

CBO

Policies to Achieve Near-Universal Health Insurance Coverage



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At a Glance

In this report, the Congressional Budget Office examines policy approaches that could achieve near-universal health insurance coverage using some form of automatic coverage through a default plan. As defined by CBO, a proposal would achieve near-universal coverage if close to 99 percent of citizens and noncitizens who are lawfully present in this country were insured either by enrolling in a comprehensive major medical plan or government program or by receiving automatic coverage through a default plan.

Components of Proposals That Would Achieve Near-Universal Coverage

Policy approaches that achieved near-universal coverage would have two primary features:

- At a minimum, if they required premiums, those premiums would be subsidized for low- and moderate-income people, and
- They would include a mandatory component that would not allow people to forgo coverage or that would provide such coverage automatically.

The mandatory component could take the form of a large and strongly enforced individual mandate penalty—which would induce people to enroll in a plan on their own by penalizing them if they did not—or a default plan that would provide automatic coverage for people who did not purchase a health insurance plan on their own during periods in which they did not have an alternative source of insurance. Because lawmakers recently eliminated the individual mandate penalty that was established by the Affordable Care Act, this report focuses on approaches that could achieve near-universal coverage by using premium subsidies and different forms of automatic coverage through a default plan.

Policy Approaches

CBO organized existing proposals into four general approaches, ranging from one that would retain existing sources of coverage to one that would almost entirely replace the current system with a government-run program. All four approaches would provide automatic coverage to people who did not enroll in a plan on their own.

- Two approaches would fully subsidize coverage for lower-income people and partially subsidize coverage for middle-income and some higher-income people while retaining employment-based coverage. Financing would come, in part, from broad-based tax revenues that were not linked to health insurance coverage. Financing also would come from higher taxes on those uninsured people who were covered by the default plan and whose premiums were not fully subsidized; those taxes would be equivalent to their share of the premium. Collecting such taxes from uninsured people would pose challenges.
- Two approaches would fully subsidize coverage for people at all income levels. Financing would come entirely from broad-based tax revenues, and people who did not enroll in a health insurance plan would not owe additional taxes.

Under some approaches, the default plan would be privately managed. Under others, it would be a public plan, operated by the federal government.

The approaches that CBO examined would require varying amounts of government spending to cover the same number of people. They would all require additional federal receipts to achieve deficit neutrality.



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As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148), the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and the effects of subsequent judicial decisions, statutory changes, and administrative actions.



Policies to Achieve Near-Universal Health Insurance Coverage

Summary

In this report, the Congressional Budget Office examines policy approaches that could achieve near-universal health insurance coverage. Such approaches would provide nearly all people in the United States with financial protection against high-cost medical events, increase overall access to health care, and decrease the costs that providers incur when they provide medical services to uninsured people. The approaches also would increase federal subsidies for health care.

As defined by CBO, a proposal would achieve near-universal coverage if close to 99 percent of citizens and noncitizens who are lawfully present in this country were insured either by enrolling in comprehensive major medical coverage or by receiving automatic coverage through a default plan. Attaining such coverage would be challenging, however. CBO is not aware of any existing proposals—legislative or otherwise—that would achieve complete (that is, 100 percent) universal coverage because they all would require some demonstration of eligibility (such as meeting criteria related to citizenship or residency) that some eligible people would not comply with for various reasons.

Essential Components of Near-Universal Health Insurance Coverage and an Overview of the Approaches That CBO Analyzed

In CBO's view, to attain near-universal coverage, a policy would need to provide premium subsidies for low- and moderate-income people and include a mandatory component that would not allow people to forgo coverage. Subsidizing premiums for low- and moderate-income people would be essential because paying the full cost of comprehensive major medical coverage out of pocket would typically be prohibitive. A mandatory component would be essential because some people would still choose not to purchase insurance even if they had the means to do so. The mandatory component could take

the form of a requirement that people purchase health insurance (sometimes known as an individual mandate), which would be strongly enforced with a large penalty, or it could provide automatic coverage through a default plan for people who did not purchase a health insurance plan of their choice.

Because the Congress recently eliminated the individual mandate penalty that was established by the Affordable Care Act (ACA), CBO did not focus on approaches that would achieve near-universal coverage using such a mandate. Instead, CBO focused on approaches that would attain near-universal coverage by using premium subsidies and different forms of automatic coverage through a default plan. (CBO uses the term “default plan” to describe a plan that would provide automatic coverage to people during periods in which they did not have an alternative source of insurance; eligible people could use it to receive medical care at any time.)

Under an individual mandate, a penalty is levied on people who do not enroll in a plan. Although those people are required to make a payment, they do not have any coverage. If the penalty was large and strongly enforced, then nearly all people would choose to purchase insurance rather than pay the penalty. By contrast, with automatic coverage through a default plan, the government provides or procures insurance for people who do not purchase it on their own and finances the cost of that coverage through the tax system. Financing could come entirely from broad-based revenues if the default plan was fully subsidized, or it could come, in part, from premium-equivalent tax payments levied on people who did not purchase a plan on their own.

In this report, CBO describes the key features—specifically, the enrollment process, premiums, cost sharing and benefits, and the role of private insurance, public programs, and employment-based insurance—of four

general approaches that could achieve near-universal coverage by using premium subsidies and different forms of automatic coverage through a default plan. Those approaches are as follows:

- **Approach 1.** A multipayer system that retains existing sources of coverage while expanding eligibility for premium subsidies and providing partially subsidized default coverage through a private plan or a new public option.¹
- **Approach 2.** A multipayer system that retains employment-based coverage and replaces the current nongroup market and the acute care portions of Medicaid and the Children’s Health Insurance Program (CHIP) with a new public program that allows people to choose between partially subsidized private plans and a publicly administered plan that provides default coverage.
- **Approach 3.** A multipayer system that provides full subsidies for all people to purchase a private plan of their choice, with a default plan that provides automatic coverage to people who do not enroll in a plan on their own.
- **Approach 4.** A single-payer system that acts as a default plan for all people.

Those four general approaches encompass all of the detailed proposals that CBO has identified as potentially achieving near-universal coverage without the use of a large and strongly enforced individual mandate penalty. Although the four approaches described in this report have the potential to achieve near-universal coverage, CBO has not analyzed specific proposals in detail.

This report focuses on people under the age of 65; the Medicare program could continue to provide coverage to people age 65 or older under all of the approaches except for the one that would adopt a single-payer system. The report does not discuss effects on national health expenditures (NHE), which might increase or decrease under different approaches depending on the details of the proposal. Approaches that lowered out-of-pocket costs would increase NHE by encouraging greater use of health care, but that increase could be offset by other features, such as lower provider prices, that would result in lower NHE.

1. A multipayer health care system is one in which more than one insurer provides health insurance coverage.

The approaches CBO examined would require varying amounts of government spending to cover the same number of people, but they would all require at least some additional federal receipts to achieve deficit neutrality. Whether the adopted approach is deficit-neutral is a choice that policymakers would need to make. Much of the new federal costs would stem from the additional tax credits or other subsidies that would be made available to people. Some of those subsidies would reduce or eliminate the out-of-pocket premiums of people who would have been uninsured under the current system, and some would go to people who would have had coverage anyway under the current system. Reallocating existing federal subsidies for health care (such as uncompensated care payments and grants to community health centers) and for other sources of coverage (such as the tax exclusion for employment-based coverage) would not be sufficient to entirely finance the additional federal costs that would be incurred under the four approaches. A complete discussion of how the subsidies for coverage expansions would be financed is outside the scope of the report.

How Subsidies Would Affect Default Coverage Under Different Approaches

All four of the approaches described in this report would provide automatic coverage through a default plan, but the role of default coverage would vary under each of the approaches. Specifically:

- The first two approaches would fully subsidize default coverage for lower-income people and partially subsidize coverage for middle-income and some higher-income people. Under those approaches, the government would collect premium-equivalent tax payments from middle- and higher-income people who did not have an alternative source of insurance. Levying taxes on those people would be the equivalent of charging mandatory premiums for the default plan. To maintain incentives to enroll in other sources of coverage, the amount of the tax associated with default coverage would be made equivalent to the net premium the person would pay to actively enroll in a plan that provided similar benefits.
- The last two approaches would fully subsidize default coverage for people at all income levels, and no premium-equivalent tax payments would be collected. Those approaches could be financed through broad-based tax revenues that are not linked to people’s health insurance coverage.

Challenges Associated With Implementing Automatic Coverage Through a Default Plan

Providing automatic coverage through a default plan to achieve near-universal coverage would present several challenges, particularly if the plan was only partially subsidized. Additional challenges would arise if the default plan was part of a risk-adjustment system that shared the cost of insuring a group of enrollees across all plans, as the current nongroup market does. (The nongroup market is a private health insurance market that enables individuals and families who are not eligible for coverage through public programs or who do not have employment-based insurance to purchase a private health insurance policy.) There also would be challenges associated with informing people about their eligibility for default coverage and its associated benefits, particularly the plan's provider network.

Collecting premium-equivalent tax payments when default coverage was partially subsidized would require verifying the coverage status of all tax filers, which would be administratively complex. Although uninsured people would gain coverage through a default plan, many people might be surprised by the new premium-equivalent tax that would be required to finance their coverage if taxes were collected many months after the period during which they were uninsured (unlike a premium, which is collected at the time a person enrolls in health insurance). That tax obligation could total thousands or even tens of thousands of dollars, particularly for the highest-income families who would not qualify for any subsidies.

Additional complexities would arise if the default plan shared the cost of insuring more or less costly people with other plans through the same risk-adjustment system. Determining the appropriate risk-adjustment payments to plans (which adjust their premiums for the cost of their enrollees) would be challenging because it would require the government to determine the number of people covered by the default plan and the cost to insure them relative to the cost of people covered by other plans in the risk-adjustment system.

The government also would need to inform people about their eligibility for default coverage and the benefits associated with that coverage. An outreach campaign could educate people about their eligibility for the default plan and its associated benefits, but it would be difficult to fully inform all people. If some providers did not participate in the default plan's network, informing people

about which providers did participate would present particular challenges. Some people might seek care without knowing whether a provider participated in the default plan's network and might be unexpectedly billed large amounts for their care if they received treatment from a nonparticipating provider.

Policy Approaches That Could Achieve Near-Universal Coverage by Using a Default Plan

CBO analyzed four approaches that have the potential to achieve near-universal coverage by using both premium subsidies and a form of default coverage. Each approach involves a general strategy for covering all people in a defined population, and the approaches have multiple variants and design choices, such as how much to subsidize premiums and the degree of cost sharing. (For a summary of approaches to achieve near-universal health insurance coverage through a default plan, see Table 1. For key features of approaches to achieve near-universal health insurance coverage through a default plan as compared with current law, see Table 2.)

Each successive approach would require more significant changes to the current system and, in general, would be more costly to the federal government. Approaches that involved more incremental changes to the current system—specifically, Approaches 1 and 2—would entail fewer transition costs and changes to existing sources of coverage, but they would impose new tax obligations on some people who did not enroll in a plan, and the resulting system would be more complex than under the other approaches. Approaches that involved more significant changes to the current system—Approaches 3 and 4—would require larger transition costs and changes to sources of coverage, but enrolling people in coverage would be simpler once those initial adjustments took place and transition costs were incurred. Those more significant changes would allow individuals with the same income and similar family characteristics to receive similar subsidies for health insurance. They also would reduce the extent to which subsidies, namely the tax preferences for employment-based health insurance, increased as income increased, or eliminate the subsidies altogether.

The approaches that CBO analyzed are as follows:

Approach 1: Partially Subsidized Default Coverage That Operates in Tandem With Current Sources of Coverage. This approach would use partially subsidized default coverage to cover all people in a defined population who did

Table 1.

Summary of Approaches to Achieve Near-Universal Health Insurance Coverage Through a Default Plan

Approach	Summary	Variants	Examples
Approach 1: Partially Subsidized Default Coverage That Operates in Tandem With Current Sources of Coverage	This approach would provide partially subsidized default coverage through a private or public plan to cover people who did not actively enroll in an alternative source of coverage and were not eligible for Medicaid or CHIP. Most key features of the ACA would remain in place, but premium subsidies would be extended to those whose income was less than 100 percent of the FPL and potentially made more generous for middle- and higher-income households. In addition, the employer firewall would be removed. ^a	Private default plan Public option as default plan	Fiedler and others (2019) ^b Blumberg and others (2019a) ^c
Approach 2: Partially Subsidized Default Coverage Through a Large Public Program That Replaces Medicaid, CHIP, and the Nongroup Market and Retains Employment-based Coverage	A new public program consisting of a publicly administered plan and several private-plan options would replace the existing nongroup market and Medicaid and CHIP acute care coverage. ^d Large employers would be required to offer coverage or make mandatory contributions to the public program, and employees could choose to receive coverage either through their employer or through the public program. Premium and cost-sharing reductions would remain income-based and would become more generous. The public plan would provide partially subsidized default coverage for those without an alternative source of coverage.	n.a.	Medicare for America Act of 2019 (H.R. 2452); Center for American Progress (2019) ^e Blumberg and others (2019b) ^f
Approach 3: Premium Subsidies for All People and Default Coverage Through a Fully Subsidized Plan	All households would receive a subsidy generous enough to cover the entire cost of a specified benchmark plan in a marketplace of private plans, potentially including a public option. Low- and middle-income households would receive cost-sharing reductions, and supplemental coverage that reduced cost sharing or provided additional benefits could be obtained through employers. A benchmark zero-premium plan would provide fully subsidized default coverage for those without an alternative source of coverage.	Subsidy covers catastrophic plan Subsidy covers generous plan	Dolan (2019); Goldman and Hagopian (2012) ^g Halvorson and Oz (2020); Joyce (2019); Janda and Ho (2019); Wynne (2017) ^h
Approach 4: A Single-Payer System	All eligible individuals would be enrolled in a single public plan, typically with no role for private coverage, and no premiums would be collected. Cost sharing could be income-based or, as in existing legislative proposals, zero for all individuals.	n.a.	Medicare for All Act of 2019 (H.R. 1384); Medicare for All Act of 2019 (S. 1129)

Source: Congressional Budget Office.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; FPL = federal poverty level; H.R. = House of Representatives; S. = Senate; n.a. = not applicable.

