How Joe Biden Would Make the Health Care System *Unravel*

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When running in the Democratic presidential primaries, Joe Biden attempted to emphasize the stability and continuity of his health care plan as it relates to the health insurance system. Biden pledged that "If you like your employer-based plan, you can keep it," and even attacked his eventual running mate, Sen. Kamala Harris (D-CA), for putting out a plan that would "eliminate employer-based insurance."[1]

But Biden's own proposal allowing workers to obtain federally subsidized coverage via state insurance Exchanges—an option largely prohibited at present—could significantly weaken employer health plans. Exchange subsidies for lower-income individuals already greatly exceed the tax preference provided to employer-sponsored coverage. Biden's plan would increase those Exchange subsidies—exacerbating the disparity between employer and Exchange plans—while allowing individuals to switch coverage, destabilizing the employer-based system.

If implemented, this change would have major implications on where and how people obtain health insurance. It could lead an estimated 24 million Americans to switch out of employer-sponsored health insurance and on to subsidized Exchange coverage. As a result, federal spending on subsidies would grow by $2.2 trillion over a decade—spending that new tax revenue from the proposal would not begin to offset.

Most importantly, the outmigration of over 15% of Americans with job-based coverage could undermine the entire system of employer-sponsored insurance. Employers would see young and healthy employees migrate to the Exchanges, while older and sicker individuals attempt to keep their employer plans. The combination of young, healthy workers leaving employer coverage and a government plan paying doctors and hospitals low rates would prompt some employers to stop offering coverage altogether, sending yet more individuals to the Exchanges.

While Biden tried to sell his plan as a moderate, incremental proposal, it could end up resembling a single-payer system. Millions of Americans switching out of employer insurance—some of them potentially doing so because their employer stopped offering covearge—and trillions in new spending bear little resemblance to the purportedly modest plan Biden promised the American people over a year ago.

THE BIDEN PROPOSAL

Biden's health plan, released last July, contains several proposals to expand Exchange subsidies.[2] The Biden plan includes three proposals included in the Healthy America plan, originally released by several Urban Institute researchers in 2018 and updated last September:

1. Increasing federal premium subsidies, by decreasing the maximum percentage of income individuals must spend on premiums from 9.78% to 8.5%;
2. Making individuals of all income levels eligible for subsidies, by eliminating the current provision capping subsidy eligibility at 400% of the federal poverty level (FPL); and
3. Linking subsidies to gold plans (which pay an average of 80% of an enrollee's estimated health expenses each year) instead of silver plans (which pay an average of 70% of estimated health expenses), providing additional assistance for deductibles, co-payments, and cost-sharing.[3]

The Biden plan also states that the "shares of income" that individuals with incomes from 100-400% FPL must contribute under the existing subsidy regime "are too high and silver plans' deductibles are too high."[4] That language, coupled with a reference to the original Healthy America plan, indicates Biden supports a subsidy regime closely resembling the Urban proposal.

14 million people would lose employer coverage because their employer stopped offering health insurance

Source: Avalere Health analysis of Center for American Progress Medicare Extra plan.

Most notably, the Biden plan also calls for making individuals with employer coverage eligible for Exchange subsidies: "If a family is covered by their employer but can get a better deal with the 8.5% premium cap, they can switch to a plan on the individual marketplace too."[5] Under current law, individuals with an offer of "affordable" employer coverage—defined as requiring out-of-pocket premium payments of less than 9.78% of income—cannot qualify for federal subsidies.[6] The July 2020 report from the "unity task force" assembled by Biden and Sen. Bernie Sanders (I-VT) echoed Biden's original proposal; it called for "untether[ing] health care from employment by repealing the 'firewall' blocking employee access to the marketplace [i.e., Exchanges]."[7]

EMPLOYEES' NEW MATH

Several factors influence individuals' health coverage choices—with premiums, deductibles and overall cost-sharing, and provider (i.e., doctor and hospital) networks among the most important. In general, less healthy individuals care more about access to favored providers and the size of their deductibles (which they anticipate meeting), while healthy individuals who do not anticipate high medical expenses focus more on premium costs. For many young and healthy individuals, the fact that most Exchange plans utilize narrow provider networks, and do not normally cover out-of-network care, might not dissuade them from switching away from employer coverage—providing they could receive significant cost savings by doing so.[8]

In many cases, subsidies for Exchange coverage greatly exceed the savings households receive by paying for employer-provided health insurance on a pretax basis. The Congressional Budget Office estimates that in 2019, the average Exchange subsidy totaled $6,490 per enrollee, while the average worker received tax savings of $1,810 per enrollee by paying for employer health coverage with pretax dollars.[9] Moreover, the subsidy provided via the Exchanges accrues largely to lower-income families who qualify for the greatest subsidies, while the tax exclusion for employer-sponsored coverage gives its greatest benefit to wealthier households in higher tax brackets. Biden's plan to increase Exchange subsidies would widen the disparity still further.

An even richer Exchange subsidy regime, and the ability for individuals with employer-sponsored coverage to access those subsidies, would change the calculus for many employees. In many cases, individuals and families of modest means could see significant savings by leaving their employer plan and using Exchange coverage instead.

COVERAGE DECISION SCENARIOS FOR A FAMILY OF FOUR

Income	Net ESI Premium	Net ESI Deductible	Exchange Premium	Exchange Deductible	Exchange Premium plus Deductible	ESI Premium plus Deductible	Exchange Savings vs. ESI	Decision
$36,900 150% FPL	$4,073	$2,961	$738	$500	$1,238	$7,034	$5,796	Likely Drop
$49,200 200% FPL	$3,965	$2,961	$1,968	$600	$2,568	$6,926	$4,358	Likely Drop
$61,500 250% FPL	$3,965	$2,961	$3,690	$1000	$4,690	$6,926	$2,236	Likely Drop
$73,800 300% FPL	$3,965	$2,961	$5,166	$1000	$6,166	$6,926	$760	Might Drop
$98,400 350% FPL	$3,965	$2,961	$8,364	$1000	$11,364	$6,926	$4,438	Keep

Source: Urban Institute Healthy America plan; Medical Expenditure Panel Survey data on employer plans; Author's calculations.

Take for instance family of four earning 250% of the poverty level, which for the 2018 plan year totaled $61,500.[10] A household with this income purchasing family coverage in 2018 would have paid an average of $5,431 in premiums for coverage with a deductible of $2,961.[11] But if the Biden/Healthy America proposal had been in effect in 2018, that same family could have paid a total of $3,690 in premiums for coverage with a deductible of only $1,000.[12] Such a household could have saved a total of $2,236 in premium and deductible costs under the Biden proposal.[13]

This calculus holds true for most households of modest means under the Biden/Healthy America proposal. Individuals with incomes below 200% FPL, and families with incomes below 250% FPL, would save at least $100 per month, or $1,200 per year, in combined premium and deductible costs. Individuals with incomes between 200-250% FPL, and families with incomes between 250-300% FPL, would also save on combined premium and deductible costs, but in amounts less than $1,200.

Assuming that most (i.e., 90%) individuals switch coverage when presented with potential savings of over $1,200, and that half do when presented with potential savings of less than $1,200, just over 24 million individuals would switch to Exchange coverage under the Biden proposal.[14]

While this analysis relies upon the cost of coverage (premium plus deductible) to determine whether households would switch from employer to Exchange coverage, other factors might influence families' decisions. For instance, 36% of those covered by employer coverage can only select from one plan type, while only 20% have a choice of three or more plans.[15] All else equal, some families might elect to use Exchange subsidies to have a greater choice of plans, or to select the plan and/or insurer with their preferred doctors and hospitals in-network. The current narrow networks in many Exchange plans could discourage some from switching out of employer coverage; however, an influx of new—and potentially younger and healthier—enrollees into the Exchanges could also prompt insurers to offer new plans, and/or plans with broader provider networks.

In addition, some "young invincibles" might find zero-premium Exchange plans enticing, regardless of the smaller networks and higher deductibles associated with them. The Biden/Healthy America plan would link Exchange subsidies to gold plan premiums, but it would allow individuals to use those subsidies for other value plans.

The below example shows the effects of richer Exchange subsidies, had they been in effect in 2018. A 40-year-old individual with income of 350% FPL would receive a subsidy of $253.39 per month, based on gold plan premiums in 2018 and the new subsidy regime.[16] That subsidy would have paid just under half of premiums for the lowest-cost gold plan. But if applied to the lowest-cost bronze plan—a plan with higher deductibles and cost-sharing, but lower monthly premiums—that subsidy would pay nearly three-quarters of the monthly premium.[17]

CASE STUDY

40-Year-Old Individual Purchasing Coverage Under Healthy America Subsidy Regime in 2018

Income (350% of poverty)	$42,210
Individual's maximum percentage of income toward premiums	7.75%
Maximum out-of-pocket premium per month (Income multiplied by maximum premium percentage)	$272.61 ($3,271 per year)
Total premium for lowest-cost gold plan	$526.00
Federal subsidy (Total gold plan premium minus maximum out-of-pocket premium)	$253.39
Total premium for lowest-cost bronze plan	$341.00
Net bronze plan premium (Total bronze plan premium minus federal subsidy)	$87.61

Source: Urban Institute Healthy America plan; National average Exchange premiums for 2018 plan year; Author's calculations.

