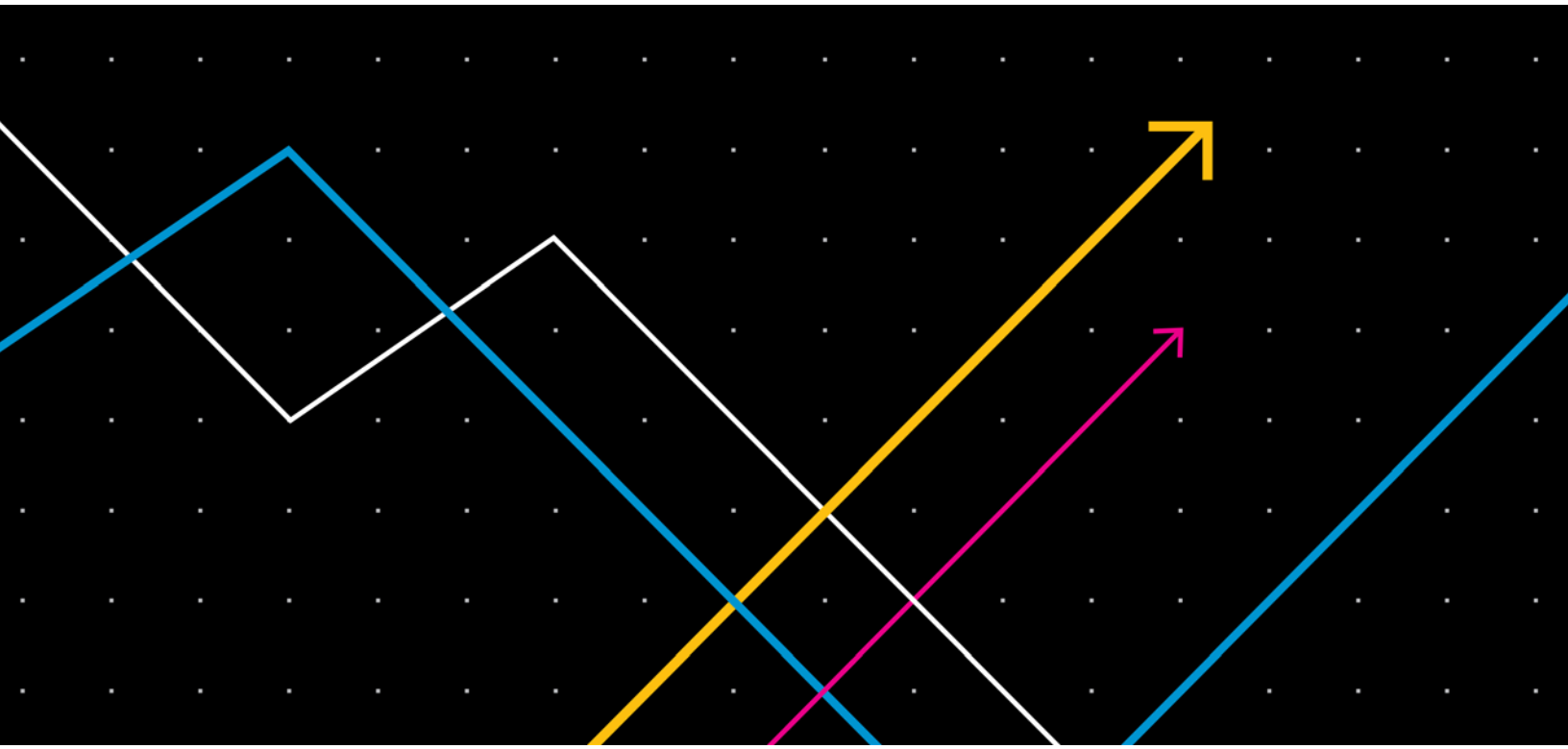

RESEARCH REPORT

Distributional Effects of Alternative Health Reform Proposals

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Distributional Effects of Alternative Health Reform Proposals

In this report, we examine the distributional effects of two health reform policies that are each financed with two alternative tax strategies. We determine the net beneficiaries, for whom new government spending exceeds new taxes, and the net contributors, who pay more in new taxes than they receive in new benefits. Health reform poses difficult choices for policymakers. It is important to know what effects health reform proposals will have on coverage and affordability and which income and demographic groups will most benefit, as well as what a reform policy will cost and who will bear the financing burden.

The first policy we examine is an incremental reform that would expand coverage considerably compared with current law, mainly in the nongroup market through enhanced premium and cost-sharing subsidies and the introduction of a public option. The second policy is a more comprehensive reform that both further improves subsidies and introduces an auto-enrollment feature resulting in universal coverage of people legally present in the United States. Each option is financed through two alternative approaches—an increase in payroll taxes that falls on both employers and employees or a proportional increase in income tax rates. We show the distribution of new spending and new taxes by income, race/ethnicity, age, and region, as well as by what coverage a person would have had without reform.

Our main findings are as follows:

- The incremental reform extends coverage to 14.8 million people, and with auto-enrollment that leads to full coverage of all legally present people; the comprehensive reform covers 27.2 million more people than without reform. The annual federal cost of the incremental reform, modeled as fully phased in in 2022, is $103.6 billion and the comprehensive reform is $168.7 billion. Both improve affordability for large numbers of people, particularly the comprehensive reform.
- Financing reform with an income tax increase is considerably more progressive than financing with a payroll tax increase. Tax units with incomes less than $200,000 pay more under a payroll tax than with income tax financing. For those with incomes higher than $200,000, tax payments are considerably higher with income tax financing.
- Both reforms are redistributive toward populations with low incomes, although more so with income tax financing. The lowest-income groups see coverage and affordability gains and pay

relatively little in new taxes. Those with incomes more than 600 percent of the federal poverty level (FPL) have relatively few new benefits and substantially more in new tax payments.

- Largely because of income differences, Black non-Hispanic,[1] Hispanic, and American Indian and Alaska Native people are net beneficiaries, while white non-Hispanic, Asian American and Pacific Islander, and other (more than one race) people are net contributors.
- There is considerable redistribution by region. People in the South are net beneficiaries in part because of the new and improved subsidies for people with low incomes in states that have not expanded Medicaid (most are in the South). On average, the other three regions are net contributors.
- The uninsured are clear net beneficiaries. They benefit from gaining coverage and improved affordability of care and, because their income is generally low, pay relatively little in new taxes. But only about 30 percent of new federal spending is on the uninsured. The remaining 70 percent of new spending improves affordability for large numbers of people who already have coverage.

Incremental and Comprehensive Reform

The two reform policies are described in table 1. The incremental policy builds on the Affordable Care Act (ACA) but does not provide universal coverage. It substantially improves premium and cost-sharing subsidies. As shown in table 2, the amounts individuals would be expected to pay in premiums are sharply reduced from the current law baseline at each income level. Further, subsidies are extended above 400 percent of the federal poverty level (FPL) with no one paying more than 8.5 percent of income for nongroup coverage. This limit is the same as under the American Rescue Plan Act (ARPA), but the subsidies modeled here are permanent, and the reforms are presented compared with a baseline with pre-ARPA subsidies. Cost-sharing subsidies are also improved relative to current law; they would be tied to gold plans and are never below 80 percent actuarial value. The reform would offer ACA essential benefits for all insurance. The policy would restore the ACA individual mandate penalties and eliminate access to short-term limited duration policies. The policy would have a public option in the nongroup market that would set provider payment rates equal to those in highly competitive markets. In states that have not expanded Medicaid, the federal government would make available marketplace coverage for those between current Medicaid eligibility levels, which are typically very low, and 100 percent of FPL. Because the federal government would pay for this coverage, the policy would also increase the Medicaid matching rate for the expansion population to 100 percent in expansion states. The reform would eliminate the employer coverage firewall, which excludes those

with household employer-sponsored insurance (ESI) offers that are deemed affordable under the ACA from federal subsidies, and there would be no penalty for employers not providing insurance.

TABLE 1
Provisions of Health Reforms Simulated

	Baseline (before ARPA)	Incremental reform	Comprehensive reform
Household premiums	Premium percent of income caps range from 2.07 to 9.83 percent of incomes (marketplaces); no premium subsidies for those with incomes above 400% FPL	Lower percent of income caps than ACA plus extension to higher incomes (marketplaces): ranging from 0 percent to 8.5 percent of income for those with incomes 400% FPL or higher	Lower percent of income caps than ACA plus extension to higher incomes (marketplaces): ranging from 0 percent to 8 percent of income for those with incomes 600% FPL or higher
Cost-sharing	Premium percent of income caps tied to 70% AV plan; additional subsidies to lower cost sharing further for those with incomes up to 250% FPL	Premium percent of income caps tied to 80% AV plan. Additional subsidies to lower cost sharing further for those with incomes up to 400% FPL	Premium percent of income caps tied to 80% AV plan. Additional subsidies to lower cost sharing for those with incomes up to 500% FPL
Covered benefits	ACA essential health benefits	ACA essential health benefits	ACA essential health benefits
Reinsurance	Reinsurance only in states with waiver	Permanent program; $10 billion per year funded by general revenues; grows by percent growth	Permanent program; $10 billion per year funded by general revenues; grows by percent growth
Automatic enrollment	No	Yes; limited to zero-premium households with SNAP or TANF receipt	Yes; all legally present residents enrolled through Continuous Auto-Enrollment with Retrospective Reimbursement (CARE)
Are there penalties for remaining uninsured?	No	Yes; restores ACA penalties	No; all legally present are insured
Is there expanded access to short-term limited duration policies?	Yes	No; returns to 2016 rules	No; all enrolled in compliant coverage
Are there limits on provider payment rates?	No	Yes, in nongroup market: public plan pays at levels equivalent to highly competitive market rates and private nongroup plans capped at same rates in and out of network; this reform requires a public option	Yes, in nongroup market: public plan pays at levels equivalent to highly competitive market rates and private nongroup plans capped at same rates in and out of network; this reform requires a public option
Does it eliminate the Medicaid eligibility gap?	No; no federal subsidies available below 100% FPL and very limited Medicaid eligibility in states that have not expanded Medicaid	Yes; federal government pays 100% of Medicaid expansion population costs in expansion states and lowers marketplace subsidy income threshold to just above Medicaid eligibility in nonexpansion states	Yes; federal government pays 100% of Medicaid expansion population costs in expansion states and lowers marketplace subsidy income threshold to just above Medicaid eligibility in nonexpansion states

	Baseline (before ARPA)	Incremental reform	Comprehensive reform
Are those with ESI offers in the household excluded from federal subsidies?	Yes; the "firewall" prevents people with an affordable offer of insurance from receiving premium subsidies	No	No
Does the program lead to universal coverage?	No	No	For legally present residents but not for undocumented immigrants
Do employers face a penalty for not insuring workers?	Yes	No	No

Source: Urban Institute.

Notes: ARPA = American Rescue Plan Act; ACA = Affordable Care Act; AV = actuarial value, which is the average percentage of covered benefits that a plan will pay; FPL = federal poverty level; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance for Needy Families.

* Nongroup public option coverage is set to approximate Medicare rates by estimating premiums in each rating area as if there were at least five competing insurers and modestly competitive provider markets. See the appendix for additional detail.