- a. Under current law, people with an affordable offer of employment-based coverage are ineligible for premium subsidies in the health insurance marketplaces because of a provision of the Affordable Care Act known as the employer firewall. In 2020, an offer of affordable employment-based coverage is defined by the Internal Revenue Service as one in which an employee's out-of-pocket premium is less than 9.78 percent of household income for a single plan. For more details about the employer firewall, see Box 1 on page 22.
- b. Rather than extending eligibility for marketplace subsidies to those whose income is below 100 percent of the FPL, the proposal includes features that would provide incentives for states that have not expanded Medicaid under the terms of the ACA to do so. See Matthew Fiedler and others, "Building on the ACA to Achieve Universal Coverage," *New England Journal of Medicine*, vol. 380, no. 18 (May 2019), pp. 1685–1688, <http://doi.org/10.1056/NEJMp1901532>.
- c. The proposal also would increase the generosity of marketplace subsidies and establish a federal reinsurance program for the nongroup market. See "Simulated Reform Packages: Reform 5," in Linda J. Blumberg and others, *From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs* (Urban Institute, October 2019a), p. 6, <https://tinyurl.com/yy9atuf7> (PDF, 1.05 MB).
- d. The nongroup market is a private health insurance market that enables individuals and families who are not eligible for coverage through public programs or who do not have employment-based insurance to purchase a private health insurance plan.
- e. See Medicare for America Act of 2019, H.R. 2452, 116th Cong. For related information, see Center for American Progress Health Policy Team, *Medicare Extra: Universal Coverage for Less Than \$3 Trillion and Lower Health Care Costs for All* (July 2019), <https://tinyurl.com/yyx9f55d> (PDF, 1.18 MB).
- f. The proposal does not require large employers to offer coverage or make mandatory contributions. See "Description of Policy Options: The Building Blocks of Healthy America," Variant 3: "HA With CARE," in Linda J. Blumberg and others, *The Healthy America Program, An Update and Additional Options* (Urban Institute, September 2019b), p. 3, <https://tinyurl.com/y3x3zyrs> (PDF, 533 KB).
- g. See Ed Dolan, *Universal Catastrophic Coverage: Principles for Bipartisan Health Care Reform* (Niskanen Center, June 2019), <https://tinyurl.com/y4jkfzco> (PDF, 969 KB). See also Dana Goldman and Kip Hagopian, "The Health-Insurance Solution," *National Affairs* (Fall 2012), <https://tinyurl.com/y3es67tp>.
- h. See George Halvorson and Mehmet Oz, "Medicare Advantage for All Can Save Our Health-Care System," *Forbes* (June 11, 2020), <https://tinyurl.com/yyjvw8j2>; Geoffrey Joyce, "Opinion: The Success of Medicare Advantage Makes It a Better Policy Choice Than 'Medicare for All,'" *MarketWatch* (November 21, 2019), <https://tinyurl.com/y42cj4zi>; Ken Janda and Vivian Ho, "Medicare Advantage for All," *The Hill* (August 27, 2019), <https://tinyurl.com/y6avusv8>; and Billy Wynne, "The Bipartisan 'Single Payer' Solution: Medicare Advantage Premium Support for All," *Health Affairs Blog* (May 11, 2017), <https://tinyurl.com/y6xba4hx>.

Table 2.

Key Features of Approaches to Achieve Near-Universal Health Insurance Coverage Through a Default Plan Compared With the System in Effect Under Current Law

Key Feature	Current Law	Approach 1: Establishes Partially Subsidized Default Coverage ^a	Approach 2: Establishes a Large Public Program ^b	Approach 3: Provides Premium Subsidies for All People ^c	Approach 4: Establishes a Single-Payer System
Premiums					
All eligible individuals have the option of zero-premium primary coverage	No	No	No	Yes	Yes
Premium subsidies are more generous for lower-income people than for higher-income people	Yes	Yes	Yes	n.a.	n.a.
All eligible individuals with income below the federal poverty level have subsidized coverage	No	Yes	Yes	Yes	Yes
Cost Sharing					
Cost-sharing reductions are more generous for lower-income people than for higher-income people	Yes	Yes	Yes	Yes	Maybe
Role of Private Plans					
All eligible individuals have the option of a private plan	Yes	Yes	Yes	Yes	No
Role of Employment-Based Coverage					
Individuals with an offer of affordable employment-based coverage are eligible for premium subsidies and cost-sharing reductions (the “employer firewall” is eliminated) ^d	No	Yes	Yes	Yes	n.a.
Employers are a large source of primary coverage	Yes	Yes	Maybe	No	No
Employment-based coverage is eliminated	No	No	No	No ^e	Yes
Role of Public Coverage					
Medicare is preserved for people over the age of 65	Yes	Yes	Yes	Yes	No
Medicaid and CHIP are preserved for acute care	Yes	Yes	No	No	No
All eligible individuals have the option of enrolling in a public plan	No	Maybe	Yes	Maybe	Yes
All eligible individuals are required to enroll in a public plan	No	No	No	No	Yes

Source: Congressional Budget Office.

CHIP = Children’s Health Insurance Program; n.a. = not applicable.

- Approach 1 could be implemented through a variant that introduced a new public option as a source of coverage that also would provide default coverage for otherwise uninsured people who did not actively enroll in another source of coverage. The new public option could be in the form of a public plan offered through existing health insurance marketplaces established by the Affordable Care Act.
- The new public program would allow people to choose between a publicly administered plan and multiple private plans meeting the same minimum requirements for cost sharing and covered benefits in a health insurance marketplace. Under some existing proposals, the new program also would replace the current Medicare program.
- The new system would allow people to use a premium subsidy to choose among multiple private plans in a marketplace. Variations of this approach also could include a publicly administered plan option alongside the private plans. The new premium support system could exist alongside the current Medicare program, or it could be combined with the current Medicare program.
- Under current law, people with an affordable offer of employment-based coverage are ineligible for premium subsidies in the health insurance marketplaces because of a provision of the Affordable Care Act known as the employer firewall. In 2020, an offer of affordable employment-based coverage is defined by the Internal Revenue Service as one in which an employee’s out-of-pocket premium is less than 9.78 percent of household income for a single plan. For more details about the employer firewall, see Box 1 on page 22.
- The only type of employment-based coverage that would remain under this approach would be for supplemental coverage that could be used to reduce cost-sharing amounts, or it could be used to offer benefits that are not available through marketplace plans, such as dental and vision services.

not otherwise enroll in a health insurance plan. Default coverage would be provided by a private or public plan for people who are ineligible for Medicaid and CHIP; it would be provided by Medicaid and CHIP to individuals who are currently eligible for but not enrolled in those programs. Existing sources of coverage—including Medicaid, CHIP, employment-based insurance, and nongroup insurance—and subsidies to purchase health insurance would remain in place.

This approach would remove the “employer firewall” provision of the ACA, thus making people with an offer of affordable employment-based coverage eligible for premium subsidies—including partially subsidized default coverage.² Most of the other features of the ACA, such as income-related premium subsidies and insurance market regulations, would remain in place. This approach also would extend full premium subsidies to people whose income was below 100 percent of the federal poverty guidelines (commonly referred to as the federal poverty level, or FPL), as well as to people whose income fell below the tax-filing threshold.³ This approach also could increase the generosity of subsidies for other households.

Under variants of this approach, default coverage could be provided by a private plan or through a new public option offered through the marketplaces. If default coverage was provided through a new public option, that public plan also would be available to all people who chose to actively enroll during an open-enrollment period. People who were otherwise uninsured and not eligible for full subsidies would be assessed a premium-equivalent tax to finance their default coverage. The amount of that tax would be the same as the premium

the uninsured person would pay to enroll in a benchmark plan in the nongroup market that provided equivalent benefits, after applying any premium tax credits for which he or she was eligible. That would preserve incentives for people to actively enroll in other plans, such as subsidized nongroup plans and employment-based plans that they might prefer because of those plans’ more generous benefits or broader provider networks.

Compared with the other approaches CBO analyzed, this approach would represent the most incremental change because most features of the current system, other than the employer firewall, would remain in place. The transition to the system outlined in this approach would lead to some changes in sources of coverage. Removing the employer firewall without imposing additional penalties or requirements on employers to offer generous coverage probably would lead some low-income people who currently receive employment-based coverage to switch to subsidized coverage through the nongroup market if they had the option of paying a lower premium. In addition, some employers might discontinue offering coverage, leaving their employees to enroll in the nongroup market. People who are uninsured under current law would gain coverage, primarily through the partially subsidized nongroup market or the default plan.

Although this approach demonstrates that attaining near-universal coverage while retaining existing sources of coverage is possible, providing default coverage would be significantly more challenging to implement than under other approaches that simplified coverage options and subsidized premiums to a greater degree. Identifying the people who were covered by the new default plan would be particularly complex under this approach because the government would need to verify the coverage status of all eligible people and determine whether they were eligible for Medicaid or CHIP, which would be administratively complex.

Approach 2: Partially Subsidized Default Coverage Through a Large Public Program That Replaces Medicaid, CHIP, and the Nongroup Market and Retains Employment-Based Coverage. This approach would establish a new public program consisting of a publicly administered plan and several privately administered plan options to replace the current nongroup market and the portions of Medicaid and CHIP that cover medical services and prescription drugs. However, many people would continue to enroll in employment-based insurance

2. Under current law, people with an affordable offer of employment-based coverage are ineligible for premium subsidies in the health insurance marketplaces because of a provision of the ACA known as the employer firewall. In 2020, an offer of affordable employment-based health insurance is defined by the Internal Revenue Service as one in which an employee’s out-of-pocket premium is less than 9.78 percent of household income for a single plan.
3. Eligibility for premium tax credits in coverage year 2019 was based on poverty guidelines for 2018. In 2018, the FPL was \$12,140 for a single person, and that amount increased by \$4,320 for each additional person in a household. People with income below a certain level, known as the tax-filing threshold, are not required to file federal income tax returns. In 2019, the tax-filing threshold for single adults under the age of 65 was \$12,200, which was just over the eligibility threshold for premium tax credits.

if those plans had lower out-of-pocket premiums, more-generous benefits, or broader provider networks than the plans offered through the public program.

All low-income people would be eligible for full premium subsidies to enroll in a public or private plan through the large public program, and middle-income people would be eligible for partial premium subsidies that were more generous than the subsidies available through the marketplaces under current law. Large employers would be required to offer private plans or offer coverage through the public program by making mandatory contributions on behalf of their employees. Employees could choose to receive coverage through the public program (in which case, they could choose between the private and public plan options offered through the public program) or through their employer if the employer continued to offer private coverage. The public program also would include income-related cost-sharing reductions for low-income people.

The new public program also would provide partially subsidized default coverage for all people who did not otherwise enroll in health insurance coverage. As with the first approach, a premium-equivalent tax would be imposed on middle- and higher-income uninsured people to finance their default coverage. That tax would equal the premium people would have paid to enroll in the public plan, so that low-income people who were eligible for full premium subsidies (including people whose income is too low to file income tax returns) would not pay such a tax.

The transition to a system following this approach would involve more significant changes than the first approach because all people obtaining coverage in the current nongroup market or through Medicaid or CHIP would transition to a plan offered through the new public program. Some people currently enrolled in employment-based coverage also would transition to the new public program if they opted for coverage through the new program rather than through their employer's plan, if their employer opted to offer coverage through the new program, or if their employer stopped offering coverage altogether. People who were uninsured under current law would gain coverage, primarily through the public program.

Approach 3: Premium Subsidies for All People and Default Coverage Through a Fully Subsidized Plan. Under this approach, all eligible people under age 65

would receive a premium subsidy that would fully cover the cost of a benchmark plan (a plan used to determine subsidies) in a marketplace of private plans. That subsidy could be provided as a refundable tax credit, which would reduce revenues and increase outlays, or through direct payments, which would only increase outlays. Under some variants of this approach, the subsidy could be less generous and cover the cost of a catastrophic plan. (Such health insurance plans, with low premiums and high deductibles, have an actuarial value of less than 60 percent, which means that enrollees are required to pay for more than 40 percent of their health care costs out of pocket, on average.) Alternatively, the subsidy could cover the full cost of a benchmark plan that was relatively generous, similar to a gold plan or the current Medicare program. (A gold plan is a health insurance plan in the marketplaces with an actuarial value of about 80 percent, which means that enrollees are required to pay for 20 percent of their health care costs out of pocket, on average.) Another variation of this approach could include a public plan as an option alongside the private plans.

There would be no requirements for employers to offer coverage. Employers would no longer provide primary health insurance coverage because of the subsidized private coverage available to their employees, but they could offer supplemental coverage to reduce cost sharing or provide additional benefits not covered by the plans their employees chose in the private market. Tax preferences for such supplemental coverage, like those for employment-based insurance under current law, would be eliminated. Low- and middle-income households would receive cost-sharing reductions under all variants of this approach. All people who did not otherwise enroll in a plan would receive fully subsidized default coverage through a benchmark zero-premium plan. The benchmark zero-premium plan could have a narrow network or high cost sharing that would lead some people to choose to pay more to enroll in a plan with a broader network or lower cost sharing. Under this approach, people's choice of health insurance plans would be preserved.

The transition to a system that provided full premium subsidies for all people would involve many more changes to the current system than the approaches discussed above because many people would transition away from employment-based coverage as their primary source of coverage, and private plans would have to adapt to a new market. To achieve deficit neutrality, large new sources of tax revenues would be required to finance universal premium subsidies, in addition to the revenues

raised because tax preferences for employment-based coverage would be eliminated and a greater share of employees' compensation would be taxed.

Once the new system was established, implementation of default coverage generally would be simpler than with the approaches already discussed because there would be no need to collect premium-equivalent tax payments from people who would be covered automatically by a zero-premium default plan. Also, people would not need to change their coverage when they changed jobs or experienced a change in income.

Approach 4: A Single-Payer System. Under this approach, the government would enroll all eligible people in a single-payer system, and in all existing proposals using this approach, there generally would be no role, or there would be a very limited role, for private insurance. If private insurance was allowed, it most likely would be limited to services not covered by the public plan. Private insurance also could be offered as an alternative source of coverage if some enrollees and providers were allowed to opt out of the single-payer system. Cost sharing under this approach typically would be lower than under current law. There would be no premiums, and to achieve deficit neutrality, such a system would need to be financed with broad-based tax revenues.

The transition to a single-payer system would involve greater changes for individuals, insurers, and health care providers than the other approaches, and it would be an enormously complex undertaking. To achieve deficit neutrality, large new sources of tax revenues would be required to finance the single-payer system, and new financing mechanisms would need to be established. However, once it was established and people obtained proof of enrollment, they would be covered under the same system for the rest of their lives.

