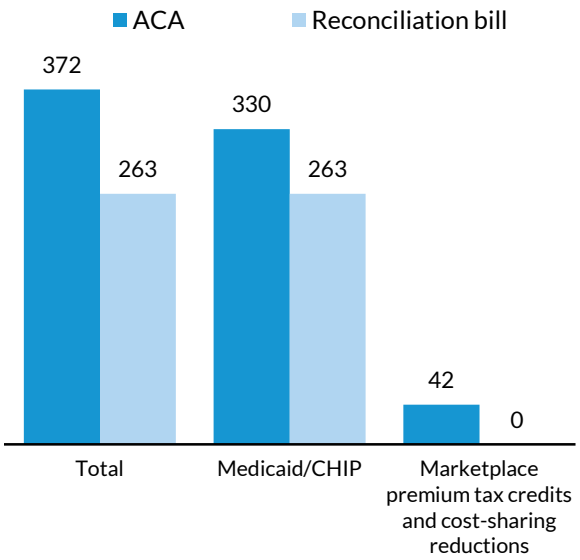
	2019			2019–28		
	ACA	Reconciliation bill	Difference	ACA	Reconciliation bill	Difference
Medicaid/CHIP spending	$525	$453	-$72	$6,643	$5,740	-$902
Federal	$330	$263	-$67	$4,153	$3,327	-$826
State	$195	$191	-$4	$2,489	$2,413	-$76
Federal Marketplace financial assistance	$42	$0	-$42	$465	$0	-$465
Total federal spending	*$372*	*$263*	*-$109*	*$4,618*	*$3,327*	*-$1,291*
Total state spending	*$195*	*$191*	*-$4*	*$2,489*	*$2,413*	*-$76*
Total federal and state spending	**$567**	**$453**	**-$114**	**$7,107**	**$5,740**	**-$1,367**

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act. Columns may not sum to totals because of rounding.

FIGURE 2

Federal Government Spending on Medicaid/CHIP and Marketplace Assistance, 2019

Billions of dollars

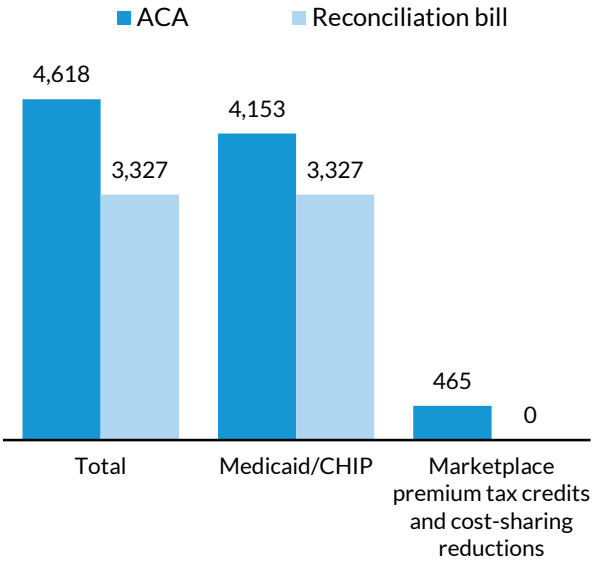


Source: Urban Institute analysis using HIPSM 2016.
Note: ACA = Affordable Care Act.

FIGURE 3

Federal Government Spending on Medicaid/CHIP and Marketplace Assistance, 2019–28

Billions of dollars



Source: Urban Institute analysis using HIPSM 2016.
Note: ACA = Affordable Care Act.

TABLE 6

Federal Spending on Medicaid/CHIP and Marketplace Financial Assistance under the ACA and under an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

Billions of dollars

	ACA			Reconciliation Bill	Difference		
State	Medicaid/ CHIP	Premium tax credits and cost-sharing reductions	Total	Medicaid/ CHIP	Medicaid/ CHIP	Premium tax credits and cost-sharing reductions	Total
Expansion states							
Alaska	$12	$2	$13	$10	-$1	-$2	-$3
Arizona	$142	$10	$152	$110	-$32	-$10	-$42
Arkansas	$42	$2	$44	$34	-$8	-$2	-$10
California	$364	$61	$425	$265	-$99	-$61	-$160
Colorado	$74	$2	$77	$44	-$31	-$2	-$33
Connecticut	$52	$4	$56	$41	-$10	-$4	-$15
Delaware	$15	<$1	$16	$12	-$3	<-$1	-$4
District of Columbia	$18	<$1	$18	$17	-$2	<-$1	-$2
Hawaii	$15	<$1	$16	$12	-$4	<-$1	-$4
Illinois	$158	$12	$170	$120	-$37	-$12	-$50
Indiana	$81	$5	$86	$67	-$14	-$5	-$19
Iowa	$34	$2	$36	$29	-$5	-$2	-$7
Kentucky	$106	$3	$108	$59	-$47	-$3	-$50
Louisiana	$74	$4	$78	$52	-$23	-$4	-$27
Maryland	$80	$4	$84	$57	-$23	-$4	-$28
Massachusetts	$95	$5	$100	$78	-$17	-$5	-$23
Michigan	$149	$8	$157	$119	-$30	-$8	-$38
Minnesota	$82	$2	$84	$68	-$15	-$2	-$16
Montana	$23	$1	$24	$14	-$9	-$1	-$10
Nevada	$35	$4	$39	$22	-$13	-$4	-$16
New Hampshire	$14	$1	$15	$10	-$4	-$1	-$5
New Jersey	$135	$7	$142	$82	-$53	-$7	-$60
New Mexico	$72	$1	$74	$46	-$27	-$1	-$28
New York	$348	$10	$358	$301	-$47	-$10	-$57
North Dakota	$7	<$1	$8	$5	-$2	<-$1	-$3
Ohio	$177	$6	$183	$135	-$42	-$6	-$48
Oregon	$83	$3	$86	$47	-$35	-$3	-$38
Pennsylvania	$154	$13	$167	$131	-$23	-$13	-$36
Rhode Island	$21	<$1	$22	$14	-$7	<-$1	-$7
Vermont	$11	<$1	$12	$9	-$2	-$1	-$3
Washington	$90	$5	$95	$52	-$38	-$5	-$43
West Virginia	$35	$2	$37	$23	-$12	-$2	-$14
Expansion states total	*$2,799*	*$184*	*$2,983*	*$2,085*	*-$715*	*-$184*	*-$899*

State	ACA			Reconciliation Bill	Difference		
	Medicaid/ CHIP	Premium tax credits and cost-sharing reductions	Total	Medicaid/ CHIP	Medicaid/ CHIP	Premium tax credits and cost-sharing reductions	Total
Nonexpansion states							
Alabama	$47	$12	$59	$43	-$3	-$12	-$15
Florida	$181	$68	$249	$162	-$19	-$68	-$87
Georgia	$101	$20	$121	$88	-$12	-$20	-$33
Idaho	$26	$4	$29	$23	-$3	-$4	-$6
Kansas	$24	$4	$28	$22	-$2	-$4	-$6
Maine	$17	$4	$21	$17	<-$1	-$4	-$5
Mississippi	$44	$5	$49	$40	-$4	-$5	-$9
Missouri	$80	$13	$93	$75	-$6	-$13	-$18
Nebraska	$15	$4	$19	$15	<-$1	-$4	-$5
North Carolina	$146	$38	$184	$125	-$21	-$38	-$59
Oklahoma	$48	$8	$56	$47	-$2	-$8	-$9
South Carolina	$54	$11	$65	$53	-$1	-$11	-$12
South Dakota	$8	$1	$9	$8	<-$1	-$1	-$1
Tennessee	$98	$11	$108	$82	-$16	-$11	-$27
Texas	$323	$46	$369	$307	-$17	-$46	-$62
Utah	$33	$3	$36	$31	-$1	-$3	-$5
Virginia	$56	$15	$72	$54	-$3	-$15	-$18
Wisconsin	$49	$11	$60	$47	-$2	-$11	-$13
Wyoming	$5	$2	$6	$4	<-$1	-$2	-$2
Nonexpansion states total	*$1,354*	*$280*	*$1,634*	*$1,242*	*-$112*	*-$280*	*-$392*
National estimate	**$4,153**	**$465**	**$4,618**	**$3,327**	**-$826**	**-$465**	**-$1,291**

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program. Numbers are rounded to the nearest $1 billion, so columns might not sum precisely to totals.

As the number of uninsured increases under the reconciliation bill, the amount of uncompensated care sought would increase as well. But the source of financing this increased demand is very unclear. The uninsured use less medical care than they would if they had health insurance coverage, but they do use some care. This care is financed in different ways: some care is paid for directly by the uninsured, some is financed by the federal government (e.g., Medicare and Medicaid disproportionate share hospital [DSH] programs), some is financed by state and local governments (e.g., uncompensated care pools, Medicaid DSH, funding for public hospitals), and some is financed by providers (e.g., hospitals, physicians, pharmaceutical companies) delivering free or reduced-price care. We assume that newly uninsured people will contribute to the costs of their own care consistent with the patterns of spending by uninsured people with similar characteristics and health needs under current law.

No source of uncompensated care funding increases automatically with an increase in the number of uninsured, so it is unclear whether funding would increase to meet the demand. We estimate that under current law, the federal government would spend $23 billion on uncompensated care in 2019 and $262 billion from 2019 to 2028 (table 7). State and local governments would spend $14 billion on uncompensated care in 2019 and $164 billion over 10 years. Providers would contribute $20 billion in services for the uninsured in 2019 and $230 billion over 10 years. These amounts are consistent with total demand for uncompensated care of $57 billion in 2019, $656 billion over 10 years.

With the uninsured increasing by almost 30 million by 2019, uninsured people would seek an additional $88 billion in uncompensated care in 2019 and an additional $1.1 trillion from 2019 to 2028. However, the federal DSH programs would not increase beyond current levels without explicit federal action, and that action was not part of the January 2016 reconciliation bill.[5] Therefore, we assume federal uncompensated care funding would remain fixed. State and local governments could increase revenue to address the uncompensated care funding shortfall, providers could increase their provision of free services to the uninsured, unmet medical need could increase because the shortfall is not financed, or some combination of these possibilities could occur.

We provide two scenarios in table 7: the first assumes the uncompensated care shortfall is addressed by providers increasing their delivery of free and reduced price care, and the second assumes the shortfall is financed by state and local governments. While neither state and local governments nor providers are likely to be able to finance the extra care sought on their own, these scenarios show the large financing challenge facing the health care system under the reconciliation bill. If state and local governments were to assume all costs related to the increase in uncompensated care sought, their support for uncompensated care would have to increase more than sixfold. If providers were to assume all the increase in demand, their support for uncompensated care would have to more than quadruple. While some combination of increases from state and local governments and providers may occur, the large increase in services sought by the uninsured is unlikely to be met, and the increased burden on the uninsured will produce even greater financial burdens and more unmet need for health care services.