TABLE 2

Enhanced Premium Tax Credit and Cost-Sharing Reduction Schedule

	Household Premium as a % of Income			Cost-Sharing Reduction Schedule AV of Plan Provided to Eligible Enrollees (%)		
Income (% of FPL)	**Before ARPA**	**Incremental reform**	**Comprehensive reform**	**Before ARPA**	**Incremental reform**	**Comprehensive reform**
100–138	2.07	0.0–1.0	0	94	95	100
138–150	3.10–4.14	1.0–2.0	0	94	95	100
150–200	4.14–6.52	2.0–4.0	0	87	95	100
200–250	6.52–8.33	4.0–6.0	0.0–1.0	73	90	95
250–300	8.33–9.83	6.0–7.0	1.0–2.0	70	90	95
300–400	9.83	7.0–8.5	2.0–4.0	70	85	90
400–500	NA	8.5	4.0–6.0	70	80	85
500–600	NA	8.5	6.0–8.0	70	80	80
More than 600	NA	8.5	8	70	80	80

Sources: Internal Revenue Service (26 CFR 601.105, "Examination of Returns and Claims for Refund, Credit, or Abatement; Determination of Correct Tax Liability," 2020, https://www.irs.gov/pub/irs-drop/rp-20-36.pdf), Health and Human Services Department ("Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Governmental Plans," 85 Fed. Reg. 29164, May 14, 2020, https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021), and Urban Institute.

Note: ARPA = American Rescue Plan Act; AV = actuarial value, which is the average percentage of covered benefits that a plan will pay; FPL = federal poverty level; baseline premiums are pegged to benchmark silver (70% AV) premium; reforms are pegged to gold (80% AV) premium.

The comprehensive policy model would also build on the ACA. It would result in universal coverage of legally present people because all Americans would be automatically enrolled in coverage even if they did not take active steps to sign up. They would be required to pay income-related premiums, either during or at the end of the year.[2] Premium and cost-sharing subsidies would still be tied to the gold metal tier but would be even more generous than in the incremental reform. As shown in table 2, for example, the amount that households would have to pay at any income level would not exceed 8 percent. The policy would have the same permanent reinsurance program, and short-term limited-duration policies would be eliminated. The option also would have a nongroup public option with provider payment rates based on highly competitive markets. The policy would eliminate the Medicaid gap, as in the incremental reform, by extending marketplace coverage to people with incomes below 100 percent of FPL, with the federal government paying all costs. The Medicaid matching rate would also be increased in current expansion states. Employers would not have a penalty for not insuring workers, and the employer coverage firewall policy would be eliminated.

The cost and coverage estimates of both reform options, as well as the distributional effects, are produced using the Urban Institute's Health Policy Simulation Model (HIPSM). We made estimates as if the reforms were fully implemented in 2022. Costs and coverage are compared with a baseline for 2022 modeled before passage (and not including the effects) of the American Rescue Plan Act (ARPA). We use this and the Urban Brookings Tax Policy Center (TPC) tax model to develop tax scenarios that will raise enough money to finance both expansions. Methods are explained in greater detail in the appendix.

Coverage and Spending Effects of the Two Reforms

In this section, we show the changes in coverage and spending for each option. Table 3 shows the changes in coverage and spending for the incremental reform, while table 4 provides the same estimates for the comprehensive reform.

Incremental reform coverage. In this reform, the number of newly insured people is 14.8 million (table 3).[3] Employer coverage falls by 16.7 million. Because of the elimination of the firewall and the enhancement of subsidies, individuals prefer to obtain coverage in either the marketplace or Medicaid. Private nongroup coverage increases by 24.3 million; almost all of this is because of marketplace coverage expansion. Many factors are responsible for this sizable expansion, including the improved subsidies, expansion of coverage in states that have not expanded Medicaid, dropping of employer coverage following elimination of the firewall, and reintroduction of the individual mandate. Medicaid coverage expands by 7.2 million largely because TANF and SNAP recipients are auto-enrolled, but the

elimination of the firewall and individual mandate reintroduction also contribute. The expansion of nongroup and Medicaid coverage together more than offset the decline in employer coverage, resulting in fewer people without minimum essential coverage (14.8 million), including 2.6 million who leave noncompliant nongroup coverage. The previously underinsured and uninsured primarily enroll in more affordable marketplace plans, but a small number enroll in employer coverage or Medicaid. This reform reduces the number without minimum essential coverage from 33.3 million to 18.5 million.

TABLE 3

Coverage of and Spending for the Nonelderly before ARPA and under Incremental Reform, 2022

(thousands of people)	Health Insurance Coverage			
	Before ARPA	**Incremental reform**	**Change from current law**	**Percent change from current law (%)**
Insured (minimum essential coverage)	*244.1*	258.9	14.8	6.1
Employer	149.3	132.6	-16.7	-11.2
Private nongroup	15.0	39.2	24.3	162.3
Basic health program	0.9	0.9	*	1.5
Marketplace with subsidy	8.5	32.8	24.3	286.9
Other ACA compliant nongroup	5.6	5.5	-0.1	-1.8
Medicaid/CHIP	71.2	78.4	7.2	10.2
Disabled	9.4	10.0	0.6	5.8
Medicaid expansion	14.8	17.7	2.8	19.1
Traditional nondisabled adult	12.7	14.4	1.7	13.5
Nondisabled Medicaid/CHIP child	34.2	36.3	2.1	6.3
State-funded program	*	*	*	1.9
Other public	8.7	8.7	0.0	0.0
Uninsured (No MEC)	33.3	18.5	-14.8	-44.4
Uninsured	30.8	18.5	-12.2	-39.7
Noncompliant nongroup	2.6	0.0	-2.6	-100.0
Total	**277.4**	**277.4**	**0.0**	**0.0**

(millions of dollars)	Spending			
	Before ARPA	**Incremental reform**	**Change from current law**	**Percent change from current law (%)**
Household	587.9	557.6	-30.2	-5.1
Premiums	300.3	271.2	-29.1	-9.7
Other health care spending	287.6	286.4	-1.2	-0.4
Federal government	467.1	570.7	103.6	22.2
Medicaid	376.1	427.6	51.5	13.7
Marketplace PTC	58.3	108.4	50.1	86.0
Marketplace CSR	0.0	7.3	7.3	nc
Reinsurance	1.3	10.0	8.7	661.0
Uncompensated care	31.4	17.4	-14.0	-44.5
State government	220.4	213.8	-6.6	-3.0
Medicaid	199.9	202.9	3.0	1.5
Marketplace PTC	0.4	0.0	-0.4	-100.0
Marketplace CSR	0.0	0.0	0.0	nc
Reinsurance	0.4	0.0	-0.4	-100.0

(millions of dollars)	Spending			
	Before ARPA	Incremental reform	Change from current law	Percent change from current law (%)
Uncompensated care	19.6	10.9	-8.7	-44.5
Employers	800.1	705.0	-95.1	-11.9
Providers	27.5	15.2	-12.2	-44.5
Total, all payers	**2,102.9**	**2,062.3**	**-40.6**	**-1.9**

Source: Health Insurance Policy Simulation Model (HIPSM), 2021. Reform simulated in 2022.
Notes: * = less than $500 million; PTC = ACA premium tax credits; CSR = cost-sharing reductions; nc = not calculated.

Incremental reform spending. Federal government spending on the incremental reform increases by $103.6 billion, after accounting for savings from the public option's reduced payment rates. Medicaid expenditures increase by $51.5 million as coverage expands. Marketplace premiums and cost-sharing subsidies, including amounts needed to fill in the Medicaid gap, increase by $57.4 billion, and spending on reinsurance increases by $8.7 billion. Uncompensated care funded by the federal government would fall by $14.0 billion. States would see savings of $6.6 billion primarily because the reduction in spending on uncompensated care ($8.7 billion) offsets the increase in Medicaid spending ($3.0 billion). Employers spend $95.1 billion less; this is a significant amount but accounts for only 12 percent of employer spending, largely because of fewer employees staying with employer coverage. We assume this is passed on to workers in the higher wages (i.e., employers do not reap savings in the end). Households save $30.2 billion because of expanded coverage and more generous subsidies. Providers incur $12.2 billion less in uncompensated care costs. National health spending under this reform would fall by $40.6 billion (1.9 percent) because of savings from the public option, decreases in the demand for uncompensated care, and the shift from employer coverage to the less expensive marketplace plans, and Medicaid more than offsets the cost of additional coverage and subsidies.

Comprehensive reform coverage. The more comprehensive option analyzed in this report, as shown in table 4, would reduce the number of uninsured by 27.2 million. This leaves 6.2 million uninsured, all of whom are ineligible for subsidies because they are not legally present in the United States. Employer coverage would fall by 18.3 million because of the elimination of the firewall and much more generous subsidies available in the marketplace. Nongroup coverage would expand by 32.9 million because of the further improvement in subsidies, the elimination of the firewall, and the auto-enrollment policy. Another 12.5 million would be newly enrolled in Medicaid; this results from the elimination of the firewall, the individual mandate reintroduction, and comprehensive auto-enrollment. Employer coverage falls by 18.3 million because of the elimination of the firewall. The expansion of private nongroup coverage and Medicaid more than offsets the decline in employer coverage. As a result, the number of uninsured falls by 27.2 million; 2.6 million of which had noncompliant nongroup coverage.

TABLE 4

Coverage of and Spending for the Nonelderly before ARPA and under Comprehensive Reform, 2022

(thousands of people)	Health Insurance Coverage			
	Before ARPA	Comprehensive reform	Change from current law	Percent change from current law
Insured (minimum essential coverage)	244.1	271.3	27.2	11.1%
Employer	149.3	131.1	-18.3	-12.2%
Private nongroup	15.0	47.8	32.9	219.8%
Basic health program	0.9	0.9	0.1	6.5%
Marketplace with subsidy	8.5	41.4	32.9	388.2%
Other ACA compliant nongroup	5.6	5.5	-0.1	-1.8%
Medicaid/CHIP	71.2	83.7	12.5	17.6%
Disabled	9.4	10.4	0.9	9.9%
Medicaid expansion	14.8	19.6	4.8	32.3%
Traditional nondisabled adult	12.7	15.0	2.3	18.3%
Nondisabled Medicaid/CHIP child	34.2	38.6	4.5	13.1%
State-funded program	*	*	*	2.2%
Other public	8.7	8.7	0.0	0.0%
Uninsured (no MEC)	33.3	6.2	-27.2	-81.5%
Uninsured	30.8	6.2	-24.6	-79.9%
Noncompliant nongroup	2.6	0.0	-2.6	-100.0%
Total	**277.4**	**277.4**	**0.0**	**0.0%**

(millions of dollars)	Spending			
	Before ARPA	Comprehensive reform	Change from current law	Percent change from current law
Household	587.9	537.2	-50.7	-8.6%
Premiums	300.3	255.3	-45.0	-15.0%
Other health care spending	287.6	281.9	-5.7	-2.0%
Federal government	467.1	635.8	168.7	36.1%
Medicaid	376.1	456.4	80.3	21.3%
Marketplace PTC	58.3	155.7	97.4	167.2%
Marketplace CSR	0.0	11.1	11.1	nc
Reinsurance	1.3	10.0	8.7	661.0%
Uncompensated care	31.4	2.6	-28.8	-91.8%
State government	220.4	213.0	-7.4	-3.3%
Medicaid	199.9	211.4	11.4	5.7%
Marketplace PTC	0.4	0.0	-0.4	-100.0%
Marketplace CSR	0.0	0.0	0.0	nc
Reinsurance	0.4	0.0	-0.4	-100.0%
Uncompensated care	19.6	1.6	-18.0	-91.8%
Employers	800.1	704.2	-95.9	-12.0%
Providers	27.5	2.3	-25.2	-91.8%
Total, all payers	**2,102.9**	**2,092.4**	**-10.5**	**-0.5%**

Source: Health Insurance Policy Simulation Model (HIPSM), 2021. Reform simulated in 2022.