Background and Scope of the Report

Under the current multipayer health care system, people under the age of 65 receive health insurance from a variety of public and private sources, most of which are partially subsidized by the federal government. That system has not resulted in near-universal health insurance coverage because not everyone is eligible for subsidized coverage—even people with very low income—and not everyone who is eligible for subsidized coverage chooses to purchase it. Lawmakers have considered a variety of proposals to decrease health insurance premiums and increase the number of people with coverage. However,

many of those proposals are not comprehensive enough to achieve near-universal coverage.

Three broad strategies for establishing a health insurance system would achieve near-universal coverage: enacting and enforcing a large individual mandate penalty, instituting automatic coverage through a default plan, or creating a single-payer system that would serve as a default plan for all people. All of those strategies would require generous subsidies for the low- and moderate-income people for whom the cost of health insurance would typically be prohibitive. In this report, CBO does not describe approaches that would achieve near-universal coverage by using an individual mandate penalty because the agency could find no recent proposals that would do so and because the Congress recently eliminated the individual mandate penalty that was established under the ACA.

Definition of Health Insurance Status and Coverage

CBO considers people who enroll in a private health insurance plan or a government program that provides comprehensive major medical coverage to be insured. Such coverage protects people against high-cost medical events, but it still could result in hundreds or thousands of dollars in out-of-pocket costs if it required significant cost sharing, such as a high deductible (an amount a patient is required to pay before a plan begins covering any costs) or large copayments (fixed dollar amounts that a patient is required to pay when using particular services).

CBO considers people who are not enrolled in such a plan or program to be uninsured—even if they are eligible to immediately enroll in a plan or government program that would pay for any previously incurred health care expenses retroactively upon enrollment. For example, people who are eligible for but not enrolled in Medicaid have an implicit protection against high-cost medical events because they can enroll in that program at any time, and they may have retroactive coverage for expenses incurred before enrollment. However, CBO still classifies those people as uninsured. In CBO's view, that definition of uninsured aligns with the concept underlying data from the National Center for Health Statistics, which relies on individuals to report their insurance status in surveys.⁴

4. For previous discussion of related issues, see Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094.

Although this report refers to all people who are not enrolled in a comprehensive major medical insurance plan or a government program as *uninsured*—to be consistent with typical definitions—it recognizes that those otherwise uninsured people would have some financial protection against high-cost medical events if they had automatic coverage through a default plan. Consequently, in this report, CBO refers to people who are not enrolled in a plan but have automatic coverage through a default plan as *having coverage* and counts them when assessing the universality of coverage. The tension of describing a group of people as uninsured yet having coverage reflects the complexity that arises when people receive financial protection against high-cost medical events without enrolling in an insurance plan. Such people also could have difficulty accessing care in the absence of a connection to a health insurance plan and provider network and might forgo some care, such as preventive services.

As classified by CBO, a policy would achieve near-universal coverage if close to 99 percent of citizens and noncitizens who are lawfully present in the country were covered either by enrolling in a comprehensive major medical plan or by receiving automatic coverage through a default plan. In addition, a policy could achieve near-universal coverage of all U.S. residents if noncitizens who are not lawfully present also were made eligible for coverage. Policymakers might allow for limited exemptions, such as for people with religious or moral objections.

In CBO's assessment, no existing proposals would achieve complete (that is, 100 percent) universal coverage because they all would require some demonstration of eligibility (such as meeting criteria related to citizenship or residency) that some eligible people would not comply with for various reasons. For example, some people would not comply because of language and literacy barriers or fears of providing information to the federal government. By CBO's classification, a health care system would achieve complete universal coverage only if all people in the country received coverage without any required demonstrations of eligibility criteria.

Sources of Coverage and Uninsured People Under Current Law

In the current multipayer system, people obtain health insurance from a variety of private and public sources. Most uninsured people have at least one subsidized option available to them, but others have no subsidized

option and purchasing health insurance can cost a large share of their income.

Sources of Health Insurance. Under current law, people under the age of 65 receive coverage through three major sources: employment-based health insurance, public programs such as Medicaid and CHIP, and nongroup health insurance for those who do not obtain health insurance through their employer and do not qualify for public programs. Those three sources all provide comprehensive major medical coverage and require no cost sharing for preventive care services, such as vaccinations. (A small number of people in the nongroup market are enrolled in plans that do not provide comprehensive major medical coverage. CBO does not consider those plans to be insurance.)

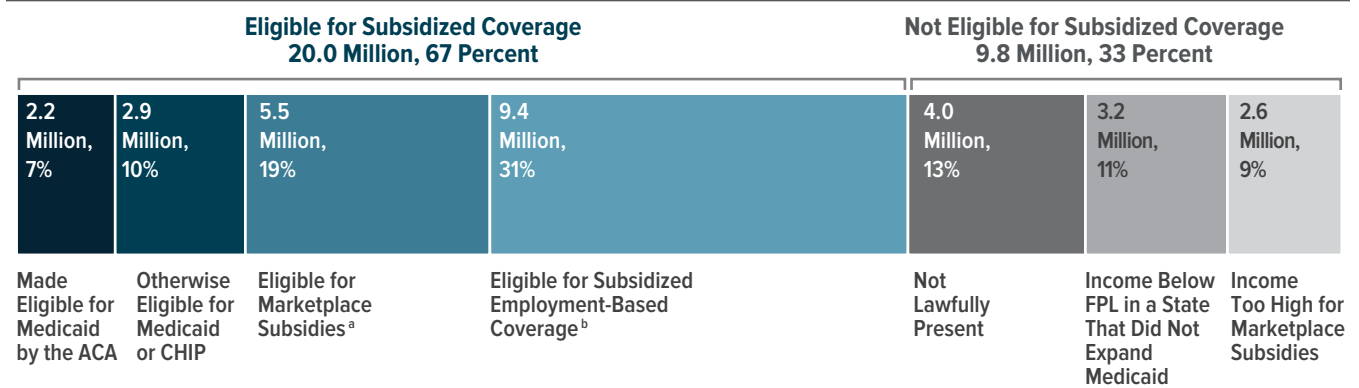
However, the amount of cost sharing required for nonpreventive care and the network of participating providers vary. Employment-based plans tend to have greater cost sharing requirements and a broader network of participating providers than Medicaid. Medicaid and CHIP require no or very limited cost sharing, but many providers do not participate in those programs. Nongroup plans tend to require even higher cost sharing than employment-based plans, and they can have a more limited network of participating providers. However, nongroup plans—including those available both in and outside of the health insurance marketplaces established under the ACA—vary considerably in their levels of cost sharing.

Plans in the nongroup market that provide comprehensive major medical coverage are classified according to their level of cost sharing using “metal tiers,” with more precious metals (for instance, gold) indicating lower levels of cost sharing but higher premiums. For example, a typical silver plan has an actuarial value of 70 percent, which means that enrollees are required to pay for 30 percent of their health care costs out of pocket, on average. By contrast, a typical gold plan has an actuarial value of 80 percent, which means that enrollees are required to pay for only 20 percent of their health care costs out of pocket, on average. Those differences in cost sharing can be seen by comparing average deductibles. In 2019, an average bronze plan had a deductible of about \$6,300, while an average gold plan had a deductible of about \$1,300.⁵ The silver plans with cost-sharing reduc-

5. See Kaiser Family Foundation, “Cost-Sharing for Plans Offered in the Federal Marketplace, 2014–2020” (December 2019), <https://tinyurl.com/y448slxf>.

Figure 1.

Eligibility for Subsidized Coverage Among Uninsured People in 2019



Source: Congressional Budget Office.

Some people may be eligible for multiple sources of coverage. CBO classified uninsured people into mutually exclusive groups on the basis of the most heavily subsidized option available to them or the primary reason they were ineligible for subsidized coverage.

CBO’s estimates of the number of uninsured people and their options for coverage were drawn from its health insurance simulation model, HISIM2, and may differ from other sources. For more details about those estimates, see Congressional Budget Office, *Who Went Without Health Insurance in 2019, and Why?* (September 2020), www.cbo.gov/publication/56504.

ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program; FPL = federal poverty level.

a. A small number of people in this group would technically be eligible for subsidies, but those subsidies would equal zero dollars.

b. A small number of people in this group were self-employed and could receive a subsidy by deducting their premiums from their income when calculating their federal income taxes.

tion (CSR) subsidies require even less cost sharing. Those subsidies are available through the health insurance marketplaces to people with income between 100 percent and 250 percent of the FPL.

People whose income is between 100 percent and 400 percent of the FPL and who are not eligible for public coverage and do not have access to an offer of affordable employment-based coverage are eligible for premium subsidies to purchase nongroup plans through the health insurance marketplaces. People with an affordable offer of employment-based coverage are ineligible for such subsidies because of the employer firewall. (In 2020, an offer of affordable employment-based coverage is defined by the Internal Revenue Service, or IRS, as one in which an employee’s out-of-pocket premium is less than 9.78 percent of household income for a single plan.) The amount of those subsidies is benchmarked to the cost of the second-lowest-cost silver plan, and it is based on affordability thresholds that vary by income. For example, people with the lowest income receive premium subsidies that allow them to purchase that benchmark plan for 2.06 percent of their income. People with higher income receive smaller subsidies that require them to pay 9.78 percent of their income for the same plan.

Options Currently Available to Uninsured People. In 2019, an estimated 30 million people under the age of 65, or 12 percent of that population, were uninsured. One reason for the lack of insurance coverage was a lack of subsidized options. About one-third of uninsured people under the age of 65 did not have access to coverage that was subsidized by the government or an employer: 13 percent were noncitizens who were not lawfully present in this country; 11 percent had income that was less than 100 percent of the FPL and lived in a state that did not expand Medicaid; and 9 percent had income that was too high to qualify for marketplace subsidies (see Figure 1). Many of those people, including nearly all of the people in the first two groups, would have to pay large premiums relative to their income to enroll in a health insurance plan.⁶

Another reason for the lack of health insurance coverage is that not all people who are eligible for subsidized coverage choose to purchase it. About two-thirds of the 30 million uninsured people under the age of 65 had access to some form of subsidized coverage but were not *enrolled*, although those options were subsidized to

6. See Congressional Budget Office, *Who Went Without Health Insurance in 2019, and Why?* (September 2020), www.cbo.gov/publication/56504.

different degrees: 17 percent were eligible for Medicaid or CHIP; 19 percent were eligible for subsidized coverage through the marketplaces established under the ACA; and 31 percent had access to coverage through an employer. Most of those people could have purchased health insurance that cost less than 10 percent of their income, but fewer people had an option that cost less than 5 percent of their income. Those people lacked health insurance coverage because they did not consider it to be worth the cost or because of the complexities of the enrollment process, among other reasons.

Legislative Proposals to Incrementally Expand Access to Coverage and Reduce Out-of-Pocket Premiums

Lawmakers have introduced legislative proposals that would reform health insurance in various ways. Such proposals generally include provisions that would incrementally expand access to coverage by providing people additional plan options, increasing subsidies, or reducing out-of-pocket premiums in other ways. For example, some legislative proposals have been introduced in the current Congress that would expand subsidies to different income groups, introduce a public option in the health insurance marketplaces, or allow people to buy in to public programs.⁷ Although legislation that would reduce out-of-pocket premiums would result in *expanded access* to partially subsidized coverage and encourage more people to enroll in a plan, it would not by itself achieve *near-universal coverage* because some people would choose not to purchase health insurance. Those people would not otherwise have financial protection against high-cost medical events.

Expansion of Subsidies. Some legislative proposals, such as H.R. 1425, the Patient Protection and Affordable Care Enhancement Act, would reduce out-of-pocket premiums by expanding the subsidies available under current law to people whose income is above 400 percent of the FPL and encourage more people to enroll in a plan. That bill also would make the premium subsidies under current law more generous by reducing the amount of income that people must contribute toward their premiums. In addition, the proposal would eliminate the provision of the ACA that prevents low- or moderate-income people from receiving subsidies if a

worker has an offer of affordable employment-based coverage for a single plan.

Public Option. Under legislative proposals that would establish a public option—such as S. 3, the Keeping Health Insurance Affordable Act of 2019, and H.R. 2085, the CHOICE Act—a new public plan would be offered in the health insurance marketplaces alongside private plans, and providers’ payment rates would be set by the government. Some other proposals also would offer a public option in the individual and small-group markets outside of the marketplaces. Such proposals aim to reduce premiums and provide people with additional plan options.

Medicare Buy-In. Under legislative proposals that would establish a Medicare buy-in—such as S. 470, the Medicare at 50 Act, and H.R. 1346, the Medicare Buy-In and Health Care Stabilization Act of 2019—certain older adults under the age of 65 who are not currently eligible for Medicare would be allowed to purchase coverage through that program. Those proposals also would allow marketplace subsidies to be used toward the purchase of that coverage for people who were eligible for subsidies, and they would provide some people with additional plan options that had lower premiums than current nongroup options.

Medicaid Buy-In. Under legislative proposals that would establish a Medicaid buy-in, such as S. 489 and H.R. 1277, the State Public Option Act, people at all income levels would be allowed to purchase coverage through participating state Medicaid programs. Such proposals would not require states to adopt that program—similar to states’ voluntary participation in the Medicaid program more broadly. Under this approach, a Medicaid buy-in program would be offered in the health insurance marketplace alongside private plans, and marketplace subsidies could be used toward the purchase of a Medicaid buy-in for people who were eligible for subsidies. Such proposals would provide some people with additional plan options that would have lower premiums than current nongroup options.

Strategies to Achieve Near-Universal Coverage

Under all three strategies—a large and enforced individual mandate penalty, automatic coverage through a default plan, and a single-payer system—generous subsidies would be required to assist low- and

7. For a comparison of some proposals, see Kaiser Family Foundation, “Compare Medicare-for-All and Public Plan Proposals” (May 15, 2019), www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals.

moderate-income people for whom the cost of health insurance would typically be prohibitive, and a mandatory component would be necessary to ensure that people did not forgo coverage. In contrast with current law, people would not be able to remain uninsured during periods in which they did not anticipate using health care services and enroll in a health plan only after they anticipated or experienced a high-cost medical event.

Large and Enforced Individual Mandate Penalty. One way to provide coverage to nearly all people under a multipayer system would be to combine generous premium subsidies with a requirement that everyone purchase health insurance. To be effective, that requirement would have to be strongly enforced, and people who did not comply would incur large financial penalties. Such a strategy is used by several European countries, including Germany and the Netherlands, that have near-universal coverage through highly regulated multipayer systems.

