



# Implementing a Basic Health Program

## Five States Where Improving Affordability Would Be Fiscally Attractive

*Matthew Buettgens*

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**Under the Affordable Care Act (ACA), states can choose to establish a Basic Health Program (BHP) to offer more affordable coverage to people with incomes up to 200 percent of the federal poverty level (FPL) who do not qualify for Medicaid. Under BHP, states contract directly with insurers to cover BHP enrollees with plans separate from the Marketplaces. The federal government pays the state 95 percent of the Marketplace premium tax credits (PTCs) that BHP enrollees would have received if they had enrolled in the Marketplaces. This may be attractive to states if BHP plans are less expensive than Marketplace plans, allowing a BHP to lower premiums and cost sharing while covering state program costs with federal payments.**

Currently, two states—New York and Minnesota—have a BHP, and Oregon has received federal approval to implement one. In this brief, we examine the fiscal feasibility of a BHP in the remaining states, finding that five states could implement a BHP that makes coverage substantially more affordable while fully covering state costs with federal payments. Provider reimbursement rates would be set above current Medicaid rates to safeguard access to services for enrollees: Iowa at Medicaid plus 10 percent; Wisconsin at Medicaid plus 15 percent; and Illinois, Wyoming, and West Virginia at Medicaid plus 25 percent.

We find that BHPs with these parameters would benefit those eligible in multiple ways:

- With high take-up, BHP could reduce the number of eligible uninsured people by between 39.5 percent and 71.5 percent in the various states.

- Health care spending of BHP enrollees would decline by between 60.8 percent and 87.4 percent, an annual decline of between \$685 and \$1,640 per person.
- BHP plans can be coordinated with Medicaid managed care plans so that people losing Medicaid eligibility as their incomes rise do not experience disruptions in coverage or health care providers. We find that most of those becoming eligible for PTCs after losing Medicaid eligibility would immediately be eligible for BHP and could be transferred to that program.

On the other hand, a BHP comes with some trade-offs:

- A BHP is not part of the private nongroup market, so the number of covered lives in that market would decrease by 22.3 to 36.7 percent in Iowa, Wisconsin, and Illinois. Wyoming would see a 45.1 percent decline because it has not expanded Medicaid eligibility under the ACA. Adults with incomes between 100 and 138 percent of FPL who would be eligible for Medicaid in expansion states can instead enroll in Marketplace coverage.
- A BHP would increase premiums for many higher-income people getting PTCs. This is a result of so-called “silver loading,” the process by which insurers set higher silver premiums to cover the cost of the ACA’s cost-sharing reductions (CSRs) available to low-income Marketplace enrollees after the Trump administration stopped federal reimbursement of CSRs. When low-income enrollees leave the Marketplace for a BHP, silver premiums are lower, changing the calculation of the PTC and reducing PTCs for everyone who remains. This increase would generally be between 8.2 percent and 9.5 percent. It would be much higher in Wyoming because the state has not expanded Medicaid, so people with incomes between 100 and 138 percent of FPL currently receive CSRs, which must be paid for by additional silver loading.
- BHPs were designed to cover people whose incomes are too high to qualify for Medicaid but are still below 200 percent of FPL. Yet, most uninsured people do not qualify for the BHP because they are eligible for Medicaid, have incomes over 200 percent of FPL, have affordable offers of coverage from an employer, or are not lawfully present in the US.

## Introduction

While the enhanced PTCs introduced in 2021 made health coverage in the Marketplaces more affordable and led to record-high Marketplace enrollment by 2023,<sup>1</sup> concerns remain about the affordability of coverage for those with incomes too high to qualify for Medicaid. People with incomes below 150 percent of FPL are eligible for free Marketplace coverage with a 94 percent actuarial value, but that coverage is still less generous than Medicaid coverage. For example, unlike Medicaid, most Marketplace plans have a deductible. For individuals with incomes this low, small copays and other costs can still be burdensome. People with incomes between 150 and 200 percent of FPL would pay small Marketplace premiums for coverage at 87 percent actuarial value, so BHP would reduce both premiums and cost sharing for this group. BHP could also eliminate deductibles, as New York has done. In this report, we estimate the impact of the BHP—a state option under the ACA—to provide more affordable coverage to those eligible for Marketplace PTCs with incomes up to 200 percent of FPL. BHP

is currently in effect in New York and Minnesota. The federal government has approved BHP in Oregon, but it has not been implemented yet.<sup>2</sup>

A BHP has several potential advantages for eligible individuals compared with Marketplace coverage. Current BHP states use the program to provide coverage with lower premiums and cost sharing than what is available in the Marketplace. In addition to being lower, BHP premiums can be structured as a fixed dollar amount by income group, making them much simpler to administer than Marketplace PTCs, which are computed on a sliding scale by family income. Also, Marketplace enrollees who receive PTCs must reconcile those amounts with the IRS at tax time, potentially having to repay PTCs if their incomes rise; BHP enrollees would not do so.

