Universal coverage reforms in the USA: From Obamacare through Trump\textsuperscript{a, b, c} \textsuperscript{1}

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\textbf{A B S T R A C T}

Since the election of Donald Trump as President, momentum towards universal health care coverage in the United States has stalled, although efforts to repeal the Affordable Care Act (ACA) in its entirety failed. The ACA resulted in almost a halving of the percentage of the population under age 65 who are uninsured. In lieu of total repeal, the Republican-led Congress repealed the individual mandate to purchase health insurance, beginning in 2019. Moreover, the Trump administration is using its administrative authority to undo many of the requirements in the health insurance exchanges. Partly as a result, premium increases for the most popular plans will rise an average of 34% in 2018 and are likely to rise further after the mandate repeal goes into effect. Moreover, the administration is proposing other changes that, in providing states with more flexibility, may lead to the sale of cheaper and less comprehensive policies. In this volatile environment it is difficult to anticipate what will occur next. In the short-term there is proposed compromise legislation, where Republicans agree to provide funding for the cost-sharing subsidies if the Democrats agree to increase state flexibility in some areas and provide relief to small employers. Much will depend on the 2018 and 2020 elections. In the meantime, the prospects are that the number of uninsured will grow.

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1. Introduction

Since the election of Donald Trump as President, momentum towards universal health care coverage in the United States has stalled. Most notable was the repeal of the individual mandate to purchase health insurance in late December 2017. However, outright repeal of President Obama’s signature piece of legislation – the Affordable Care Act (ACA) – has not yet come to pass. Though the Republican Party controls the Presidency and both Houses of Congress, attempts at wholesale repeal and replacement of the ACA during the summer and early fall of 2017 failed. Congressional leaders could not muster enough votes in large measure because Congress’ own budget office reported that repeal would result in 23 million Americans losing their coverage [1]. As a result, the ACA’s expansion of Medicaid remains fully intact and individuals continue to receive the same financial subsidies to purchase coverage from private insurers on the ACA’s insurance exchanges. Political developments, nevertheless, are taking place at breakneck speed, making it difficult for the world community to know where things stand. In this article, which constitutes an analysis of major legislative and policy changes observed by the authors, we review past progress towards universal coverage in the U.S., present the key issues under debate now, and outline possible future scenarios.

2. Health insurance coverage in the U.S. before the ACA

Until the major provisions of the ACA went into effect in January 2014, health insurance coverage was always voluntary. About 30% of the population was covered through the two major public pro-
grams enacted in 1965: Medicare for seniors (later extended to the disabled) and Medicaid for poorer Americans [2]. Most others received coverage through their employment, either as employees or dependents, but such coverage was always voluntary: employers did not have to provide it, and individuals were not required to buy it. Less than 10% purchased coverage on their own.

As far back as the 1950s those with pre-existing illnesses generally found individual insurance policies unaffordable because insurers could charge higher premiums to those with a history of illness. The ACA increased individual coverage by: prohibiting insurance companies from excluding people or charging more for pre-existing conditions; mandating that all individuals obtain insurance; and by helping individuals pay for this through income-based premium subsidies.

Nearly all other high-income countries provide coverage for those unable to afford it, but this has not been true of the U.S. Until the ACA, only about half of poor adults were covered by Medicaid and almost 30% of both the poor and near-poor under age 65 lacked any coverage at all [3,4]. Coverage rates were higher for children in part because of the Children’s Health Insurance Program (CHIP). Enacted in 1997, under CHIP the federal government matches state contributions to provide coverage for children in families with incomes above Medicaid thresholds, but who typically cannot afford private coverage [5].

Medicaid’s limited success in extending coverage to the poor was mainly because program eligibility varied by state; states continue to have substantial powers in determining eligibility, health benefits covered, and provider payment. Some established significant barriers to eligibility such as requiring adults to have dependent children to be covered. Income requirements are also sometimes severe. For example, a parent with two dependent children in Texas, one of the most populous states, is ineligible for Medicaid if she earns just 18% (that is, less than one-fifth) of the federal poverty line (FPL) – only $3700 per year [6]. The ACA originally was designed so that all poor and some near-poor persons would receive Medicaid coverage, but that intent was stymied by a ruling by the U.S. Supreme Court, as described next.