The ACA combined an individual mandate with an increase in subsidized coverage options. However, the ACA did not result in near-universal coverage because the financial penalties for the individual mandate were modest and only partially enforced and because some low-income people, particularly low-income adults below the FPL in states that did not expand Medicaid, were not made eligible for the new subsidized coverage options. (For example, the ACA prohibited the use of liens or levies by the IRS to collect the financial penalties for not complying with the individual mandate, and people could not be prosecuted for failing to pay the penalty. However, the IRS could offset the financial penalty with any tax refund owed to a person.)⁸ In addition, the Congress later eliminated the financial penalty for not complying with the individual mandate in Public Law 115-97, referred to here as the 2017 tax act.

Automatic Coverage Through a Default Plan. In the absence of a large and strongly enforced individual mandate penalty to induce people to purchase coverage, another strategy to achieve near-universal coverage would be to combine premium subsidies with a mechanism that automatically provided coverage through a default plan. One strategy used by several countries with near-universal coverage is a single-payer system that serves as a

default plan. A single-payer system is an extreme example of a default plan because people would not have a choice of a health insurance plan and everyone who was eligible would be enrolled in the same public plan. Automatic coverage through a default plan also could be used in a multipayer system that fully subsidized the cost of health insurance premiums while still allowing people to choose from among multiple private plans.

Such a default coverage mechanism also could be used to achieve near-universal coverage under a multipayer system that did not fully subsidize the cost of health insurance for all people, as is the case in Switzerland. However, the system would become significantly more complex for the government to administer because it would need a way to identify and collect payments from people who chose not to enroll in a plan and were not eligible for full subsidies.⁹ Those people would be required to make a payment if they did not enroll in any source of coverage, as would be the case under a system that used an individual mandate penalty. However, they would receive health insurance coverage through a default plan for any period in which they did not have another source of coverage—which is different from what would occur under a system that used an individual mandate penalty (in which a person is liable for a tax payment but not covered by insurance). Using the default plan, otherwise uninsured people could receive covered health care services at any time, without waiting for an open enrollment period.

Single-Payer System. A third strategy to achieve near-universal coverage would entail establishing a single-payer system. As discussed above, a single-payer system could serve as a default plan and all people who demonstrated eligibility would enroll in that program and receive care that was covered by the single-payer system. A single-payer system is included here as a separate strategy because, unlike a default plan under a multipayer system, the government would operate the single-payer system, and it would determine payment rates for health care providers. Premiums would be fully subsidized through broad-based tax revenues. Such a

8. See Internal Revenue Service, *Questions and Answers on the Individual Shared Responsibility Provision* (June 2020), <https://go.usa.gov/xGbSD>.

9. See Ewout van Ginneken and Thomas Rice, “Enforcing Enrollment in Health Insurance Exchanges: Evidence From the Netherlands, Switzerland, and Germany,” *Medical Care Research and Review* (April 2015), vol. 72 no. 4, pp. 496–509, <https://doi.org/10.1177/1077558715579867>.

strategy is used by several countries, including Canada, Denmark, and the United Kingdom.¹⁰

Scope of the Report

This report discusses the primary features of four general approaches that could achieve near-universal coverage using a combination of premium subsidies and automatic coverage through a default plan, including a single-payer system. The role of default coverage would vary across each of the four approaches, but in all cases, a default plan would provide coverage to people during periods in which they did not have another source of coverage, whether or not they used any health care services during the year. CBO focused on approaches that would achieve near-universal coverage by using the strategy of automatic coverage through a default plan, rather than by using large and strongly enforced individual mandate penalties, because the Congress recently eliminated the ACA's individual mandate penalty.¹¹ CBO is not aware of any current detailed proposals that would reinstate an individual mandate penalty that would be strongly enforced and large enough to result in near-universal coverage.

Policymakers would need to specify numerous details in drafting legislation that followed any of those approaches, and this report does not address every aspect that would need to be specified. For example, the report does not discuss the extent to which noncitizens who are not lawfully present would be eligible for subsidized coverage. This report focuses on how expansions of health insurance coverage could achieve the goal of near-universal coverage; a discussion of how the subsidies for those coverage expansions would be financed is outside the scope of the report. The report also does not include estimates of the budgetary effects of any of the approaches because those effects would vary considerably under different variants of the approaches and would depend on how numerous other details were specified.

10. For additional discussion of single-payer systems, see Congressional Budget Office, *Key Design Components and Considerations for Establishing a Single-Payer System* (May 2019), www.cbo.gov/publication/55150; and Chris Pope, *Medicare for All? Lessons From Abroad for Comprehensive Health-Care Reform* (Manhattan Institute, November 2019), <https://tinyurl.com/tqq9d52>.

11. For CBO's analysis of the effect of the ACA's individual mandate penalty, see Congressional Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (November 2017), www.cbo.gov/publication/53300.

Automatic Coverage Through a Default Plan for People Without an Alternative Source of Health Insurance: Design Considerations and Challenges

All four approaches discussed in this report would make use of a default plan to achieve near-universal coverage. The role of the default plan would vary on the basis of the design and other features of the policy approach. The defining feature of each type of default coverage is that everyone without an alternative source of insurance could receive covered care—including comprehensive major medical services and prescription drugs—at any time, without waiting for an open-enrollment period.

Some features of the default coverage would depend on the answers to the following questions: Would default coverage be partially subsidized and require mandatory contributions from uninsured people who are eligible for such coverage, or would it be fully subsidized through broad-based tax revenues? How heavily subsidized would the default coverage be if it was only partially subsidized? And, would default coverage be provided through a private or public plan?

Implementing default coverage would present particular challenges if it was partially subsidized. Additional challenges would arise if the default plan was included in a risk-adjustment system that shared the cost of insuring a group of enrollees with other plans that were available for active enrollment. There also would be challenges associated with informing people about their eligibility for default coverage and the benefits associated with that coverage, particularly the default plan's provider network.

Enrollment in a Default Plan and Use of Health Care Under That Plan

The default plan would provide coverage to everyone during periods in which they did not have an alternative source of insurance, whether or not they used any health care services or actively initiated coverage during the year. The key feature of default coverage is that eligible people could enroll in the default plan and receive covered health care services at any time, without waiting for an open-enrollment period. To use the default plan to receive covered health care services, people could enroll in the plan in one of three ways:

- *Point-of-Service Enrollment.* Certain health care providers would be authorized to enroll their patients at the point of service, which means that

an uninsured person seeking care through those providers would receive health care covered by the default plan without any prior active enrollment. The providers that facilitated such enrollment would be similar to the providers—for instance, most hospitals and certain other safety-net providers such as community health centers—that currently assist with the enrollment of uninsured patients in Medicaid and CHIP (when they are eligible). For example, a person who sought care in a hospital emergency room or medical clinic would be signed up for coverage by the provider at that time. The provider would bill the default plan for payment, minus any required patient cost sharing, for any patient who did not provide proof of enrollment in another source of health insurance. Other providers that agreed to participate in the default plan would accept payment from the default plan, but they would first require patients to enroll in and provide proof of default coverage before seeking care.

- *Self-Enrollment.* Individuals could actively enroll at any time in a default plan through an online portal or an alternative process. Under such a process, they would receive proof of coverage and information on the benefit package, provider network, and other features of the default plan. That would allow the person to make an appointment with any health care provider in the default plan's network and to present proof of enrollment as a source of payment at any participating provider.
- *Automatic Enrollment.* Some people could be enrolled automatically in the default plan and then informed of their enrollment. Automatic enrollment would be more feasible for people who were eligible for full premium subsidies if the government had sufficient information about their income eligibility and coverage status.

Default Coverage Under Medicaid and CHIP. Medicaid and CHIP provide default coverage under current law for some low-income adults and children, with no waiting period to enroll in those programs. For Medicaid and some CHIP programs, certain providers are authorized to enroll people who appear to be eligible for those programs on a presumptive basis at the point of service using a simplified income screen. For example, an uninsured person who visits an emergency room today can be enrolled in Medicaid by the hospital on the basis of a simplified income screen, if he or she appears to be

eligible. In many states, people who enroll in Medicaid also can receive retroactive coverage for up to three months before their application date for any medical expenses incurred during that period. That retroactive coverage removes the financial liability from individuals for the three-month period and allows providers to receive payment for services that are rendered before those individuals can submit a complete application.

However, many people may not be aware that they are eligible for Medicaid or CHIP, or that the presumptive and retroactive eligibility policies exist. As a result, those people may be less likely to seek health care than people who are enrolled and know they have coverage. If a default plan was available to all otherwise uninsured people, those people might be more aware of the option of accessing health care that was paid for by a default plan and more likely to seek care as a result than uninsured people who are eligible for Medicaid and CHIP under current law.

Differences Between Automatic Enrollment in a Default Plan and Automatic Coverage by That Plan.

Under all four approaches discussed in this report, a default plan would provide *automatic coverage* to all eligible but otherwise uninsured people even if they never enrolled in a plan. Each approach also could make use of *automatic enrollment* in other types of health insurance to minimize the number of eligible people who never enroll in a plan. Automatic enrollment identifies eligible people and registers them for coverage, typically when no premiums are required. However, many uninsured people are not eligible for zero-premium options under current law, and identifying eligible uninsured people to auto-enroll would be challenging. Automatic enrollment typically applies on a prospective basis, meaning that people gain coverage only after they are identified as uninsured and their enrollment is processed, which could be many months after they become uninsured. By contrast, automatic coverage does not require identifying uninsured people at the moment they become uninsured.

Under automatic enrollment, more people would be enrolled in coverage than under current law, but eligible people who could not be automatically enrolled would not be covered, and people who were automatically enrolled would generally have coverage only after their enrollment was processed. In CBO's assessment, it would be extremely difficult to identify and automatically enroll otherwise uninsured people when they owed premiums, and millions of people would remain uninsured unless a default plan that provided automatic coverage also

was established. Most Medicaid and some CHIP enrollees would have retroactive coverage for any expenses incurred up to three months before enrollment, but people automatically enrolled in marketplace plans would have no such protections under current law.

Under *automatic coverage*, all people without other sources of health insurance would be covered by a default plan. Expanding the use of automatic enrollment in public and private coverage would increase the number of people who were enrolled in a health insurance plan throughout the year and potentially reduce the number of remaining uninsured people who would be responsible for tax payments to finance default coverage. However, if an automatic coverage mechanism was not in place, the approach would not reach near-universal coverage because some people could not be auto-enrolled. (Other analysts use different terminology to refer to automatic coverage through a default plan, including retroactive coverage by a backstop plan and continuous auto-enrollment with retroactive enforcement.)

Key Design Choices Associated With Default Coverage

Proposals to establish default coverage would require several key design choices, including the extent to which coverage would be subsidized and whether it would be provided by a private or a public plan. Another design choice would center on the degree of cost sharing that would be required under the default plan.

Partially or Fully Subsidized Default Coverage? A key design choice for establishing default coverage would be how heavily to subsidize the cost of that coverage for otherwise uninsured people who would be covered by the default plan. If default coverage was partially subsidized, some people in the eligible population, such as those with low income, would receive a subsidy to cover the entire cost of a benchmark plan while other people in the eligible population, such as middle-income people and some high-income people, would receive a subsidy to partially cover the cost of a benchmark plan; other high-income people would not be eligible to receive any subsidies. Financing would come, in part, from higher taxes on those uninsured individuals who were covered by the default plan and, in part, from broad-based tax revenues that were not linked to health insurance coverage. Default coverage would be partially subsidized under Approaches 1 and 2, both of which would subsidize the entire cost of a benchmark plan for low-income people, but it would provide only partial subsidies for middle-income and some higher-income people.

Levying taxes on uninsured people who were covered by the default plan would be the equivalent of charging mandatory premiums for that coverage. To maintain incentives to enroll in other sources of coverage, the amount of the tax associated with default coverage would be made equal to the net premium the individual would pay to actively enroll in a benchmark plan providing the same benefits. However, some people would choose to continue enrolling in employment-based coverage or other types of plans if those plans included a broader network or more generous benefits.

Some proposals refer to financing for a default plan as retroactive premiums because the funds collected at the end of the year would serve as payment for default coverage provided during the previous year. Legislation specifying such financing as a tax would increase the likelihood that those payments would be upheld as constitutional. Although those people would be required to make a payment if they did not enroll in any source of coverage—as was the case with the ACA's individual mandate penalty—they also would receive health insurance coverage through a default plan for any period in which they did not have another source of coverage.

The amount of the premium-equivalent tax could vary on the basis of income or other criteria. For example, if partially subsidized default coverage was added to existing sources of coverage and subsidies, the benchmark plan could be a silver plan available through the health insurance marketplaces. The amount of the premium-equivalent tax would then be the premium uninsured people would pay to enroll in that silver plan after applying any premium tax credits for which they were eligible.

If default coverage was fully subsidized for all eligible people, everyone in the eligible population would receive a subsidy to cover the entire cost of a benchmark plan. Such coverage would be implemented under Approaches 3 and 4. Financing would come entirely from broad-based tax revenues, and people who did not enroll in a health insurance plan would not owe additional taxes.

A Private or Public Default Plan? Proposals would need to specify whether default coverage would be provided through a private or a public plan. If a private or public plan in the marketplace served as a default plan, all plans in the nongroup market would adjust their premiums to reflect the expected costs of adding enrollees through

the default coverage mechanism to the existing risk-adjustment system. If default coverage was provided by a private plan, a government agency would receive tax revenues to finance default coverage and use those revenues to make periodic premium payments to the private default plan for each person estimated to be covered by that plan. The legislation might specify the characteristics of the private plan that would be designated to serve as the default plan—such as the least expensive silver plan offered in the health insurance marketplace. A private default plan also could be identified through a competitive bidding process, with plans submitting premium bids on the basis of the expected costs of providing coverage to people who would be enrolled through the default coverage mechanism.

If the default plan was a public plan, such as a new public option offered through the marketplaces, the government would set the premium in one of two ways: on the basis of the expected costs of providing coverage to people who would enroll through the marketplaces and the default coverage mechanism, as well as the costs of any risk-adjustment payments; or on the basis of private-market estimates of the cost of insuring a person of average health status, such as the benchmark premium of the second-lowest-cost silver plan in the marketplace. Other plans would adjust their premiums if the public default plan was part of the same risk-adjustment system.

If default coverage was provided by a private plan, provider networks and payment rates could be negotiated by insurers and providers, subject to existing requirements about network adequacy. If default coverage was provided by a public plan, administrators could set payment rates, establish criteria regarding provider participation, and impose other requirements based on those used by the Medicare program or develop new approaches.