In this case, a 40-year-old individual would have paid $1,051 in out-of-pocket premiums in 2018 for the lowest-cost bronze plan on the Exchange—$87.61 per month. That sum nearly equals the average individual premium for employer-sponsored coverage in 2018, after subtracting the savings associated with paying the premiums on a pretax basis.[18] All things equal, such an individual likely would not switch to the Exchange, given that bronze plans generally come with higher deductibles than the typical employer plan.

But Obamacare's age rating regime allows insurance companies to charge younger applicants one-third the rates of older applicants.[19] As a result, individuals under age 40 see lower premiums than the example above, which means their subsidy dollars can go much farther. Under Biden's proposed subsidy regime, many, if not most, individuals in their 20s and 30s could qualify for zero-premium plans by applying the richer subsidies to bronze coverage.

A total of 7.4 million individuals aged 18-34 with incomes between 300-500% FPL obtain

coverage from their employer.[20] At least some of these individuals would likely prefer a zero-premium plan from the Exchanges to paying $50-150 per month for employer coverage, even if these zero-premium plans might come with higher deductibles. This choice may make sense for young and healthy individuals, but it would raise premiums paid by the remaining workers, who will likely have higher health costs. As the cost of coverage rises, more individuals will shift to the Exchanges, further driving up costs until it becomes prohibitively expensive for employers to keep offering coverage.

TRILLIONS IN NEW, INEFFICIENT SPENDING

Some, particularly on the Left, may consider the prospect of additional households receiving Exchange subsidies a feature rather than a bug. If households of modest means can reduce their health care costs substantially, doesn't that represent a positive outcome? Unfortunately, however, the Biden plan will have significant implications for the rest of the health care system.

For starters, funding the additional Exchange subsidies will drastically increase federal spending. Based on the average per-enrollee cost of subsidized individuals currently in state Exchanges, extending subsidies to the 24 million people likely to switch from employer to Exchange coverage would cost $165.8 billion in 2020, and just over $2.2 trillion over a decade (2020-2029).[21]

$2.2 trillion
total cost of the subsidy spending

$1.7 trillion
net cost after offsetting revenues
(both over ten years)

By comparison, the federal government will spend a projected $53 billion on Exchange subsidies for an estimated 8 million Americans in 2020, and $612 billion over the coming decade.[22] In both the number of subsidized enrollees and total spending, the migration of individuals from employer-sponsored coverage would vastly expand the Exchanges' size and scope.

Allowing individuals to switch from employer to Exchange coverage could bring in revenue from two sources. First, because employees pay premiums for employer-sponsored coverage on a pretax basis, employees who switch would face taxes on the money they previously dedicated to their share of premiums; the income taxes generated by this change would total an estimated $61.4 billion over a decade.[23] Second, employees obtaining Exchange subsidies could trigger employer mandate taxes on businesses (discussed in greater detail below). However, these revenue sources would not begin to pay for all the higher spending on Exchange subsidies. After taking both these offsets into account, net spending would still total nearly $1.7 trillion over ten years.[24]

When releasing its health care plan last July, the Biden campaign claimed it would cost $750 billion over a decade.[25] But if 24 million people leave employer coverage, the nearly $1.7 trillion cost of *this one provision* will more than double the Biden campaign's stated cost of *its entire plan*. For instance, this estimated increase in spending on subsidies excludes Biden's other health care proposals, from enrolling individuals in states that have not expanded Medicaid in the new government-run health plan to expanding Medicare to individuals aged 60-64.[26]

As a reminder: While other elements of the Biden plan might reduce the number of uninsured, the additional spending on subsidies discussed here will merely provide health coverage to *people who already had insurance*. Given that federal debt hit post-World War II highs prior to the coronavirus pandemic, and will exceed the nation's gross domestic product (GDP) by the end of the upcoming fiscal year, the federal government spending trillions of dollars to replace private-sector spending seems highly inefficient.[27]

POTENTIAL TAX EFFECTS ON EMPLOYERS

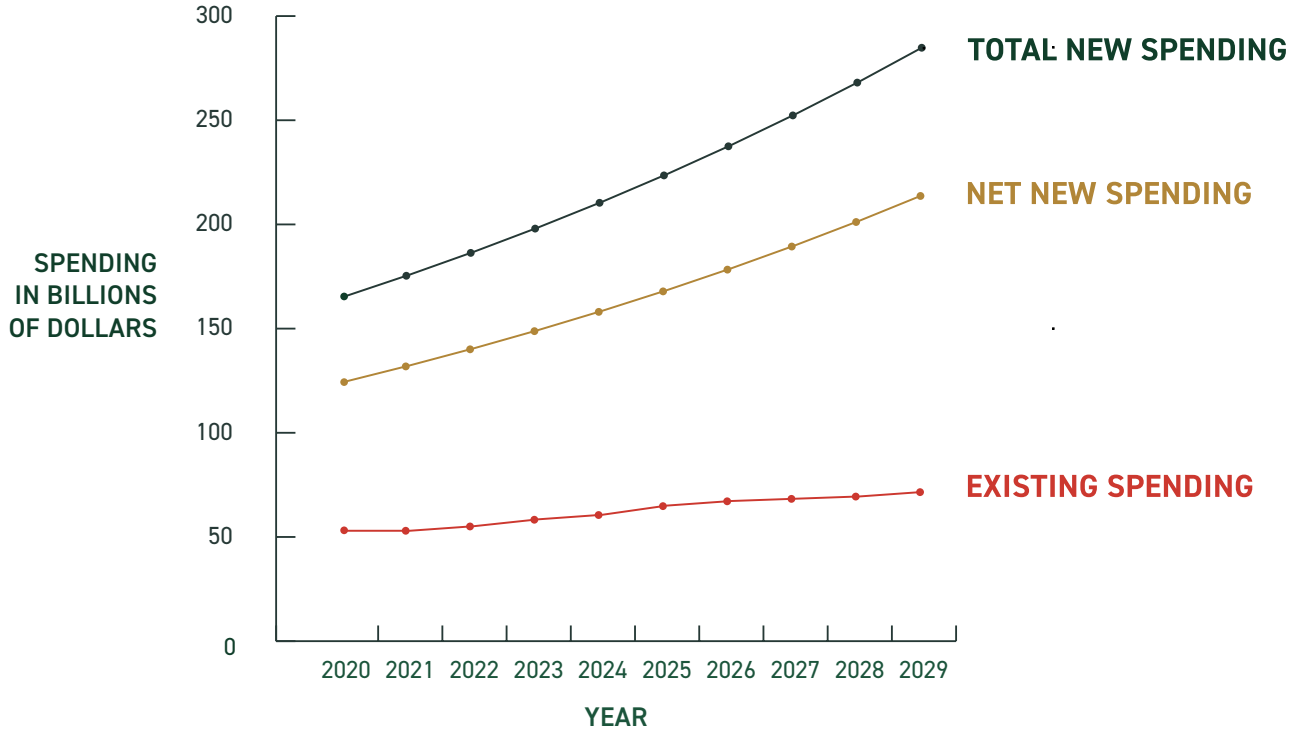
Currently, Obamacare contains a two-pronged employer mandate that taxes large businesses—those with over 50 full-time employees—whose workers access Exchange subsidies. The first prong of the mandate, affecting employers who do not offer coverage, imposes a tax, originally set at $2,000 per worker and applying to *all* of the company's full-time workers, if *one* of those employees accesses Exchange subsidies.[28] The second prong of the mandate, which applies to firms that do offer employer coverage, imposes a tax originally set at $3,000 if a worker accesses Exchange subsidies—but this higher tax only applies to the employee or employees receiving Exchange subsidies, not all full-time workers.[29]

At present, employees cannot access Exchange subsidies if they have an offer of "affordable" coverage from their employer, so firms that offer such coverage by definition do not currently face the mandate tax.[30] However, absent additional action by Congress, repealing the firewall separating employer and Exchange coverage would see employers paying taxes under Obamacare's employer mandate if their workers elect to receive federal Exchange subsidies.

$481.4 BILLION IN TAXES
on large employers over ten years
The equivalent of 441,000+ jobs in 2018

The Urban Institute's Healthy America plan assumes that employers would not face taxes if their employees voluntarily switch from employer to Exchange coverage.[31] However, the Biden campaign plan gives no indication whether it would modify the employer mandate so that businesses whose employees switch coverage would not face higher taxes.[32]

ESTIMATED SPENDING ON EXCHANGE SUBSIDIES
2020-2029



SOURCE: CONGRESSIONAL BUDGET OFFICE MAY 2019 BASELINE; AUTHOR'S CALCULATIONS.

Policymakers could face competing pressures when considering the interactions between the employer-Exchange firewall and the employer mandate. On the one hand, lawmakers should not want to penalize businesses who "do the right thing" and maintain employer coverage, even if some of their workers switch to the Exchanges. On the other hand, Congress may need revenue from higher employer mandate taxes to offset some of the trillions in new spending outlined above.