3. What the ACA did – and did not – do

The ACA was passed in 2010 during a period in which the Democratic Party controlled the Presidency and both Houses of Congress. Box 1 lists its major provisions.

Uninsurance rates among the under age 65 population have almost halved, from a peak of 18.2% in 2010 to 10.3% in 2017 (Fig. 1). Researchers have estimated that average spending of adults (premiums plus out of pocket costs) fell by 12% during the first two years of full implementation – and by over 20% for the poor and near-poor [7]. The ACA did not achieve universal coverage, for several reasons: First, with the Supreme Court ruling, approximately 4.5 million poor and near-poor people still do not receive Medicaid [8]. Generally, these people are excluded from the individual mandate because they would have to spend more than 8% of their income on premiums. Second, some people choose to pay the penalty rather than purchase insurance; both penalties and enforcement of the mandate are far milder in the U.S. than in Germany, the Netherlands, and Switzerland, all of which require that people purchase coverage [9]. Third, undocumented individuals are forbidden from purchasing on the exchanges and are not eligible for subsidies – 42% are estimated to be uninsured [10].

4. Policy changes during the Trump administration

As noted, despite calls to repeal the ACA “on day one,” the President Trump, even with the support of a Republican Congress, was not able to repeal the legislation – although the vote in the U.S. Senate was very close. (Whether the House of Representatives would have passed the Senate bill is conjectural.) Due to arcane rules in the U.S. Senate, repeal before the U.S. National 2018 congressional elections will be extremely difficult because it would require 60 votes out of 100 – and Democrats and Democrat-leaning independents hold 48 seats.

The Republicans were able to make a major legislative dent, however, by repealing the individual mandate. This was accomplished by including this provision in a major overhaul of the federal income tax system that passed Congress and was signed into law just before the end of 2017. Because Senate rules allow budget-related legislation to pass with a majority vote, the Republicans were able to succeed. The main reason was to fulfill, at least in part the promise they made to voters to repeal the ACA, but another was more pragmatic. Repeal of the mandate will reduce the number of people purchasing coverage from the exchanges, which in turn will reduce federal outlays. This allowed the Republican party to increase the size of the tax cuts that were included in the legislation.

One would expect to see an uptick in the number of uninsured for two reasons: (1) the financial penalty for being uninsured will be removed beginning in 2019, and (2) premiums will rise due to adverse selection, by an estimated 10%, although most people are protected through rising financial subsidies. Estimates by the Congressional Budget Office project that by 2027, five million Americans would lose individual coverage; another five million, Medicaid coverage; and three million more, employer cov-

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**Box 1: Major Provisions of the Affordable Care Act.**

- Established “health exchanges” or “marketplaces” on a statewide basis that sold community-rated individual and family insurance policies that were required to cover ten sets of “essential health benefits.” Policies could be sold in four “metal tiers,” Bronze, Silver, Gold, and Platinum, which cover 60%, 70%, 80%, and 90%, respectively, of typical health expenses. The tiers with the more comprehensive coverage generally have higher premiums.
- Provided income-based subsidies to purchase insurance policies on the exchanges. Families earning up to four times the FPL were eligible for at least some financial assistance to pay for insurance. Various restrictions applied; for example, people with access to employer-sponsored health insurance, and those with incomes below the U.S. poverty level, could not purchase on the exchanges.
- Provided coverage free of cost-sharing requirements for specific services (e.g., annual physicals, some screenings) and for poorer Americans.
- Required that insurers sell coverage to applicants regardless of health status (called “guarantee issue”)
- Liberalized Medicaid coverage so that (as passed originally) everyone up to 138% of the FPL (except legal immigrants, who may have to wait five years before obtaining coverage) would be eligible for Medicaid, regardless of their family circumstances. In 2012 the U.S. Supreme Court ruled that requiring states to expand their Medicaid was unconstitutional. Nineteen states have chosen not to expand Medicaid even though 90% of costs were to be paid for by the federal government.
- Required that most people have health insurance or pay a penalty, a provision called the “individual mandate.” Employers with more than 50 employees were also required to provide coverage or pay a penalty although implementation of this provision was delayed.
- Required that employers that provide family coverage to workers cover workers’ children until the reach the age of 26.
average [11]. Moreover, the Trump Administration has made various administrative decisions that will lead to fewer people choosing to purchase coverage, including: (1) occasionally stating that it would not have the Internal Revenue Service enforce the tax penalties for those who choose to remain uninsured – this is relevant to 2018, when the individual mandate is still in force; (2) severely cutting funding for outreach during the annual open enrollment period, as well as the length of the period; (3) providing negative public statements about the ACA; and (4) choosing not to fund the so-called “cost-sharing subsidies.”