Under variants of Approaches 1 and 3, the default plan would be a private plan. Default coverage also could be provided by a public plan, such as a new public option under one variant of Approach 1. A public plan also would serve as the default plan under Approach 2, one variant of Approach 3, and Approach 4.

Default coverage could vary on the basis of the characteristics of the population. For example, Medicaid and CHIP could continue to serve as default coverage for people who were eligible for but not currently enrolled in those programs, and another private or public plan could

serve as default coverage for other uninsured individuals who were not eligible for Medicaid or CHIP (as under Approach 1).

Other Design Choices. Other design choices for default coverage would include the degree of cost sharing that individuals would be responsible for when using care under the default plan. The generosity of the default plan could affect the size of the premium-equivalent tax for people whose coverage was not fully subsidized. For example, if a gold plan was specified as the default plan, all people who were enrolled in the plan would have lower cost sharing than if they were enrolled in a catastrophic plan, but people who were not eligible for subsidies would owe a larger amount in premium-equivalent taxes.

Key Challenges of Implementing Default Coverage

The key challenges of implementing default coverage are as follows: how to ensure that the appropriate premium-equivalent tax payments are collected if default coverage is partially subsidized; how to determine the appropriate premium adjustments for plans when the default plan is part of a risk-adjustment system; and how to inform people about their eligibility for default coverage and the default plan's benefits, particularly the provider network.

Implementing default coverage would be less administratively complex if the requirements for assessing premium-equivalent taxes to finance default coverage were straightforward and fewer alternative sources of coverage were available. For example, implementing default coverage in a single-payer system (as in Approach 4) would present the fewest challenges relative to other approaches because coverage would be fully subsidized through broad-based tax revenues and the government would not need to verify enrollment in other sources of coverage. However, a single-payer system would result in the largest increase in government spending.

Implementing partially subsidized default coverage that operated in tandem with currently available sources of coverage (including Medicaid, CHIP, employment-based insurance, and private nongroup insurance) would present the most challenges relative to other approaches. That is because the government would need to verify enrollment using data from many potential sources of coverage and collect premium-equivalent tax payments from people who were not enrolled in those other plans or programs.

Collecting Premium-Equivalent Taxes When Default Coverage Is Partially Subsidized. Under Approaches 1 and 2, which would provide partially subsidized default coverage, the government would collect premium-equivalent taxes from people who were covered by the default plan because they did not have an alternative source of coverage. Collecting those taxes would be challenging for several reasons. First, in many cases, it would be difficult to determine which people did not have an alternative source of coverage and therefore were responsible for premium-equivalent taxes. Second, the tax payments would be large for higher-income people without other sources of coverage who were eligible for small or no subsidies. Third, both of the two main options for structuring the taxes would add additional complexity to the tax system and would make withholding the appropriate amount of taxes from workers' paychecks throughout the year more difficult.

Identifying People Responsible for Paying Premium-Equivalent Taxes. Under Approaches 1 and 2, the IRS would need to identify the coverage status of all income tax filers and determine their eligibility for premium subsidies in order to collect premium-equivalent taxes. When tax returns were filed, each person's insurance status and eligibility for subsidized coverage would be assessed for each month of the previous calendar year.¹² For each month that an individual did not have an alternative source of coverage, the person would be considered to have been covered by the default plan and, depending on that person's income and eligibility for premium subsidies, he or she would owe additional tax payments. If default coverage was partially subsidized, the premium-equivalent tax would be set equal to the premium of the default plan minus any premium tax credits or subsidies for which the person was eligible.

The IRS would determine coverage status on the basis of self-reported information that would be verified by matching it to information submitted by third parties (such as insurance companies). However, the currently available third-party information is not accurate enough

to adequately enforce such a policy.¹³ Imposing new taxes on the basis of coverage status—and collecting those taxes—would require the IRS to obtain more accurate and comprehensive data on insurance status than are currently available through the information returns filed by third parties. The IRS could use that more accurate data to verify the information that people report on their tax returns. Legislation establishing the default coverage policy could include additional reporting requirements and provide funding for the IRS to improve its ability to accurately measure the monthly coverage status of tax filers, which would enhance the IRS's ability to audit.

The IRS would only be able to verify the coverage status of, and enforce the collection of tax payments from, people who filed income tax returns. Exempting people whose income fell below the tax-filing threshold from the tax obligations associated with default coverage would facilitate enforcement. Exempting those people would have a very small effect on the taxes collected because they tend to have very low income and they would be eligible for large premium subsidies to offset all or nearly all of the tax obligation under all of the proposals that CBO reviewed. (For tax year 2019, a single adult under the age of 65 did not have to file an income tax return if his or her gross income was less than \$12,200, which was just over the eligibility threshold for a premium tax credit. The legislation also could adjust the tax-filing threshold.)

Under proposals in which the Medicaid and CHIP programs continued to exist and provide default coverage for people who were eligible for those programs—similar to Approach 1—the IRS also would have to identify whether people were eligible for those programs to determine whether they would be responsible for taxes to finance the default plan. That would require collecting information from state agencies or making a simplified

12. For a detailed proposal that would require the IRS to collect additional tax payments linked to coverage status, see the description of a retroactive coverage backstop in Christen L. Young, *Three Ways to Make Health Insurance Auto-Enrollment Work* (USC-Brookings Schaeffer Initiative for Health Policy, June 2019), www.brookings.edu/wp-content/uploads/2019/06/Yonu_Autoenrollment_6.19.19.pdf (445 KB).

13. A recent study found that the number of people identified as not having insurance using the currently available third-party reporting (13 percent) was substantially higher than the number of people estimated to not have insurance using nationally representative survey data (9 percent to 10 percent). By contrast, the number of people without coverage who self-reported being uninsured on their tax returns (8 percent) was lower than the nationally representative estimates. Those differences indicate that currently available third-party reporting to the IRS is insufficient to verify the self-reported information. See Ithai Z. Lurie and James Pearce, *Health Insurance Coverage From Administrative Tax Data*, Office of Tax Analysis Working Paper 117 (Department of the Treasury, February 2019), <https://go.usa.gov/xGBZV> (PDF, 18.49 KB).

eligibility determination on the basis of the income and age that tax filers reported on tax returns. It would be challenging for the IRS to make accurate eligibility determinations during the tax-filing process, because eligibility for Medicaid and CHIP is based on monthly income, which may vary throughout the year, whereas the IRS relies on annual income.

Amount of the New Taxes. Partially subsidized default coverage could create a large new tax obligation for people without an alternative source of coverage, particularly people with income that was too high to qualify for premium subsidies. For example, if people with income above 400 percent of the FPL were not eligible for any subsidies other than for employment-based coverage (as is the case under current law), the new tax obligation for someone with an income just above the eligibility threshold (\$48,560 for a single person in 2019) would have been about \$5,700 for a 40-year-old if the cost of the default plan was similar to the cost of the second-lowest-cost silver plan under current law in 2019.¹⁴ That would have amounted to about 12 percent of income for someone with an income just above 400 percent of the FPL and about 8 percent of income for someone with an income equal to 600 percent of the FPL.

Those amounts far exceed the maximum of 2.5 percent of income that was specified under the ACA as the penalty for not having health insurance coverage before that penalty was eliminated under the 2017 tax act. However, those people also would receive health insurance coverage through a default plan for the period in which they did not have another source of coverage; that would not be the case under systems using an individual mandate penalty. As people became more familiar with such a policy over time, more people might elect to actively enroll in a plan and pay premiums earlier in the year, which would reduce the number of people responsible for large tax payments at the time tax returns were filed.

It could be difficult for the IRS to enforce the payment of premium-equivalent taxes, particularly if those taxes were large and exceeded the amount of the tax refund that filers were owed otherwise. The IRS had limited

authority to collect the individual mandate penalties specified under the ACA. Legislation that enacted partially subsidized default coverage could grant the IRS greater authority to collect premium-equivalent taxes by garnishing wages, imposing liens, or other means. However, those strategies might be controversial.

Structuring Premium-Equivalent Taxes. The premium-equivalent tax could be structured and collected in two main ways, both of which would add reporting requirements and additional complexities to the tax system. The simplest option would be to levy a tax directly on those covered by the default plan. That would include people who enrolled in the default plan on their own or through a health care provider or who were enrolled by the government automatically. It also would include people whom the IRS determined did not have another source of coverage for certain periods of the year. That option would be more likely to result in large tax bills at the end of the year for people covered by the default plan, unless withholding was adjusted by those taxpayers during the year to reflect their lack of coverage and anticipated tax obligation. Although income withholding amounts can be changed, most workers do not routinely make adjustments. People who actively enrolled in the default plan during the year could begin making estimated tax payments when they enrolled. Alternatively, the IRS could automatically withhold people's estimated tax obligations if their coverage status could not be verified.

Another option for collecting the new tax would be to levy a premium-equivalent tax on all tax filers, including people who were enrolled in coverage for the entire year. People who demonstrated through third-party reporting that they had qualifying health insurance would then be able to fully offset that tax obligation with a tax credit of equivalent size. Efforts could be made to allow insured filers to adjust their withholding accordingly throughout the year to anticipate the offsetting tax credit. However, because some people who were enrolled in employment-based insurance or other plans might not adjust their withholding, this option probably would cause some of those people to pay too much in taxes during the year and then receive large tax refunds at the end of the year when the IRS determined that they were eligible for a fully offsetting tax credit. This option would reduce the number of people with a large tax obligation due at the time of tax filing, but it also would be more complex to administer.

14. For estimates of average marketplace premiums, see Kaiser Family Foundation, "Average Marketplace Premiums by Metal Tier, 2018–2020," <https://tinyurl.com/y2pzm34>.

Determining Payments to Insurers When the Default Plan Is Part of a Risk-Adjustment System. To ensure that the premium-equivalent taxes for the default plan were similar to equivalent plans that were available for active enrollment, the default plan could be part of a risk-adjustment system that included those plans. In a risk-adjustment system, all plans in the system make or receive payments that adjust their premiums for the costliness of their enrollees relative to that of enrollees in other plans in the system. In anticipation of receiving or making those payments, plans in the risk-adjustment system set their premiums in part to reflect the cost of covering all enrollees in the risk pool. (A risk pool refers to a group of plans that share the cost of covering all enrollees in the pool. Those costs are shared through a risk-adjustment system.) Determining the appropriate payments to compensate plans that are included in the risk-adjustment system would require determining the number of people covered by the default plan and the expected cost to insure them relative to that of enrollees in other plans.

Determining the Number of People Covered by the Default Plan. One challenge would be estimating the number of people who would be covered by the default plan. Two groups would be covered by the default plan: people who were enrolled in the plan and people whom the IRS would need to identify as not having another source of coverage. (People might enroll during the year on their own or through a health care provider, or they might be enrolled by the government automatically.) The people who enrolled in the default plan during the year would all be identified, but the IRS might have difficulty identifying everyone else without another source of coverage because of the gaps in reporting discussed earlier. In addition, it would be even more difficult for the IRS to identify the coverage status of people who did not file tax returns because their income fell below the tax-filing threshold. If the IRS underestimated the number of people who did not have another source of coverage during the year, the people who enrolled in the default plan during the year (many of whom would do so only after experiencing a costly episode of care) would represent a larger share of the people who were identified as covered by the default plan. The risk-adjustment payments to the default plan would then have to be larger to reflect the higher average cost of the people who were identified as being covered by the default plan relative to the entire group of eligible people.

Setting Payments for Insurers Using a Risk-Adjustment System. Once the government identified the group of people who would be covered by the default plan, it would determine the risk-adjustment payments for all plans in the system on the basis of the expected health care spending of people covered by the default plan and other plans in the risk pool. To determine the size of the payments, the government would start with a measure of average spending for all people in the risk pool and then adjust that average up or down to account for plans that tended to have more or less costly enrollees than average.

Those calculations would be done using a new or modified risk-adjustment system, but the ability of the risk-adjustment system to predict the expected cost of people covered by the default plan would be imperfect.¹⁵ Under current law, the health insurance marketplaces use a risk-adjustment system established by the ACA that compensates insurers who attract a more costly group of enrollees by transferring funds from insurers who attract a less costly group of enrollees. That system adjusts payments primarily on the basis of chronic conditions, such as diabetes and hypertension. Such a risk-adjustment system probably would not adequately compensate insurers for the people who would be identified as being covered by the default plan because their spending would disproportionately include acute care events, such as heart attacks and car accidents. Modifications to the risk-adjustment system would be required to adequately capture the differences in costs between people who would be covered by the default plan and people who would actively enroll in other plans. Risk scores for some people who were eligible for default coverage would have to be computed solely on the basis of their demographic characteristics.

15. Existing risk-adjustment systems (such as those used in the Medicare Advantage and Medicare Part D programs and the nongroup market) do not entirely capture the cost of people in the markets in which they are currently used. In particular, some plans are able to receive larger risk-adjustment payments because they record additional health conditions for their enrollees. See Michael Geruso and Timothy Layton, "Upcoding: Evidence From Medicare on Squishy Risk Adjustment," *Journal of Political Economy*, vol. 128, no. 3 (2020), pp. 984–1026, <http://doi.org/10.1086/704756>. Research also shows that insurers change their benefit designs to attract enrollees who result in risk-adjustment payments that are large relative to their cost. See Colleen Carey, "Technological Change and Risk Adjustment: Benefit Design Incentives in Medicare Part D," *American Economic Journal: Economic Policy*, vol. 9, no. 1 (2017), pp. 38–73, <http://doi.org/10.1257/pol.20140171>.

Determining the appropriate risk-adjustment payments also would depend on the overall risk pool that the default plan was a part of—that is, the other plans that participated in the risk-adjustment system. The default plan could be part of the same risk pool as other plans that are available for active enrollment, such as the nongroup market under current law. The default plan probably would draw a less costly group of people than the current nongroup market because, on average, those who do not enroll in coverage tend to spend less on health care. If the IRS was able to accurately identify the less-costly people who would be covered by the default plan, then adding a default plan to the same risk pool as the current nongroup market would probably reduce overall premiums in that market.

Other Risk-Management Tools. The government also might need to use other tools to compensate insurers for the cost and financial risk of administering the default plan or for the cost of being part of the same risk-adjustment system. Particularly in the initial years, private insurers would be uncertain as to the number of people who would be covered by the default plan and their health care spending. As a result of that uncertainty, private insurers might be less willing to participate in a risk-adjustment system that included a default plan or they would require higher premiums to take on the additional risk of offering coverage in the initial years of implementation. To mitigate those concerns, the government could use other tools, such as a reinsurance or risk-corridor program, to reduce uncertainty and stabilize premiums for the default plan and other plans in the risk pool in the initial years after the default plan was introduced.