TABLE 7

Alternative Scenarios for Financing Uncompensated Care, 2019 and 2019–28

Billions of dollars

	2019			2019–28		
	ACA	Reconciliation bill	Difference	ACA	Reconciliation bill	Difference
Total demand for uncompensated care	$57	$145	$88	$656	$1,723	$1,067
	Scenario 1: No increase in federal or state/local uncompensated care funds; all increase in demand borne by providers					
Federal government	$23	$23	$0	$262	$262	$0
State/local government	$14	$14	$0	$164	$164	$0
Providers	$20	$108	$88	$230	$1,296	$1,067
	Scenario 2: No increase in federal uncompensated care funds or provider contributions; all increase in demand borne by states and localities					
Federal government	$23	$23	$0	$262	$262	$0
State/local government	$14	$102	$88	$164	$1,231	$1,067
Providers	$20	$20	$0	$230	$230	$0

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act. Columns may not sum to totals because of rounding.

Elimination of the Individual and Employer Mandates in 2017

So far, our analysis has focused on the 2019 effects of the reconciliation approach. In this section, we analyze the implications of eliminating the individual and employer mandates immediately after passage in 2017. We do this because the 2016 reconciliation bill would have immediately stopped collections of these penalties.

ACA-compliant nongroup premiums for 2017 were set in 2016 before the start of the open enrollment period, following months of review by state departments of insurance and, in some cases, the federal government. Before the governmental review process, insurers assess and refine their product offerings for the coming year, and their actuaries and others prepare their proposed premiums based on last year's experiences, expected changes in the nongroup risk pool for the coming year, and other considerations. Once premiums are approved, they are locked in for the coming plan year.

Eliminating the individual mandate (and, to a much smaller degree, the employer mandate) in the middle of a plan year would change the rules of the insurance market after the year's premiums have been set. Fewer people would keep their health insurance for the remainder of the year. Once they are informed that there would no longer be a tax penalty for remaining uninsured, some people would drop their coverage after the start of the plan year. As healthier people drop coverage, premium collections across the nongroup market would be lower than the health care costs incurred by those who remain insured. This type of pricing disconnect would affect not only those insurers providing Marketplace coverage but also those selling nongroup coverage outside the Marketplaces, since the entire ACA-compliant nongroup market is treated as a single risk pool.

If the individual and employer mandates are eliminated while the ACA's Medicaid expansion, Marketplace tax credits and cost-sharing reductions, insurance market reforms, and other components are left in place in 2017, 4.3 million people would drop their ACA-compliant nongroup insurance coverage and become uninsured (table 8). Average health insurance claims for those remaining in the ACA-compliant private nongroup insurance markets would be about 10 percent higher than if the 4.3 million people stayed in the pool as they would under the ACA (data not shown); this would place financial pressure on the markets' insurers. The continuation of Marketplace financial assistance is critical to averting even higher short-run increases in average claims because the lower-priced coverage provided to many modest-income people is attractive even without a mandate in place.

TABLE 8

Nonelderly Coverage Distribution and Insurers' Premium Revenue in 2017

Thousands of people

	Current law	Elimination of individual and employer mandates early in year	Difference
Coverage			
Medicaid	67,950	67,950	0
Medicare	3,953	3,953	0
Employer-sponsored insurance	149,511	149,511	0
Other public	4,505	4,505	0
Nongroup	18,418	14,085	-4,334
Uninsured	*28,342*	*32,676*	*4,334*
Total	**272,680**	**272,680**	

Premium revenue (billions)	
Total premium revenue: current law	$46
Total premium revenue: no mandates, fixed premiums	$37
Actuarially fair premiums necessary to cover insurer costs if mandates eliminated	$40
Shortfall in insurer revenue caused by eliminating mandates mid–plan year	$3

Source: Urban Institute analysis using HIPSM 2016.
Note: Premium revenue includes direct payments by enrollees and premium tax credits financed by the federal government.

Under current law, insurers would collect an estimated $46 billion in premiums (combining those paid directly by enrollees and the premium tax credits provided by the federal government). If the individual mandate is eliminated early in 2017, insurer premium revenue would drop almost $10 billion to $37 billion, yet this revenue would fall more than $3 billion short of covering insurers' claims and administrative costs. Facing significant financial losses, insurers could request midyear premium adjustments, absorb the financial losses and remain in the markets, or exit the markets entirely. Midyear premium adjustments are likely unfeasible because the standard premium development, review, and approval processes require several months. Some larger insurers could decide to remain in the markets and internalize the losses, but others would surely leave. As a result, even if some insurers remain in some areas, more people would become uninsured in 2017, insurers would suffer financial

losses, and many consumers would be displaced from coverage and provider networks they chose during 2017 open enrollment. Financial burdens for consumers with insurers that leave the market during the year would increase because enrollees would lose credit for deductibles and cost-sharing already paid, even if they are able to enroll with a different insurer. The number of insurers leaving the nongroup market and the effect on consumers would likely be significantly larger in 2018 than in 2017. The 2016 reconciliation bill would have immediately stopped the reinsurance program as well. That would cause further financial losses to insurers than we have estimated here.

The bottom line is that eliminating the individual mandate penalties midyear would lead to a much faster unwinding of private nongroup insurance markets than would occur if the mandate were repealed in 2019. The 2019 estimates presented earlier would still hold, but the effects would begin earlier if the mandates were eliminated prior to the other changes. The effects would begin in 2017 but would likely accelerate in 2018. Any changes to the market rules, mandate, or financial assistance after premiums are set for the plan year would significantly disrupt coverage and care and would cause private financial losses for households and insurers.

Our analysis does not include the additional disruptions to insurers and consumers that would occur if the federal government immediately ceased paying cost-sharing reductions on behalf of low-income Marketplace enrollees. This is the issue under consideration in the *House v. Burwell* case. We have analyzed the potential implications of the case elsewhere (Blumberg and Buettgens 2016) but not in combination with the issues analyzed here. Eliminating the cost-sharing reductions immediately would impose greater losses on Marketplace insurers than estimated here and would force more insurers out of the Marketplaces, resulting in much broader immediate disruptions for consumers.

Discussion

We estimate that the effects of passing and implementing the reconciliation bill would be large and swift. Yet actual effects would likely be larger, for the following reasons.

- We assume that no additional states would adopt Medicaid expansions if the ACA remains in effect. If additional states expanded Medicaid, the drop in coverage relative to what would occur under current law would be greater than we estimate here.
- The ACA's individual mandate penalties increase in 2016 to their maximum level. These higher penalties, which will be felt in early 2017 when taxpayers file their returns, could lead to more people enrolling in coverage the next plan year. We do not include this possible bump in insurance coverage in our ACA estimates. Therefore, we may be underestimating the future coverage gains under the ACA as well as the decline in coverage resulting from partial repeal using a reconciliation approach.
- Many of those remaining uninsured under the ACA are eligible for Medicaid or subsidized private Marketplace coverage. Additional targeted outreach and enrollment assistance could increase health coverage further if the ACA remains in place (Blumberg et al. 2016); by ignoring

this pool of potential coverage expansion, we likely understate the decline in coverage relative to what might occur under current law.

- Repeal would mean that states that had expanded insurance coverage before the ACA using Medicaid waivers would likely need to renegotiate those waivers to keep program eligibility where it was before 2014. However, the new administration may not grant such waivers or may require substantial changes to them that would affect states' ability to provide coverage to the same number of people that they had before the ACA.

In addition, this analysis only covers the decrease in federal health care spending and does not provide a complete picture of the effect of the anticipated reconciliation bill on the federal budget. Specifically, we do not estimate the revenue consequences of eliminating the high-cost plan or "Cadillac" tax, the individual mandate penalties, the employer mandate penalties, and other tax changes. Therefore, our estimates cannot be interpreted as federal budget effects, only decreases in spending on health care. In addition, the anticipated reconciliation bill has implications for state budgets beyond the changes in direct Medicaid spending estimated in this analysis. As a number of states have reported, the Medicaid expansion has led to additional state budgetary spending, and its repeal could have significant negative economic consequences for states.[7]

It is also possible that particular states would raise revenues to offset some of the coverage losses created by such a federal approach. But the state revenue required makes this response unlikely, and any state action of this sort would likely be concentrated in the highest-income states. Massachusetts was the only state that had significantly expanded coverage through its own reforms prior to the ACA, and even that state relied heavily on federal Medicaid dollars via a waiver to finance the financial assistance that was provided. Given those caveats, our central findings are that the anticipated reconciliation bill would have the following effects:

- The number of uninsured people would increase by 29.8 million by 2019.
- The number of people with Medicaid or CHIP coverage would decrease by 12.9 million, and 17.7 million fewer people would have private nongroup insurance by 2019.
- About 56 percent of those losing coverage would be non-Hispanic whites, 82 percent would be in working families, and 80 percent of adults would have less than a college degree.
- Federal spending on health care would be $109 billion lower in 2019 and $1.3 trillion lower between 2019 and 2028.
- State and local spending on Medicaid and CHIP would be $4 billion lower in 2019 and $76 billion lower between 2019 and 2028. However, uncompensated care pressures on state and local governments and on health care providers would increase significantly with the growing number of uninsured. The newly uninsured would seek an additional $1.1 trillion in uncompensated care between 2019 and 2028. Increases in uncompensated care funding would not occur automatically, and if governments or providers do not increase the funding of care for

the uninsured substantially from current levels, unmet medical need would increase even further and fiscal pressures on providers would intensify significantly.

- Eliminating the individual mandate in 2017 would lead to a significant erosion of the private nongroup insurance markets inside and outside the Marketplaces that year, with lower coverage (an additional 4.3 million uninsured), some midyear insurer exits, substantial financial losses for insurers ($3 billion), and displacement and financial losses for consumers having to change plans.

These changes in coverage and spending add up to substantial decreases in health care spending on nonelderly adults and children, with a disproportionate share of that decrease falling on middle- and low-income people, although we have not included these estimated effects here. The decrease in spending would reduce hospital admissions, visits to doctors and other health care providers, prescriptions filled, and other forms of health care, despite possible increases in public spending on uncompensated care. This scenario does not just move the country back to the situation before the ACA. Because it would lead to a near-collapse of the nongroup insurance market, it moves the country to a situation with higher uninsurance rates than before the ACA's reforms. To replace the ACA after reconciliation with new policies designed to increase insurance coverage, the federal government would have to raise new taxes, substantially cut spending, or increase the deficit.

Methods

Our estimates are based on the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). The model has been used in a broad array of analyses of the ACA at the federal and state levels. The Supreme Court majority cited HIPSM analysis in the *King v. Burwell* case. The model has accurately forecast the stability of employer-based health insurance under the ACA. The model's estimates of the effect of the ACA on overall coverage and federal government costs compare favorably in accuracy to that of other microsimulation models, including that of the Congressional Budget Office (Glied, Arora, and Solis-Roman 2015).