Current BHPs build from states' Medicaid provider networks and payment arrangements to create a plan based on Medicaid coverage. Insurers participating in a BHP would likely include current Medicaid insurers. This coordination between Medicaid and BHP would streamline transitions between the programs as people's circumstances change over time. Provider payment rates would be between Medicaid and commercial insurance because covering more people at low Medicaid reimbursement rates may limit access to care for BHP enrollees.

BHP plans are separate from the Marketplace and from the state's private nongroup market more generally. Thus, fewer people remain in that market, potentially making it less attractive to insurers, though existing BHPs have not reduced insurer participation.

BHPs are funded by the federal government, at least in part. The federal government pays 95 percent of the PTCs BHP enrollees would have received in the Marketplace. This federal funding is put into a trust fund that can only be used for BHP health care costs. States must set provider payment rates, actuarial value, and premiums such that the program's cost does not exceed federal payments unless they want to provide additional state funding for a BHP.

In this brief, we assess the fiscal feasibility—whether federal payments would cover states' costs—of a BHP that would increase affordability for enrollees in states without federal approval. We identify states where a BHP would be fiscally feasible and provide an overview of how it would affect health coverage and costs in these potential new BHP states.

## Methods

We simulated BHPs in all states using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options (Buettgens and Banthin 2020). The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM is designed for quick-turnaround analyses of policy proposals. It can be rapidly adapted to analyze various new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years. Results from HIPSM simulations have been

favorably compared with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015).

To estimate the number of people eligible for a BHP, we expand upon our previous approach, which focuses on people whose income puts them within the BHP income thresholds, and extend our estimates to include people losing Medicaid eligibility. Our new methodology captures transitions in eligibility within a year and is based on an analysis of data from the Survey of Income and Program Participation, which follows respondents as their income and other characteristics change over time. Using machine learning techniques, we impute whether people in the sample of observations in HIPSM who are not currently eligible for Medicaid were previously eligible for that program. We then examine the eligibility for BHP and Marketplace PTCs among those losing Medicaid eligibility.

## Results

To cover total BHP costs with federal payments set to only 95 percent of Marketplace PTCs, a BHP generally requires provider reimbursement to be lower than in the Marketplaces. We take Medicaid plus 10 percent as a minimum provider payment rate. Providing coverage to new populations at low Medicaid reimbursement rates could make it difficult for BHP plans to be negotiated with providers and could limit access to care for BHP enrollees. We estimate that Medicaid plus 10 percent would be Iowa's most feasible rate (table 1). Rates could be raised to Medicaid plus 15 percent in Wisconsin and Medicaid plus 25 percent in Illinois, Wyoming, and West Virginia.

We assume that a state considering BHP would do so only if it provided gains in affordability for those eligible. We assume there would be no BHP premiums for those with incomes up to 150 percent of FPL because there are currently no Marketplace premiums for silver coverage with enhanced PTCs. For those with higher incomes, we set premiums to \$120 a year per person to ensure enrollees pay less than they would have paid for Marketplace coverage. In some cases, states could eliminate these premiums and still design a program that would be at no cost to the state.<sup>3</sup>

We assume BHP coverage would be more generous than coverage under Marketplace plans with CSRs. We based our modeling of cost sharing on existing BHP state programs in Minnesota and New York (Corlette et al. 2023). Minnesota has higher cost sharing (equivalent to about 94 percent actuarial value at all incomes) than New York (no cost sharing for most services for individuals under 150 percent of FPL, minimal cost sharing, and no deductible between 150 and 200 percent of FPL). We used the higher cost-sharing requirements of Minnesota's BHP for Iowa and Wisconsin, which required the lowest provider payment rates to be feasible (table 1). We used the lower cost-sharing requirements of New York's BHP in the remaining states.

TABLE 1

## Summary of Selected BHP Results, 2024

	Iowa		Wisconsin		Illinois		Wyoming	
	Low take-up	High take-up	Low take-up	High take-up	Low take-up	High take-up	Low take-up	High take-up
<b>Maximum Feasible BHP Parameters</b>								
Provider payment rates	Medicaid + 10%		Medicaid + 15%		Medicaid + 25%		Medicaid + 25%	
Annual premium, up to 150% of FPL	\$0		\$0		\$0		\$0	
Annual premium, 150%-200% of FPL	\$120		\$120		\$120		\$120	
Cost sharing (compared with current BHP states)	Minnesota		Minnesota		New York		New York	
<b>Impact on the Uninsured</b>								
Uninsured people eligible for BHP (thousands)	10		35		39		7	
Share of total uninsured eligible for BHP	8.6%		12.5%		4.4%		8.8%	
Reduction in the uninsured with BHP (thousands)	-4	-7	-5	-16	-12	-16	-2	-5
Percent reduction in the uninsured eligible for BHP	-	-	-	-	-	-	-	-
	28.9%	-44.7%	13.0%	-46.4%	30.3%	-39.5%	36.4%	-71.5%
<b>Nongroup Market Size</b>								
Without BHP (thousands)	123		266		508		48	
With BHP (thousands)	96		169		364		26	
Percent difference	-22.3%		-36.7%		-28.5%		-45.1%	
<b>Household Spending on Health Coverage for BHP Eligibles</b>								
Average per person change in premium and OOP spending	-1,035		-685		-1,246		-1,640	
Percent change	-63.8%		-60.8%		-83.0%		-87.4%	
<b>Household Spending on Health Coverage for Marketplace PTC Recipients (changes because of reductions in silver loading of CSRs)</b>								
Average per person change in premium and OOP spending	460		434		497		1,409	
Percent change	9.4%		8.2%		9.5%		26.1%	
<b>Government Spending</b>								
Annual change in federal spending (millions of dollars)	-22	28	49	192	-74	-6	-4	7
Percent change in federal spending in the state	-0.5%	0.6%	0.7%	2.8%	-0.6%	-0.1%	-0.4%	0.7%
Annual net BHP trust fund balance, state costs minus federal payments (millions of dollars)	-9	-7	-17	-22	-230	-233	-10	-7