Some have also argued that businesses might attempt to induce their least healthy, and therefore costliest, employees to switch to the Exchanges, to reduce the employer's overall costs.[33] This strategy would represent the inverse of the adverse selection problem—healthy individuals moving from employer to Exchange coverage—discussed above, and illustrates the problems inherent in allowing individuals to switch between two parallel systems (i.e., employer coverage and the Exchanges).

If Congress retains the employer mandate tax as currently constituted, an estimated 9.2 million of the 24 million Americans who would have switched to the Exchanges in 2018 under the Biden plan would have worked at firms with over 50 full-time employees.[34] These

individuals would have triggered an estimated $32.1 billion in mandate taxes in 2018—equivalent to over 441,000 jobs that year.[35] Over the decade from 2020-2029, the mandate would generate $481.4 billion in taxes—a substantial sum, but not nearly enough to equal the new spending on Exchange subsidies.[36]

EMPLOYER DEATH SPIRAL?

Breaking the firewall between employer and Exchange coverage could have impacts far beyond potential taxes on employers; it could break the employer-based insurance system entirely. The 24 million individuals who would have switched out of employer coverage in 2018 under the Biden proposal represent 15.2% of the 158 million non-elderly Americans with employer coverage that year.[37] Any proposal resulting in this much dislocation to the current insurance system will have second-order effects on the composition of individuals with employer coverage.

Specifically, the demographics of those likely to leave employer coverage present adverse selection problems for employer plans. An estimated 64.1% of these 24 million Americans are under age 35—younger than the population as a whole, and younger than the majority of individuals with employer coverage.[38] With age serving as a rough approximation of health status, the migration of so many young and healthy individuals from employer coverage to the Exchanges would leave firms with an older, sicker pool of participants.

In the worst-case scenario, this adverse selection—that is, disproportionately sicker workers remaining in employer-based coverage—could start a proverbial "death spiral," whereby some healthy individuals exit the employer pool, forcing the insurer to raise premiums, which leads more healthy individuals to leave the pool. The adverse selection concerns sparked by breaking down the firewall between employer and Exchange plans could prompt firms to consider dropping coverage.

24 MILLION PEOPLE
switching out of employer coverage
15.2% of all those with employer plans

Estimates of one plan similar to the Healthy America proposal referenced by the Biden campaign show a substantial number of employers dropping coverage outright. Last year, consultants at Avalere Health modeled the Medicare Extra plan released by the Center for American Progress.[39] As with Healthy America, the Medicare Extra proposal would increase premium and cost-sharing subsidies on the Exchanges, and permit individuals with employer coverage to switch to subsidized Exchange plans.[40]

Avalere found that while Medicare Extra would cause 18 million individuals to switch voluntarily, an additional 14 million individuals would lose their employer coverage

involuntarily, because their employer stopped offering health coverage.[41] Moreover, Avalere assumed that employer plans could utilize the arbitrarily low rates imposed by a new government-run plan. If employer plans did not have access to these government-set rates, it would "increase the cost of employer coverage...causing a greater shift to" the Exchanges beyond the 32 million included in its estimate.[42]

The Avalere estimates confirm what some might intuit: The richer Exchange subsidies proposed by the Biden campaign would prove so lucrative that they would lead to a major erosion, and potential long-run elimination, of employer coverage. In 2014, the Congressional Budget Office noted that Obamacare's employer mandate could cause employers to "reduce or limit their full-time staffing and to hire more part-time employees."[43] The richer Exchange subsidies, coupled with the repeal of the firewall between employer and Exchange coverage, will provide a similarly large incentive for employers and employees to restructure their operations in ways that maximize receipt of the federal dollars on offer.

If and when a few "early adopters" decide to drop employer coverage altogether, many more could well follow suit. If a lengthy recession means the economic environment remains uncertain, and unemployment elevated for a prolonged period, businesses would have an additional incentive to drop coverage, as workers upset by the decision would have few other options in unsettled labor markets.

THE LARGER STRATEGY

Repealing the firewall between employer and Exchange coverage serves one important purpose for Biden and the Left: Enrolling as many people as possible in the new government-run health plan that Democrats want to create as part of the Exchanges. The Biden-Sanders task force admitted as much when it called for "[un-]blocking employee access to the [Exchanges], *including the public option*."[44]

The words "public option" appear no fewer than 12 separate times in Biden's original ten-page health plan.[45] But the word "option" bears little resemblance to a plan into which the government will shift Americans via subsidies—subsidies not optional to taxpayers who will bear the growing costs.

Both the original Biden plan and the Biden-Sanders task force propose automatically enrolling low-income people in the government-run plan in states that have not expanded Medicaid to the able-bodied, and people enrolled in food stamps or cash welfare.[46] In making the government plan—not necessarily the lowest-cost plan, or the plan with the best doctors, or the plan with the highest quality scores—the default option while ignoring

its actual cost, Biden and Democrats place the ideological goal of maximizing enrollment in government health plans over the best interests of American patients.

A government-run plan paying doctors and hospitals Medicare reimbursement rates would have cascading effects throughout the health care system. Medicare pays doctors approximately 75% of private insurance rates, and hospitals 58% of private insurance.[47] These low payment rates mean that in 2018, hospitals lost an average of 9.3% on every Medicare inpatient they treated.[48]

Expanding the number of individuals in low-paying government programs by millions—or, more likely, tens of millions—would put financial stress on health care providers. A 2019 analysis found that a government-run plan paying Medicare rates would cause a hypothetical small hospital system to lose more than 10% of its revenue, which would see it go from running a slight annual surplus (2.3%) to incurring sizable losses (-6.3%).[49] Hospitals could pressure employers and private insurers to pay higher rates and pick up the slack, but pushing them too hard could prompt employers to drop coverage altogether.

The intellectual father of the "public option," Jacob Hacker, has admitted its ultimate purpose: To create a single-payer system of socialized medicine in the United States.[50] During a 2008 speech, he recounted that "someone once said to me this is a Trojan horse for single payer. And I said, 'Well, it's not a Trojan horse, right? *It's just right there*!'"[51]

Nearly two-thirds of those likely to switch out of employer coverage are under age 35,

meaning employers will be left with an older (and sicker) workforce

THE EXPRESSWAY TO SINGLE PAYER

Biden's claims of moderation aside, repealing the firewall between employer and Exchange coverage represents the equivalent of pulling the drain plug from a bathtub. Spending trillions of dollars to fund new insurance for tens of millions of individuals who already had health coverage provides a clear path towards the eventual elimination of employer-based health insurance, as part of a rapid march towards single payer.

In January 2019, Sen. Kamala Harris, Biden's running mate, infamously claimed regarding the existing health insurance system: "Let's eliminate all of that. Let's move on."[52] Biden and Harris' plan to remove the firewall between employer coverage and the Exchanges will ultimately do just that.

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Analytical Appendix

CALCULATING COVERAGE COSTS

To determine the number of individuals who might switch from employer to Exchange coverage, this analysis first examines the financial decisions of those with employer-provided health insurance:

1. It uses 2018 data from the Medical Expenditure Panel Survey (MEPS) regarding the percentage of employees who selected individual, self-plus-one, and family coverage, and extrapolates those data to determine the total number of covered lives in each type of policy.[53] As virtually all (99.8%) children aged 0-18 hold employer coverage from a parent or dependent, as opposed to coverage obtained through their own job, it assigns one-quarter of children to self-plus-one coverage, with the remaining three-quarters in family coverage.[54]
2. It uses 2018 MEPS employer plan premiums for individual, self-plus-one, and family coverage.[55] To take into account the exclusion for employer-provided health coverage, it discounts those premiums by either 25% or 27%, reflecting federal income taxes (10% or 12%), the employee portion of payroll taxes (7.65%), and state and local income taxes (6.35%).
3. It uses 2018 MEPS data regarding average deductibles for those in plans with a deductible, lowering them to reflect the fact that 12.7% of employees faced no plan deductible in 2018.[56]
4. To calculate the newly enriched Exchange subsidies, it uses premium and deductible specifications provided in the Urban Institute's Healthy America plan.[57] Because the paper analyzes household decisions in the 2018 plan year, it relies upon the specifications in the original Urban plan, released in May 2018, rather than the updated version released in September 2019.[58] It also uses prior year (i.e., 2017) income levels to determine subsidy eligibility, as per current practice.[59]

This analysis compares the cost of coverage (premium plus deductible) associated with an employer plan to the cost of Exchange coverage at each of the "break points" outlined in the Healthy America plan: 150%, 200%, 250%, 300%, and 400% of the federal poverty line (FPL). It does so for individual coverage, self-plus-one coverage, and family coverage (assuming a family of four, consistent with the average family size calculated in step one above).