Our primary source of data for the demographic and economic characteristics of Americans is the American Community Survey. Its large sample size enables state-level analysis. We use the latest available enrollment data from the Marketplaces and Medicaid to impute new coverage. As a result, our estimates of enrollees in each state match actual enrollment. After calibrating HIPSM to reproduce 2016 Medicaid and Marketplace enrollment, we estimate that 10.3 percent of the nonelderly are uninsured in that year. This estimate almost exactly matches the National Health Interview Survey's January–June 2016 estimate of 10.4 percent of the nonelderly uninsured at the time of interview (Zammitti, Cohen, and Martinez 2016, 13). HIPSM coverage estimates represent an annual average number of people in each coverage status.

Our estimates of coverage under the ACA after 2016 do not assume notably higher take-up of Medicaid or Marketplace coverage than in 2016. We recognize that participation rates could increase over time. Nonetheless, we ignore this possibility because we choose to base our estimate of ACA effects on what has already happened. We also adopt conservative assumptions for the cost of health care. Although some studies have found that the ACA contributed to the slowing growth of health care costs in recent years, there is no generally accepted estimate of how large that contribution was

(McMorrow and Holahan 2016). Accordingly, we assume that the underlying growth rate of health care costs would be the same with or without the ACA.

The methods used here are generally consistent with those described in our earlier analysis of full repeal of the ACA (Buettgens et al. 2016). Additional detail on our methods can be found in that document. We have made three changes in our methods. First, this analysis leaves the ACA components with no budgetary implications (i.e., the insurance market reforms in the nongroup insurance market and the small group insurance market) in place. As explained in the results section of this paper, this difference has substantial ramifications for the viability of the private nongroup insurance market and leads to larger coverage effects than our earlier simulations. Second, this analysis focuses on 2019 and the 10-year budget window of 2019 to 2028 instead of 2017 to 2026.

Third, we take a somewhat different approach to allocating the costs associated with increased demand for uncompensated care. We compute the demand for uncompensated care in the same way as prior analyses, but we present the implications for federal, state, and local governments and providers differently than in the last report. We calculate the demand for uncompensated care for each uninsured person based upon their characteristics and health risk. We calibrate uncompensated care costs so that the uncompensated care provided to the uninsured in 2013 matches the estimated amount spent on uncompensated care that year. We inflate the value of uncompensated care over time for each person by the projected per capita growth in medical costs. We also assume that newly uninsured people will spend money on their own care and that their levels of spending will be consistent with those of people of similar health circumstances and characteristics observed under current law. However, in the current analysis we recognize that policy changes would be required in order for federal or state/local spending on uncompensated care to increase significantly beyond current levels. In the prior analysis, we assumed all sources of uncompensated care funding would increase proportionately with the increase in demand for such care. Given that Congress did not include an increase over current levels in federal spending on uncompensated care programs in the 2016 reconciliation bill, we assume a 2017 reconciliation bill would keep federal spending at current levels as well. Therefore, we show the estimated increase in uncompensated care sought due to the increase in the uninsured and compute the relative increase in spending that it would require from states and localities or the relative increase in free care provided by doctors, hospitals, and other providers if they were to finance an increase of that magnitude.

This analysis does not include estimates of the revenue reductions of eliminating the Cadillac tax, the individual mandate penalties, the employer mandate penalties, and other tax changes. We provide decreases in federal spending on health programs, but we do not provide overall federal budget effects. The latter would be considerably smaller than the former. In addition, the anticipated reconciliation bill has implications for state budgets beyond the changes in direct Medicaid spending shown here. As a number of states have reported, the Medicaid expansion has led to additional state budgetary savings, and its repeal could have significant negative economic consequences for states; those consequences are not included in this analysis.

APPENDIX TABLE A.1

Federal and State Medicaid/CHIP Spending under the ACA and an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019

Millions of dollars

	ACA			Reconciliation Bill			Difference		
State	**Federal**	**State**	**Total**	**Federal**	**State**	**Total**	**Federal**	**State**	**Total**
National	**330,191**	**194,951**	**525,142**	**262,720**	**190,654**	**453,374**	**-67,471**	**-4,298**	**-71,768**
Expansion states									
Alaska	903	756	1,659	795	795	1,591	-107	40	-68
Arizona	11,138	4,594	15,732	8,567	4,176	12,743	-2,571	-418	-2,989
Arkansas	3,328	1,215	4,544	2,699	1,151	3,850	-629	-64	-693
California	29,016	23,213	52,229	20,963	20,963	41,927	-8,053	-2,250	-10,302
Colorado	5,920	3,402	9,322	3,412	3,269	6,681	-2,508	-134	-2,642
Connecticut	4,156	3,123	7,279	3,290	3,220	6,511	-866	97	-769
Delaware	1,192	687	1,879	970	765	1,735	-222	78	-144
District of Columbia	1,455	521	1,977	1,316	564	1,880	-139	43	-97
Hawaii	1,220	818	2,038	914	849	1,764	-306	31	-274
Illinois	12,618	8,954	21,572	9,543	9,051	18,594	-3,074	97	-2,978
Indiana	6,450	2,433	8,883	5,304	2,581	7,885	-1,146	148	-998
Iowa	2,726	1,513	4,239	2,280	1,594	3,874	-446	81	-365
Kentucky	8,512	2,257	10,769	4,679	1,998	6,677	-3,834	-259	-4,092
Louisiana	5,986	2,819	8,805	4,126	2,618	6,744	-1,860	-201	-2,062
Maryland	6,379	4,466	10,846	4,472	4,472	8,943	-1,908	5	-1,903
Massachusetts	7,593	6,166	13,759	6,179	5,976	12,155	-1,414	-190	-1,604
Michigan	12,023	4,525	16,548	9,510	4,785	14,295	-2,513	260	-2,253
Minnesota	6,485	4,907	11,392	5,292	5,292	10,583	-1,193	385	-808
Montana	1,797	621	2,418	1,099	535	1,634	-698	-86	-784
Nevada	2,758	1,063	3,821	1,730	995	2,725	-1,028	-68	-1,096
New Hampshire	1,144	780	1,924	815	815	1,630	-329	35	-295
New Jersey	10,906	5,916	16,822	6,544	6,265	12,809	-4,363	350	-4,013
New Mexico	5,808	1,735	7,544	3,608	1,606	5,213	-2,201	-130	-2,330
New York	27,846	21,110	48,956	23,880	23,235	47,116	-3,966	2,126	-1,840
North Dakota	559	336	895	390	386	776	-169	49	-119
Ohio	14,233	6,156	20,389	10,735	6,299	17,034	-3,498	143	-3,355
Oregon	6,624	2,115	8,739	3,747	2,115	5,861	-2,877	-1	-2,878
Pennsylvania	12,257	7,912	20,169	10,373	8,614	18,987	-1,883	702	-1,182

	ACA			Reconciliation Bill			Difference		
State	**Federal**	**State**	**Total**	**Federal**	**State**	**Total**	**Federal**	**State**	**Total**
Rhode Island	1,691	1,228	2,920	1,136	1,131	2,267	-556	-98	-653
Vermont	917	554	1,471	746	608	1,354	-171	54	-117
Washington	7,221	4,131	11,352	4,121	4,043	8,164	-3,100	-88	-3,188
West Virginia	2,860	782	3,642	1,849	726	2,575	-1,011	-56	-1,067
Expansion states total	***223,722***	***130,811***	***354,533***	***165,085***	***131,492***	***296,576***	***-58,638***	***681***	***-57,956***
Nonexpansion states									
Alabama	3,710	1,642	5,353	3,439	1,525	4,964	-271	-117	-388
Florida	14,230	9,728	23,958	12,719	8,732	21,452	-1,511	-996	-2,507
Georgia	7,834	3,929	11,763	6,881	3,454	10,334	-953	-475	-1,428
Idaho	2,006	777	2,784	1,798	698	2,496	-208	-79	-288
Kansas	1,877	1,363	3,240	1,734	1,258	2,992	-143	-105	-248
Maine	1,376	839	2,215	1,335	820	2,155	-41	-19	-60
Mississippi	3,498	1,263	4,761	3,185	1,150	4,335	-313	-112	-426
Missouri	6,389	3,784	10,173	5,946	3,534	9,480	-444	-250	-694
Nebraska	1,162	960	2,122	1,149	950	2,100	-12	-10	-22
North Carolina	11,436	5,817	17,254	9,803	5,009	14,811	-1,634	-808	-2,442
Oklahoma	3,810	2,141	5,951	3,675	2,065	5,740	-135	-76	-211
South Carolina	4,287	1,788	6,075	4,200	1,751	5,951	-88	-37	-124
South Dakota	645	555	1,200	624	537	1,162	-21	-18	-39
Tennessee	7,717	3,961	11,678	6,457	3,346	9,803	-1,260	-615	-1,875
Texas	25,288	17,257	42,545	23,978	16,363	40,341	-1,310	-894	-2,204
Utah	2,529	1,041	3,569	2,412	992	3,405	-116	-48	-165
Virginia	4,415	4,299	8,713	4,210	4,100	8,311	-204	-198	-403
Wisconsin	3,899	2,643	6,542	3,742	2,533	6,276	-157	-109	-266
Wyoming	360	353	713	350	343	692	-10	-10	-21
Nonexpansion states total	***106,469***	***64,141***	***170,609***	***97,636***	***59,162***	***156,798***	***-8,833***	***-4,979***	***-13,812***

Source: Urban Institute analysis using HIPSM 2016.

APPENDIX TABLE A.2

Number of People Losing Federal Financial Assistance for Marketplace Coverage, Average Assistance Forgone, and Aggregate Federal Assistance Forgone under an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019

State	People who would receive tax credits under the ACA (thousands)	Average tax credit and cost-sharing assistance per recipient ($)	Premium tax credits ($ millions)	Cost-sharing reductions ($ millions)	Total federal assistance forgone ($ millions)
National	**9,322**	**$4,480**	**35,338**	**6,427**	**41,765**
Expansion states					
Alaska	19	$8,810	150	21	171
Arizona	126	$6,975	827	49	877
Arkansas	55	$3,516	159	35	194
California	1,403	$3,945	4,783	752	5,534
Colorado	78	$2,840	190	33	223
Connecticut	74	$5,272	348	43	391
Delaware	20	$4,025	71	10	81
District of Columbia	3	$2,368	7	0	8
Hawaii	11	$4,351	42	6	47
Illinois	258	$4,355	1,001	122	1,122
Indiana	104	$4,448	385	78	463
Iowa	42	$4,281	156	24	180
Kentucky	57	$4,547	213	46	259
Louisiana	70	$5,230	316	50	366
Maryland	129	$2,981	332	53	385
Massachusetts	126	$3,881	415	75	491
Michigan	232	$3,230	633	118	750
Minnesota	47	$3,512	163	2	165
Montana	23	$4,776	97	12	109
Nevada	63	$4,956	262	50	312
New Hampshire	29	$2,898	70	16	85
New Jersey	193	$3,152	513	94	607
New Mexico	33	$2,805	77	16	93
New York	310	$2,869	771	120	891
North Dakota	17	$3,182	47	7	54
Ohio	155	$3,446	438	97	535
Oregon	111	$2,656	255	41	296
Pennsylvania	239	$4,996	1,074	121	1,195
Rhode Island	30	$2,002	50	10	60