A reinsurance program would compensate all insurers that participated in the same risk-adjustment system (for example, all insurers in the nongroup market) if the market as a whole experienced unanticipated higher costs in the years following the introduction of the default plan. A risk-corridor program would compensate particular plans (such as the default plan) if their actual costs exceeded anticipated costs by a particular threshold.

Informing People About Their Eligibility for Default Coverage and the Plan’s Benefits. In order for the default plan to provide comprehensive access to care to otherwise uninsured people, those without an alternative source of coverage would need to be made aware that they were automatically covered by the default plan and

be informed of the plan’s benefits. In the initial years following implementation of default coverage, an outreach campaign could educate people about their eligibility for the default plan and its associated benefits. People would need to know who would be covered by the default plan automatically, what cost sharing would be required by that plan, and which providers participated in the default plan. An effective outreach campaign would increase the number of people who would seek health care knowing that the cost of their care would be covered by the default plan, but it would be difficult to fully inform all people.

If only some providers participated in the default plan, informing people about which providers were included in the default plan’s network would be challenging because, in many cases, those people would not have previous experience using the default plan. If people were not adequately informed, some would seek care without knowing whether a provider was in or out of the default plan’s network. If people received treatment from a provider that did not participate in the network of the default plan, they could encounter “surprise billing”—that is, they could be required unexpectedly to pay for the full cost of that care at the out-of-network rate (a price that is typically much higher than the rate negotiated by insurers for providers that participate in the plan’s network).

Policy Approaches

CBO identified four general approaches that have the potential to achieve near-universal coverage using premium subsidies and automatic coverage through a default plan that would be partially or fully subsidized. The introduction of default coverage could be accomplished while otherwise preserving most features of the current system or by completely overhauling the system. The four approaches described here cover that spectrum; each successive approach would require more significant changes.

Approach 1: Partially Subsidized Default Coverage That Operates in Tandem With Current Sources of Coverage

Policies based on this model would retain most key features of the current system. Specifically, employment-based coverage would continue to play a large role, income-based subsidized coverage would still be available through existing health insurance marketplaces, and

current eligibility criteria for Medicaid and CHIP would be preserved.

The most significant new feature of this approach relative to current law would be the introduction of automatic coverage through a partially subsidized default plan for people who do not otherwise enroll in health insurance and are not eligible for Medicaid or CHIP. To provide subsidized default coverage to nearly all people who do not enroll in another source of coverage, the employer firewall also would be eliminated. (See Box 1 for a discussion of the challenges of providing default coverage while retaining the employer firewall.) Full premium subsidies would be extended to people whose income is below 100 percent of the FPL. Policies based on this approach could further reduce out-of-pocket premiums and encourage active enrollment in coverage from other sources by increasing the generosity of premium subsidies for other income groups.

Default Coverage. For people who are ineligible for Medicaid and CHIP and not enrolled in another source of coverage, default coverage would be provided either by a private plan or by a new public health insurance option that would be offered through existing health insurance marketplaces. Premium-equivalent taxes would be collected from those otherwise uninsured people through the tax system to help finance the default coverage and maintain incentives for people to actively enroll in other sources of insurance. Those taxes would be equal to the premium of the default plan less any premium tax credits for which the person was eligible (similar to the amounts those people would pay to enroll in an equivalent plan through the marketplaces) for each month the person did not have another source of coverage. Lower-income people would contribute less to the financing of default coverage, and people whose income fell below the tax-filing threshold would not be required to pay any premium-equivalent taxes. People who are currently eligible for but not enrolled in Medicaid and CHIP would receive default coverage through those programs (and no premium-equivalent taxes would be collected).

Enrollment Process. The enrollment process for Medicaid and CHIP, nongroup coverage, and other sources of coverage would remain unchanged from that in effect under current law. For people who did not actively enroll in a plan during an open-enrollment period, a default private or public plan (or Medicaid and CHIP, for those who were eligible) would provide

coverage without the need for individuals to actively enroll. To use the default plan to receive covered health care, individuals who were uninsured could enroll in the plan at any time themselves or through certain health care providers.

Premiums. Under this approach, premiums for nongroup coverage would continue to be subsidized through premium tax credits for low- and middle-income people who obtained coverage through the health insurance marketplaces.

Premium Subsidies for Nongroup Coverage. Eligibility for premium tax credits to purchase nongroup coverage through the health insurance marketplaces would be extended to those whose income is below 100 percent of the FPL, allowing them to purchase a plan at a zero net premium and filling in the “coverage gap” for people in states that have not expanded Medicaid under the ACA. (Under current law, many adults who reside in states that have not expanded Medicaid and whose income is below 100 percent of the FPL have no options for subsidized coverage because they are ineligible for both Medicaid and premium subsidies for plans obtained through the health insurance marketplaces. Those people are often referred to as falling into a coverage gap.)

Eligibility for health insurance subsidies could be extended to additional households by raising the eligibility threshold for premium subsidies from 400 percent of the FPL to 500 percent of the FPL, or higher. Under current law, people whose income is just under 400 percent of the FPL are eligible for subsidies that limit their cost of purchasing a silver plan to 9.78 percent of their income, whereas people with income just over 400 percent of the FPL receive no subsidies. (In 2019, the eligibility threshold was \$48,560 for a single person and \$100,400 for a family of four.) People who are eligible for subsidies pay premiums that are based primarily on their income. People who are not eligible for subsidies pay premiums that primarily depend on their age, and those premiums are smaller for younger people. The effect on premium payments of having income just below or above the eligibility threshold is correspondingly small for younger people and much larger for older people. For example, 27-year-old single adults paid about 9 percent of their income, on average, for the lowest-cost silver plan in 2019 if their income was \$45,000 (eligible for a subsidy) or \$50,000 (not eligible). Sixty-year-old single adults paid, on average, about 8 percent of their

Box 1.

Introducing Default Coverage While Maintaining an Employer Firewall: Implications and Challenges

Under current law, people with an offer of affordable employment-based coverage are ineligible for premium subsidies in the health insurance marketplaces because of a provision of the Affordable Care Act known as the employer firewall. In 2020, an offer of affordable employment-based coverage is defined by the Internal Revenue Service as one in which an employee's out-of-pocket premium is less than 9.78 percent of household income for a single plan. The employer firewall was enacted as a way to minimize reductions in employment-based insurance by preventing people with an offer of affordable employment-based coverage from switching to subsidized coverage in the marketplaces and to encourage employers to continue offering such coverage.

Although introducing default coverage while maintaining an employer firewall is possible, the Congressional Budget Office did not find any detailed policy proposals that would achieve near-universal coverage while maintaining the firewall. Maintaining an employer firewall would present several challenges. Those challenges would arise only for proposals in which default coverage was partially subsidized. An employer firewall would not be relevant for proposals in which default coverage was fully subsidized through broad-based tax revenues.

The key implications of introducing default coverage while maintaining the employer firewall, compared with approaches that would remove the firewall, are as follows:

- Fewer changes would be made to people's sources of coverage under current law, depending on the relative generosity of the subsidy for default coverage and other sources of coverage.
- Fewer gains in coverage would occur if people with an offer of affordable employment-based insurance were not required to enroll in default coverage. If those people were eligible for default coverage and responsible for the associated tax payment, the firewall would prevent them from being eligible for subsidies to offset the tax obligation, and they would be liable for a large tax payment.
- Administrative complexity would be greater because a government entity would have to verify whether each uninsured person had an offer of affordable employment-based coverage.

Fewer Changes to Sources of Coverage

Under proposals that introduced default coverage and retained the employer firewall, there probably would be fewer changes to current sources of coverage than under the approaches described in this report that would remove the firewall. That is, more people with employment-based insurance probably would retain that coverage if the firewall remained intact.

The extent of changes to sources of coverage would depend on the relative generosity of the subsidy for default coverage and other sources of coverage, the size of the firm, and the income distribution of employees eligible for an offer of employment-based coverage. If the subsidy available for default and other sources of coverage was the same as the premium tax credits under current law, employers' incentives to offer coverage most likely would be similar to the incentives that exist under current law. However, if subsidies became more generous and enough employees found subsidized default and other coverage to be a more attractive alternative to employment-based coverage, some employers might have fewer incentives to offer coverage.

Fewer Gains in Coverage If People With an Offer of Affordable Employment-Based Insurance Were Ineligible for Default Coverage

A policy that introduced partially subsidized default coverage while maintaining the employer firewall would need to specify whether people with an offer of affordable employment-based coverage who chose not to enroll in their employer's plan (or an alternative plan) would be required to enroll in default coverage and responsible for the associated premium-equivalent tax to finance that coverage. If those people were eligible for default coverage and responsible for paying the associated tax, the firewall would prevent them from being eligible for subsidies (such as premium tax credits) to offset the tax obligation. Those people would then be liable for a large tax, which could be surprising and particularly burdensome for people with modest income.

A proposal could include additional requirements to minimize the number of people who would be covered by the default plan and responsible for large tax payments. For example, the policy could require employers to automatically enroll all of their employees in their least expensive plan during the open-enrollment period unless the employee chose an alternative plan offered by the employer, provided proof of

Continued

Box 1.

Continued

Introducing Default Coverage While Maintaining an Employer Firewall: Implications and Challenges

other coverage, or opted out. (A requirement that certain large employers with more than 200 employees auto-enroll those employees in a health insurance plan was attempted in the past, but that requirement was not implemented and was repealed by Bipartisan Budget Act of 2015 before it took effect. Some of the concerns related to employer auto-enrollment include how to determine whether an employee already has coverage through a family member or dependent and how much discretion employers have in choosing a health insurance plan for their employees.)

Alternatively, if a proposal prevented people with an offer of affordable employment-based coverage from receiving default coverage and it did not levy the associated tax to finance default coverage, such a proposal would result in fewer gains in coverage. In that case, many uninsured people who do not currently take up their offer of affordable employment-based

coverage (or another source) would probably continue to decline such coverage, leaving millions of people without health insurance.

Increased Administrative Complexity

Maintaining an employer firewall alongside default coverage would increase the administrative complexity and cost of implementing default coverage. Those administrative complexities and costs would arise because a government entity would have to verify whether each uninsured person had an offer of affordable employment-based coverage, which could require developing new reporting systems. The effectiveness of the employer firewall also would depend on how strongly it was enforced—proposals that increased the relative generosity of the subsidy for default and other coverage would increase the need to enforce compliance with the employer firewall.

income if that income was \$45,000 and 23 percent if their income was \$50,000.¹⁶ Extending eligibility to households whose income is up to 500 percent or more of the FPL would eliminate any sharp increases in premiums for people in that income range, but older people just above the new eligibility threshold might face a similar sharp increase.

Premium subsidies could be made more generous by decreasing the affordability thresholds (the percentage of income that people who qualify for subsidies are expected to pay for a benchmark plan) or by benchmarking the subsidy level to a more generous plan—for example, to the second-lowest-cost gold plan rather than the second-lowest-cost silver plan. More generous subsidies would both reduce the amount that people would pay to enroll in nongroup plans and reduce the size of the premium-equivalent tax that would be levied on people if they did not enroll in a plan. But larger subsidies also would increase the cost to the government.

Gross Premiums in the Nongroup Market. Gross premiums (the total premium charged by insurers before any

premium subsidies are applied) in the nongroup market probably would decrease because previously uninsured and less costly individuals would be brought into the risk pool through default coverage.

If the approach included a new public option, premiums could be even lower. The public option could have lower premiums than comparable private plans available through the health insurance marketplaces if the public option had lower costs—because of lower provider payment rates or administrative costs, for example. Gross premiums in the marketplaces also might decrease if the public option put downward pressure on the premiums of private plans. Alternatively, the public option could have higher premiums if it operated less efficiently, used fewer managed care tools that constrained utilization (such as prior authorization or gatekeeping), or attracted enrollees who were less healthy in ways that were not captured by the risk-adjustment system. A public option with higher premiums also could have a broader network of participating providers or higher payment rates, which would make care more accessible.

In addition, some low- and middle-income people who previously obtained coverage through their employers would be brought into the nongroup market once they were eligible for premium subsidies—because of

16. See Figure 2 in Rachel Fehr and others, *How Affordable Are 2019 ACA Premiums for Middle-Income People?* (Kaiser Family Foundation, March 2019), <https://tinyurl.com/y2lvvmkh>.

the elimination of the firewall—which could increase or decrease gross premiums, depending on the average spending of those enrollees.

Net Premiums in the Nongroup Market. Those lower gross premiums in the nongroup market would primarily decrease net premiums (the premiums paid by individuals after any premium subsidies are applied) for unsubsidized, higher-income households because net premiums for subsidized households are already capped as a percentage of their income. Net premiums for low- and middle-income subsidized households could decrease if the policy increased the generosity of premium subsidies in the ways discussed earlier. Net premiums also would fall to zero for low-income households that became newly eligible for premium subsidies because they were living in a state that had not expanded Medicaid.

Premiums for Other Types of Insurance. Premiums for employment-based insurance would continue to be subsidized through existing tax preferences. Premiums for some employment-based plans might change, depending on whether the people who switched from employment-based coverage to subsidized marketplace coverage were more or less healthy than the people who retained employment-based coverage. Premiums for people obtaining coverage through other sources (such as CHIP) would remain about the same.

Cost Sharing and Benefits. Cost sharing for existing sources of coverage could remain unchanged from current law under some specifications, or it could decrease. For example, cost sharing could decrease for some groups if eligibility for cost-sharing reductions was expanded, or if premium subsidies were benchmarked to a more generous plan, such as a gold plan. Covered benefits for existing sources of coverage would remain unchanged from current law. The default private or public plan could be required to have the same amount of cost sharing as the benchmark plan used to determine premium subsidies (currently a silver plan, with income-based CSRs) or a less generous plan.

Role of Private Plans. Private plans would continue to play a large role under this approach. Most people under the age of 65 would continue to receive private coverage either through employers or through the nongroup market. Enrollment in nongroup private plans would increase if default coverage was provided by a private plan. People who were newly eligible for subsidized

coverage through the marketplaces would enroll in private plans, and some people would gain coverage through a private default plan.