Note: * = less than $500 million; MEC = ACA minimum essential coverage; PTC = ACA premium tax credits; CSR = cost-sharing reductions; nc = not calculated.

Comprehensive reform spending. Federal government spending would increase by $168.7 billion because of coverage expansion (again, net of the savings from the public option). Of this, $80.3 billion would be for Medicaid. Marketplace premium tax credits and cost-sharing reductions would amount to $108.5 billion; reinsurance payments would increase by $8.7 billion. Offsetting this to some degree would be a reduction in payments for uncompensated care of $28.8 billion. States would save $7.4 billion, almost completely because of $18 billion less in uncompensated care costs, but they would have $11.4 billion in net new spending on Medicaid. Employers would spend $95.9 billion less on health insurance; again, slightly more than 12 percent of current spending. Households would save $50.7 billion because of expanded coverage and much more generous subsidies. Providers would see a reduction of $25.2 billion in spending on uncompensated care. Thus, this reform would achieve universal coverage, leaving no legally present residents without insurance. It would result in $168.7 billion in new federal spending but significantly reduce household, employer, and state spending. Overall, the comprehensive reform package would reduce national health spending by $10.5 billion (0.5 percent). The improved subsidies and additional coverage still do not fully offset savings from the public option, reduction in demand for uncompensated care for the uninsured, and the movement of people from employer to less expensive marketplace or Medicaid coverage.

Tax Financing

We use two approaches to raise the funds necessary to pay for the federal costs of each health reform option—$103.6 billion for the incremental reform and $168.7 billion for the comprehensive reform. The first is a proportional increase in income tax rates; the second is an increase in payroll taxes that would be split evenly between employers and employees. The first is a relatively progressive financing approach—higher-income groups pay a higher percent of income than do lower-income groups. The latter is more regressive—the payroll tax increase applies the same rate at all income levels.

We use the Urban-Brookings Tax Policy Center (TPC) tax model to develop tax scenarios that raise enough revenue for each reform scenario. TPC solves for a proportional increase in income tax rates (the more progressive option) and new payroll tax (the less progressive option) that raised the needed amount of revenue. The revenue estimates include the impact of increased taxable income, as reduced ESI coverage translates into higher-wage income under both coverage scenarios. We assume that the employers cannot reduce worker compensation as they compete for labor; thus, when people leave ESI, payments for health benefits are replaced by higher wages.

Table 5 shows income tax rates under current law and for scenarios raising $103.6 billion and $168.7 billion, respectively. For the incremental reform, the income tax scenario increases tax rates by 4.7 percent (e.g., increases the top rate from 37.0 percent to 38.7 percent). The payroll tax scenario imposes a new payroll tax of 0.9 percent split evenly between employers and employees. For the comprehensive scenario, the income tax scenario increases tax rates by 8.8 percent (e.g., increases the top rate from 37.0 percent to 40.3 percent). The payroll tax scenario imposes a new payroll tax of 1.7 percent, split evenly between employers and employees.

TABLE 5

Tax Rates Needed to Finance Reforms with Income Tax Increases

Taxable income brackets (dollars)				Marginal tax rates (%)		
Single filers		Married filing jointly		Current law	Incremental reform	Comprehensive reform
More than	But not more than	More than	But not more than			
--	$10,075	--	$20,150	10.0	10.5	10.9
$10,075	$40,950	$20,150	$81,900	12.0	12.6	13.1
$40,950	$87,325	$81,900	$174,650	22.0	23.0	23.9
$87,325	$166,725	$174,650	$333,450	24.0	25.1	26.1
$166,725	$211,725	$333,450	$423,450	32.0	33.5	34.8
$211,725	$529,300	$423,450	$635,150	35.0	36.6	38.1
$529,300	--	$635,150	--	37.0	38.7	40.3

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0920-2).
Note: Income brackets simulated for 2022.

Table 6 shows the average tax change by income group under each scenario. Under both reform scenarios, tax units with incomes below $200,000 see larger tax increases under the payroll tax option, while tax units with incomes above $200,000 see larger tax increases under the income tax option. The difference between the income tax and payroll tax options is largest at the highest-income levels. For example, tax units with incomes of more than $1,000,000 would see tax increases of $26,350 under the incremental reform and $50,140 under the comprehensive reform under the income tax scenario versus only $8,270 and $15,370, respectively, under the payroll tax scenario.

TABLE 6

Change in Tax Burden by Income Group under Reforms Raising $104 Billion and $169 Billion, 2022

	Average Federal Tax Change ($)			
	Incremental reform ($104 billion)		Comprehensive reform ($169 billion)	
Expanded cash income level (2019 dollars)[a]	Increase in income tax rates	Employer and employee payroll tax	Increase in income tax rates	Employer and employee payroll tax
Less than 10,000	10	40	10	60
10,000–20,000	80	140	80	190
20,000–30,000	100	190	110	280
30,000–40,000	190	290	230	420
40,000–50,000	330	430	390	590
50,000–75,000	490	600	620	820
75,000–100,000	640	720	880	1,040
100,000–200,000	810	830	1,310	1,370
200,000–500,000	1,720	1,330	3,210	2,470
500,000–1,000,000	5,560	2,840	10,560	5,380
More than 1,000,000	26,350	8,270	50,140	15,730
All	670	590	1,110	950

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319-2).

Notes: Data are from calendar year 2022. Estimates include the impact of increased taxable income as reduced ESI coverage translates into higher wages. Baseline is the law currently in place as of March 17, 2020.

[a] Includes both filing and nonfiling units but excludes those that are dependents of other tax units. Tax units with negative adjusted gross income are excluded from their respective income class but included in the totals. For a description of expanded cash income, see "Income Measure Used in Distributional Analyses by the Tax Policy Center," Tax Policy Center, accessed May 3, 2021, http://www.taxpolicycenter.org/TaxModel/income.cfm.

The total changes in tax burden implied by these distributional estimates are assigned to families in HIPSM for the analysis below that compares benefits with taxes for individuals with various characteristics. The increases in total tax burdens distributed under these two reforms exceed the revenue increases for the income tax scenarios because of TPC conventions for distributional and revenue analyses. Revenue estimates include tax units' behavioral responses while distributional estimates do not. Under these reforms, this results in the increase in tax burdens for distributional purposes exceeding the revenue gains because the revenue estimates include the effect of tax filers sheltering income in response to higher income tax rates while the distributional estimates keep taxable income fixed.[4] In addition, differences in treatment of income used for contributions to pretax retirement accounts further widen the gap between TPC revenue and distributional estimates for changes in income tax rates.[5]

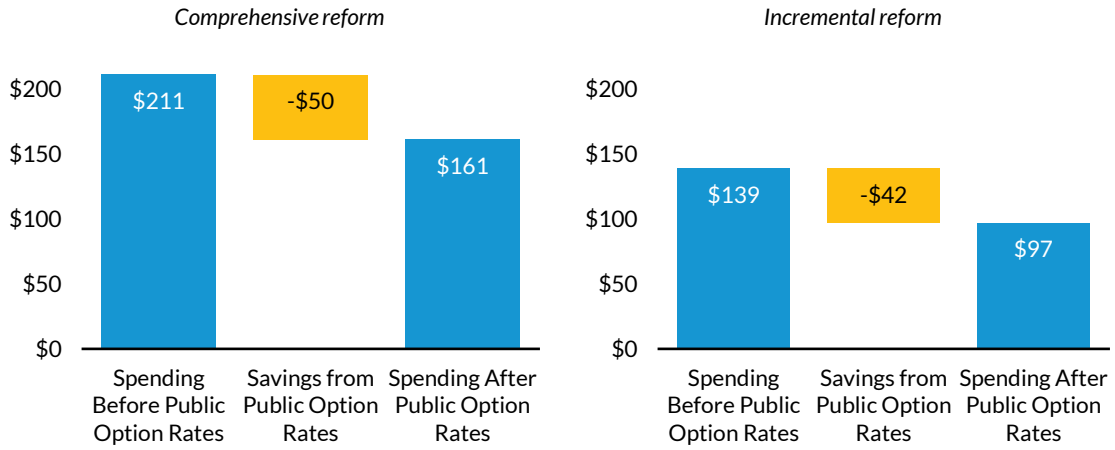
Distributional Analysis

In this section, we show the changes in government spending (federal and state) and changes in federal taxes under the incremental and comprehensive reforms. Tables 7 and 8 show spending and taxes in billions of dollars for both reforms; per capita versions of those tables are available in the appendix. We show spending, tax payments, and net spending (spending minus taxes) by income, race/ethnicity, age, prereform insurance status, and region.

Both reforms examined include a public option that pays reduced rates to providers in the nongroup market and pays lower prices for prescription drugs. Because these rates lower government spending on nongroup enrollees but are not assumed to lower the amount of care provided, figure 1 presents an estimate of changes in benefits equal to the spending that would occur at current law prices for these beneficiaries. Figure 1 shows the change in spending without the public option rate reductions, which represents the increase in health services provided under each option. The figure then shows the savings from the public option's reduced payment rates and, finally, spending after accounting for the public option savings. We use the latter concept in the rest of the report because it shows actual spending and the amount of new revenue that must be raised. We mention this because by focusing on spending after the public option effects, we are understating benefits that some people will receive—payment rates are lower, but we assume no change in services received.[6] These will have the greatest effects on groups most likely to have marketplace coverage (e.g, those with incomes between 100 percent and 400 percent of FPL). Those residing in the South have benefits understated further because newly subsidized people with incomes below 100 percent of FPL in nonexpansion states are enrolled in marketplace coverage. Figures comparing per capita changes in net health services provided (benefits) and net spending are in the appendix.

FIGURE 1

Effects of the Public Option Provider Rate Reduction on Spending under Incremental and Comprehensive Reform



Source: Health Insurance Policy Simulation Model (HIPSM), 2021. Reform simulated in 2022
Note: Dollars are in billions.

Table 7 shows the incremental reform's federal costs would be $103.6 billion; $6.6 billion of this would be savings to states. Thus, the increase in government spending is $97.0 billion; this amount, distributed to people and offset by the new taxes they pay, is represented in figures 2 and 3. The table also shows that the tax burden needed to raise tax revenues to finance incremental reform under the income tax scenario would be $119.2 billion, which is greater than the increased spending for reasons explained above. Table 8 shows that for the comprehensive reform, federal costs would be $168.7 billion, with states saving $7.4 billion for an increase in all government spending of $161.3 billion. The income tax burden to raise the needed funds would be greater, at $196.2 billion. The figures below consistently show more in net contributors than in net benefits for two reasons. First, new federal spending exceeds new government spending because some of it provides savings to states. Second, the new federal taxes exceed the cost of new federal spending for reasons explained earlier.

Incremental Reform

Income. In the first panel of table 7, as well as in figure 2, we show results by income. Those with incomes below 100 percent of FPL receive a considerable amount of new government spending, mostly coming from the new coverage of individuals below FPL in nonexpansion states. Individuals at this income level pay little in either federal income or payroll taxes. Thus, they have the greatest increase in net new spending under this health reform ($35.7 billion with income tax financing and $32.8 billion in payroll tax financing; $519 and $477, respectively, on a per capita basis).