For all types of coverage, the smaller premium contributions and smaller deductibles result in substantial cost savings below 200% FPL. Above 200% FPL, net Exchange premiums for

individuals start to become more expensive than net employer premiums, mitigating the effects of lower deductibles. However, between 200-300% FPL, net Exchange premiums remain competitive to net employer premiums for self-plus-one and family coverage, allowing lower deductibles to deliver savings in many cases. The phase-out of reduced deductibles at 300% FPL makes employer coverage more affordable than the newly enriched Exchange subsidy regime for households above that threshold.

DECISION TO KEEP OR CHANGE COVERAGE

This analysis assumes that, where the potential savings by switching to Exchange coverage exceeds $100 per month, or $1,200 per year, 90% of covered lives will leave employer coverage. In almost any scenario, a small fraction of individuals will continue with their current plan, whether due to inertia or a strong desire for continuity of insurer and/or providers. However, the prospect of substantial financial savings should see most households switching to the Exchanges, particularly in households with modest incomes. This scenario applies to individual coverage below 200% FPL, to self-plus-one coverage below 300% FPL, and to family coverage below 250% FPL.

Where the potential savings associated with switching to Exchange coverage falls between $0 and $1,200, this analysis assumes that 50% of covered lives will leave employer coverage. In these cases, inertia will take on a larger role, as more households may not consider a change in insurer, plan, and provider network "worth it" to save smaller sums. Additionally, some employees may not expect or believe they will hit their plan deductible, and therefore will not see any savings from switching to an Exchange plan with a lower deductible. This scenario applies to individual coverage between 200-250% FPL, and family coverage between 250-300% FPL.

The Urban Institute's September 2019 analysis of its Healthy America plan concluded that, among households switching from employer coverage to the Exchanges, savings would average a total of $1,147 annually—$673 per year in premiums and $473 in out-of-pocket health care costs.[60] (The original 2018 analysis contained no such breakout of cost savings for potential switchers.) It seems reasonable to assume that most households with savings above Urban's average will switch plans, and that some households who will save money, but less than the average calculated by the Urban Institute, will do so as well.

In cases where the total cost of Exchange coverage exceeds the total cost of employer coverage, this analysis assumes no switching from the latter to the former. However, other factors could still prove enticing enough to switch. For instance, some individuals focused on lowering premium costs might wish to select a zero-premium Exchange plan, even if it comes with higher deductibles than their current employer coverage. Other individuals

may switch to have a choice of insurance plans, or have a particular doctor or hospital in-network. However, such considerations remain outside the scope of this analysis.

CALCULATING COVERAGE LOSSES

THIS ANALYSIS RELIES UPON DATA from the Census Bureau's 2018 Current Population Survey, Annual Social and Economic Supplement (ASEC), to estimate coverage changes. Those data are broken out by insurance status (i.e., employer-based), age, and multiples of the federal poverty level. It adjusts these numbers proportionally downward, to reflect the fact that the Congressional Budget Office calculated a lower number of individuals under age 65 with employer coverage in 2018 (158 million) than reported employer coverage via the Census survey (167.4 million).[61]

It excludes individuals with incomes below 138% FPL. In states that have expanded Medicaid, most of these individuals cannot access Exchange subsidies, because they have access to another form of "minimum essential coverage."[62] Because the Census ASEC data do not measure coverage precisely at 138% FPL, it reduces the numbers of individuals with employer coverage at incomes between 125-150% FPL by half, to approximate the number of covered individuals with incomes of 138-150% FPL.

Within each cohort—138-150% FPL, 150-200% FPL, 200-250% FPL, and 250-300% FPL—this analysis attributes enrollees with employer-sponsored health coverage to individual, self-plus-one, or family coverage, using the percentages and methods outlined above. After attributing enrollees, it then applies the assumed percentages of coverage losses (0%, 50%, or 90%), based upon the criteria outlined above, to obtain the number of individuals likely to leave employer coverage, first for each cohort and then as a whole.

COVERAGE DECISION SCENARIOS FOR AN INDIVIDUAL WITH SINGLE COVERAGE

Income	Tax Bracket	ESI Premium	Net ESI Premium	Exchange Contribution	Exchange Premium	Exchange Deductible	Exchange Premium plus Deductible	ESI Premium plus Deductible	Exchange Savings vs. ESI	Decision
$18,090 150% FPL	25%	$1,427	$1,070	2.0%	$362	$250	$612	$2,682	$2,070	Likely Drop
$24,120 200% FPL	27%	$1,427	$1,042	4.0%	$965	$300	$1,265	$2,653	$1,388	Likely Drop
$30,150 250% FPL	27%	$1,427	$1,042	6.0%	$1,809	$500	$2,309	$2,653	$344	Might Drop
$36,180 300% FPL	27%	$1,427	$1,042	7.0%	$2,533	$500	$3,033	$2,653	$379	Keep
$48,240 350% FPL	27%	$1,427	$1,042	8.5%	$4,100	$1,500	$5,600	$2,653	$2,947	Keep

Source: Urban Institute Healthy America plan; Medical Expenditure Panel Survey data on employer plans; Author's calculations.

COVERAGE DECISION SCENARIOS FOR A COUPLE WITH SELF-PLUS-ONE COVERAGE

Income	Tax Bracket	ESI Premium	Net ESI Premium	Exchange Contribution	Exchange Premium	Exchange Deductible	Exchange Premium plus Deductible	ESI Premium plus Deductible	Exchange Savings vs. ESI	Decision
$24,360 150% FPL	25%	$3,634	$2,726	2.0%	$487	$500	$987	$5,687	$4,700	Likely Drop
$32,480 200% FPL	25%	$3,634	$2,726	4.0%	$1,299	$600	$1,899	$5,687	$3,788	Likely Drop
$40,600 250% FPL	25%	$3,634	$2,726	6.0%	$2,436	$1,000	$3,436	$5,687	$2,251	Likely Drop
$48,720 300% FPL	27%	$3,634	$2,653	7.0%	$3,410	$1,000	$4,410	$5,614	$1,204	Likely Drop
$64,960 350% FPL	27%	$3,634	$2,653	8.5%	$5,552	$3,000	$8,522	$5,614	$2,908	Keep

Source: Urban Institute Healthy America plan; Medical Expenditure Panel Survey data on employer plans; Author's calculations.

SUBSIDY SPENDING AND OFFSETTING TAXES

THIS ANALYSIS MULTIPLIES THE NUMBER of individuals likely to leave employer coverage in 2018 by the average Exchange subsidy in that year, as calculated by the Congressional Budget Office (CBO), to estimate new federal spending on those individuals. For the years 2020-2029, it uses the May 2019 CBO Exchange baseline to calculate an average subsidy increase for the years 2019-2029. It then multiplies the 2018 subsidy spending by this projected average subsidy increase to generate subsidy amounts in each year.[63] Because the analysis relies upon the current law baseline, it does not reflect the higher per-person costs associated with proposals to enrich the Exchange subsidy regime.

The analysis also assumes that workers who decide to switch to Exchange coverage will pay taxes on the employee's share of premiums, previously paid on a pretax basis. Because most additional payroll tax revenues would likely get paid out in larger future Social Security benefits, it does not assume any revenue from the payroll tax, but it does assume additional revenue from the income tax. It does not assume that employers will increase wages equivalent to the employer's insurance contribution for workers who switch, as it is unclear whether businesses will increase compensation for only those workers who move to the Exchanges, while keeping compensation static for those who remain in employer coverage.

The analysis calculates the income tax impact of households expected to switch coverage, based on their federal income tax bracket (either 10% or 12%), type of coverage (individual, self-plus-one, or family), and MEPS estimated premiums for employer-sponsored coverage for 2018. After deriving a calculation for 2018, it then increases revenues by the average projected Exchange subsidy increase for the years 2019-2029, as with the Exchange subsidies described above, to arrive at a ten-year total (2020-2029) of estimated taxes.

POTENTIAL TAXES ON BUSINESSES

Under current law, individuals who receive Exchange subsidies trigger employer mandate taxes on large employers (those with over 50 full-time workers). Specifically, employers who offer qualifying health coverage, but have one or more employees receive Exchange subsidies, face a tax originally set at $3,000 for each worker receiving federal subsidies.[64] Therefore, allowing workers to receive Exchange subsidies would automatically trigger taxes on large employers, absent modifications to or a repeal of the employer mandate.

Whether Congress modifies the employer mandate may depend upon a debate among health policy analysts about the effects of allowing choices between employer and Exchange coverage. In 2018, analysts at the Brookings Institution asserted that allowing employees a choice between Health Reimbursement Arrangements, which would give workers funds to purchase Exchange coverage, and traditional employer-based health coverage would encourage selective dropping by employers. The Brookings analysts concluded that allowing choices between the Exchanges and traditional employer plans could nearly double Exchange premiums, because businesses would route their sickest workers to the Exchanges.[65] On the other hand, the Urban Institute assumed that unspecified "strong antidiscrimination rules"—whether those currently in law, or new ones created by Congress—would prevent selective employer dropping in the Healthy America plan, which allows workers to purchase Exchange coverage.[66]

In part because the Urban Institute analysts assumed that antidiscrimination rules would prevent selective employer dropping, its Healthy America plan would not assess taxes on employers whose workers voluntarily switch to subsidized Exchange coverage.[67] However, the Biden campaign plan does not indicate whether it supports such a move.[68]

Given the uncertainty surrounding whether employer mandate taxes would apply if an employee voluntarily switches coverage, this analysis quantified the impact of such taxes should they take effect:

1. It uses Bureau of Labor Statistics (BLS) data regarding the percentage of private sector employees working at firms employing more than 50 workers in 2018, and removes part-time workers employed at such firms, to calculate the number of full-time workers at large firms to which the employer mandate would apply.[69]
2. It applies the percentage of working-age adults (i.e., those aged 18-64) estimated to leave employer coverage to the number of full-time employees working at large firms, to calculate the number of employees for which firms would pay employer mandate taxes.