Even if the approach included a public option, private plans would still continue to play a large role. Most people under the age of 65 would continue to receive private coverage through employers or in the nongroup market. Enrollment in nongroup private plans could increase or decrease: On the one hand, some people would switch from private coverage to the new public option; on the other hand, the total size of the nongroup market would increase as more people whose income fell below 100 percent of the FPL became eligible for premium subsidies and as some low- and middle-income workers switched from employment-based coverage to a subsidized marketplace plan.

Role of Employment-Based Coverage. Employment-based coverage would play a smaller role under this approach than under current law, but most people who currently obtain coverage through employers probably would continue to do so, in part because of its tax advantages. Employment-based insurance also would continue because of its effectiveness in pooling risks and because of the lower costs for some administrative activities (for instance, for marketing and collecting premiums) compared with nongroup insurance.

Eliminating the employer firewall would lead some low- and middle-income people who are eligible for employment-based coverage to forgo that coverage in favor of subsidized marketplace or default coverage. Lower-income workers who were eligible for the largest premium subsidies would be the most likely to choose marketplace coverage over employment-based coverage, and some firms would design their insurance offerings to encourage them to do so. For example, some firms might increase employees' premium contributions to a level that would make it more expensive for their lower-income workers to purchase the employment-based plan rather than purchase subsidized marketplace coverage.

Number of Employers Offering Insurance. Employers would respond differently to the elimination of the firewall, depending on the income mix of their workers and the number of workers in their firm. Employers with workers whose income was too high to qualify for marketplace subsidies would have a strong incentive to offer insurance even in the absence of the firewall. Employers

with only some workers who were eligible for such subsidies would weigh the costs and benefits to their employees of offering insurance. Those employers also would consider what fraction of their employees would be likely to take up that offer, because insurers often charge higher premiums to small firms that do not have high participation rates among their workers. Small firms with many workers who qualified for subsidies would be the most likely to stop offering coverage if removing the firewall caused those workers to switch to subsidized marketplace coverage.

Altogether, employers probably would have fewer incentives to offer coverage once the employer firewall was eliminated, but the number of employers that changed their offerings would depend on the generosity of the premium subsidies available to their workers. If the generosity of premium subsidies for marketplace plans remained unchanged from current law, the number of employers who stopped offering insurance would probably be small. Some employers might not offer coverage if enough of their employees found subsidized marketplace and default coverage to be a more attractive alternative than employment-based coverage. In that case, employers generally would offset that reduction in health benefits by offering higher wages to their employees.

However, eliminating the employer firewall might lead a few additional employers to offer coverage. Currently, some firms may choose not to offer coverage because if they did so, the firewall would prevent their low- and middle-income employees from enrolling in more attractive subsidized marketplace coverage. If the firewall was eliminated, those firms could offer coverage primarily for the benefit of higher-income employees, who would not qualify for subsidies, without preventing their low- and middle-income employees from being eligible for subsidized marketplace or default coverage. Because enrollment in that employment-based coverage would largely be limited to higher-income employees, those firms' total costs of offering coverage would be lower in the absence of the firewall.

Although eliminating the firewall might lead slightly more firms to offer employment-based coverage, overall enrollment in that coverage probably would decline because the number of low- and middle-income employees switching to marketplace or default coverage probably would exceed the number of higher-income

employees enrolling in newly offered employment-based coverage.

Role of Public Programs. Under this approach, existing public programs would play a role similar to the role they play under current law. Many low-income people would continue to receive coverage through Medicaid or CHIP, and some would continue to use other public coverage, such as Medicare for the disabled.

Along with extending eligibility for marketplace subsidies to people whose income was below 100 percent of the FPL, the federal government would finance the entire cost of the expansion population in states that expanded Medicaid under the terms of the ACA (rather than 90 percent of the costs as under current law). That would give state policymakers flexibility to choose whether to provide subsidized coverage to people below 100 percent of the FPL through Medicaid or marketplace plans. Because both forms of coverage would be fully subsidized by the federal government, states that have already expanded Medicaid under the terms of the ACA would not have a financial incentive to scale back their expansion of the program. Other states could choose to expand Medicaid (with the federal government financing the entire cost) or they could cover those people through marketplace subsidies, depending on their priorities. Fully financing the cost of Medicaid enrollees made eligible through expansion under the terms of the ACA would increase costs incurred by the federal government for covering those people.

Public plans would play a larger role if the approach included a new public option that was offered through health insurance marketplaces and that provided default coverage. More people would be enrolled in public coverage through the new public option, but enrollment in the public option would be a small share of overall enrollment because most people who currently obtain private insurance through employers would continue to do so, and some people in the nongroup market would continue to choose private plans.

Variants and Examples of This Approach. Covering all people without an alternative source of coverage with a default plan could be accomplished in different ways by defining what type of entity would provide default coverage. Variants of this approach include a default plan that would be provided by private insurers or through a

public option that also would be available to all people through existing health care marketplaces.

Private Default Coverage. Under this variant, a private plan could serve as default coverage for people who did not enroll in another plan or program. A proposal by Fiedler and others incorporates all of the key features of this approach, including a similar default coverage mechanism and the expansion of eligibility for subsidized coverage, but it does so in ways that are somewhat different from those described here.¹⁷ For example, rather than extending eligibility for marketplace subsidies to those whose income was below 100 percent of the FPL, the proposal would provide states that have not expanded Medicaid incentives to do so. That proposal has the potential to achieve near-universal coverage if all states chose to expand Medicaid when faced with those incentives.

Public Option Offered Through the Marketplaces. A public option that was offered through the existing health insurance marketplaces could provide near-universal coverage if the option acted as a default plan and provided coverage to all otherwise uninsured people. The public option could be specified to have the same generosity as the benchmark plan used to determine the amount of premium subsidies (currently, a silver plan), with comparable income-based cost-sharing-reduction subsidies. People who were assigned to the public option through the default mechanism would be responsible for tax payments that were equal to the net premium they would have faced had they enrolled through the health insurance marketplaces.

Another proposal, by Blumberg and others, would incorporate all of the key features of this approach, including introducing a public option with a similar default role and expanding eligibility for subsidized coverage.¹⁸ That proposal also would increase the generosity of

marketplace subsidies and establish a federal reinsurance program for the nongroup market. Many other proposals would introduce a public option in the nongroup market, but they would not achieve near-universal coverage unless paired with a default coverage mechanism.¹⁹

Approach 2: Partially Subsidized Default Coverage Through a Large Public Program That Replaces Medicaid, CHIP, and the Nongroup Market and Retains Employment-Based Coverage

Under this approach, a new public health insurance program would replace the current nongroup market and Medicaid and CHIP acute care coverage, and all coverage would be provided through employers, the new public program, or existing public programs such as TRICARE. The public program would allow people to choose between a publicly administered plan and multiple privately administered plans meeting the same minimum requirements for cost sharing and covered benefits. That structure would be similar to that of the Medicare program, which allows beneficiaries to choose between the publicly administered Medicare fee-for-service program and private Medicare Advantage plans. The publicly administered plan would serve as the default plan, which would provide automatic coverage for people who did not have an alternative source of coverage.

Large employers would be required to offer coverage that qualified for the same tax preferences that are available under current law or to make mandatory contributions to the public program. Employees could choose to receive coverage through their employer or the public program. All low- and middle-income people, including those with an offer of employment-based coverage, would be eligible for premium subsidies to purchase coverage through the public program.

Enrollment Process. Enrollment in the public program could occur through an online portal or an alternative process administered by one or more federal or state agencies, whereas the enrollment process for employment-based coverage and other sources of coverage would remain unchanged from the processes used

17. See Matthew Fiedler and others, "Building on the ACA to Achieve Universal Coverage," *New England Journal of Medicine*, vol. 380, no. 18 (May 2, 2019), pp. 1685–1688, <http://doi.org/10.1056/NEJMp1901532>.

18. See "Simulated Reform Packages: Reform 5," in Linda J. Blumberg and others, *From Incremental to Comprehensive Health Insurance Reform: How Various Options Compare on Coverage and Costs* (Urban Institute, October 2019), p. 6, <https://tinyurl.com/yy9atuf7> (PDF, 1.05 MB).

19. See the Keeping Health Insurance Affordable Act of 2019, S. 3, 116th Cong.; the Choose Medicare Act, H.R. 2463 and S. 1261, 116th Cong.; the Medicare-X Choice Act of 2019, H.R. 2000 and S. 981, 116th Cong.; and the CHOICE Act, H.R. 2085 and S. 1033, 116th Cong.

under current law. For people who did not actively enroll in a plan, the public plan would provide default coverage without the need for active enrollment.

Premiums. Premiums in the new public program could be regulated in a manner similar to that governing the nongroup market under current law (which stipulates that premiums can vary by age, family size, geography, and tobacco use). Alternatively, they might be allowed to vary on the basis of a more limited set of factors (such as requiring that a plan charge the same premium to all people within the same geographic area). Those choices would affect both the gross premiums under the new program and the net premiums that different people would face after applying any relevant premium subsidies. As under current law, premium subsidies would be based on the percentage of income that people would be required to pay to purchase a benchmark plan.

Gross Premiums in the Public Program. Gross premiums in the public program would depend on the average health care spending of people who were enrolled in the program, which might be different from the average spending of people enrolled in nongroup plans under proposals similar to Approach 1 (whether or not a public option was offered). In addition to covering people currently enrolled in marketplace plans and other nongroup insurance plans, the public program would cover people who are currently uninsured (who tend to be younger and healthier), those who are currently enrolled in Medicaid and CHIP (who tend to be less healthy), and some people who are currently enrolled in employment-based plans (who could be more or less healthy, depending on the generosity of the public program and how employers adjusted their coverage offerings in response to the new policy).

Net Premiums in the Public Program. If premiums in the new program were regulated in a manner similar to that governing the nongroup market under current law, net premiums in the proposed public program would be lower than in the nongroup market (as it operates under current law) for the low- and middle-income people who were eligible for subsidies. People with low income would receive a subsidy that would cover the full cost of the benchmark plan used to determine subsidies in the new public program. Middle-income people would be eligible for more generous premium subsidies than the ones that are available through the health insurance marketplaces under current law. As with Approach 1, people

who received coverage through the default mechanism would have a net tax liability equal to the income-based premiums they would have paid if they had actively enrolled in the public plan. Higher-income people who enrolled in the new public program and were not eligible for subsidies would face the entire gross premium of plans in the program.

Premiums for Employment-Based Insurance. Premiums for employment-based coverage also might change if the public program attracted a large number of people who currently are enrolled in employment-based plans, and if the risk profile of those remaining in employment-based coverage differed from that existing under current law. For example, if the public program attracted less healthy individuals (who tend to be more costly to insure), premiums could decrease for those remaining in employment-based coverage.

Cost Sharing and Benefits. Plans in the public program would be required to have a minimum generosity level. For example, they could be required to have the same generosity as a silver or gold plan, with income-based cost-sharing requirements. As is the case with cost-sharing reductions in the marketplaces under current law, lower-income individuals would be responsible for smaller cost-sharing payments. Depending on the specifications of the benefit design, cost sharing could remain unchanged from current law, or it could decrease. For example, cost sharing could decrease for some groups if income-based cost sharing was more generous than under current law or if the minimum plan generosity required by the public program was specified to be greater than under current law.

Covered benefits could be specified to include the essential health benefits required in the marketplaces under current law, or they could be expanded to include additional services, such as dental and vision coverage and long-term services and supports. (Long-term services and supports consist of health care and related services provided to people with functional or cognitive limitations to help them perform routine daily activities over an extended period).

Role of Private Plans. Private plans would continue to play a large role in both the new public program and employment-based insurance. Some people under the age of 65 would continue to receive private coverage through their employers, but enrollment in

employment-based insurance would decrease as some workers and their families enrolled in the new public program. The extent to which people shifted to the public program would depend on the generosity of premium subsidies, the generosity of coverage under the program (that is, the actuarial value and covered benefits) relative to employment-based coverage, and the size of the required employer contributions and any other requirements or penalties to continue offering coverage.

Role of Employment-Based Coverage. Employment-based coverage would continue, but it would play a smaller role under this approach than under current law. Large employers would be required to offer private coverage or to offer coverage through the public program by making mandatory contributions on behalf of their employees (in which case employees could choose between private plans and the public plan offered through the public program). Those mandatory contributions would be larger than the penalties employers face for not offering coverage under current law. The ability of employers to make contributions toward plans offered through the public program would resemble the final rule governing recent health reimbursement arrangements in effect under current law; that rule allows employers to direct a limited amount of pretax premium contributions to subsidize their employees' choice of private plans offered in the nongroup market.²⁰

Many large employers probably would continue offering coverage outside of the public program, particularly if the cost of offering that coverage was less than the contributions they would be required to make to offer coverage through the public program; but the incentives for employers to continue offering coverage would depend on various features of the policy. For example, if the mandatory contributions were structured as a percentage of the employer's payroll, firms employing higher-income workers probably would find it less expensive to continue offering coverage outside of the public program. If the policy did not include sufficiently large employer penalties or requirements to offer coverage, employers would have less incentive to offer coverage outside of the public program.

A more generous level of benefits and premium subsidies for plans offered through the public program also would make covering employees through the public program more attractive than offering coverage outside of the program. Although many employers would continue to offer coverage, others would discontinue coverage and their employees would receive coverage through the public program. Some people, particularly those in lower-income households who would have low or no premiums for the public program, would opt for the public program over employment-based coverage even if their employer offered coverage. As a result, people who retained employment-based coverage would have higher income, on average, than the people enrolled in employment-based coverage under current law and than participants in the public program would have under this approach.

Role of Public Programs. Enrollment in public coverage would increase relative to current law. Although many people would enroll in the public plan through the new public program, many others would select a private plan through the new program or through their employers. The new public program could be based on an existing program, such as Medicare, or it could be an entirely new program. Some individuals would continue to use other public coverage, such as the coverage Medicare provides for the disabled.

Examples of This Approach. The Medicare for America Act of 2019 (H.R. 2452) uses a model that is similar to the one described in this approach. That bill incorporates all of the key features of this approach, including a new large public program called Medicare for America that would entirely replace Medicaid, CHIP, and the nongroup market.²¹ It also includes requirements for large employers and other elements that ensure many people would continue to use private employment-based coverage.

However, H.R. 2452 offers more specific details than the general approach described here, and it includes some elements that are different. For example, H.R. 2452 also would eliminate the existing Medicare program, and it would cover those people in the new Medicare for

20. For further discussion of the final rule for health reimbursement arrangements, see Katie Keith, "Final Rule on Health Reimbursement Arrangements Could Shake Up Markets," *Health Affairs Blog* (June 14, 2019), <https://tinyurl.com/y6re7gdt>.