TABLE 7

Spending under Current Law and the Two Reforms (Nonelderly Population), 2022

(billions of dollars)		Change in Spending for Acute Health Care			Change in Tax Burden		Net Change: New Benefits Minus New Taxes	
	Number of people (millions)	All gov't	Federal gov't	State gov't	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes
by income								
Less than 100% of FPL	69	36.5	40.1	-3.6	0.8	3.6	35.7	32.8
Between 100% and 200% of FPL	67	12.0	14.4	-2.4	6.8	10.2	5.2	1.8
Between 200% and 400% of FPL	93	36.9	38.5	-1.6	33.2	39.0	3.8	-2.1
Between 400% and 600% of FPL	52	6.4	6.2	0.2	12.6	13.8	-6.3	-7.4
More than 600% of FPL	55	5.2	4.4	0.8	65.7	37.0	-60.5	-31.8
by race/ethnicity								
American Indian and Alaskan native	5	1.9	2.1	-0.2	1.2	1.3	0.7	0.6
Asian and Pacific islander	18	4.1	4.5	-0.3	7.6	6.0	-3.4	-1.9
Black, non-Hispanic	39	15.6	16.3	-0.7	9.3	10.2	6.3	5.4
Hispanic	55	17.6	18.6	-1.0	9.9	10.9	7.8	6.7
White, non-Hispanic	213	56.5	60.9	-4.4	88.9	73.2	-32.3	-16.7
Other	6	1.3	1.2	0.0	2.3	1.9	-1.1	-0.6
by age								
Birth to age 18	79	9.4	6.3	3.1	24.4	22.0	-15.0	-12.6
Ages 19–34	71	21.9	25.7	-3.8	15.9	18.3	6.0	3.6
Ages 35–54	88	42.0	43.6	-1.6	39.6	34.7	2.4	7.3
Ages 55–64	39	23.7	28.0	-4.3	25.2	21.6	-1.5	2.1
Ages 65 and older	59	0.0	0.0	0.0	14.1	7.0	-14.1	-7.0
by coverage type before reform								
Employer sponsored	150	69.3	62.7	6.6	89.9	78.6	-20.6	-9.2
Medicaid	71	0.0	9.8	-9.8	4.8	7.8	-4.8	-7.8
Other public	65	0.0	0.0	0.0	14.2	8.0	-14.2	-8.0
Nongroup	15	-7.6	-7.1	-0.5	4.9	3.8	-12.5	-11.4
Uninsured or STLD	35	35.3	38.2	-2.9	5.3	5.4	30.0	29.9
by region								
Northeast	57	10.3	12.1	-1.8	22.9	17.2	-12.5	-6.9
Midwest	69	20.4	21.1	-0.7	22.9	21.7	-2.5	-1.3

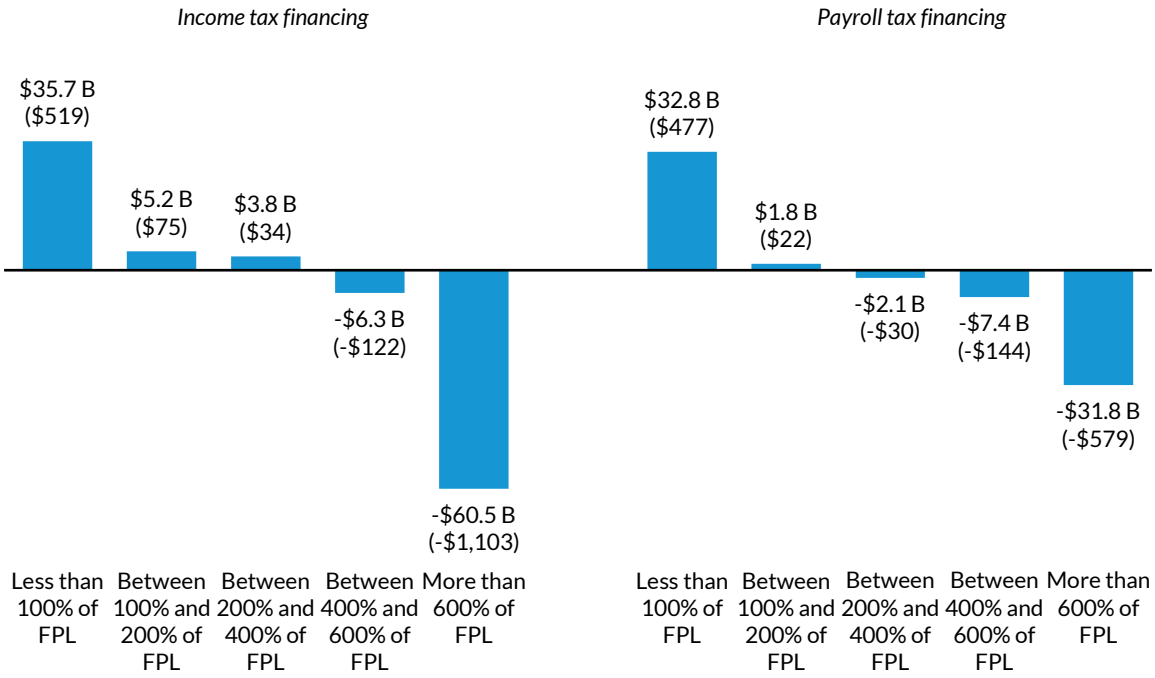
(billions of dollars)		Change in Spending for Acute Health Care			Change in Tax Burden		Net Change: New Benefits Minus New Taxes	
	Number of people (millions)	All gov't	Federal gov't	State gov't	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes
by income								
South	129	45.8	45.9	-0.1	43.3	39.9	2.5	5.9
West	81	20.5	24.5	-4.0	30.2	24.8	-9.6	-4.3
Overall	**336**	**97.0**	**103.6**	**-6.6**	**119.2**	**103.6**	**-22.1**	**-6.6**

Source: Health Insurance Policy Simulation Model (HIPSM), 2021; Urban-Brookings Tax Policy Center Microsimulation Model (version 0920-2); reform simulated in 2022.
Notes: Federal spending includes the federal share of Medicaid and federal spending for ACA premium tax credits (PTCs), cost-sharing reductions (CSRs), reinsurance, and uncompensated care for the uninsured. State spending includes the state share of Medicaid and state spending for PTCs, CSRs, reinsurance, and uncompensated care for the uninsured. Government spending is the total of federal and state spending. Income tax funding is a percent increase over current marginal tax rates, so higher earners in higher-rate brackets face a larger increase than those in lower-rate brackets. Payroll tax funding is a new flat-rate tax on all wages, salaries, and self-employment income. The statistical matching process importing tax changes into HIPSM did not control for race, region, or health insurance status. The tax estimates presented here for those classifications reflect differences in income and demographics across those groups in HIPSM. STLD = short-term or limited-duration plan that does not provide ACA minimum essential coverage.

Those with incomes between 100 and 200 percent of FPL also receive substantial assistance because of the more generous subsidy schedule. They also pay relatively little in federal taxes; thus, they are also net beneficiaries from reform. Those with incomes between 200 and 400 percent of FPL also receive significant new spending from the improved subsidy schedule. Both two-income groups include many who have left employer coverage because of the elimination of the firewall. However, individuals with incomes between 200 and 400 percent of FPL begin to pay more in taxes; as a result, the net spending is positive but relatively small if the reform is financed by income taxes. In the scenario with increased payroll taxes, new tax payments slightly exceed new spending.

FIGURE 2

Effects on Governmental Spending of Incremental Reform, by Income Level



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Source: Health Insurance Policy Simulation Model (HIPSM), 2021. Reform simulated in 2022.
Note: Numbers in parentheses are per capita contributions.

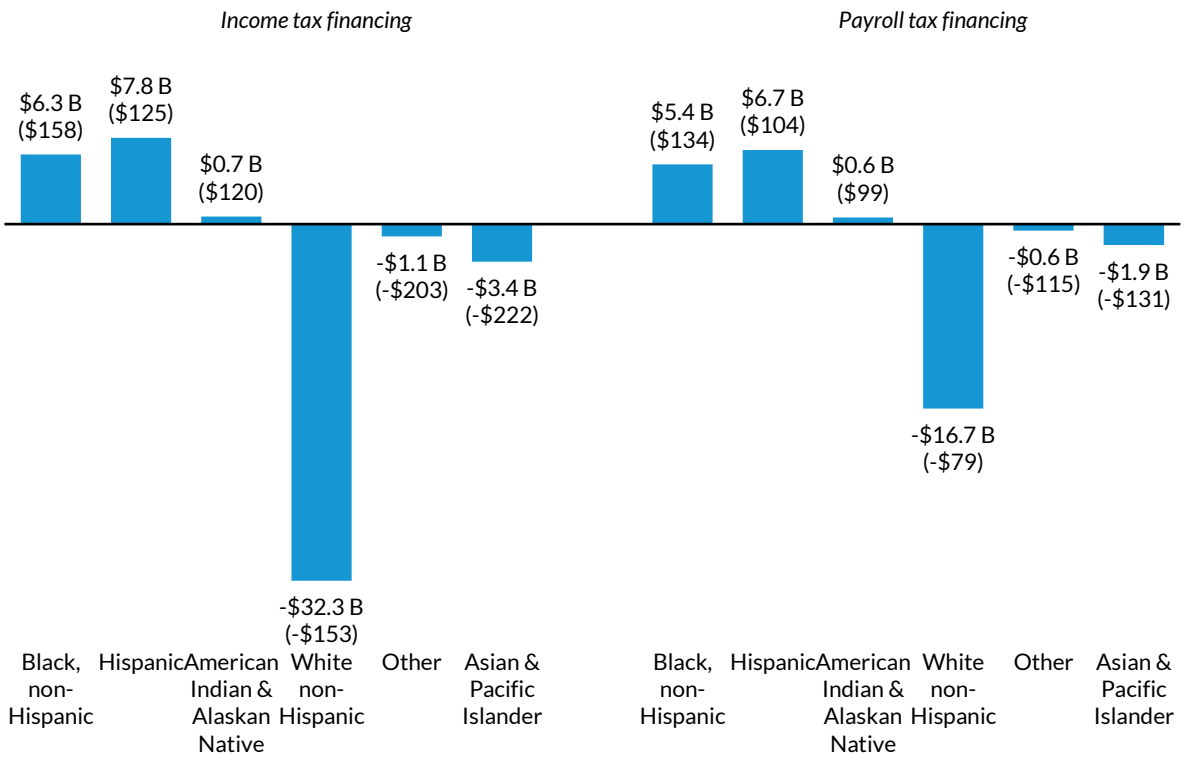
Those with incomes between 400 and 600 percent of FPL benefit from the elimination of the cap on marketplace tax credits, but at these income levels individuals pay more in taxes; thus, they are relatively small net contributors, more so with payroll than with income tax financing—$122 and $144, respectively, on a per capita basis.

Those with incomes above 600 percent of FPL have little in these reforms that benefit them other than the cap on nongroup premiums, which affects relatively few people. They pay substantial amounts in additional taxes, particularly with the income tax increase. They have a net contribution of $60.5 billion under the income tax scenario and $31.8 billion in the payroll tax scenario. On a per capita basis, these are $1,103 and $579, respectively. Thus, the incremental reform is fairly redistributive, particularly when financed with income taxes.