3. It applies the employer mandate tax ($3,480 in 2018) to calculate the total impact of the mandate on businesses.[70]
4. It divides the total mandate tax by BLS data on average total compensation in 2018, to calculate the net jobs impact of the mandate taxes that year.[71]
5. It increases the 2018 revenue total by the average projected Exchange subsidy increase for the years 2019-2029, as described above, to arrive at a ten-year total (2020-2029) of estimated taxes.[72]

FACTORS AFFECTING ESTIMATES

Several factors might mean the estimates in this analysis—whether the number of people switching to Exchange coverage, or the costs associated with such changes—exceed the actual costs of eliminating the firewall between employer and Exchange coverage:

1. Because they examine the state of employer-based health coverage as of 2018, the estimates do not take into consideration the coronavirus pandemic and its resulting economic impacts. If employers convert temporary furloughs into permanent layoffs, that could reduce the number of individuals with employer-sponsored coverage. Moreover, to the extent that employers disproportionately lay off lower-wage workers, such reductions could reduce the number of people with employer-sponsored coverage for whom it might make financial sense to switch to subsidized Exchange coverage if given the opportunity.
2. They assume that significant financial incentives will result in significant amounts of switching to the Exchanges. A variety of factors, from unfamiliarity with the Exchanges to *status quo* bias, could reduce switching. The combination of restrictive plans (e.g., Health Maintenance Organizations, which generally do not cover out-of-network care) and narrow plan networks for Exchange coverage could discourage individuals, particularly older and/or sicker individuals, from switching.[73] However, an influx of new, and potentially younger, enrollees joining the Exchanges could result in new insurer offerings, including those with broader networks.
3. They show a much younger population joining the Exchanges. Whereas at present, just over one-third (34.6%) of Exchange enrollees are under age 35, this report estimates that nearly two-thirds (64.1%) of those

switching to the Exchanges would be under that age.[74] The entry of a younger, and likely healthier, population could improve the Exchanges' risk pool, lowering per-enrollee subsidy spending. On the other hand, if employers with sicker risk pools choose to drop coverage entirely and send those workers to the Exchanges, that would reduce the effects of young, healthy employees voluntarily joining the Exchanges. In addition, as noted in #6 below, Biden simultaneously proposes to make Exchange subsidies more generous, such that the two factors—a healthier risk pool and a more generous subsidy regime—could negate each other when calculating per-enrollee subsidy costs.

4. They assume that individuals will switch out of employer coverage, when in some cases that decision may not be theirs to make. Beginning in 2010, Obamacare permitted individuals to remain on their parents' health insurance up until age 26.[75] A total of 4.7 million individuals aged 18-34, and with incomes between 138-300% FPL, receive coverage through an employer, but not through their own job.[76] An unknown percentage of these individuals receive coverage through their parents, who may not have the same financial incentives to switch plans as their children.
5. They assume that employers will not raise wages for workers who voluntarily switch from employer to Exchange coverage, to reflect the savings on the employer's share of coverage costs. If some or all employers do so, the additional income tax revenue will help to offset the additional spending on Exchange subsidies. However, if the employer mandate remains unaltered, and employers face tax penalties for workers who switch to the Exchanges, those taxes would mitigate employers' ability to pass on savings in the form of higher wages. Moreover, firms that agree to increase compensation for workers who switch to the Exchanges could incentivize that very behavior, potentially increasing the migration out of employer coverage, and spending on Exchange subsidies.

On the other hand, other factors suggest these estimates could understate the effects of repealing the firewall between employer-sponsored coverage and the Exchanges:

1. They exclude 11.7 million individuals with employer coverage in households with incomes below 138% FPL.[77] At present, most such individuals in states that have expanded Medicaid do not qualify for Exchange subsidies, because they have access to other "minimum essential coverage."[78] However, Biden has proposed auto-enrolling

Medicaid-eligible individuals in non-expansion states into the government-run health plan, which would raise subsidy costs, and could cause individuals to leave employer coverage.[79]

2. They exclude 13.4 million individuals over age 65 with employer coverage.[80] Most of these individuals would not qualify for Exchange subsidies, because they have access to other "minimum essential coverage" via Medicare.[81] However, if employers drop coverage entirely, these individuals would lose access to their employer plan.
3. They exclude individuals with incomes over 250% FPL, and families with incomes over 300% FPL, who might find subsidized Exchange policies more attractive than their employer coverage for a variety of reasons (e.g., more choice of plans, desire to have a particular medical provider in-network, etc.). For instance, it excludes the 7.2 million individuals aged 18-34 with incomes between 300-500% FPL who obtain coverage from their own employer, and might find a zero-premium bronze plan on the Exchanges more attractive than employer coverage.[82]
4. They exclude the impact of employers dropping coverage outright, which would also impact households with incomes over 300% FPL. However, given the prospect of a deterioration of the risk pool from workers who jump to the Exchanges, the chances for at least some employers dropping coverage seem high, in which case spending on Exchange subsidies will exceed these projections.
5. They exclude the 3.3 million uninsured individuals and families who cannot currently qualify for Exchange subsidies because they have an offer of "affordable" insurance from their employer.[83] Many of these individuals might use a repeal of that firewall to purchase subsidized Exchange coverage. While these individuals would newly obtain coverage—as opposed to the 24 million in this analysis who would merely substitute Exchange plans for employer coverage—they would also raise federal spending, and could trigger additional mandate taxes for their employers by utilizing Exchange subsidies.
6. They use a per-enrollee subsidy cost based on the Congressional Budget Office's current law baseline. However, the changes proposed by Biden would, if enacted, increase the average Exchange subsidy provided. While the younger population migrating from employer coverage would improve the risk profile of Exchange plans, lowering per-enrollee costs,

the richer subsidy regime would have the opposite effect of increasing per-enrollee spending.

7. They rely on MEPS data that has in the past consistently underestimated health spending when compared to estimates compiled by the Centers for Medicare and Medicaid Services' Office of the Actuary.[84] If the MEPS data under-state what employees actually pay for employer-provided health coverage, that would increase the financial incentives to leave employer coverage, and encourage additional switching beyond the numbers analyzed here.
8. The net cost estimate assumes that the employer mandate remains in effect as currently constituted. Modifying that mandate to eliminate taxes on workers who voluntarily switch to the Exchanges would raise the net cost of eliminating the firewall by $481 billion. In addition, if repealing or modifying the employer mandate incentivizes employers to send their sickest workers to the Exchanges, it would raise spending on Exchange subsidies—because more individuals would migrate to the Exchanges, and because the sicker individuals could cause per-enrollee subsidy spending to rise.

Given all of these factors, it seems reasonable to conclude that repealing the firewall between employer coverage and the Exchanges could cost $1.7 trillion over a decade, and potentially more than that amount.

COMPARISON WITH OTHER ANALYSES

THE PRECEDING ANALYSIS ECHOES REPORTS regarding two similar plans—the Urban Institute's Healthy America proposal, and an Avalere Health analysis of the Center for American Progress' Medicare Extra plan. For ease of comparison, a chart summarizes the major statistical findings of each paper, with discussion following.

	Urban/Healthy America	Avalere/ Medicare Extra	Juniper Research
Switching	18.9 million (Voluntary and Involuntary)	18 million (Voluntary) 14 million (Involuntary)	24 million (Voluntary)
Percentage who Switch	12.8%	20.8%	15.2%
Gross Ten-Year Cost	Unspecified	$2.8-$4.5 trillion (Including other provisions)	$2.2 trillion
Offsets	Income taxes ($16 billion per year) Reduced uncompensated care spending ($17 billion per year) Prescription drug rebates ($15 billion per year) Assumed 0.5% reduction in health cost trends	Increased employer mandate taxes (Amounts unspecified) Menu of tax increases on the wealthy proposed	Income taxes ($61.4 billion over ten years) Employer mandate taxes, if collected ($481.3 billion over ten years)
Net Ten-Year Cost	$1.3-$1.4 trillion (Including other provisions)	"About $1 trillion" to "improv[e] coverage for employees who shift"	$1.66 trillion

Healthy America: In May 2018, the Urban Institute released its Healthy America plan.[85] Designed as a comprehensive health coverage proposal, the plan would restructure the federal-state Medicaid program, and includes new policies designed to reduce the number of uninsured. It would increase Exchange subsidies—lowering the percentage of income Americans must pay out-of-pocket in premiums, and providing additional cost-sharing

assistance—while repealing the firewall that currently prohibits most individuals with an offer of employer coverage from receiving those subsidies.