State	People who would receive tax credits under the ACA (thousands)	Average tax credit and cost-sharing assistance per recipient ($)	Premium tax credits ($ millions)	Cost-sharing reductions ($ millions)	Total federal assistance forgone ($ millions)
Vermont	24	$3,888	83	9	91
Washington	142	$3,005	352	73	425
West Virginia	29	$5,668	143	21	164
Expansion states total	**4,254**	**$3,908**	**14,423**	**2,203**	**16,626**
Nonexpansion states					
Alabama	151	$7,156	931	147	1,078
Florida	1,366	$4,481	5,106	1,013	6,119
Georgia	437	$4,148	1,430	381	1,811
Idaho	79	$4,178	276	56	331
Kansas	78	$4,999	329	60	389
Maine	67	$5,788	331	57	388
Mississippi	72	$6,642	390	85	475
Missouri	225	$5,216	960	212	1,172
Nebraska	70	$5,671	345	52	397
North Carolina	493	$6,943	2,947	475	3,421
Oklahoma	110	$6,260	601	87	689
South Carolina	163	$5,842	787	164	951
South Dakota	20	$5,243	90	15	105
Tennessee	173	$5,573	834	132	966
Texas	941	$4,310	3,234	822	4,057
Utah	83	$3,468	242	46	288
Virginia	326	$4,218	1,122	252	1,374
Wisconsin	197	$4,953	837	139	976
Wyoming	19	$8,190	122	30	152
Nonexpansion states total	**5,068**	**$4,961**	**20,914**	**4,225**	**25,139**

Source: Urban Institute analysis using HIPSM 2016.

Notes: Average assistance per recipient is calculated as the total of premium tax credits and cost-sharing reductions provided in each state, divided by the number of people in families receiving assistance. All those receiving Marketplace assistance receive tax credits; some receive both tax credits and cost-sharing assistance. For example, a family of four receiving a tax credit through a Marketplace would count as four people in tallies of those receiving assistance.

APPENDIX TABLE A.3

Federal and State Medicaid/CHIP Spending under the ACA and an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

Millions of dollars

	ACA		Reconciliation Bill		Difference	
State	**Federal**	**State**	**Federal**	**State**	**Federal**	**State**
Expansion states						
Alaska	$11,516	$9,756	$10,198	$10,198	-$1,318	$442
Arizona	$142,127	$59,683	$110,043	$53,638	-$32,084	-$6,044
Arkansas	$41,909	$15,586	$34,148	$14,565	-$7,761	-$1,021
California	$363,744	$295,051	$264,676	$264,676	-$99,068	-$30,375
Colorado	$74,434	$44,204	$43,583	$41,713	-$30,851	-$2,491
Connecticut	$51,903	$39,643	$41,431	$40,547	-$10,472	$904
Delaware	$14,978	$8,821	$12,287	$9,687	-$2,690	$866
District of Columbia	$18,223	$6,671	$16,564	$7,099	-$1,659	$427
Hawaii	$15,314	$10,506	$11,586	$10,759	-$3,728	$253
Illinois	$157,567	$113,855	$120,198	$113,893	-$37,369	$38
Indiana	$81,176	$31,465	$67,268	$32,725	-$13,908	$1,260
Iowa	$34,394	$19,436	$28,998	$20,265	-$5,396	$829
Kentucky	$105,571	$29,683	$58,774	$25,098	-$46,797	-$4,585
Louisiana	$74,411	$35,939	$51,729	$32,817	-$22,682	-$3,122
Maryland	$80,069	$57,286	$56,627	$56,627	-$23,443	-$660
Massachusetts	$95,075	$78,018	$77,912	$75,343	-$17,163	-$2,675
Michigan	$148,780	$57,731	$118,792	$59,758	-$29,988	$2,026
Minnesota	$82,245	$63,400	$67,686	$67,686	-$14,559	$4,286
Montana	$22,512	$8,091	$13,945	$6,790	-$8,568	-$1,302
Nevada	$35,236	$14,091	$22,328	$12,835	-$12,908	-$1,256
New Hampshire	$14,138	$9,874	$10,172	$10,172	-$3,966	$299
New Jersey	$135,378	$76,052	$82,380	$78,785	-$52,998	$2,733
New Mexico	$72,465	$22,723	$45,594	$20,293	-$26,871	-$2,430
New York	$347,954	$267,729	$300,605	$292,248	-$47,349	$24,520
North Dakota	$7,043	$4,357	$4,980	$4,928	-$2,063	$571
Ohio	$176,730	$78,643	$134,545	$78,951	-$42,185	$308
Oregon	$82,541	$27,876	$47,423	$26,745	-$35,118	-$1,131
Pennsylvania	$154,018	$101,149	$131,365	$109,020	-$22,654	$7,871
Rhode Island	$21,045	$15,610	$14,316	$14,254	-$6,728	-$1,357

	ACA		Reconciliation Bill		Difference	
State	**Federal**	**State**	**Federal**	**State**	**Federal**	**State**
Vermont	$11,281	$6,956	$9,346	$7,612	-$1,935	$656
Washington	$90,347	$53,511	$52,283	$51,284	-$38,064	-$2,227
West Virginia	$35,274	$10,101	$23,027	$9,047	-$12,247	-$1,054
Expansion states total	*$2,799,399*	*$1,673,497*	*$2,084,808*	*$1,660,058*	*-$714,591*	*-$13,439*
Nonexpansion states						
Alabama	$46,751	$20,673	$43,341	$19,203	-$3,410	-$1,470
Florida	$180,752	$123,567	$161,626	$110,954	-$19,126	-$12,613
Georgia	$100,670	$50,498	$88,488	$44,414	-$12,182	-$6,084
Idaho	$25,670	$9,944	$23,025	$8,936	-$2,645	-$1,008
Kansas	$23,772	$17,247	$21,975	$15,922	-$1,797	-$1,325
Maine	$17,064	$10,412	$16,566	$10,179	-$498	-$233
Mississippi	$43,816	$15,814	$39,928	$14,420	-$3,888	-$1,393
Missouri	$80,482	$47,643	$74,971	$44,535	-$5,510	-$3,108
Nebraska	$14,733	$12,181	$14,581	$12,056	-$152	-$126
North Carolina	$145,642	$74,079	$124,923	$63,824	-$20,719	-$10,255
Oklahoma	$48,324	$27,159	$46,666	$26,227	-$1,659	-$932
South Carolina	$54,112	$22,566	$53,036	$22,118	-$1,075	-$448
South Dakota	$8,248	$7,103	$7,979	$6,871	-$269	-$232
Tennessee	$97,562	$50,078	$81,654	$42,303	-$15,908	-$7,775
Texas	$323,489	$220,741	$306,920	$209,439	-$16,568	-$11,303
Utah	$32,712	$13,459	$31,221	$12,842	-$1,492	-$617
Virginia	$56,263	$54,756	$53,659	$52,232	-$2,604	-$2,524
Wisconsin	$49,352	$33,442	$47,447	$32,108	-$1,905	-$1,334
Wyoming	$4,555	$4,467	$4,432	$4,343	-$123	-$124
Nonexpansion states total	*$1,353,966*	*$815,830*	*$1,242,436*	*$752,926*	*-$111,530*	*-$62,904*
National estimate	**$4,153,365**	**$2,489,327**	**$3,327,244**	**$2,412,984**	**-$826,121**	**-$76,342**

Source: Urban Institute analysis using HIPSM 2016.

Note: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

APPENDIX TABLE A.4

Forgone Federal Spending on Marketplace Financial Assistance under an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

Millions of dollars

State	Federal Marketplace financial assistance	State	Federal Marketplace financial assistance
Expansion states		*Nonexpansion states*	
Alaska	1,900	Alabama	11,944
Arizona	10,017	Florida	68,139
Arkansas	2,147	Georgia	20,484
California	61,116	Idaho	3,710
Colorado	2,479	Kansas	4,316
Connecticut	4,305	Maine	4,212
Delaware	898	Mississippi	5,232
District of Columbia	85	Missouri	12,909
Hawaii	532	Nebraska	4,398
Illinois	12,483	North Carolina	38,239
Indiana	5,095	Oklahoma	7,682
Iowa	1,982	South Carolina	10,580
Kentucky	2,861	South Dakota	1,166
Louisiana	4,048	Tennessee	10,777
Maryland	4,338	Texas	45,594
Massachusetts	5,361	Utah	3,262
Michigan	8,177	Virginia	15,400
Minnesota	1,875	Wisconsin	10,722
Montana	1,205	Wyoming	1,681
Nevada	3,529	*Nonexpansion states total*	*280,449*
New Hampshire	927		
New Jersey	6,694		
New Mexico	1,027		
New York	9,853		
North Dakota	592		
Ohio	5,842		
Oregon	3,286		
Pennsylvania	13,276		
Rhode Island	653		
Vermont	989		
Washington	4,691		
West Virginia	1,794		
Expansion states total	*184,058*		
National total	**464,507**	**National total**	**464,507**

Source: Urban Institute analysis using HIPSM 2016.
Note: ACA = Affordable Care Act.

APPENDIX TABLE A.5

Total Federal and State Spending on Medicaid/CHIP and Marketplace Assistance under the ACA and an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

Millions of dollars

	ACA		Reconciliation Bill		Difference	
State	**Federal**	**State**	**Federal**	**State**	**Federal**	**State**
Expansion states						
Alaska	$13,416	$9,756	$10,198	$10,198	-$3,218	$442
Arizona	$152,144	$59,683	$110,043	$53,638	-$42,101	-$6,044
Arkansas	$44,056	$15,586	$34,148	$14,565	-$9,908	-$1,021
California	$424,860	$295,051	$264,676	$264,676	-$160,184	-$30,375
Colorado	$76,913	$44,204	$43,583	$41,713	-$33,330	-$2,491
Connecticut	$56,209	$39,643	$41,431	$40,547	-$14,778	$904
Delaware	$15,876	$8,821	$12,287	$9,687	-$3,589	$866
District of Columbia	$18,308	$6,671	$16,564	$7,099	-$1,744	$427
Hawaii	$15,846	$10,506	$11,586	$10,759	-$4,261	$253
Illinois	$170,051	$113,855	$120,198	$113,893	-$49,852	$38
Indiana	$86,271	$31,465	$67,268	$32,725	-$19,003	$1,260
Iowa	$36,376	$19,436	$28,998	$20,265	-$7,378	$829
Kentucky	$108,432	$29,683	$58,774	$25,098	-$49,658	-$4,585
Louisiana	$78,459	$35,939	$51,729	$32,817	-$26,730	-$3,122
Maryland	$84,408	$57,286	$56,627	$56,627	-$27,781	-$660
Massachusetts	$100,435	$78,018	$77,912	$75,343	-$22,523	-$2,675
Michigan	$156,956	$57,731	$118,792	$59,758	-$38,164	$2,026
Minnesota	$84,119	$63,400	$67,686	$67,686	-$16,434	$4,286
Montana	$23,717	$8,091	$13,945	$6,790	-$9,773	-$1,302
Nevada	$38,765	$14,091	$22,328	$12,835	-$16,437	-$1,256
New Hampshire	$15,065	$9,874	$10,172	$10,172	-$4,893	$299
New Jersey	$142,073	$76,052	$82,380	$78,785	-$59,693	$2,733
New Mexico	$73,492	$22,723	$45,594	$20,293	-$27,899	-$2,430
New York	$357,807	$267,729	$300,605	$292,248	-$57,202	$24,520
North Dakota	$7,635	$4,357	$4,980	$4,928	-$2,655	$571
Ohio	$182,572	$78,643	$134,545	$78,951	-$48,027	$308
Oregon	$85,826	$27,876	$47,423	$26,745	-$38,403	-$1,131
Pennsylvania	$167,294	$101,149	$131,365	$109,020	-$35,930	$7,871