Race/ethnicity. The next panel shows results by race and ethnicity. Results are also shown in figure 3. American Indian and Alaska native, Black non-Hispanic, and Hispanic people are all net beneficiaries because the benefits they receive from new coverage and expanded subsidies exceed the new tax payments they are required to make. These groups tend to have lower incomes, which affects both benefits and tax payments. In contrast, white non-Hispanic and Asian and Pacific Islander people, as well as people of other races (those reporting two or more races in survey data) all pay more in new taxes than they receive in new health spending. Each group receives positive new spending, but new tax payments are greater. These groups have higher levels of insurance coverage as well as higher incomes, so there is less to gain from reform, and they have more resources with which to pay. Net spending is particularly negative for white non-Hispanic people, who pay $32.3 billion more in taxes than they receive in spending under the income tax scenario and $16.7 billion more in the payroll tax scenario. Much of this large total reflects the white non-Hispanic group's large size; total change in net spending depends on both the change in net spending per person and on group size. On a per capita basis, they are net contributors by $153 and $78, respectively, under income and payroll tax financing. Overall, the gains to groups that are net beneficiaries are greater under income tax financing, and the net contributions are greater for groups who are net contributors, relative to payroll tax financing. Changes in new spending per person range from an increase of $158 for Black non-Hispanic people to a decrease of $222 for Asian and Pacific Islander people, both under income tax financing.

FIGURE 3

Effects on Governmental Spending of Incremental Reform, by Race/Ethnicity



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Source: Health Insurance Policy Simulation Model (HIPSM), 2021. Reform simulated in 2022.
Note: Numbers in parentheses are per capita contributions.

Age. The third panel of table 7 examines distributional effects by age. Younger adults, both ages 19 to 34 and 35 to 54, receive more in new spending than they pay in taxes. This changes for those ages 55 to 64. Under the income tax scenario, they are slight net contributors, while under payroll tax financing they have a small increase in net spending. The first two columns show that those ages 55 to 64 received substantial new spending, but they are also at an age when incomes are typically highest, thus resulting in higher tax payments.

Adults ages 65 and older and children ages 18 and younger are net contributors in both income tax and payroll tax scenarios. People ages 65 and older are assumed all to be covered by Medicare, so they receive no new net spending from these reforms, but they do contribute to the program's financing with both income taxes and payroll taxes. Children are also net contributors. They receive a small amount of new spending, because broad coverage for children already exists; uninsurance among children (5.4

percent nationally among those ages 18 and younger) is rare compared with adults (16.1 percent for those ages 19 to 64). However, we attribute tax burdens to all family members; children do not personally pay either income or payroll taxes, but their share of the family's increased tax is assigned to them. The allocation of tax burdens across all family members reflects the fact that children are affected by changes in taxes; that is, by making tax payments, the family has less disposable income, which will affect their ability to spend on children. Considering new net benefits provided, children ages 18 and younger and adults ages 65 and older pay more in new taxes than they receive in new spending (because coverage for these groups is already very high), while adults ages 19 to 64 are all better off.

Prereform insurance status. The fourth panel shows changes in benefits by insurance status in the absence of reform. With the elimination of the employer coverage firewall, those with ESI can leave that coverage and enroll in marketplace coverage even if they had affordable coverage. A relatively small share of those with ESI shifts to marketplace or Medicaid coverage, but because individuals with ESI before reform is a very large group, the total spending for those leaving ESI and receiving new marketplace subsidies or Medicaid is substantial. (There is no change in spending for those who keep their employer coverage.) Because those with ESI tend to have relatively high incomes, tax payments exceed spending for this group, particularly with income tax financing.

Coverage does not change for those on Medicaid, but all costs for the expansion population under the reform shift from states to the federal government. Medicaid recipients do pay small amounts in taxes; thus, they appear as net contributors in both the income and payroll tax scenarios. The other public group consists primarily of Medicare, but also includes some other forms of coverage (e.g., Tricare). They receive no new benefits but do pay both income and payroll taxes.

Those with nongroup coverage have a reduction in spending ($7.6 billion). They contribute both income and payroll taxes and are thus net financial contributors. The drop in spending is, however, not actually a reduction in services provided as such, but rather a reduction in subsidy costs because the public option's introduction lowers benchmark premiums. This saves the federal government by lowering subsidy costs. It shows up as a reduction in spending on these groups, but it is not a loss in health benefits (an issue addressed in figure 1).

The uninsured are clear net beneficiaries. They see a substantial increase in spending. Because they predominantly have low incomes, their tax payments are low. Thus, they are fairly large net gainers regardless of whether reform is financed through income or payroll taxes—$30.0 billion in net new spending with income tax financing and $29.9 billion with payroll taxes. In addition, as many people gain coverage under the reform, the demand for uncompensated care on their behalf decreases. This

suggests that because total new federal spending exceeds new spending on the uninsured by a considerable amount, health reform does more than help the uninsured; it also makes insurance more affordable for people who had coverage prereform.

Region. The final panel of table 7 shows that in the incremental reform the Northeast, Midwest, and West all are net contributors and the South net beneficiaries. The Northeast, in particular, receives far less new government spending than they pay in new taxes—$10.3 billion in spending versus $22.8 million in tax payments with income tax financing and $17.3 billion with payroll tax financing—so they are large net contributors. The South has the largest amount of new spending, about 47 percent of the total increase. The South also makes substantial tax payments, but these account for only 36 percent of new income tax revenue and 39 percent of new payroll tax revenue. New spending exceeds these tax payments, so they are net beneficiaries. The Midwest and, more so, the West have less in new spending than they see in new tax payments, but, except for the West under income taxes, they have more new benefits than taxes.

Comprehensive Reform

Comprehensive reform's distributional effects, as shown in table 8, are largely similar to the effects of incremental reform across different groups but significantly larger in magnitude. Both new government spending and the tax payments needed to finance the reform are greater than under incremental reform. Below we present only the main differences between incremental and comprehensive reform.

TABLE 8

Distribution of Changes in Government Spending for Acute Health Care and in Federal Taxes under Comprehensive Reform

(billions of dollars)		Change in Spending for Acute Health Care			Change in Tax Burden		Net Change: New Benefits Minus New Taxes	
	Number of people (millions)	All gov't	Federal gov't	State gov't	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes
by income								
Less than 100% of FPL	69	51.5	53.1	-1.6	0.9	6.3	50.6	45.2
Between 100% and 200% of FPL	67	30.1	32.0	-1.9	7.8	14.5	22.3	15.6
Between 200% and 400% of FPL	93	70.6	72.5	-1.9	40.2	51.7	30.4	18.9
Between 400% and 600% of FPL	52	7.3	8.5	-1.2	23.0	25.6	-15.7	-18.3
More than 600% of FPL	55	1.8	2.5	-0.7	124.3	70.7	-122.5	-68.9
by race/ethnicity								
American Indian and Alaskan native	5	3.1	3.4	-0.3	1.8	2.1	1.3	1.0
Asian and Pacific islander	18	7.5	7.9	-0.4	13.0	10.3	-5.5	-2.7
Black, non-Hispanic	39	23.9	24.3	-0.3	13.5	15.4	10.4	8.5
Hispanic	55	29.6	29.8	-0.2	14.9	17.2	14.6	12.4
White, non-Hispanic	213	95.1	101.3	-6.3	149.0	120.7	-53.9	-25.6
Other	6	2.1	2.0	0.1	3.9	3.1	-1.8	-1.0
by age								
Birth to age 18	79	19.0	12.9	6.1	38.6	34.5	-19.6	-15.5
Ages 19–34	71	38.1	42.7	-4.6	26.0	31.1	12.1	7.0
Ages 35–54	88	67.8	70.8	-3.0	66.4	57.7	1.4	10.1
Ages 55–64	39	36.4	42.3	-5.9	39.7	33.2	-3.3	3.2
Ages 65 and older	59	0.0	0.0	0.0	25.5	12.2	-25.5	-12.2
by coverage type before reform								
Employer sponsored	150	89.0	80.1	8.9	144.8	124.7	-55.8	-35.7
Medicaid	71	0.0	9.8	-9.8	6.5	12.4	-6.5	-12.4
Other public	65	0.0	0.0	0.0	25.6	14.0	-25.6	-14.0
Nongroup	15	2.7	3.2	-0.5	9.4	7.4	-6.7	-4.7
Uninsured or STLD	35	69.6	75.6	-6.0	9.9	10.2	59.7	59.4
by region								
Northeast	57	19.8	21.3	-1.4	40.1	29.7	-20.2	-9.9

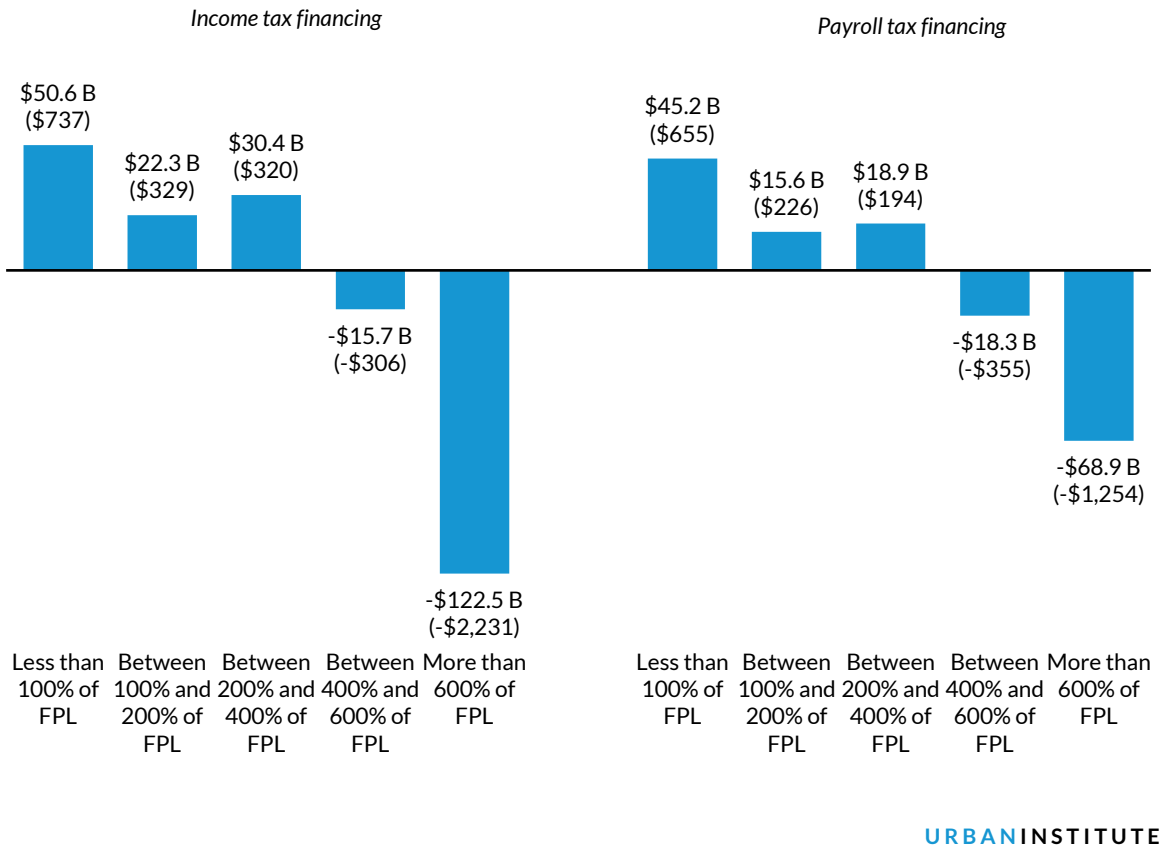
(billions of dollars)		Change in Spending for Acute Health Care			Change in Tax Burden		Net Change: New Benefits Minus New Taxes	
	Number of people (millions)	All gov't	Federal gov't	State gov't	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes
Midwest	69	33.7	34.6	-0.9	36.1	34.3	-2.4	-0.6
South	129	70.9	71.2	-0.3	69.0	63.3	1.9	7.6
West	81	36.8	41.6	-4.8	51.0	41.4	-14.1	-4.5
Overall	**336**	**161.3**	**168.7**	**-7.4**	**196.2**	**168.7**	**-34.9**	**-7.4**

Sources: Urban Institute Health Insurance Policy Simulation Model, 2021; Urban-Brookings Tax Policy Center Microsimulation Model (version 0920-2); reform simulated in 2022.
Notes: Federal spending includes the federal share of Medicaid and federal spending for ACA premium tax credits (PTCs), cost-sharing reductions (CSRs), reinsurance, and uncompensated care for the uninsured. State spending includes the state share of Medicaid and state spending for PTCs, CSRs, reinsurance, and uncompensated care for the uninsured. Government spending is the total of federal and state spending. Income tax funding is a percent increase over current marginal tax rates, so higher earners in higher-rate brackets face a larger increase than those in lower-rate brackets. Payroll tax funding is a new flat-rate tax on all wages, salaries, and self-employment income. The statistical matching process importing tax changes into HIPSM did not control for race, region, or health insurance status. The tax estimates presented here for those classifications reflect differences in income and demographics across those groups in HIPSM. STLD = short-term or limited-duration plan that does not provide ACA minimum essential coverage.