In September 2019, Urban issued an updated analysis of Healthy America. It concluded that the plan would lead approximately 18.9 million individuals to migrate from employer coverage to the revamped Exchanges—a decline in employer coverage of 12.8 percent overall.[86]

Urban's results do not specify how many of the 18.9 million workers losing employer coverage voluntarily switch into the Exchanges, and how many end up there because their employers dropped coverage. However, Urban does state that the combination of existing tax incentives for employer-provided coverage, coupled with nondiscrimination rules intended to prevent employers from selectively dropping their low-income and/or less healthy workers on to Exchanges, would mean that "most firms would continue to find it advantageous to provide [employer] coverage."[87] In a footnote, however, the analysts do concede that if the "program's insurance options prove to be more attractive than those provided by typical employers, there could be more movement from employer-based insurance to Healthy America coverage," increasing subsidy costs.[88]

Unlike Biden's health care proposal, one variation of the Healthy America plan would reinstitute an individual mandate to purchase health coverage. According to Urban, however, a version of the plan without an individual mandate would reduce the erosion of employer-sponsored coverage by approximately 367,000 individuals—suggesting that an individual mandate would actually encourage additional migration to the Exchanges.[89] This finding seems somewhat counterintuitive, given that the individual mandate prompted more individuals to take up existing offers of employer coverage.[90] However, the Urban researchers did not discuss or elaborate upon this finding in their paper.

With respect to spending, Urban estimates a net federal cost of approximately $123-125 billion in 2020, and $1.3-1.4 trillion over ten years, for its Healthy America plan—a lower spending number than this analysis.[91] Because Urban analyzed a comprehensive health care proposal—as opposed to one element of that proposal, i.e., removal of the firewall between employer and Exchange coverage—multiple factors explain the difference in spending:

1. A lower number of individuals assumed to leave employer coverage, for reasons outlined above, lowers the number of individuals using Exchange subsidies.
2. A lower baseline of individuals (147.6 million) originally in employer coverage compared to this analysis (158 million—the Congressional Budget Office coverage baseline) lowers the number of individuals switching to subsidized Exchange coverage.

3. Tying subsidy levels to the cost of the government-run "public option" lowers the per-enrollee subsidy cost, and overall subsidy spending.
4. Capping reimbursement levels in the government-run plan (i.e., the subsidy benchmark) and all other Exchange plans also lowers the per-enrollee subsidy cost, and overall subsidy spending.
5. Lower uncompensated care spending associated with a reduction in the number of uninsured lowers the net federal cost.
6. An expansion of Medicaid drug rebates (i.e., price controls) within the Medicare program lowers the net federal cost.
7. Tax revenue from a reinstituted individual mandate lowers the net federal cost.

These net spending estimates also rely on two additional assumptions. First, Urban assumes that a reduction in employer-sponsored coverage would lead employers to increase taxable wages, resulting in income tax revenue of approximately $16 billion annually that reduces the plan's net cost.[92] As with this analysis, Urban does not count increases in payroll tax revenues as an offset for its plan.

Urban appears to imply that businesses would save money by ceding some of their sicker risks to the Exchanges. Their analysis finds that "decreases in employer contributions to workers' health insurance would...be passed back to all workers in the firm via higher wages."[93] However, Urban also says it assumes that "employers' decreased spending on inactive workers are not passed on to workers via higher wages; they simply constitute savings to employers."[94] This wording indicates Urban's belief that employers would save money above and beyond lower spending on "inactive workers"—i.e., those who voluntarily switch to Exchange coverage—suggesting that employers might reduce both overall and per-enrollee spending if some of their higher-cost employees switched to Exchange coverage.

Second, in citing a net federal cost of $1.3-1.4 trillion over ten years, Urban says it assumes that "cost growth within the [Healthy America] program structure could be constrained to 0.5 percentage points below recent trends in the commercial insurance market."[95] However, the paper includes little discussion of new cost containment mechanisms incorporated into Healthy America to warrant such an assumption.

Medicare Extra: In February 2018, the Center for American Progress (CAP) released its Medicare Extra proposal.[96] The plan would make many changes to the health care system, expanding benefits in traditional Medicare, and folding the state-federal Medicaid program into the Exchanges, which it would rename Medicare Extra. The plan also allows individuals with an offer of employer coverage to buy into the new program, using a system of premium

and deductible subsidies similar to, if not slightly more generous than, the Healthy America program described above.

The Medicare Extra plan includes two features separating it from Healthy America. While Healthy America would eliminate employer mandate taxes where workers voluntarily switch to Exchange coverage, Medicare Extra would impose new mandates on employers. Firms would have to offer insurance paying an average of 80% of workers' health care costs—up from 60% under current law—and pay at least 70% of the total premium costs for such coverage. Large firms with at least 100 employees who fail to offer compliant coverage would face taxes equal to 10% of total payroll costs—in most cases, a larger penalty than the employer mandate taxes under Obamacare. These tighter requirements for employer coverage could prompt some businesses to drop coverage, particularly firms whose insurance offerings do not meet the new standards.

Second, Medicare Extra would allow employees who decide to switch to Exchange coverage to "cash out" their employer's contribution toward health insurance, and use those funds to buy an Exchange plan. While this feature could encourage workers to depart for the Exchanges, it could also keep employers offering some form of health coverage, rather than dropping coverage entirely.

In July 2019, CAP published an analysis commissioned from Avalere Health regarding Medicare Extra. According to the Avalere analysis, the plan would reduce employer coverage by approximately 32 million individuals—18 million because they chose to migrate to the Exchanges, 9 million because their small employer stopped offering coverage, and 5 million because their large employer stopped offering coverage.[97]

The 18 million number in the Avalere estimate equates to the 24 million figure in this analysis—the number of individuals who voluntarily migrate from employer coverage to the Exchanges/Medicare Extra. One specification in the plan largely explains this disparity: Medicare Extra would extend current Medicare payment rates, with a 10% increase for hospital payments, to all employer plans.[98]

The Avalere analysis concludes that applying Medicare reimbursement rates to employer coverage would result in lower cost-sharing for individuals in employer coverage.[99] As a result, CAP admits that not applying these price controls to the employer market "would increase the cost of employer coverage relative to Medicare Extra [i.e., the Exchanges], causing a greater shift to Medicare Extra. The federal cost [of subsidies] would increase and employees who remain in employer coverage would face higher costs."[100]

Avalere concludes that CAP's "low-cost" option would increase federal spending by $2.8 trillion over ten years, with the "medium-cost" option increasing spending by $3.5 trillion and the "high-cost" option increasing spending by $4.5 trillion.[101] Of the $2.8 trillion in spending on the "low-cost" option, CAP claims that "about $1 trillion derives from

improving coverage for employees who shift to Medicare Extra."[102]

It is unclear whether this $1 trillion figure reflects 1) the marginal cost of the richer benefits for individuals who migrate from employer coverage to the Exchanges/Medicare Extra, 2) the cost of the richer benefits for the 18 million individuals who voluntarily migrate from employer coverage (as opposed to having their employer stop offering coverage entirely), or 3) the total cost of subsidies for the 32 million individuals estimated to migrate from employer coverage, both voluntarily and otherwise.

However, as CAP concedes, eliminating its proposed extension of Medicare's price controls to employer plans would increase federal subsidy costs, by increasing the cost disparities between employer and Exchange/Medicare Extra coverage, encouraging more individuals to switch. Removing that change would likely result in coverage and cost effects similar to this analysis.

ENDNOTES

1 Jon Greenberg, "'If You Like Your Plan, You Can Keep It:' Biden's Health Pitch Invokes Obama's Troubled Claim," Politifact July 18, 2019, https://www.politifact.com/article/2019/jul/18/if-you-your-plan-you-can-keep-it-bidens-healthcare/; NBC News, "Democratic Debate Transcript: July 31, 2019," https://www.nbcnews.com/politics/2020-election/democratic-debate-transcript-july-31-2019-n1038016.

2 Biden for President, "The Biden Plan for Health Care," July 15, 2019, https://joebiden.com/healthcare/.

3 Ibid.; Linda Blumberg, John Holahan, and Stephen Zuckerman, "The Healthy America Plan: Building on the Best of Medicare and the Affordable Care Act," Urban Institute, May 11, 2018, https://www.urban.org/sites/default/files/publication/98432/2001826_2018.05.11_healthy_america_final_1.pdf; Linda Blumberg, et al., "The Healthy America Program: An Update and Additional Options," Urban Institute, September 4, 2019, https://www.urban.org/sites/default/files/publication/100910/the_healthy_america_program_an_update-1_2.pdf.

4 Biden for President, "The Biden Plan for Health Care."

5 Ibid. Chart sources: Urban Institute Healthy America plan; Medical Expenditure Panel Survey data on employer plans; Author's calculations.