Rhode Island	$21,698	$15,610	$14,316	$14,254	-$7,382	-$1,357
Vermont	$12,269	$6,956	$9,346	$7,612	-$2,924	$656
Washington	$95,038	$53,511	$52,283	$51,284	-$42,755	-$2,227
West Virginia	$37,068	$10,101	$23,027	$9,047	-$14,042	-$1,054
Expansion states total	*$2,983,457*	*$1,673,497*	*$2,084,808*	*$1,660,058*	*-$898,649*	*-$13,439*
Nonexpansion states						
Alabama	$58,695	$20,673	$43,341	$19,203	-$15,353	-$1,470
Florida	$248,890	$123,567	$161,626	$110,954	-$87,265	-$12,613
Georgia	$121,154	$50,498	$88,488	$44,414	-$32,666	-$6,084
Idaho	$29,380	$9,944	$23,025	$8,936	-$6,355	-$1,008
Kansas	$28,087	$17,247	$21,975	$15,922	-$6,113	-$1,325
Maine	$21,276	$10,412	$16,566	$10,179	-$4,710	-$233
Mississippi	$49,048	$15,814	$39,928	$14,420	-$9,120	-$1,393
Missouri	$93,391	$47,643	$74,971	$44,535	-$18,420	-$3,108
Nebraska	$19,131	$12,181	$14,581	$12,056	-$4,550	-$126
North Carolina	$183,881	$74,079	$124,923	$63,824	-$58,958	-$10,255
Oklahoma	$56,006	$27,159	$46,666	$26,227	-$9,341	-$932
South Carolina	$64,691	$22,566	$53,036	$22,118	-$11,655	-$448
South Dakota	$9,414	$7,103	$7,979	$6,871	-$1,435	-$232
Tennessee	$108,339	$50,078	$81,654	$42,303	-$26,685	-$7,775
Texas	$369,083	$220,741	$306,920	$209,439	-$62,162	-$11,303
Utah	$35,975	$13,459	$31,221	$12,842	-$4,754	-$617
Virginia	$71,664	$54,756	$53,659	$52,232	-$18,004	-$2,524
Wisconsin	$60,074	$33,442	$47,447	$32,108	-$12,627	-$1,334
Wyoming	$6,236	$4,467	$4,432	$4,343	-$1,804	-$124
Nonexpansion states total	*$1,634,415*	*$815,830*	*$1,242,436*	*$752,926*	*-$391,979*	*-$62,904*
National total	**$4,617,872**	**$2,489,327**	**$3,327,244**	**$2,412,984**	**-$1,290,628**	**-$76,218**

Source: Urban Institute analysis using HIPSM 2016.
Note: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

Notes

1. Alex Moe, "Congress Sends Obamacare Repeal to President for First Time," NBC News, January 6, 2016, http://www.nbcnews.com/news/us-news/congress-send-obamacare-repeal-president-n491316.
2. Steven T. Dennis and Billy House, "GOP Eyes Lightning Strike on Obamacare to Kick Off Trump Era," Bloomberg, November 29, 2016, http://www.bloomberg.com/politics/articles/2016-11-29/gop-eyes-lightning-strike-on-obamacare-to-kick-off-trump-era; and Lisa Mascaro, "Repeal and Replace Obamacare? It Won't Happen on Trump's First Day," *Los Angeles Times*, November 29, 2016, http://www.latimes.com/nation/politics/trailguide/la-na-trailguide-updates-1480442605-htmlstory.html.
3. "Summary of the Byrd rule," US House of Representatives Committee on Rules, accessed November 22, 2016, http://archives.democrats.rules.house.gov/archives/byrd_rule.htm.
4. A number of other provisions of the 2016 reconciliation bill that would have affected coverage would have taken effect immediately or before two years. These include the early repeal of the maintenance-of-effort requirement for eligibility of children under Medicaid/CHIP and the elimination of the tax credit reconciliation caps. These provisions are not included in the estimates presented here.
5. We assume that federal DSH payments increase very modestly over the 10-year period. The Medicare DSH cuts in the ACA were left in place in the prior reconciliation bill, as were all Medicare savings provisions. We assume that would still be the case. The ACA's Medicaid DSH cuts have never been implemented, and we assume that they are restored permanently and held constant and that there would be no congressional interest in increasing them. Medicaid supplemental payments contribute in part to funding uncompensated care, and states could increase their use of them, but there would be fewer Medicaid patients to attach them to. Other sources of federal funding for uncompensated care could increase, but these would be modest given the new administration's commitment to budget cuts.
6. The Congressional Budget Office (2016) estimates Marketplace premium tax credits in the amount of $60 billion and cost-sharing reductions in the amount of $12 billion in 2019. Those larger federal spending estimates are the result of an estimate of subsidized Marketplace enrollment of 16 million people in 2019. This level of subsidized enrollment is significantly higher than that produced by HIPSM and would represent a very large increase in enrollment relative to administrative data. According to the Department of Health and Human Services, subsidized Marketplace enrollment was 9.4 million people in March 2016 (US Department of Health and Human Services, Centers for Medicare and Medicaid Services, "March 31, 2016 Effectuated Enrollment Snapshot," media release, June 30, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html), and Marketplace enrollment has fallen somewhat over the course of each calendar year from March levels. Our 2019 subsidized Marketplace enrollment of 9.3 million represents an average for calendar year 2019; thus, while conservative, it represents a modest increase in coverage between 2016 and 2019.
7. See, for example, Brian Fanney, Michael R. Wickline, and Spencer Williams, "Arkansas House Speaker Details Cuts if Medicaid Plan Fails," *Arkansas Online*, April 12, 2016, http://www.arkansasonline.com/news/2016/apr/12/plan-wields-ax-to-anticipate-a-medicaid/. Medicaid expansion in Arkansas was extended on April 21, 2016; see David Ramsey, "Using Novel Line-Item Veto, Ark. Governor Extends Medicaid Expansion," Kaiser Health News, April 21, 2016, http://khn.org/news/using-novel-line-item-veto-ark-governor-extends-medicaid-expansion; and Dorn et al. (2015).

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Linda Blumberg is a senior 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 level, and interpreting and analyzing the implications of particular policies. She codirects a large, multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in states and nationally. Examples of her research include several analyses of competition in nongroup Marketplaces, an array of studies on the implications of the *King v. Burwell* Supreme Court case, analysis of the remaining uninsured, and codirecting 22 state case studies of stakeholder perspectives on ACA implementation. She also led the quantitative analysis supporting the development of a "Roadmap to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state. She received her PhD in economics from the University of Michigan.

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Addenda

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Instead of ACA Repeal and Replace, Fix It

John Holahan and Linda J. Blumberg

January 2017

Executive Summary

Repealing the Affordable Care Act (ACA) via the budget reconciliation process without replacement policies in place risks dramatically increasing the number of uninsured people and causing chaos in the individual (nongroup) insurance markets. Replacement plans will likely be controversial and cover fewer people than the ACA. Any replacement plan will need to receive some support from Democrats in order to pass the Senate. After repeal, an ACA replacement will require new revenues because there will be a new spending and revenue baseline. This may prove to be extremely challenging.

Faced with this reality, policymakers should consider fixing the major problems they have with the ACA rather than repealing it; this would not disrupt the parts that are working effectively. To that end, we propose a range of policies that would address critics' concerns and also strengthen the law, expand coverage, improve affordability, increase market stability, and lower the high premiums that exist in some markets.

We propose the following:

1. Replace the individual mandate with a modified version of the late enrollment penalties currently used in Medicare Parts B and D.
2. End the employer mandate. The limited gains in coverage and the revenue it generates have not been worth the controversy it has caused.
3. Replace the Cadillac tax with a cap on the tax exclusion for employer-based insurance, ideally setting the cap at levels that would generate additional revenues to help finance vital enhancements.

4. Improve affordability by reducing premiums, deductibles, and other cost-sharing requirements for modest-income individuals, and extend to higher-income individuals a cap on premiums at 8.5 percent of income.
5. With a premium cap at 8.5 percent of income applied to all, relax the 3:1 age rating to be more in line with actual differences in spending for younger and older individuals.
6. Examine the essential health benefits package, recognizing that eliminating certain benefits would eliminate risk pooling for those services, shifting all costs to individuals needing those services. That is problematic for any service, but particularly so for prescription drugs, mental health, and substance use disorder treatment.
7. Stabilize the Marketplaces by taking steps to increase enrollment. This would include investing in additional outreach and enrollment assistance and allowing states to extend Medicaid eligibility to 100 percent of the federal poverty level (FPL) rather than 138 percent of FPL. People with incomes between 100 and 138 percent of FPL would move from Medicaid to Marketplace coverage and thereby benefit from the affordability provisions mentioned above. Further, it should be made easier for working families to be eligible for income-related tax credits.
8. Address the impact of insurer and provider concentration on nongroup market premiums by capping provider payments in those plans at Medicare rates or some multiple thereof—an approach currently used by the Medicare Advantage program. This would limit the use of market power by large provider systems and make it easier for insurers to enter new markets.
9. Use a broad-based source of revenue (e.g., assessments on all health insurance and stop-loss coverage premiums or general revenues) to permanently protect nongroup insurers from the consequences of enrolling a disproportionate share of very high-cost enrollees, as is done in Medicare Part D and Medicare Advantage.

Most of these steps have had bipartisan support in other contexts and therefore can provide a framework for a bipartisan compromise.

Introduction

As the new Congress contemplates partial repeal of the Affordable Care Act through the budget reconciliation process, they run the risk of increasing the number of uninsured Americans by approximately 30 million, crippling the private nongroup insurance market, causing nongroup insurance premiums to rise precipitously, and imposing significant added uncompensated care costs on state and local governments, hospitals, and other health care providers (Blumberg, Buettgens, and Holahan 2016; Buettgens, Blumberg, and Holahan 2017).