Income. The first panels of table 8 and figure 4 show the changes by income. Compared with incremental reform, spending and benefits are larger for each group under comprehensive reform, except the highest-income group.[7] This reflects the fact that subsidies are more generous at each income level. Tax payments are also larger to finance the greater spending. Tax payments increase dramatically at higher incomes under the income tax scenario, but they are larger under comprehensive reform at each income level for either type of financing.

FIGURE 4

Effect on Governmental Spending of Comprehensive Reform, by Income Level



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021; reforms simulated in 2022.
Note: Numbers in parentheses are per capita contributions.

The lowest-income group has large increases in spending relative to the incremental approach. Tax payments are only slightly higher. The result is net spending is dramatically higher for the lowest-income group, $50.6 billion with income tax financing and $45.2 billion with a payroll tax increase—$737 and $655 per capita, respectively, under income and payroll tax financing.

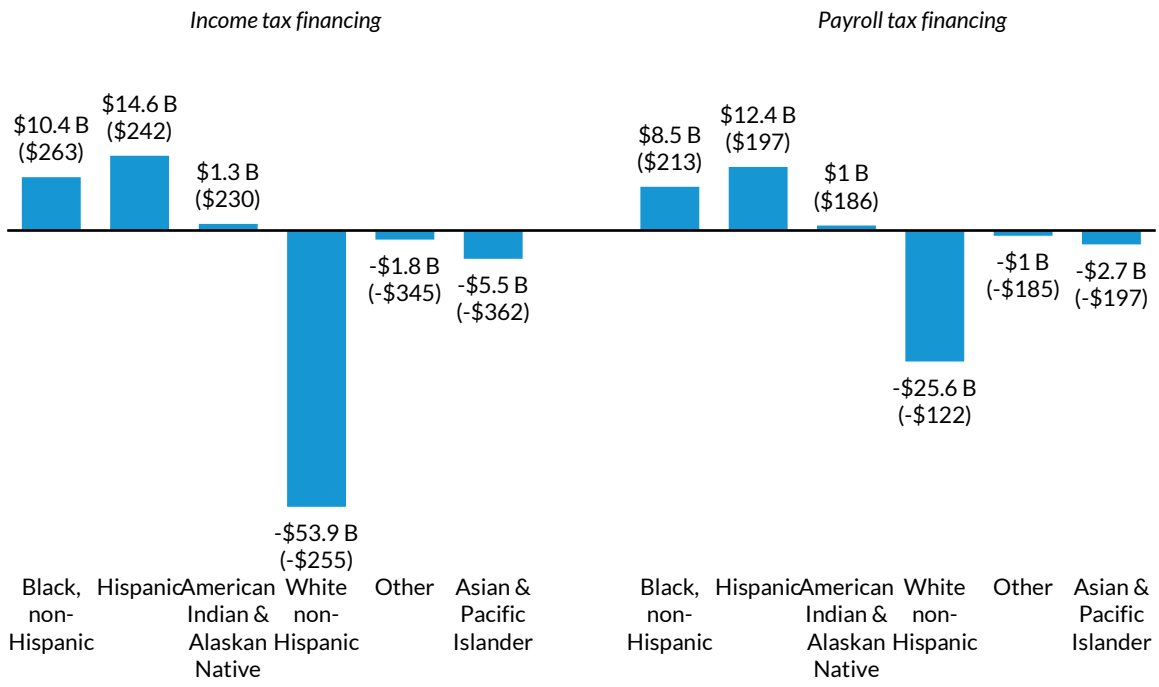
At the other end, those with incomes above 600 percent of FPL see relatively low new spending, but tax payments are substantially higher under either the income tax or payroll tax scenarios; thus, the net contributions are higher for those with incomes above 600 percent of FPL: $122.5 billion under the income tax scenario and $68.9 billion under the payroll tax scenario.

The amount the highest-income group pays in new taxes is substantially greater under comprehensive reform than under incremental reform. This is true particularly true for income taxes, but also for payroll taxes. Thus, the highest-income group members are substantial net contributors: $122.5 billion under the income tax scenario and $68.9 under the payroll tax scenario compared with $60.5 billion and $31.8 billion, respectively, under the incremental reform.

Race/ethnicity. Each race and ethnicity group sees higher spending under the comprehensive reform than under current law or the incremental reform, reflecting the filled Medicaid gap, more generous subsidies, and auto-enrollment of all otherwise-uninsured people into coverage. With the program's higher cost, each group pays substantially more in income or payroll taxes. This is particularly true for white non-Hispanic people, Asian and Pacific Islander people, and people of other races. As shown in figure 5, the net new spending is greater for Black non-Hispanic, Hispanic, and American Indian and Alaskan native people because gains in coverage and affordability exceed new tax payments, while the net contributions are larger for white non-Hispanic people, Asian and Pacific Islander people, and people of other races. This for the most part reflects prereform insurance coverage and income differences, as well as the relative size of each group. Changes in net new spending per person range from an increase of $263 for Black non-Hispanic people to a decrease of $362 for Asian and Pacific Islander people, both under income tax financing.

FIGURE 5

Effect on Governmental Spending of Comprehensive Reform, by Race/Ethnicity



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021; reforms simulated in 2022.
Note: Numbers in parentheses are per capita contributions.

Age. Results by age show a similar pattern. Per capita new spending is higher as age increases, except for those ages 65 and older where there are no new net benefits because the reforms do not change Medicare coverage. Tax payments for each age group are also higher than under incremental reform for both the income and payroll tax scenarios. Income tax payments rise more with increasing age because younger workers have, on average, lower incomes. The age gradient is smaller with the payroll tax scenario.

Prereform insurance coverage. Net spending for those with ESI is greater under the comprehensive reform than under the incremental reform because subsidies are greater, making it more attractive for people to leave their employer coverage once the firewall is eliminated. Overall, 18.3 million people leave ESI under comprehensive reform, versus 16.7 million people under incremental reform. Those with ESI tend to have higher incomes; they therefore pay more in both income and payroll taxes (particularly income taxes, as marginal rates increase with income) and are significant net contributors.

The uninsured receive substantial new benefits, roughly twice that seen in the incremental reform. They pay somewhat more in new taxes, particularly with payroll tax financing. Because new spending for the previously uninsured is substantially greater than new tax payments, the previously uninsured are large net beneficiaries. The gains are about the same if the reform is financed with income or payroll tax increases ($59.7 and $59.4 billion, respectively, in new spending).

Region. The final panel of table 8 shows that in this reform people in the Northeast, Midwest, and West are net contributors and in the South are net beneficiaries. The Northeast and West contribute considerably more in tax payments than they receive in new spending. Both prereform coverage levels and incomes are higher in the Northeast than elsewhere. The difference between spending and tax payments is particularly large with income tax financing. The South again has substantial new spending because of large gains in coverage and new subsidies. About 44 percent of new spending under comprehensive reform goes to the South. But because of lower per capita incomes, the region contributes 35 percent of new income tax revenues and 38 percent of new payroll tax revenues. The Midwest is a small net contributor under either form of financing. The West is a substantial net contributor with income tax financing and a smaller net contributor with payroll tax financing.

Conclusion

In this report, we examined two health care reform options—incremental and comprehensive. The incremental reform reduces the number of people without minimum essential coverage by 14.8 million. The comprehensive reform would reduce the number without minimum essential coverage by 27.2 million. Under these options, the number with employer coverage would fall by 16.7 million and 18.3 million, respectively. Marketplace coverage would increase by more than 24 million in the incremental reform and 32.9 million in the comprehensive reform. Medicaid enrollment would increase by 7.2 million and 12.2 million, respectively.

Spending in the incremental reform by the federal government would increase by $103.6 billion. In the comprehensive reform, spending by the federal government would increase by $168.7 billion. Net new government spending (federal spending minus savings to states) increases by $97.0 billion with incremental reform and $161.3 billion with comprehensive reform. In the incremental reform, Medicaid spending would increase by $51.5 billion and marketplace premium and cost-sharing subsidies by $57.4 billion. In the comprehensive plan, Medicaid spending would increase by $80.3 billion while marketplace premium tax credits and cost-sharing reductions would increase by $117.1 billion

(including reinsurance payments). Thus, the incremental and comprehensive reforms differ substantially in scope and cost.

In the distributional analysis, we show considerable redistribution by income. Those with incomes below 200 percent of FPL benefit considerably, while those with incomes above 600 percent of FPL are substantial net contributors, more so with income tax financing. Important redistribution by race/ethnicity also exists. Black non-Hispanic, Hispanic, and American Indian people tend to be net gainers. White non-Hispanic people, Asian American and Pacific Islander people, and people of other races are net contributors. Regions also have considerable redistribution—people in the South are net gainers and other regions net contributors.

Finally, we show more redistribution with income tax financing than with payroll tax financing; the former reduces the amount paid by people with low incomes and increases the amount paid by the highest-income group. In the incremental reform, net benefits per capita are $519 with income tax financing and $477 with payroll tax financing for those with incomes below 100 percent of FPL. For those with incomes above 600 percent of FPL, net contributions per capita are $1,103 with income tax financing and $579 with payroll tax financing. In the comprehensive reform, net benefits per capita for those with incomes below 100 percent of FPL are $737 with income tax financing and $655 with payroll tax financing. For those with incomes above 600 percent of FPL, net contributions are $2,231 with income tax financing and $1,254 with payroll tax financing.

The uninsured benefit considerably with substantial new benefits and relatively little in new tax payments. But only about 30 percent of new federal spending goes to the uninsured. The remainder goes to making insurance substantially more affordable for individuals who already had employer or nongroup coverage.

Methods

The estimates presented here are produced using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM is designed for quick-turnaround analyses of policy proposals. It can be rapidly adapted to analyze various new scenarios—from novel health insurance

offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years.

HIPSM is based on two years of the American Community Survey, which provides a representative sample of families large enough for us to produce estimates for individual states and smaller regions, such as cities. The model is designed to incorporate timely, real-world data to the extent they are available. In particular, we regularly update the model to reflect published Medicaid and Marketplace enrollment and costs in each state.