Where, then, do things now stand? The Medicaid expansion remains in place in 31 states; those eligible will continue to receive coverage, which typically has a broad benefit package and little or no premiums or patient cost-sharing. However, because many physicians do not accept Medicaid patients, due in large measure to low fees, access is often not the same as for those with private insurance and Medicare. Regarding the exchanges, in spite of the efforts of the Trump Administration, outlined above, enrollment during the 2018 open enrollment period was fairly stable. In 2018, an estimated 11.8 million million people enrolled through the federal and various state exchanges, just 4% lower than the previous year [12]. Enrollment results are not yet in for the several states that have their own exchanges.

In addition, the administration is proposing other changes that could lead to the sale of cheaper and less comprehensive policies at a cost of reducing consumer protections. States would gain more flexibility in defining what constitutes essential health benefits. Individuals would be allowed to purchase health insurance across state lines, which would give people in a state with tougher regulations the ability to purchase from another state where regulations are lower and insurance is cheaper. Regulations governing small employers that group together to create their own plans (called “association health plans”) would be modified to permit less comprehensive policies. And the sale of short-term policies would be permitted [13,14]. Such plans do not have to cover mandated “essential health benefits” under the ACA or comply with pre-existing condition regulations. They are currently limited to no more than three months, but the Trump Administration is discussing extending that time period, perhaps up to a full year [15]. Overall the result would be a market containing some bare-bones plans, which are mostly attractive to healthy people. By drawing these healthy individuals away from the exchanges, premiums on the exchanges would likely increase.

The cost-sharing subsidies have been one of the most contentious issues – but also the one on which prominent members of Congress are striving to reach a bipartisan solution. The most common plan under the individual exchanges, called Silver, has annual deductibles that average more than $3000 for those with individual coverage [16]. Since costs like these are unaffordable to many people purchasing on the exchanges, the ACA also specified sharply reduced cost sharing for those with incomes below 250% of the FPL. The insurer pays them and is reimbursed by the federal government. However, the ACA legislation did not include a funding source for these subsidies, and thus, a federal court ruled them unconstitutional. The Obama administration was in the process of appealing the court ruling when President Trump was elected, and he chose not to continue with the appeal.

Loss of the cost-sharing subsidies alone means that premiums will rise by an estimated 19% in 2018, varying from 7% to 38% by state [17] – and by far more (between 35% and 90%) over a three-year period [18]. This is on top of other premium increases resulting from higher than anticipated service utilization. (Premium increases from repeal of the individual mandate will not occur until 2019.) While the size of premium increases varies a great deal by state, they were substantial during the 2018 open enrollment period (which ended on 15 December 2017 in the federal marketplace) – an average increase of 34% for Silver plans [19]. Elimination of the subsidies, however, may have unintended consequences. This is because insurers raised premiums in Silver plans the most to offset anticipated cuts to cost-sharing subsidies, which only apply to those plans in the 4-tier exchange plans (Bronze, Silver, Gold, Platinum). Premium subsidies to those below 400% of the FPL, which are required by law and are not affected by this executive order, are calculated using the price of the second cheapest Silver plan. Thus, subsidies will increase for many consumers, allowing them to afford more generous Gold-tier plans, should they choose to purchase them. Interestingly, it is estimated that the net effect of elimination of the cost-sharing subsidies will be to increase federal spending by an average of $3 billion a year over the next ten years. This is because the increase in premium subsidies resulting

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Fig. 1. Uninsured Rate Among the Nonelderly Population, 1972-2017.
from higher premiums for Silver plans will exceed the reduction in cost-sharing payments made by the federal government to health insurers [20].