Moreover, as Congress works to craft a replacement plan that is based upon outlines of reform proposals,[1] they are likely to find it impossible to meet their stated goals of maintaining or broadening insurance coverage, making insurance more affordable, reducing government spending, improving quality of care, expanding consumer choice, and giving states and health care providers more flexibility and fewer regulations.[2] Difficult tradeoffs will have to be made, unpopular decisions will be required,

and complex and confusing rules and regulations—as onerous as those necessitated by the ACA—will prove unavoidable. In addition, replacement following repeal will require new sources of revenue to finance new policies because the revenue and spending baseline would change immediately, and a replacement plan will need some Democratic support. This constitutes a substantial political challenge.

Given the possibility of insurance market chaos during the period between repeal and effective replacement and the unavoidable challenges of implementing a new set of reforms, policymakers should ask whether correcting the flaws in the ACA might sufficiently address critics' major concerns. Fixing the existing structure could avert an increase in the uninsured population, a surge in health care costs, or another period of uncertainty during which stakeholders wonder if whatever is enacted will itself be overturned when the political landscape inevitably shifts.

The Case against Partial or Complete Repeal and the Challenges of Replacement

Simply repealing the financial assistance (premium tax credits and cost-sharing reductions for Marketplace insurance), Medicaid expansion, and individual mandate while leaving the insurance market reforms (e.g., essential health benefit requirements, prohibitions on pre-existing condition exclusions, modified community rating) in place—as is being considered as part of the 2017 budget reconciliation process[3]—would cause enormous disruption to individuals and insurers, and it would be fraught with political peril. Nearly 30 million people would lose coverage (Blumberg, Buettgens, and Holahan 2016). Hospitals and other health care providers would lose large amounts of revenue (Buettgens, Blumberg, and Holahan 2017). Private insurers selling coverage in the nongroup market would lose large numbers of covered lives. People who do not have access to employer coverage or public insurance would see such sharp spikes in premiums that the vast majority would not be able to afford coverage. If insurance market reforms were eventually repealed as well (this would have to be done through separate legislation, not budget reconciliation), many of those with health problems could be denied coverage outright or offered only limited benefit plans at high premiums.

State budgets would be adversely affected as the number of uninsured climbs and the demand for uncompensated care climbs with it. In addition, states have reaped savings by no longer funding services now provided through the Medicaid expansion and the Marketplaces; those savings would vanish (Dorn et al. 2015).[4] Providers would be faced with more patients unable to pay their bills (Buettgens, Blumberg, and Holahan 2017). Plus, the recent slowdown in health care spending would be put at risk because at least some of that slowdown is attributable to changes brought by the ACA (McMorrow and Holahan 2016).

Contrary to what some have claimed, the ACA has not been a high-cost program (Clemans-Cope, Holahan, and Garfield 2016). The Congressional Budget Office estimates that the tax exemption of contributions to employer-sponsored health insurance leads to about $250 billion in forgone revenue per year for the federal government (CBO 2013, 243–49). But we estimate that the cost of financial

assistance through the Marketplaces and the ACA's Medicaid expansion will cost the federal government only $109.3 billion in 2019 under current law (Blumberg, Buettgens, and Holahan 2016). Elsewhere, we estimated that national health expenditures for 2014 to 2019 will be $2.6 trillion lower than originally estimated, partly because of various provisions of the ACA (McMorrow and Holahan 2016). Together, the Marketplaces' use of relatively large deductibles and other cost-sharing requirements for middle-income enrollees and narrow provider networks combined with a significant coverage expansion via Medicaid for low-income enrollees have kept costs down (Blumberg and Holahan 2015a).

The central components of the current replacement proposals include expansion of health savings accounts (HSAs), replacement of income-related tax credits and expanded Medicaid eligibility with age-related tax credits, and sales of insurance across state lines. But these provisions are likely insufficient to provide affordable access to necessary care for low-income people—those most likely to become uninsured in the absence of the ACA. HSAs largely benefit higher-income people because the tax benefit increases with marginal income tax rates; low- and middle-income people benefit much less because of their lower tax rates, and they generally do not have the extra resources to contribute to the accounts anyway. In addition, HSAs are most beneficial to those not using much medical care. As a result, expanding them would have little effect on coverage.

Age-related tax credits available to all regardless of income would provide much smaller subsidies to modest- and lower-income people than income-related tax credits would, unless much more federal spending is provided to fund them. The smaller amount of assistance per eligible person would mean that affordable health insurance plans would have substantially higher cost-sharing requirements and narrower covered benefits, leaving those with health care needs facing higher costs and reduced access to care.[5] Plus, the smaller the amounts of assistance, the lower the levels of insurance coverage and the higher the number of uninsured.

Allowing insurers to sell coverage across state lines in an insurance environment largely unregulated by the federal government would permit insurers domiciled in unregulated states to effectively undermine laws in states with more regulation (Blumberg 2016). This could lead insurers to offer only high cost-sharing, limited-benefit policies nationwide in order to avoid adverse selection, in turn decreasing consumer choice and placing increased financial burdens on those with health care service needs.

Traditional high-risk pools are often proposed as a mechanism for insuring those with high health care needs separately from others, but past experiences with these pools have proven them to be unsuccessful in addressing the needs of most high-cost or high-risk people (Blumberg 2011; Pollitz 2016). Such pools either cover too few high-risk people because of inadequate government spending commitments (likely implemented through very strict eligibility requirements or enrollment limits) or, if they are designed to adequately cover the large high-risk population, would be prohibitively expensive.

These policy approaches would substantially increase segmentation of insurance risk pools, making insurance extremely expensive and often inaccessible for those with any significant health care risk.[6]

While these policies could decrease premiums for the young and healthy, they would increase premiums for many people, and out-of-pocket costs would increase markedly for virtually all those purchasing insurance in the nongroup market.

Approaches to Address the ACA's Problems and Opponents' Concerns

We recommend a number of policies that could both respond to the ACA's most serious problems and address many of the most significant complaints made by the law's opponents. Our policy recommendations would address issues with the individual and employer mandates; the excise tax on high-cost health plans, or "Cadillac" tax; the affordability of coverage; age rating; essential health benefits requirements; and high nongroup insurance premiums in some geographic areas. A package of reforms to the ACA could include the following approaches.

Replace the Individual Mandate Penalties

The income tax penalties associated with the individual mandate are by far the most unpopular feature of the ACA (Karpman, Blavin, and Zuckerman 2016; Kirzinger, Sugarman, and Brodie 2016). The mandate and penalties are intended to

1. maximize insurance coverage, short of instituting a fully financed government system into which the entire population is automatically enrolled; and
2. retain the currently insured and attract the healthiest uninsured individuals into coverage, such that health care risks of a diverse population can be shared broadly.

The reason the individual mandate is important for reaching the first objective is clear: more people enroll in insurance if they are required to do so or subject to a fine than would without these stipulations. The second objective is most critical for those without access to affordable employer-based insurance because without an individual mandate, insurers fear adverse selection, particularly in nongroup insurance markets. Enrollment rates in employer-based insurance are high, so adverse selection concerns are much lower in those markets. An individual mandate provides more robust enrollment in nongroup plans, which lowers premiums and ensures that the pre-existing condition prohibition and other consumer protections against health status discrimination can function without bankrupting insurers.

To replace the tax penalties, some proposals would introduce a continuous coverage provision, recognizing the need to encourage younger and healthier people to enroll in insurance and maintain coverage.[7] This requirement is actually an individual mandate but with much harsher and longer-lasting penalties that would fall very heavily on those with health problems, unstable employment, and limited income (Blumberg and Holahan 2015b). Under a continuous coverage requirement, those missing a one-time open enrollment period and those experiencing a period of uninsurance in the future could face medical underwriting without limits,[8] effectively locking many of those with health needs out of

coverage until they either gain access to employer-sponsored insurance or until they reach age 65 and become eligible for Medicare.[9] Middle- and lower-income people are more likely to have gaps in insurance coverage because of changing employment, life, and financial circumstances, and they are least likely to be able to pay for medically underwritten coverage that would have higher premiums, fewer covered benefits, higher cost-sharing requirements, or a combination of these. As a result, they are the most vulnerable to becoming uninsured and going without access to needed care long-term, under a continuous coverage requirement.

A better alternative, which would not differentially penalize those with health issues and would take the income of the uninsured person into account, would be to replace the ACA's tax penalties with a modified version of the premium surcharges used today in Medicare Part B and Part D. These premium surcharges have had bipartisan support under Medicare. Individuals who do not sign up for Part B upon becoming eligible pay a penalty of 10 percent of the regular Part B premium for each 12-month delay in enrolling, with the penalty assessed for the rest of their lives while enrolled, once they do ultimately enroll.[10] In Part D, a penalty for late enrollment is also imposed via the premium, equal to 1 percent per month that the individual is without qualified prescription drug coverage; again, this penalty is imposed for the rest of the person's life while enrolled.

Medicare imposes monthly or annual penalties that amount to small percentages of premiums per month uninsured, but they accumulate without end and apply to premiums paid by beneficiaries indefinitely. For a younger population, we suggest stronger penalties that apply once a person enrolls but are not long-lasting. Ideally, the premium surcharge would be designed to approximate the size of the current individual mandate penalties. This approach would set the level of the premium surcharge (e.g., 1.5 to 2.0 percent per month), a maximum period of time to "look back" for the duration of uninsurance (e.g., one or two years uninsured), and a maximum period of time for the surcharge to be applied (e.g., charged for a maximum of one or two years).

The objective of the surcharge should be to make the penalties strong enough to be effective in maximizing enrollment, yet not so punitive as to risk making coverage so expensive that the vast majority of individuals could not afford to obtain coverage after a long spell of uninsurance. Clearly, this is a challenging balance to strike. To ensure the penalties are smaller for lower-income people than for higher-income people, the surcharge should be imposed on the portion of the premium paid by the household, not the portion paid for by the federal government. It will also be necessary to set the premium surcharge percentage lower for family policies than for single policies, since the thresholds for income relative to poverty increase much more slowly with family size than do premiums.

Although they are far preferable to a continuous coverage requirement, premium surcharges may be less successful than the current ACA penalties in increasing enrollment among healthy people. Many would likely be unaware of the surcharges until they decided to enroll, whereas uninsured individuals experience the ACA penalty each year when filing their tax returns. Participation in Medicare Parts B and D is very high, yet those high enrollment rates are most likely due to the high subsidization of these programs (75 percent for most enrollees) or to a single qualifying event—namely, turning 65 years old. Consequently, high participation rates under a "stick" like a premium surcharge are most likely to be

achieved if implemented in combination with improved "carrots"—increased premium tax credits and cost-sharing assistance (discussed further below).

This new approach would need to be coupled with increased education and outreach efforts and increased enrollment assistance. In addition, an administrative mechanism to collect and compile information on previous insurance coverage would have to be developed.

It is critical to remember that merely increasing penalties without improving affordability would have little effect. Most individuals who remain uninsured under the ACA are exempt from the individual mandate penalties because they don't have access to qualifying coverage that is deemed affordable under the law's standard. If additional penalties are to have a significant effect on coverage levels, coverage would have to be made more affordable for more people.