Given uncertain economic conditions in 2020, owing to the COVID-19 pandemic and consequent recession and its rapid evolution, we use a 2022 current-law baseline, a year when conditions should be more stable. In doing so, we assume, consistent with Congressional Budget Office projections, that the economy will have partly recovered from the pandemic recession by that time.[8] We assume the characteristics of people who remain unemployed at that time are largely consistent with the distribution identified in US Department of Labor data from August 2020, which showed that higher-wage jobs had recovered to a much greater extent than lower-wage jobs.

The simulations account for relevant state regulations, such as banning short-term, limited-duration plans. Our current-law estimates account for the federal individual mandate penalties set to $0 beginning in plan year 2019, as well as the fact that California, the District of Columbia, Massachusetts, and New Jersey have their own individual mandate penalties. We treat Missouri and Oklahoma, where the ACA Medicaid expansion has been approved by ballot initiative but not yet implemented, as nonexpansion states. We do this because the political environments surrounding expansion, even once ballot initiatives are passed, remain uncertain, and the timing and implementation of these expansions are therefore still uncertain.

The current version of HIPSM is calibrated to state-specific targets for marketplace enrollment following the 2020 open enrollment period, 2020 marketplace premiums, and late 2019 Medicaid enrollment from the Centers for Medicare and Medicaid Services monthly enrollment snapshots. Aging our projections to 2022 involved several steps. First, we aged the 2020 population to 2022 using projections from the Urban Institute's Mapping America's Futures program. We then inflated incomes and health costs to 2022. Because the pandemic has reduced use of expensive care, we assume costs for private nongroup health insurance and Medicaid are flat in 2021 but return to default inflation assumptions in 2022. Under our default assumptions, we estimate Medicaid will grow at 5 percent, and out-of-pocket spending and uncompensated care will grow at 3 percent.

We use the Urban-Brookings Tax Policy Center (TPC) tax model to develop tax scenarios raising enough revenue to finance the coverage scenarios in 2022.[9] For each coverage scenario, we solve for a proportional increase in income tax rates (more progressive option) and a rate for a new payroll tax (less progressive option) that raises the needed amount of revenue. The revenue estimates include the impact of increased taxable compensation because of reduced ESI coverage under both coverage scenarios.[10] For the combined distributional analysis of health benefits and taxes, we export increases in tax burden from tax units in the tax model to families in HIPSM using a statistical matching process.[11]

The estimates presented in this report were completed before the American Rescue Plan (ARP) Act was enacted in early March 2021. Some aspects of that plan, such as enhanced subsidies for ACA marketplace insurance, are similar to the plans presented here; however some provisions of the reforms modeled (e.g., auto-enrollment, public option in the nongroup market, full federal funding of Medicaid expansion) are not in the ARP, while some aspects of the ARP (Consolidated Omnibus Budget Reconciliation Act subsidies, assignment of maximum subsidies to those who have received unemployment benefits) are not in the modeled plans. In addition, the reforms presented here are assumed permanent while the ARP provisions are temporary.

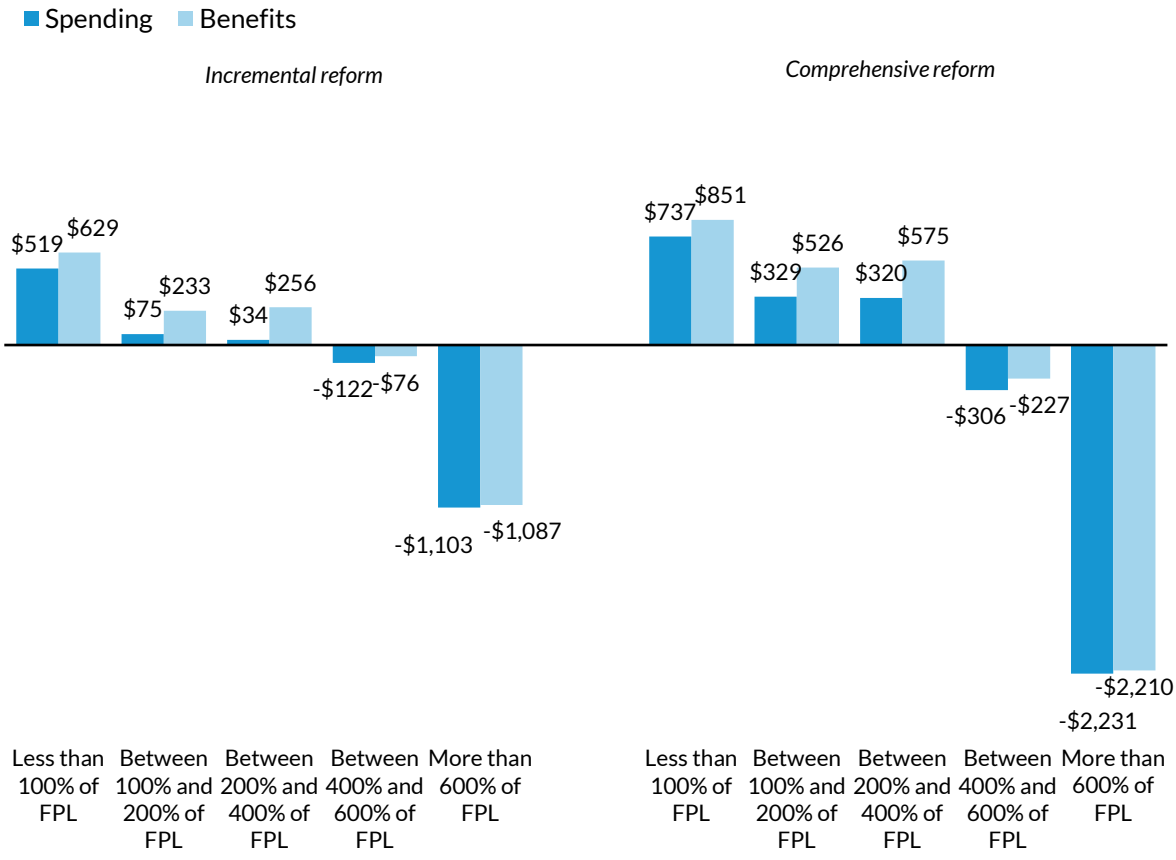
For this analysis, we assume the Medicaid enhanced federal medical assistance percentage and maintenance-of-effort provisions in the Families First Coronavirus Response Act would have expired before 2022. However, in a letter to governors sent in late January 2021, the acting secretary of the US Department of Health and Human Services indicated the public health emergency declaration will be extended through calendar year 2021.[12] This means the maintenance-of-effort requirement, which prohibits states from disenrolling Medicaid enrollees unless they request it, will last through January 2022, and the enhanced federal medical assistance percentage will be available through March 2022. Consequently, Medicaid enrollment will be notably higher in early 2022 than indicated in our estimates. However, it will decline to the levels we show later in the year. Also, the federal government will pay a higher share of Medicaid costs in the first quarter of 2022 than we indicate.

Appendix. New Services Provided Compared with New Spending

The following three figures show the differences between net spending and net new services provided (labeled benefits) on a per capita basis for the incremental reform and comprehensive reforms. Differences between net spending and new services provided do not vary with financing, so the results with payroll tax financing are similar (not shown). Results are shown by income level, race/ethnicity, and region.

FIGURE A.1

Effects on Net Spending and Net Benefits with Income Tax Financing, by Income Level (dollars per person)

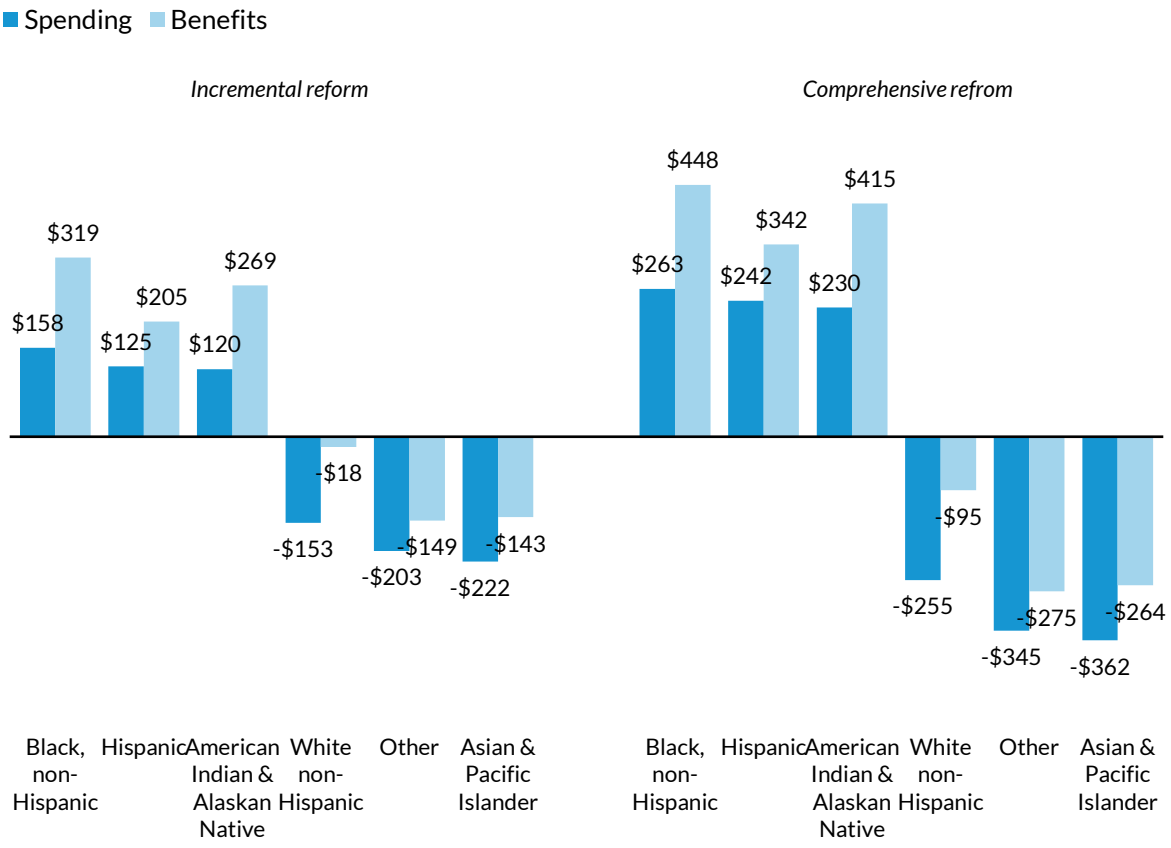


URBAN INSTITUTE

Source: Urban Institute Health Insurance Policy Simulation Model, 2021; reform simulated in 2022.