5. Next steps – and beyond

In such a volatile and fast-paced environment it is difficult to anticipate how things will turn out. One thing is nearly certain: the push towards universal coverage is stalled, if not reversing course. The individual mandate expires after 2018, and all signs from both the Trump Administration and Congress are that they want to undo as many other federal rules brought about through the ACA as they can. By doing so, many Republicans expect to make the ACA untenable and redistribute the federal spending back to the states to spend as they wish. This, in fact, was explicit in a recent proposal, dubbed Graham-Cassidy, that, while approved by the House of Representatives, failed Senate approval by a single vote in September 2017.

There is talk of political compromise, as well as a bipartisan bill [21], whereby the Republicans agree to provide funding for the cost-sharing subsidies if the Democrats agree to increase state flexibility through “innovation waivers” and provide relief to small employers. Such compromise is likely to be difficult to achieve, with many Republicans balking at increasing the price tag of the ACA, and many Democrats being reluctant to support any proposals that allow insurers to sell policies in which those with pre-existing conditions are charged more. At time of writing, the most recent development was a letter from the federal Centers for Medicare & Medicaid Services (CMS), which administers the Medicare and Medicaid programs, that would give states the flexibility to establish a work or community engagement requirement as a condition of Medicaid eligibility. Such a requirement has already been approved for Kentucky, and nine other states have made similar requests [22,23].

Moving further into the future, much depends on upcoming November 2018 midterm election. All members of the House of Representatives, and about one-third of the Senate, are up for election. If Republicans retain control of both, they will have two more years to make major alterations to the ACA or even repeal it. Presidential elections follow in 2020. In the meantime, the prospects are that the number of uninsured will grow and some of the insurance policies that are purchased will provide less comprehensive coverage.

Because the political future of the country is so uncertain, it is not possible to know even the rough direction of future major health policy reforms. Box 2 lists some of the options being discussed; it is divided into left-leaning and right-leaning proposals. Proposals on the left include the recently-released “Medicare Extra for All” and single-payer. The former, proposed by the Center for American Progress, may be viewed as “single payer light,” in that employers can choose to continue providing coverage if they wish. On the right, up till now most emphasis has been on repealing the ACA, so there are few proposals that propose reforming the health care system from scratch. We provide information about Republican plans to channel far more monies to states through block grants, as well as expanding health savings accounts (HSAs). HSAs generally are not considered a model for national health systems, with the key exception of Singapore.

Universal health coverage through universal health insurance remains an elusive goal for the U.S. The country started late but it has come a long way. Nevertheless, it may never catch up with other industrialized countries because the concept remains controversial even though 60% say that “it is the federal government’s responsibility to make sure all Americans have healthcare coverage” [24]. Those who disagree hold strong opinions on this topic and the American Constitution was written to protect minorities with intense opinions. And so it still does today.

**Conflict of interest**

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**Box 2: Selected Proposals to Reform the U.S. Health Care System**

**LEFT-LEANING PROPOSALS**

Medicare Extra for All

Example: Proposal by Center for American Progress, “Medicare Extra for All” [26]. Provides universal coverage in part by expanding the Medicare program to anyone who chooses to join, as well as all newborns and individuals turning age 65 – who are automatically enrolled. Medicare Extra has broad benefits package including dental, vision, and hearing services. Cost sharing requirements and premiums are income-related and free for those below 150% of the poverty level. Provider payment rates are the same irrespective of the source of patient insurance coverage, and are based on current Medicare fee levels. Government would negotiate prescription drug prices. Single Payer

Example: Proposal by Senator and 2016 Democrat presidential candidate Bernie Sanders [29]. Provides universal coverage by creating a single, public insurance system. Care would be free at point of service, and cover “the entire continuum of health care.” Likely to be financed through employer premium payments, income-based household premium payments, and federal income taxes.

**RIGHT-LEANING PROPOSALS**

State-Based Block Grants and Spending Caps

Example: Graham-Cassidy, H.R. 1628 [27]. Proposal to repeal and replace the Affordable Care Act. Employers have the choice of continuing to provide coverage, or enrolling their employees into Medicare Extra. Has broad benefits package including dental, vision, and hearing services. Cost sharing requirements and premiums are income-related and free for those below 150% of the poverty level. Provider payment rates are the same irrespective of the source of patient insurance coverage, and are based on current Medicare fee levels. Government would negotiate prescription drug prices. It is to be financed through employer contributions, income-related premiums, and taxes on high-income individuals.

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