Ending the Employer Mandate

An ACA component that is particularly unpopular with employers is the so-called employer mandate. This component was included in the law out of concern that employers would otherwise drop health insurance coverage, sending their workers into the private nongroup insurance market and increasing the costs of federal financial assistance provided there. As we and other researchers have shown, the ACA's employer mandate has little impact on insurance coverage, and eliminating it would not lead to significantly lower rates of employers offering insurance to their workers or lower rates of workers enrolling in that coverage (Blumberg, Holahan, and Buettgens 2013a, 2013b; Price and Saltzman 2013).

Employer coverage has remained stable under the ACA because contributions to employer-based health insurance are not taxable and because employers provide coverage and tailor benefits to their workers' preferences in order to attract the best workers, maintain employee loyalty, and reduce turnover (Blumberg et al. 2012). These incentives would remain strong without the employer mandate in place, just as they existed before the ACA. Therefore, eliminating the ACA's employer mandate could improve its popularity without sacrificing the law's coverage gains.

Replacing the Cadillac Tax

A third unpopular component of the ACA is the high-cost plan, or "Cadillac," tax. This excise tax on employer-sponsored insurance plans whose costs exceed a certain threshold was intended as a cost containment strategy, meant to discourage employers from purchasing overly generous policies that might encourage enrollees to over-use medical care. It was also intended to raise revenue to help finance the financial assistance the ACA provides to low- and middle-income populations. Critics of the tax have raised several concerns, arguing that the tax does not sufficiently allow for variation in employer health insurance costs, imposes overly tight indexing rules, and has the potential to increase cost-sharing requirements that would have adverse effects on those with health problems and modest incomes (Aaron et al. 2017).

Capping or eliminating the exclusion has been a staple of proposed health policy changes for many years and has enjoyed bipartisan support among health economists. As we have shown, a cap on the

exclusion would have the same distributional effects as the Cadillac tax in most circumstances, and the same criticisms levied against the former could be levied against the latter (Blumberg, Holahan, and Mermin 2015). But carefully designed policy strategies can address much of this criticism, and under certain circumstances, a tax cap is more progressive than the Cadillac tax. Potential fixes include pegging growth in the tax thresholds to GDP instead of CPI; adjusting thresholds based on employer size, geographic differences, and health status variability across employers; and using some of the revenue to offset high out-of-pocket spending requirements for modest-income families.[11]

Thus, the Cadillac tax could be replaced with a cap on the tax exclusion of employer contributions to health insurance, if this is indeed more politically palatable. The thresholds to which the cap would apply could be set at levels that would help finance some of the proposed reforms below. However, the lower the cap on the tax exclusion, the weaker the incentives for employers to provide work-based insurance and for workers to take it up; as a result, employer-based insurance risk pools could be disrupted.

Improving Affordability

A major criticism of the ACA—from both supporters and opponents—is the continued presence of high nongroup cost-sharing requirements (e.g., high deductibles, high out-of-pocket maximums) and high nongroup premiums for some enrollees. Addressing this would require increasing federal financial assistance to make coverage for low- and moderate-income Americans less costly. As we have written elsewhere, such assistance should include increasing both premium tax credits and cost-sharing assistance for Marketplace coverage (Blumberg and Holahan 2015a). While the ACA has made substantial strides in increasing the affordability of coverage, many people still face very steep costs to obtain insurance (Blumberg, Holahan, and Buettgens 2015).

Additional assistance should be income-related as under current law. Tax credits that vary with age but not income, which are part of several replacement plans, would either be too small to make adequate coverage affordable for middle- and low-income people or would require extraordinary increases in federal resources. Setting levels of financial assistance to make adequate coverage affordable to all, regardless of their income, requires not only affordable premiums but also affordable cost-sharing requirements (e.g., deductibles, coinsurance, copayments, out-of-pocket maximums) to ensure that people can use their insurance to effectively access medical care when they need it.

Elsewhere we have proposed a tax credit and cost-sharing assistance schedule for nongroup insurance that would reduce premiums and lower cost-sharing requirements at every level of income below 400 percent of FPL (Blumberg and Holahan 2015a). We also proposed a cap of 8.5 percent of income on benchmark insurance premiums, rather than the 9.69 percent cap set by the ACA for 2017.[12] The 8.5 percent cap would apply to all enrollees, including those with incomes above 400 percent of FPL (ACA assistance with Marketplace premiums stops at 400 percent of FPL today). Unlike the flat dollar-amount tax credits, the 8.5 percent cap for the higher-income group would not affect most of the higher-income individuals potentially eligible for it because premiums do not increase as incomes increase. However, it would provide additional protection particularly for those older adults, between 400 and 500 percent of the federal poverty level, who face the full effect of age rating under the ACA—

premiums up to three times the amount charged to a young adult—but whose income is not high and who are not eligible for financial assistance to help defray the cost. Our approach would also peg premium tax credits to the gold level (80 percent actuarial value) of insurance premiums instead of to the silver level (70 percent actuarial value) premiums used under current law, which would have the effect of reducing deductibles, coinsurance, and out-of-pocket maximums.[13]

Making Marketplace coverage more valuable and affordable would increase enrollment in nongroup markets, improve the nongroup insurance risk pools, reduce deductibles and overall financial burdens, and improve access to care for those with modest incomes.

Age Rating of Nongroup Insurance Premiums

ACA critics routinely cite age rating as a significant concern. Many insurers have complained that the ACA's 3:1 age rating bands for nongroup insurance do not reflect the true cost differences between their oldest and youngest adult customers (Blumberg, Buettgens, and Garrett 2009). The ACA's age bands were intended to make coverage more affordable for older adults, spreading a portion of their higher costs more broadly across the age distribution than was the case prior to 2014. The narrower the age bands, the more health care costs are shared across the age distribution.

We suggest that the additional health care risk of older adults be redistributed by income rather than by age. With the enhanced set of premium tax credits and cost-sharing reductions outlined above, especially the cap at 8.5 percent of income for benchmark premiums, age rating bands could be changed from 3:1 to 5:1 without making coverage unaffordable for older adults. With enhanced financial assistance in place, older nonelderly adults would have limits on their financial exposure, and loosening the age rating regulations would reduce the extent to which their health insurance costs are shared through the premiums of younger adults (Blumberg and Buettgens 2013).

Essential Health Benefits

Some critics blame high premiums on the ACA's essential health benefits requirements for nongroup insurance. Ten categories of benefits are required in all ACA-compliant nongroup insurance plans,[14] and states were provided with a number of options for defining how those requirements would be implemented (Corlette, Lucia, and Levin 2013). Some definition of required benefits is necessary to ensure that guaranteed issue of policies, prohibitions on pre-existing condition exclusions, and other strategies to eliminate insurer discrimination against the sick are meaningful. In most states, the essential health benefits benchmark plan was based on the small group insurance plan in that state with the most enrollment or the largest HMO plan, both reflecting a broadly accepted range of covered benefits. Additional benefits were added if necessary to meet federal standards.

Policymakers can re-examine the essential health benefits requirements under the law, but this is risky territory. Most of the health care claims costs associated with essential health benefits are attributable to services such as hospital inpatient and outpatient care, emergency room care, physician

and clinic services, laboratory and imaging services, and prescription drugs; these are the core of any insurance plan most Americans would consider adequate.

Cutting a benefit from the rest of the package puts the cost of that type of care wholly on those families who have a health care need for it. In many circumstances, such cuts would make obtaining that type of care unaffordable for those needing it. Eliminating a benefit eliminates the sharing of risk for that type of care. For example, men do not use maternity care and women do not use prostate care, but everyone's contributions to all types of care, regardless of individual needs, allow the costs of everyone's care to be spread over a large population (all those in the insurance pool). Cutting mental health and substance abuse disorder services from the benefit package would eliminate risk pooling for these services, and access to and use of these services would drop precipitously. Given the recent focus on mental health services as a mechanism to address gun violence and rising concerns over opioid addiction and other substance use disorders, restricting coverage for these services would contradict those expressed concerns and could require the development of a costly new government program to address these issues.

Finally, eliminating benefits for certain types of care could lead to increased costs within the set of insured benefits as well. For example, removing maternity care from the benefits package could lead to more medical complications among newborns and mothers later on. Eliminating prescription drug coverage would make it difficult for many people to treat their conditions with medications—an approach that is often substantially more cost-effective than hospitalization and other more expensive interventions.

Stabilizing Nongroup Insurance Markets

The ACA's nongroup insurance reforms, including the Marketplaces, were designed to increase the sharing of health care risk. Increasing nongroup insurance enrollment, both inside and outside the Marketplaces, could go a long way toward stabilizing the subset of markets that have experienced high premiums and reduced insurer participation. We suggest three policies (in addition to the increased financial assistance and modified individual mandate penalty structure presented earlier) that could increase nongroup enrollment significantly, with much of that enrollment among healthy new enrollees (Blumberg and Holahan 2017). In addition, we provide two policy strategies that would address the sources of high premiums and low insurer participation in some nongroup insurance markets.

MEASURES TO INCREASE ENROLLMENT

Three strategies that would increase enrollment in the nongroup Marketplaces are (1) increased funding for education, outreach, and enrollment assistance; (2) fixing the so-called family glitch; and (3) allowing Medicaid expansion up to 100 percent of FPL, instead of requiring it up to 138 percent of FPL. Additional federal funds are needed for education, outreach, and enrollment assistance to increase awareness of coverage options, available financial assistance, and premium surcharges for late enrollment, and to make it easier for individuals to sign up for coverage. This is essential and not expensive.

The "family glitch" denies Marketplace financial assistance to families facing high-cost employer insurance when one family member has access to affordable worker-only (but not necessarily family) coverage. This inequity, which results from a regulatory interpretation of the law, should be eliminated. Doing so would substantially improve the affordability of coverage for significant numbers of low- and moderate-income families and would create a strong incentive for these generally healthy families to enroll in nongroup Marketplace insurance plans, boosting overall enrollment in the nongroup insurance market (Blumberg and Holahan 2015a; Buettgens, Dubay, and Kenney 2016).

Allowing states to receive the ACA's enhanced federal matching rate if they expand Medicaid eligibility up to 100 percent of FPL, instead of 138 percent as required by current law, would likely encourage some of the states that have not yet chosen to do so to expand Medicaid. This is critical to making adequate coverage affordable for this very low-income population. In addition, if states that have already expanded Medicaid move their eligibility rules down from 138 to 100 percent of FPL, nongroup enrollment would increase in those states. The proposed increase in premium and cost-sharing assistance (discussed above) would apply to those moving from Medicaid into private coverage. Most of this increased nongroup market enrollment should come from relatively healthy people, and they would be likely to improve the nongroup market risk pool once enrolled.[15]

REDUCING PREMIUMS

Two additional policy strategies would address other sources of high premiums in some nongroup insurance markets: (1) limits on provider payment rates paid by nongroup insurers and (2) government funding for high-risk people, allowing them to be fully integrated into the array of private insurance plans offered through the nongroup market (Blumberg and Holahan 2017). First, many nongroup insurance markets (both inside and outside Marketplaces) have significant insurer and/or provider concentration. This problem existed before the ACA and would persist even if the ACA was repealed. Consolidation of providers and insurers drives insurance premiums upward because insurers have little incentive to operate efficiently in the case of insurer concentration or, in the case of provider consolidation, because insurers have little to no leverage to negotiate payment rates with providers (Roberts, Chernew, and McWilliams 2017).