FIGURE A.2

Effects on Net Spending and Net Benefits with Income Tax Financing, by Race/Ethnicity (dollars per person)

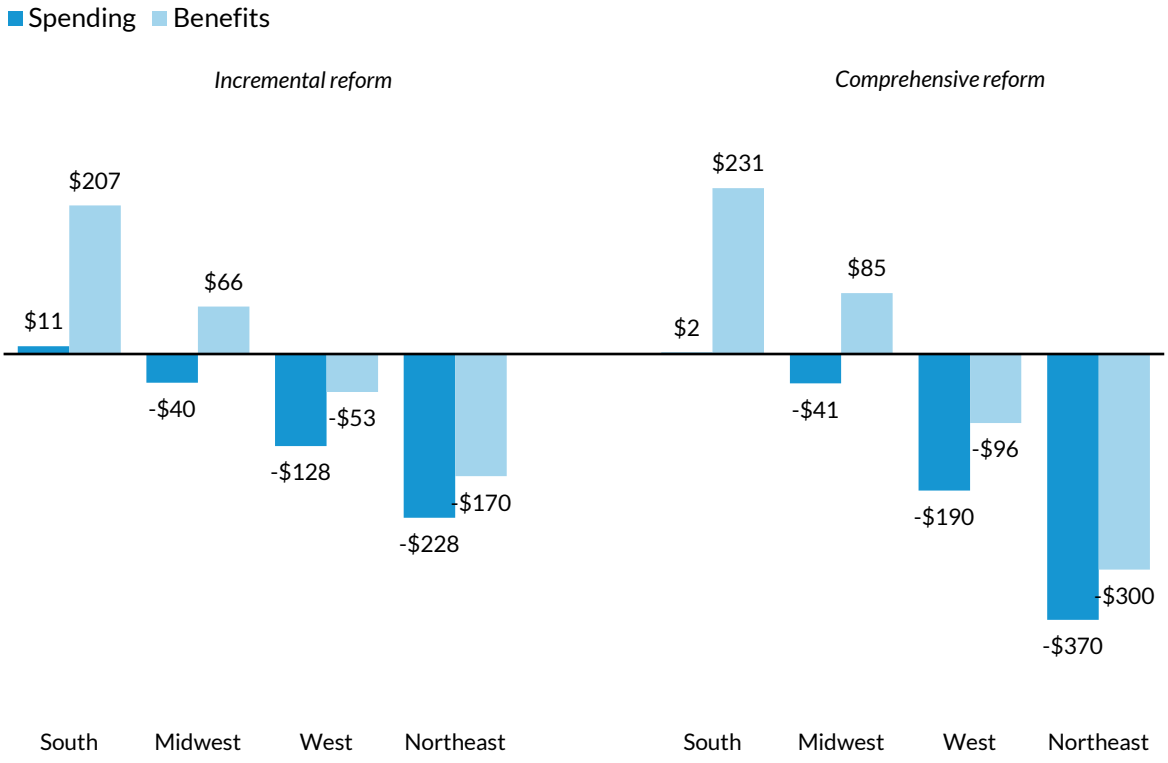


URBAN INSTITUTE

Source: Urban Institute Health Insurance Policy Simulation Model, 2021; reform simulated in 2022.

FIGURE A.3

Effects on Net Spending and Net Benefits with Income Tax Financing, by Region (dollars per person)



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021; reform simulated in 2022.

TABLE A.1

Distribution of Changes in Government Spending for Acute Health Care and in Federal Taxes under Incremental Reform

Dollars per Person	Average Change in Spending for Acute Health Care			Average Change in Tax Burden		Net Change: Average New Benefits Minus Average New Taxes	
	All gov't	Federal gov't	State gov't	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes
by income							
Less than 100% of FPL	531	584	-53	12	55	519	477
Between 100% and 200% of FPL	179	215	-36	104	157	75	22
Between 200% and 400% of FPL	398	415	-17	364	428	34	-30
Between 400% and 600% of FPL	122	118	4	244	266	-122	-144
More than 600% of FPL	94	79	15	1,197	673	-1,103	-579
by race/ethnicity							
American Indian and Alaskan native	348	381	-33	228	249	120	99
Asian and Pacific islander	229	248	-19	451	360	-222	-131
Black, non-Hispanic	398	416	-18	240	264	158	134
Hispanic	321	339	-18	196	217	125	104
White, non-Hispanic	265	286	-20	418	344	-153	-79
Other	226	221	5	429	341	-203	-115
by age							
Birth to age 18	119	79	40	310	280	-192	-161
Ages 19–34	309	363	-54	235	271	74	38
Ages 35–54	476	495	-18	463	405	14	72
Ages 55–64	604	713	-109	648	555	-44	49
Ages 65 and older	0	0	0	240	120	-240	-120
by coverage type before reform							
Employer sponsored	463	419	44	609	532	-146	-69
Medicaid	0	138	-138	67	110	-67	-110
Other public	0	0	0	218	123	-218	-123
Nongroup	-508	-473	-36	336	261	-844	-770
Uninsured or STLD	1,004	1,085	-82	172	175	831	828
by region							
Northeast	181	212	-31	410	309	-228	-127
Midwest	296	307	-10	336	319	-40	-22

Dollars per Person	Average Change in Spending for Acute Health Care			Average Change in Tax Burden		Net Change: Average New Benefits Minus Average New Taxes	
	All gov't	Federal gov't	State gov't	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes
South	354	355	-1	342	315	11	38
West	253	302	-49	381	314	-128	-61
Overall	**288**	**308**	**-20**	**362**	**315**	**-73**	**-26**

Sources: Urban Institute Health Insurance Policy Simulation Model, 2021; Urban-Brookings Tax Policy Center Microsimulation Model (version 0920-2); reform simulated in 2022.
Notes: Federal spending includes the federal share of Medicaid and federal spending for ACA premium tax credits (PTCs), cost-sharing reductions (CSRs), reinsurance, and uncompensated care for the uninsured. State spending includes the state share of Medicaid and state spending for PTCs, CSRs, reinsurance, and uncompensated care for the uninsured. Government spending is the total of federal and state spending. Income tax funding is a percent increase over current marginal tax rates, so higher earners in higher-rate brackets face a larger increase than those in lower-rate brackets. Payroll tax funding is a new flat-rate tax on all wages, salaries, and self-employment income. The statistical matching process importing tax changes into HIPSM did not control for race, region, or health insurance status. The tax estimates presented here for those classifications reflect differences in income and demographics across those groups in HIPSM. STLD = short-term or limited-duration plan that does not provide ACA minimum essential coverage.

TABLE A.2

Distribution of Changes in Government Spending for Acute Health Care and in Federal Taxes under Comprehensive Reform

Dollars per Person	Average Change in Spending for Acute Health Care			Average Change in Tax Burden		Net Change: Average New Benefits Minus Average New Taxes	
	All gov't	Federal gov't	State gov't	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes
by income							
Less than 100% of FPL	750	774	-24	13	95	737	655
Between 100% and 200% of FPL	449	477	-28	120	222	329	226
Between 200% and 400% of FPL	760	781	-21	440	566	320	194
Between 400% and 600% of FPL	139	163	-24	445	494	-306	-355
More than 600% of FPL	33	45	-12	2,263	1,286	-2,231	-1,254
by race/ethnicity							
American Indian and Alaskan native	574	622	-48	344	387	230	186
Asian and Pacific islander	417	437	-20	779	614	-362	-197
Black, non-Hispanic	611	620	-9	348	399	263	213
Hispanic	539	542	-4	296	341	242	197
White, non-Hispanic	446	475	-29	700	567	-255	-122
Other	376	365	11	721	561	-345	-185
by age							
Birth to age 18	240	163	77	492	440	-252	-200
Ages 19–34	537	601	-64	384	459	153	78
Ages 35–54	769	803	-34	775	674	-6	95
Ages 55–64	927	1,079	-151	1,020	853	-93	75
Ages 65 and older	0	0	0	435	208	-435	-208
by coverage type before reform							
Employer sponsored	595	535	60	981	845	-386	-250
Medicaid	0	138	-138	91	174	-91	-174
Other public	0	0	0	393	215	-393	-215
Nongroup	181	214	-33	639	506	-458	-325
Uninsured or STLD	1,979	2,150	-171	321	332	1,658	1,646
by region							
Northeast	348	374	-25	718	533	-370	-184

Dollars per Person	Average Change in Spending for Acute Health Care			Average Change in Tax Burden		Net Change: Average New Benefits Minus Average New Taxes	
	All gov't	Federal gov't	State gov't	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes
Midwest	490	503	-12	531	504	-41	-14
South	548	550	-2	546	501	2	47
West	454	513	-59	644	523	-190	-69
Overall	**480**	**501**	**-22**	**596**	**512**	**-116**	**-33**

Sources: Urban Institute Health Insurance Policy Simulation Model, 2021; Urban-Brookings Tax Policy Center Microsimulation Model (version 0920-2); reform simulated in 2022.
Notes: Federal spending includes the federal share of Medicaid and federal spending for ACA premium tax credits (PTCs), cost-sharing reductions (CSRs), reinsurance, and uncompensated care for the uninsured. State spending includes the state share of Medicaid and state spending for PTCs, CSRs, reinsurance, and uncompensated care for the uninsured. Government spending is the total of federal and state spending. Income tax funding is a percent increase over current marginal tax rates, so higher earners in higher-rate brackets face a larger increase than those in lower-rate brackets. Payroll tax funding is a new flat-rate tax on all wages, salaries, and self-employment income. The statistical matching process importing tax changes into HIPSM did not control for race, region, or health insurance status. The tax estimates presented here for those classifications reflect differences in income and demographics across those groups in HIPSM. STLD = short-term or limited-duration plan that does not provide ACA minimum essential coverage.

Notes

[1] This report uses terms for race/ethnicity that match, or are collapsed from, those used in the American Community Survey, on which the HIPSM model is based. The authors acknowledge these may not be the preferred identifiers, and we remain committed to using inclusive language wherever possible.

[2] For more information on auto-enrollment options, see Blumberg, Holahan, and Levitis (forthcoming).

[3] Throughout the report, "uninsured" includes everyone without minimal essential coverage, including both people with no insurance and with short-term limited-duration plans.

[4] TPC excludes microdynamic responses from distributional analysis to better capture the impact of tax changes on well-being. For example, an increase in the capital gains rate can result in reduced revenues because of reduced realizations. But the households paying less tax because of reduced realizations are not better off because they face increased tax rates. For that reason, TPC holds realization fixed when analyzing the distributional impact of changes in capital gains rates.

[5] For distributional analysis, to equate the measure of tax subsidies for contributions to traditional and Roth retirement accounts, TPC books tax increases on income used for pretax contributions to retirement accounts in the year the income is earned as opposed to in the future year when the income is withdrawn. For more information see Toder and Khitatrakun (2020).

[6] There will also be an offsetting effect of lower value than presented for people who would choose not to have coverage but who will be automatically enrolled under the comprehensive plan.

[7] In this case, a small increase in spending is slightly more than offset by a small decrease in demand for uncompensated care that accompanies universal coverage of the legally present.

[8] "Interim Economic Projections for 2020 and 2021," Congressional Budget Office, accessed June 25, 2020, https://www.cbo.gov/system/files/2020-05/56351-CBO-interim-projections.pdf.

[9] For more information on the TPC tax model, see "Brief Description of the Tax Model," Tax Policy Center, updated August 23, 2018, https://www.taxpolicycenter.org/resources/brief-description-tax-model.

[10] We assume that employers hold total compensation fixed so reductions in nontaxable ESI benefits result in increased taxable wages. Before considering changes in tax policy, both coverage scenarios increase tax revenues in 2022 by $34 billion. We used a statistical matching process to import changes in ESI coverage from HIPSM into the tax model. For a description of the matching process, see Mermin and Buettgens (2020).

[11] The process is similar to the one described in Mermin and Buettgens (2020), except that the tax model, as opposed to HIPSM, is the donor database.

[12] Alex M. Azar, "Renewal of Determination that a Public Health Emergency Exists," Department of Health and Human Services, January 7, 2021, https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-07Jan2021.aspx.

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