21. See the Medicare for America Act of 2019, H.R. 2452, 116th Cong. For a related proposal, see Center for American Progress Health Policy Team, *Medicare Extra: Universal Coverage for Less Than \$3 Trillion and Lower Health Care Costs for All* (July 2019), <https://tinyurl.com/yvx9f55d> (PDF, 1.18 MB).

America program, which would allow them to choose either a publicly administered plan or one of multiple participating private plans. Large employers would pay an 8 percent payroll tax to help finance the new public program if they did not offer coverage.

If enacted, the legislation would require the government to auto-enroll all uninsured people in Medicare for America. In CBO's assessment, however, prospective auto-enrollment of all uninsured people would not be feasible because it would require the government to identify every person at the moment they lost other coverage and to begin collecting premiums from them. The legislation has the potential to achieve near-universal coverage if the public program also served as a default plan that provided automatic coverage to uninsured people who could not be auto-enrolled.

A different proposal by Blumberg and others also shares the key features of this approach, including a new regulated marketplace of private plans and a public plan that would replace the current nongroup market, Medicaid, and CHIP; generous subsidies to purchase insurance through that marketplace; a continued role for employment-based coverage; and default coverage through a public plan.²² However, that proposal would not require large employers to offer coverage or make mandatory contributions.

Approach 3: Premium Subsidies for All People and Default Coverage Through a Fully Subsidized Plan

The defining feature of this approach (often called a premium support system) is that all people in the eligible population under the age of 65 would receive a premium subsidy from the government that was large enough to cover the entire cost of a benchmark plan. Under this approach, a specified level of benefits would be provided, along with cost-sharing reductions for low-income people. People would use the subsidy to purchase a plan of their choice from a health insurance marketplace that included multiple private plans and, potentially, a public option. Under this approach, preferential tax treatment

for employment-based health insurance would be eliminated. Employers would have little incentive to offer primary health insurance coverage, but they might offer supplemental coverage to reduce cost sharing or provide additional benefits not covered by marketplace plans.

The subsidies could be provided as a refundable tax credit, which would reduce revenues and increase outlays, or as direct payments, which would only increase outlays; the two would be economically equivalent.²³ Different variants could specify a less generous level of benefits (for instance, catastrophic coverage only) that would be similar to those available through a bronze plan under current law. Alternatively, the variants could specify a more generous level of benefits that would be similar to those available through Medicare or a gold plan.

This approach would represent a significant change from the current system: Employment-based insurance would have a much smaller role than under current law, and Medicaid and CHIP would no longer provide primary coverage for acute care services, which include comprehensive major medical services and prescription drugs. The Medicare program would continue to exist for people over the age of 65 and the disabled population.

A fully subsidized benchmark plan would provide default coverage for people who did not actively enroll in a plan and would require no additional tax payments. Because no additional tax payments for default coverage would need to be collected from uninsured people, default coverage would be substantially easier to implement than would be the case with Approaches 1 and 2.

22. That proposal refers to default coverage as continuous autoenrollment with retroactive enforcement. See "Description of Policy Options: The Building Blocks of Healthy America," Variant 3: "HA With CARE," in Linda J. Blumberg and others, *The Healthy America Program, An Update and Additional Options* (Urban Institute, September 2019), p. 3, <https://tinyurl.com/y3x3zyrs> (PDF, 533 KB).

23. For example, under President George H.W. Bush's 1992 proposal, low- and middle-income individuals who were not covered by Medicare, Medicaid, the Veterans Health Administration, or the Civilian Health and Medical Program of the Uniformed Services would have been eligible for a tax credit or tax deduction to purchase health insurance. The tax credit would have extended up to a certain threshold based on modified adjusted gross income and then it would have been phased out. Such a proposal paired with the additional elements of default coverage or a large and enforced individual mandate penalty could achieve near-universal coverage. See R. Glenn Hubbard, "The President's 1992 Health Care White Paper: An Economic Perspective," *National Tax Journal*, vol. 45 no. 3 (1992), pp. 347–356, <https://ntanet.org/NTJ/45/3/ntj-v45n03p347-56-president-1992-health-care.html>.

Enrollment Process. People would use the premium subsidy to purchase a plan from a health insurance marketplace. They would be able to select a new plan each year during an open-enrollment period.²⁴ For people who did not actively enroll in a plan, a default zero-premium plan would provide coverage without the need for them to actively enroll.

Premiums. A premium subsidy that was equal to the full premium of a specified benchmark plan in the marketplace would be more equitable if it varied with both age and income instead of just with income.²⁵ People who chose the benchmark plan (or a plan that cost less than the benchmark plan) could enroll without paying a premium. They could still choose to enroll in a more expensive plan, which would cover additional benefits or have lower cost sharing, but they would be responsible for any additional costs above the benchmark subsidy. The premium subsidy could be made more or less generous by adjusting the plan to which it was benchmarked.

Cost Sharing and Benefits. The premium subsidy would be large enough to cover the entire cost of a benchmark plan with a minimum level of cost-sharing and covered benefits. The minimum amount of cost sharing could be relatively high, as in a plan that provided only basic catastrophic coverage for high-cost medical events in excess of a certain dollar amount, or it could be relatively low, similar to that of a gold plan available through the current health insurance marketplaces. Cost-sharing reductions also would be available for certain populations, such as low-income people. People without cost-sharing reductions could choose to enroll in a plan with lower cost-sharing amounts.

24. Some people also would be eligible to switch plans during a special enrollment period if they experienced a qualifying life event, such as the birth of a child.

25. If the 3:1 age-rating rule in effect under current law remained in place and the refundable tax credit or direct payment did not vary with age, the level of benefits that could be purchased with the refundable tax credit or direct payment amounts would vary by age—for instance, a 64-year-old person would be able to buy a much less generous plan than a 21-year-old. The amount of benefits that could be purchased with a refundable flat tax credit or direct payment also would vary by geographic area because premiums vary by geographic area and state. For further discussion of flat premium tax credits, see American Academy of Actuaries, “Auto-Enrollment Into Individual Market Health Insurance Coverage” (September 2018), <https://tinyurl.com/y5a3v6yo> (PDF, 215 KB).

The required covered benefits under a premium support system could be similar to the essential health benefits specified by the ACA or the benefits provided by Medicare, or they could be based on something else, such as a cost-effectiveness criterion. They could include additional benefits, such as dental and vision services.

Role of Private Plans. Private plans would continue to play a significant role under this approach. People under the age of 65 could use the premium subsidy to purchase a private plan from a marketplace; otherwise, they would be covered under a zero-premium default plan.

Role of Employment-Based Insurance. Employers probably would have little incentive to offer primary health insurance coverage under a premium support system if everyone in the eligible population received a premium subsidy from the government to purchase coverage through a marketplace. However, depending on the premium subsidy amount, cost-sharing requirements, and the type of benefits offered by the marketplace plans, this approach could allow employers to offer supplemental coverage to their employees. Such supplemental coverage could be used to reduce cost-sharing amounts, or it could be used to offer benefits that were not available through marketplace plans, such as dental and vision services. If a marketplace plan provided basic catastrophic coverage, for example, then employers could offer coverage that provided the same benefits they would have provided under current law on top of the catastrophic coverage. In such a case, their employees would experience little change in health insurance benefits under this approach compared with current law.

Because tax preferences for employment-based health insurance would be eliminated under this approach, people with the same income and similar family responsibilities would receive the same benefits for medical costs, and subsidies would not be larger in higher tax brackets. (Current law results in larger subsidies for people in higher tax brackets because of the structure of tax preferences for employment-based coverage).

Role of Public Programs. A premium support system could include a public option that would be available along with private plans in the new marketplace. As in Approach 1, the public option could be modeled on an existing public program, such as Medicare. A premium support system also would need to specify the role of other public programs, such as Medicaid, TRICARE, and the Veterans Health Administration. Some components

of those programs could continue to operate or provide benefits for services not covered by the premium support system. The Medicaid and CHIP programs would be substantially smaller because they would no longer provide primary coverage for acute care services. But those programs could continue to provide long-term services and supports for low-income and disabled populations.

Variants and Examples of This Approach. An approach that offered everyone a subsidy covering the entire cost of a benchmark plan that would be purchased through a marketplace would depend on the way the benchmark plan was defined and how the marketplace was structured.

Fully Subsidized Catastrophic Coverage for All. One variant would be to benchmark premium subsidies to a catastrophic plan with high levels of first-dollar cost sharing, such as a high-deductible plan.²⁶ However, under the catastrophic plan, there would be no cost sharing for the treatment of chronic conditions and preventive services, such as vaccinations and prenatal care. Deductibles would vary on the basis of household income, and individuals whose income was below a certain level would not have a deductible. People could use their subsidy to enroll in a catastrophic plan at no cost or they could use their subsidy toward the cost of a more generous plan offered through a marketplace of private plans if they paid the additional premium. Under this variant, there also could be a public option in the marketplace. Various analysts have proposed an approach similar to the one described here.²⁷

Fully Subsidized Generous Coverage for All. Another variant of this approach would be to benchmark premium subsidies to a plan with generous benefits, similar to the Medicare program or a gold plan under current law. Under this approach, people would use their subsidy to purchase a plan of their choice from a health insurance marketplace that included multiple private

plans.²⁸ A public option also could be offered alongside private plans, similar to the current Medicare program, which gives people the choice of enrolling in traditional Medicare or a Medicare Advantage plan.²⁹ An approach that offered fully subsidized generous coverage would require more federal spending than an approach that offered fully subsidized catastrophic coverage.

Approach 4: A Single-Payer System

Under a single-payer system, everyone in the defined population would receive health insurance coverage from the same public plan, and there generally would be no role for private insurance. There would be no premiums, and to achieve deficit neutrality, such a system would need to be financed through broad-based tax revenues; that is, new mechanisms of financing also would be required.³⁰ This approach would involve the most significant departure from the current health care system, and it would be an enormously complex undertaking. Under current law, people receive coverage through various public and private sources, as described earlier in this report. Under a single-payer system, there generally would be no role for employment-based insurance, and the role of other public programs, such as Medicaid and Medicare, would be greatly reduced or eliminated.

Enrollment Process. Under a single-payer system, the government would strive to enroll all people in the defined population in the public plan. People also could be automatically enrolled at the time they were issued Social Security numbers, newborns could be enrolled in hospitals, and other eligible people could be enrolled at the time they sought medical care. Some people seeking medical care would not be eligible for enrollment—because they were visiting from another country,

26. First-dollar cost sharing is the amount that an enrollee is required to pay out of pocket before the health plan starts to pay for benefits.

27. See Ed Dolan, *Universal Catastrophic Coverage: Principles for Bipartisan Health Care Reform* (Niskanen Center, June 2019), <https://tinyurl.com/y4jkkfzco> (PDF, 969 KB). See also Dana Goldman and Kip Hagopian, “The Health-Insurance Solution,” *National Affairs* (Fall 2012), <https://tinyurl.com/y3es67tp>.

28. See George Halvorson and Mehmet Oz, “Medicare Advantage for All Can Save Our Healthcare System,” *Forbes* (June 11, 2020), <https://tinyurl.com/yjyvw8j2>.

29. See Billy Wynne, “The Bipartisan ‘Single Payer’ Solution: Medicare Advantage Premium Support for All,” *Health Affairs Blog* (May 2017), <https://tinyurl.com/y6xba4hx>; Geoffrey Joyce, “Opinion: The Success of Medicare Advantage Makes It a Better Policy Choice Than ‘Medicare for All,’” *MarketWatch* (November 21, 2019), <https://tinyurl.com/y42cj4z>; and Ken Janda and Vivian Ho, “Medicare Advantage for All,” *The Hill* (August 27, 2019), <https://tinyurl.com/y6avusv8>.

30. For further details, see Congressional Budget Office, *Key Design Components and Considerations for Establishing a Single-Payer Health Care System* (May 2019), www.cbo.gov/publication/55150.

for instance—and the enrollment system would need to confirm that they were not eligible. Because people would need to provide information to the enrollment system and some would not do so, coverage would not be completely universal.

Premiums. There would be no premiums under a single-payer system. To achieve deficit neutrality, such a system would need to be financed through broad-based tax revenues.

Cost Sharing and Benefits. A single-payer system would have lower cost sharing than the average under current law. Such a system could include no cost sharing for most services. If the single-payer system included cost sharing, there could be exceptions for certain populations, such as people with low income, children, and the disabled.

The single-payer system would provide comprehensive major medical coverage, but certain items and services, such as over-the-counter medications and cosmetic procedures, could be excluded from coverage. Existing proposals cover a more comprehensive set of benefits than many current sources of coverage, including dental, vision, hearing, and long-term services and supports, but a single-payer system could be designed without those additional benefits.

Role of Private Plans. There generally would be no role, or a very limited role, for private insurance. If private insurance was allowed, it could be limited to services not covered by the public plan. However, private insurance

also could be offered as an alternative source of coverage if enrollees and providers were allowed to opt out of the single-payer system. Alternatively, private insurance could provide benefit enhancements, such as faster access to care or private rooms instead of semiprivate rooms for inpatient stays, or it could be used to access providers that opt out of the single-payer system or to seek care abroad.

Role of Employment-Based Insurance. Employment-based insurance probably would no longer exist under a single-payer health system, or its role would be greatly reduced. For instance, it might provide supplemental coverage for services not covered by the public plan or reduce cost-sharing amounts, if any.

Role of Public Programs. Most public programs, such as Medicaid, CHIP, and Medicare probably would have a limited role or be eliminated under a single-payer system. Some components of those programs could continue to operate separately and provide benefits for services not covered by the single-payer health plan. For example, Medicaid and CHIP could continue to provide long-term services and support benefits only to low-income populations, but the Medicare program would no longer exist.

Examples of This Approach. The two versions of the Medicare for All Act of 2019 include many of the features described in this approach, including no premiums, comprehensive major medical coverage, limited to no cost sharing, and no private insurance that would duplicate the benefits of the single-payer system.³¹

31. See the Medicare for All Act of 2019, H.R. 1384 and S. 1129, 116th Cong.



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About This Document

This report was prepared at the request of Chairman John Yarmuth of the House Committee on the Budget and Representatives Angie Craig, Lizzie Fletcher, and Susan Wild. In keeping with the Congressional Budget Office's mandate to provide objective, impartial analysis, the report makes no recommendations.

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CBO continually seeks feedback to make its work as useful as possible. Please send any comments to communications@cbo.gov.

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