The most realistic proposal for addressing both types of concentration is to rely upon the precedent set by Medicare Advantage, a program for which there has been bipartisan support (Blumberg and Holahan 2017). This approach would place a cap on provider payment rates for nongroup insurers and their enrollees. The payment caps could be set at Medicare levels or some percentage above Medicare levels, or they could use some other metric. The cap would apply to in- and out-of-network services. Insurers could negotiate with providers for payment rates lower than the cap, but they would not pay more than the cap. Some providers may choose not to participate, even at rates significantly above Medicare payment levels, but most likely would participate because participation at Medicare rates is high and because the nongroup market represents a small share of the population. This approach would allow more insurers to enter markets where few insurers currently participate. Some insurers currently cannot participate in markets they want to enter because they cannot negotiate competitive payment

rates with providers there; with a payment rate cap, they would be able to enter new markets and pay lower payment rates to local providers than they could have negotiated on their own.

Second, renewed attention must be paid to the importance of additional sharing of health care risks for those purchasing coverage as individuals. Not all ACA-compliant nongroup insurance markets are enrolling a disproportionately high-cost population of enrollees, compared with the employer-sponsored insurance market, but some are (Blumberg, Holahan, and Wengle 2016). The three-year limit on the reinsurance program included in the ACA was insufficient for some markets, particularly those with low enrollment. Thus, implementing a mechanism for adjusting risk between the nongroup insurance market and the broader population (either the employer-sponsored insurance market or the larger taxpayer population) would correct for long-term differences in health care risk that may persist in some areas. The approach should be designed to redistribute funds to the nongroup market from the much larger employer-based insurance markets or from general revenues, when that nongroup market is experiencing significant adverse selection. In essence, this would be akin to raising high-risk pool revenues from a large population base that would be distributed to nongroup insurers enrolling a disproportionate share of high-cost individuals. Another way to think about the approach is as a risk adjustment mechanism between nongroup insurers and employer insurers or between nongroup insurers and the population at large.

Medicare Advantage and Medicare Part D offer precedents for permanent programs like this. For example, some percentage of each claim against a nongroup insurer exceeding $1,000,000 could be reimbursed from general revenues or from a broad-based dedicated revenue source beyond nongroup insurance enrollees and their insurers (e.g., all those with employer-based or nongroup insurance). Extremely high claims can be devastating for an insurer, and risk adjustment within the nongroup market alone cannot sufficiently limit exposure if the incidence of such large claims is higher than in the wider population. Such a broadly financed program would reduce risk for insurers, making it more attractive for them to participate in and out of the Marketplaces, lowering premiums, and increasing the markets' stability year to year.

Conclusion

Congress is seriously considering repeal of the coverage and tax provisions of the ACA, with the expectation that replace legislation will follow. This will not be a straightforward process. If the ACA is partially repealed, there will be a new spending and revenue baseline. The replace proposal will need bipartisan agreement on the design, and it will need new sources of revenue. The Congressional Budget Office (and others) will weigh in on coverage and cost impacts. Developing a plan that could garner the support needed in the House of Representatives and the Senate will be challenging.

With this in mind, we have delineated a package of health care reforms that could short-circuit this process. The proposals outlined here, many of which have had broad bipartisan support in other contexts, would address many of the problems raised by ACA critics and acknowledged by ACA supporters. Pursuing these policies would permit the new administration and Congress to put its own

stamp on health care reform while avoiding the consequences of repeal, which include increasing the number of uninsured by approximately 30 million people (Blumberg, Buettgens, and Holahan 2016), creating adverse financial impacts for hospitals and other providers, leading to turmoil in the insurance industry, and negatively impacting state and local budgets. If a new framework like this is agreed upon and enacted through legislation with bipartisan support, robust implementation efforts must follow in order for it to succeed.

Notes

1. "A Better Way to Fix Health Care: Snapshot," Office of the Speaker of the House, June 22, 2016, http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-Snapshot.pdf; and "Empowering Patients First Act: Section-by-Section Overview," Office of Congressman Tom Price, May 13, 2016, http://tomprice.house.gov/sites/tomprice.house.gov/files/Section%20by%20Section%20of%20HR%202300%20Empowering%20Patients%20First%20Act%202015.pdf.

2. Joseph Antos and James Capretta, "The Problems with 'Repeal and Delay,'" *Health Affairs Blog*, January 3, 2017, http://healthaffairs.org/blog/2017/01/03/the-problems-with-repeal-and-delay/; and Ezra Klein, "There Is No 'Terrific' Replacement for Obamacare," *Vox*, January 9, 2017, http://www.vox.com/policy-and-politics/2017/1/9/14206052/obamacare-replacement-mcconnell-trump.

3. Steven T. Dennis and Billy House, "GOP Eyes Lightning Strike on Obamacare to Kick Off Trump Era," *Bloomberg*, November 29, 2016, https://www.bloomberg.com/politics/articles/2016-11-29/gop-eyes-lightning-strike-on-obamacare-to-kick-off-trump-era; and Lisa Mascaro, "Repeal and Replace Obamacare? It Won't Happen on Trump's First Day, GOP Leader Says," *Los Angeles Times*, November 29, 2016, http://www.latimes.com/nation/politics/trailguide/la-na-trailguide-updates-1480442605-htmlstory.html.

4. See Brian Fanney, Michael R. Wickline, and Spencer Willems, "Arkansas House Speaker Details Cuts If Medicaid Plan Fails," *ArkansasOnline*, April 12, 2016, http://www.arkansasonline.com/news/2016/apr/12/plan-wields-ax-to-anticipate-a-medicaid/; and David Ramsey, "Using Novel Line-Item Veto, Ark. Governor Extends Medicaid Expansion," *Kaiser Health News*, April 21, 2016, http://khn.org/news/using-novel-line-item-veto-ark-governor-extends-medicaid-expansion/. Medicaid expansion in Arkansas was extended on April 21, 2016.

5. In addition, current proposals would offer larger tax credits to older adults, but none would provide tax credits large enough to compensate for the higher premiums older adults would face if 3:1 age rating limits were replaced with 5:1 or 6:1 limits—another change from the ACA envisioned under these approaches. Consequently, affordability of coverage and, ultimately, access to medical care would be increasingly compromised with age. Age rating bands limit the extent to which insurers can vary premiums with age. For example, 3:1 age bands under the ACA prohibit nongroup and fully insured small group insurers from charging premiums for 64-year-olds that are more than three times the premium charged for the youngest adult for the same plan.

6. Linda Blumberg and John Holahan, "Don't Let the Talking Points Fool You: It's All about the Risk Pool," *Health Affairs Blog*, March 15, 2016, http://healthaffairs.org/blog/2016/03/15/dont-let-the-talking-points-fool-you-its-all-about-the-risk-pool/.

7. "A Better Way: Health Care," Office of the Speaker of the House, June 22, 2016, http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf; and "Patient Choice, Affordability, Responsibility, and Empowerment Act," US House Committee on Energy and Commerce, February 5, 2015, https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf.

8. Much depends upon how the rule would ultimately be drafted; no specifics have yet been provided in any of the public proposals. Still, it is hard to see how a time limit on this type of requirement could be implemented. If the person seeks coverage after a period of uninsurance and is denied or charged a premium that they cannot afford, they would remain uninsured. When would a "time clock" on such a requirement begin, and when would

it end? Would it start at the beginning of a spell of uninsurance? When someone shopped for insurance and found it unavailable or unaffordable? How would that be documented? Would it end after a defined period of uninsurance? Could that time be differentiated in terms of whether the individual sought coverage and was refused, could not afford to enroll at higher rates, or simply remained uninsured without shopping? Limits could be imposed on how much more someone could be charged relative to "standard" rates, but there has been no mention of such limits in the proposals released. Even if limits were put in place, the coverage would likely remain unaffordable for most of those who would be charged the higher premium, so the limit may not provide any practical protection compared with a no-limit scenario.

9. Medical underwriting is prohibited in the nongroup and fully insured small group insurance markets under the ACA. Underwriting is the process that insurers undertake to assess the health care risk of potential enrollees, and that information was used to determine whether coverage was to be offered at all in the nongroup market (federal law prohibited coverage denials in the small group market beginning in 1996), the premium to be charged if coverage was offered to an applicant, and the benefit and cost-sharing packages offered to applicants (in states that permitted such differentiation based on health risk).

10. "Part B Late Enrollment Penalty," Centers for Medicare and Medicaid Services, https://www.medicare.gov/your-medicare-costs/part-b-costs/penalty/part-b-late-enrollment-penalty.html; and "Part D Late Enrollment Penalty," Centers for Medicare and Medicaid Services, https://www.medicare.gov/part-d/costs/penalty/part-d-late-enrollment-penalty.html. Special enrollment periods are available for those not taking Part B due to enrollment in a group health insurance plan. No penalty is assessed for those enrolling late under these provisions.

11. Aaron and colleagues (2017) provide a detailed discussion of policy approaches to address the criticisms of the Cadillac tax or a cap on the employer-based insurance tax exclusion.

12. The benchmark, or second-lowest-cost silver premium offered in the enrollee's rating region, is used to determine the amount of premium tax credit for which an applicant is eligible under the ACA. The percent-of-income caps used to determine premium tax credit amounts increase somewhat for every year that health care costs grow faster than general inflation. In addition to proposing lower percent-of-income caps to improve affordability, we suggest eliminating the indexing of the caps.

13. Under current law, individuals choosing the second-lowest-cost silver Marketplace plan available in their area cannot be charged a premium that exceeds the percent-of-income cap applicable for the applicant's income level. If the individual picks a more expensive option, they must pay the full difference in cost; if they choose a less expensive option, they will get the savings. If the premium tax credits were instead tied to the second-lowest-cost *gold* plan available in the area, individuals could much more easily afford higher actuarial value coverage, with lower deductibles, coinsurance, copayments, and out-of-pocket maximums.

14. "What Marketplace Health Insurance Plans Cover," Centers for Medicare and Medicaid Services, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/.

15. Under current law, Medicaid-eligible people can enroll in the program even if their employer offers insurance deemed affordable to them; however, Marketplace tax credit–eligible individuals are prohibited from getting financial assistance if their employer offers them affordable coverage. In states that move eligibility to 100 percent of FPL, the law should allow those with incomes between 100 and 138 percent of FPL access to Marketplace premium tax credits and cost-sharing assistance, even if they have an employer offer of insurance. The enhanced premium tax credit and cost-sharing assistance schedules we propose would reduce the negative financial impact of a transition from Medicaid to Marketplace coverage for people in states that had already expanded to 138 percent of FPL and made a decision to change their Medicaid eligibility threshold to 100 percent of FPL.

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