6 26 U.S.C. 36B(c)(2)(C), as codified by Section 1401 of the Patient Protection and Affordable Care Act, P.L. 111-148, and amended by Section 1001(a)(2)(A) of the Health Care and Education Reconciliation Act, P.L. 111-152; Internal Revenue Service, Revenue Procedure 2019-29, August 5, 2019, https://www.irs.gov/pub/irs-drop/rp-19-29.pdf.

7 Biden for President, "Biden-Sanders Unity Task Force Recommendations," July 8, 2020, https://assets.documentcloud.org/documents/6983111/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf, p. 93. Chart sources: Urban Institute Healthy America plan; National average Exchange premiums for 2018 plan year; Author's calculations

8 McKinsey Center for Health Reform, "Hospital Networks: Perspective from Four Years of the Individual Market Exchanges," May 2017, https://healthcare.mckinsey.com/sites/default/files/2017%20Hospital%20networks%20-%20Perspectives%20from%20four%20years%20of%20the%20individual_%20exchanges%20vF.pdf; Chris Sloan, "2020 Exchange Plan Networks Are the Most Restrictive Since 2014," Avalere Health, December 11, 2019, https://avalere.com/press-releases/2020-exchange-plan-networks-are-the-most-restrictive-since-2014.

9 Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2020 to 2029," May 2, 2019, https://www.cbo.gov/system/files/2019-05/55085-HealthCoverageSubsidies_0.pdf, Figure 2-2: Average Federal Subsidies for Recipients by Type of Health Insurance, Calendar Year 2019, p. 19.

10 Department of Health and Human Services, "Annual Update of the HHS Poverty Guidelines," Federal Register January 31, 2017, https://www.govinfo.gov/content/pkg/FR-2017-01-31/pdf/2017-02076.pdf, p. 8832. 2018 subsidy levels were calculated based on the 2017 income guidelines. See also Analytical Appendix.

11 Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey, Insurance Component: 2018 Chartbook," AHRQ Publication No. 19-0077, September 2019, https://meps.ahrq.gov/data_files/publications/cb23/cb23.pdf, pp. 99, 144. See also Analytical Appendix.

12 Author's calculations using Blumberg, Holahan, and Zuckerman, "Healthy America," pp. 5-6; see Analytical Appendix.

13 Author's calculations; see Analytical Appendix.

14 Author's calculations; see Analytical Appendix.

15 Kaiser Family Foundation, Employer Health Benefits: 2019 Annual Survey, September 25, 2019, http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019, Figure 4.2: Among

Firms Offering Health Benefits, Percentage of Covered Workers in Firms Offering One, Two, or Three or More Plan Types, by Firm Size, 2019, p. 76.

16 Kaiser Family Foundation, "Average Marketplace Premiums by Metal Tier, 2018-2020," October 2019, https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/; Blumberg, et al., "Healthy America: An Update," p. 4. Calculations based on national average lowest-cost gold plan premium for 2018.

17 Ibid. Calculations based on national average lowest-cost bronze plan premium for 2018.

18 AHRQ, "MEPS Chartbook," p. 99.

19 42 U.S.C. 300gg(a)(1), as amended by Section 1201(4) of PPACA.

20 Includes 4.1 million individuals with incomes between 300-400% FPL, and 3.3 million with incomes between 400-500% FPL. Census Bureau, 2018 Current Population Survey, Annual Social and Economic Supplement, https://www.census.gov/cps/data/cpstablecreator.html, adjusted to Congressional Budget Office baseline. See also Analytical Appendix.

21 Author's calculations using Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables from CBO's May 2019 Projections," May 2, 2019, https://www.cbo.gov/system/files/2019-05/51298-2019-05-healthinsurance.pdf; see Analytical Appendix.

22 CBO, "Federal Subsidies for Health Insurance Coverage: Tables from CBO's May 2019 Projections."

23 Author's calculations; see Analytical Appendix. Chart sources: Congressional Budget Office May 2019 baseline; Author's calculations; and Urban Institute Healthy America plan; Medical Expenditure Panel Survey data on employer plans; Author's calculations

24 Author's calculations; see Analytical Appendix.

25 Dan Diamond, "Biden Unveils Health Care Plan: Affordable Care Act 2.0," Politico July 15, 2019, https://www.politico.com/story/2019/07/15/joe-biden-health-care-plan-1415850.

26 Biden for President, "The Biden Plan for Health Care;" Biden for President, "Joe Biden Outlines New Steps to Ease Economic Burden on Working People," Medium April 9, 2020, https://medium.com/@JoeBiden/joe-biden-outlines-new-steps-to-ease-economic-burden-on-working-people-e3e121037322.

27 Congressional Budget Office, "Federal Debt: A Primer," March 12, 2020, https://www.cbo.gov/system/files/2020-03/56165-CBO-debt-primer.pdf, p.5; Congressional Budget Office, "An Update to the Budget and Economic Outlook: 2020 to 2030," September 2, 2020, https://www.cbo.gov/system/files/2020-09/56517-Budget-Outlook.pdf, p. 2..

28 26 U.S.C. 4980H(a), as codified by Section 1513(a) of PPACA.

29 26 U.S.C. 4980H(b).

30 26 U.S.C. 36B(c)(2)(C).

31 Blumberg, et al., "Healthy America: An Update," p. 6.

32 Biden for President, "The Biden Plan for Health Care."

33 Matthew Fiedler, "Effects of Weakening Safeguards in the Administration's Health Reimbursement Arrangement Proposal," Brookings Institution, December 28, 2018, https://www.brookings.edu/research/effects-of-weakening-safeguards-in-the-administrations-health-reimbursement-arrangement-proposal/. See also Analytical Appendix.

34 Author's calculations; see Analytical Appendix.

35 Author's calculations; see Analytical Appendix.

36 Author's calculations; see Analytical Appendix.

37 Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables from CBO's Spring 2018 Projections," May 23, 2018, https://www.cbo.gov/system/files/2018-06/51298-2018-05-healthinsurance.pdf.

38 Author's calculations; see Analytical Appendix.

39 Center for American Progress, "Medicare Extra: Universal Coverage for Less Than $3 Trillion and Lower Health Care Costs for All," July 23, 2019, https://cdn.americanprogress.org/content/uploads/2019/07/22132250/Medicare.-Extra.pdf.

40 Center for American Progress, "Medicare Extra for All: A Plan to Guarantee Universal Health Coverage in the United States," February 22, 2018, https://cdn.americanprogress.org/content/uploads/2018/02/21130514/MedicareExtra-report.pdf.

41 Center for American Progress, "Medicare Extra: Universal Coverage," Table 2: Changes in Health Insurance Enrollment by Coverage Type, p. 6.

42 Ibid., p. 8.

43 Congressional Budget Office, "The Budget and Economic Outlook: 2014 to 2024," February 4, 2014, https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/45010-outlook2014feb0.pdf, Appendix C: Labor Market Effects of the Affordable Care Act: Updated Estimates, p. 124.

44 Biden for President, "Unity Task Force Recommendations," p. 93. Author's emphasis.

45 Biden for President, "The Biden Plan for Health Care."

46 Ibid.; Biden for President, "Unity Task Force Recommendations," pp. 92-93.

47 John Shatto and Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," Centers for Medicare and Medicaid Services Office of the Actuary memorandum, April 22, 2020, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2019TRAlternativeScenario.pdf, p. 7.

48 Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 15, 2020, http://medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf?sfvrsn=0, p. 89.

49 Jeff Goldsmith, Jeff Leibach, and Kurt Eicher, "Medicare Expansion: A Preliminary Analysis of Hospital Financial Impacts," Navigant Consulting, March 2019, https://americashealthcarefuture.org/wp-content/uploads/2020/03/Navigant_Medicare-Expansion-Hospitals.pdf.

50 Jia Lynn Yang, "The Man Who Invented Health Care's 'Public Option,'" Fortune September 4, 2009, http://archive.fortune.com/2009/09/04/news/economy/public_option_hacker.fortune/index.htm.

51 Video available at https://www.youtube.com/watch?v=3sTfZJBYo1I. Author's emphasis.

52 CNN Town Hall with Sen. Kamala Harris, January 28, 2019, http://www.cnn.com/TRANSCRIPTS/1901/28/se.01.html.

53 Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey, Insurance Component: 2018 Chartbook," AHRQ Publication No. 19-0077, September 2019, https://meps.ahrq.gov/data_files/publications/cb23/cb23.pdf, p. 53.

54 Census Bureau, 2018 Current Population Survey, Annual Social and Economic Supplement, https://www.census.gov/cps/data/cpstablecreator.html.

55 AHRQ, "MEPS 2018 Chartbook," p. 99.

56 AHRQ, "MEPS 2018 Chartbook," pp. 144-45.

57 Linda Blumberg, John Holahan, and Stephen Zuckerman, "The Healthy America Plan: Building on the Best of Medicare and the Affordable Care Act," Urban Institute, May 11, 2018, https://www.urban.org/sites/default/files/publication/98432/2001826_2018.05.11_healthy_america_final_1.pdf.

58 Linda Blumberg, et al., "The Healthy America Program: An Update and Additional Options," Urban Institute, September 4, 2019, https://www.urban.org/sites/default/files/publication/100910/the_healthy_america_program_an_update-1_2.pdf.

59 Department of Health and Human Services, "Annual Update of the HHS Poverty Guidelines," Federal Register January 31, 2017, https://www.govinfo.gov/content/pkg/FR-2017-01-31/pdf/2017-02076.pdf, p. 8832.

60 Blumberg, et al., "Healthy America: An Update," Table 4: Average Household Direct Spending on Premiums and OOP Health Costs per Covered Life Switching from ESI to Healthy America, 2020, p. 12.

61 Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables from CBO's Spring 2018 Projections," May 23, 2018, https://www.cbo.gov/system/files/2018-06/51298-2018-05-healthinsurance.pdf; Census Bureau, 2018 Current Population Survey, Annual Social and Economic Supplement.

62 26 U.S.C. 36B(c)(2)(B), as codified by Section 1401 of the Patient Protection and Affordable Care Act, P.L. 111-148. While individuals who qualify for Medicaid cannot access Exchange subsidies, Section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) prohibits most legal aliens from qualifying for Medicaid coverage for five years after their arrival in the United States. Because these legal aliens do not qualify for Medicaid, they can receive Exchange subsidies. However, for simplicity's sake this analysis excludes all individuals with incomes below 138% FPL.

63 Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables from CBO's May 2019 Projections," May 2, 2019, https://www.cbo.gov/system/files/2019-05/51298-2019-05-healthinsurance.pdf. While CBO released updated Exchange spending projections on March 19, 2020, it did not release updated enrollment estimates with those projections; therefore, this analysis uses the prior baseline for consistency purposes. The analysis uses CBO's average projected increase in per-enrollee subsidies (6.2%) for 2019-2029 because some year's increases indicate the presence of statistical "noise." For instance, when projected subsidized enrollment falls from 8 million in 2020 to 7 million in 2021, the per-enrollee subsidy increases 0.0% in 2020, followed by a 14.3% jump in 2021. This jump likely reflects the effects caused by CBO rounding its enrollment estimates to the nearest million, whereby a hypothetical enrollment decline from 7.7 million to 7.4 million (3.9%) gets magnified to a decline from 8 million to 7 million (12.5%), and per-enrollee subsidy spending jumps accordingly. Using the projected average subsidy increase for 2019-2029 minimizes the effects of these statistical anomalies in any given year, while illustrating the larger trend.

64 26 U.S.C. 4980H(b), as codified by Section 1513(a) of PPACA.

65 Matthew Fiedler, "Effects of Weakening Safeguards in the Administration's Health Reimbursement Arrangement Proposal," Brookings Institution, December 28, 2018, https://www.brookings.edu/research/effects-of-weakening-safeguards-in-the-administrations-health-reimbursement-arrangement-proposal/.

66 26 U.S.C. 105(h); Blumberg et al., "Healthy America: An Update," p. 6.

67 Blumberg, et al., "Healthy America: An Update," p. 6.

68 Biden for President, "The Biden Plan for Health Care," July 15, 2019, https://joebiden.com/healthcare/.

69 Bureau of Labor Statistics, National Business Employment Dynamics Data by Firm Size Class, https://www.bls.gov/web/cewbd/table_f.txt, Table F: Distribution of Private Sector Employment by Firm Class Size, Not Seasonally Adjusted; see for instance Bureau of Labor Statistics, "The Employment Situation—January 2018," February 2, 2018, https://www.bls.gov/news.release/archives/emp-

sit_02022018.pdf, Summary Table A: Household Data, Seasonally Adjusted, p. 9, and Bureau of Labor Statistics, "The Employment Situation—December 2018," January 4, 2019, https://www.bls.gov/news.release/archives/empsit_01042019.pdf, Summary Table A: Household Data, Seasonally Adjusted, p. 6.

70 Internal Revenue Service, "Questions and Answers on Employer Shared Responsibility Payment," February 18, 2020, https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act#collapseCollapsible1582041068772.

71 Bureau of Labor Statistics, "Employer Costs for Employee Compensation Archived News Releases," https://www.bls.gov/bls/news-release/ecec.htm.

72 Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage: Tables from CBO's May 2019 Projections." While most taxes rise according to general inflation, the employer mandate codified in Section 1513(a) of PPACA (26 U.S.C. 4980H(c)(5)(A)(ii)) links increases in the tax to the "premium adjustment percentage" defined in Section 1302(c)(4) of the law. Therefore, using the average projected increase in Exchange subsidies as a proxy for rising health care costs yields a more accurate estimate.

73 Chris Sloan, "2020 Exchange Plan Networks Are the Most Restrictive Since 2014," Avalere Health, December 11, 2019, https://avalere.com/press-releases/2020-exchange-plan-networks-are-the-most-restrictive-since-2014; McKinsey Center for Health Reform, "Hospital Networks: Perspective from Four Years of the Individual Market Exchanges," May 2017, https://healthcare.mckinsey.com/sites/default/files/2017%20Hospital%20networks%20-%20Perspectives%20from%20four%20years%20of%20the%20individual_%20exchanges%20vF.pdf.

74 Centers for Medicare and Medicaid Services, "2020 Marketplace Open Enrollment Period Public Use Files," April 2, 2020, https://www.cms.gov/files/zip/2020-oep-state-level-public-use-file.zip; Author's calculations.

75 42 U.S.C. 300gg-14, as amended by Section 1001(5) of PPACA and Section 2301(b) of HCERA.

76 Census Bureau, 2018 Current Population Survey, Annual Social and Economic Supplement, adjusted to Congressional Budget Office baseline.

77 Includes 6.6 million individuals with household incomes below 100% FPL, 3.3 million with incomes between 100-125% FPL, and an estimated 1.8 million with incomes between 125-138% FPL. Census Bureau, 2018 Current Population Survey, Annual Social and Economic Supplement, adjusted to Congressional Budget Office baseline.

78 26 U.S.C. 36B(c)(2)(B).

79 Biden for President, "The Biden Plan for Health Care."

80 Census Bureau, 2018 Current Population Survey, Annual Social and Economic Supplement.

81 26 U.S.C. 36B(c)(2)(B).

82 Includes 4.1 million individuals with incomes between 300-400% FPL, and 3.3 million with incomes between 400-500% FPL. Census Bureau, 2018 Current Population Survey, Annual Social and Economic Supplement, adjusted to Congressional Budget Office baseline.

83 Jennifer Tolbert, et al., "Key Facts about the Uninsured Population," Kaiser Family Foundation, December 13, 2019, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

84 Didem Bernard, et al., "Reconciling Medical Expenditure Estimates from the MEPS and NHEA, 2007," Medicare and Medicaid Research Review 2:4 (December 28, 2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4006479/.

85 Linda Blumberg, John Holahan, and Stephen Zuckerman, "The Healthy America Plan: Building on the Best of Medicare and the Affordable Care Act," Urban Institute, May 11, 2018, https://www.urban.org/sites/default/files/publication/98432/2001826_2018.05.11_healthy_america_final_1.pdf.

86 Linda Blumberg, et al., "The Healthy America Program: An Update and Additional Options," Urban Institute, September 4, 2019, https://www.urban.org/sites/default/files/publication/100910/the_healthy_america_program_an_update-1_2.pdf, p. 10.

87 Ibid., p. 6.

88 Ibid., p. 16.

89 Ibid., Table 2: Health Insurance Coverage Distribution of the Nonelderly Population (under Age 65) under Current Law and Healthy America, 2020, p. 10.

90 In November 2017, the Congressional Budget Office estimated that setting the mandate penalty to $0, which Congress did via the Tax Cuts and Jobs Act later that year, would reduce levels of employer-sponsored coverage by 2-3 million individuals per year. Congressional Budget Office, "Repealing the Individual Health Insurance Mandate: An Updated Estimate," November 8, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf, Table 2: Effects of Repealing the Individual Mandate on Health Insurance Coverage for People Under Age 65, p. 3.

91 Blumberg, et al., "Healthy America: An Update," Table 5: Acute Health Care Spending for the Nonelderly under Current Law and Reform Options, 2020, p. 13.

92 Ibid., p. 14.

93 Ibid., pp. 8-9.

94 Ibid., p. 9.

95 Ibid., p. 14.

96 Center for American Progress, "Medicare Extra for All: A Plan to Guarantee Universal Health Coverage in the United States," February 22, 2018, https://cdn.americanprogress.org/content/uploads/2018/02/21130514/MedicareExtra-report.pdf.

97 Center for American Progress, "Medicare Extra: Universal Coverage for Less Than $3 Trillion and Lower Health Care Costs for All," July 23, 2019, https://cdn.americanprogress.org/content/uploads/2019/07/22132250/Medicare.-Extra.pdf, Table 2: Changes in Health Insurance Enrollment by Coverage Type, p. 6.

98 Ibid., p. 3.

99 Ibid., Table 3: Reductions in Premiums and Cost-Sharing, 2031, p. 7.

100 Ibid., p. 8.

101 Ibid., p. 7.

102 Ibid., p. 8.