Source: Urban Institute Health Insurance Policy Simulation Model 2023.

Notes: BHP = Basic Health Program; FPL = federal poverty level; OOP = out-of-pocket; PTC = premium tax credit; CSR = cost-sharing reductions.

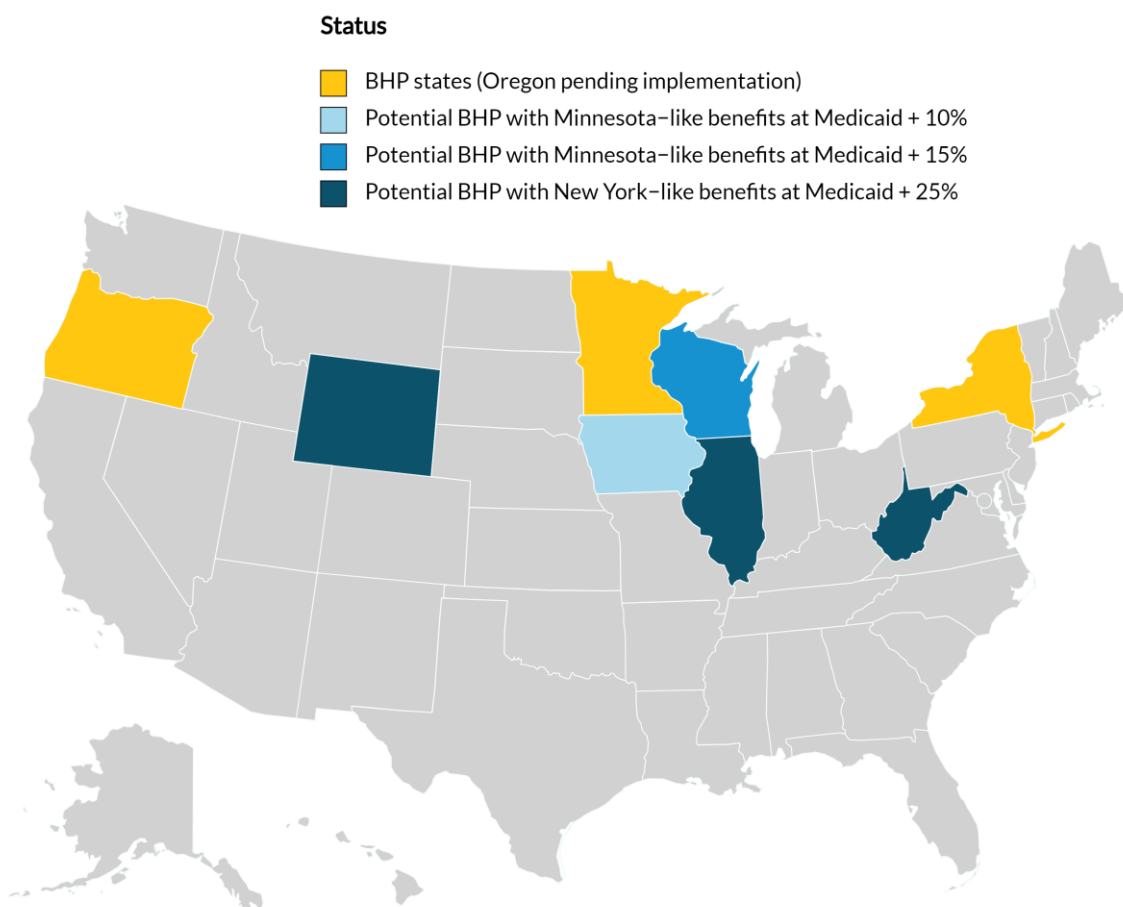
\* = Estimates for BHP in West Virginia were previously published in Buettgens and Ramchandani 2023a.

## Potential New BHP States

We find that federal payments to states of 95 percent of Marketplace PTCs would fully cover the costs of a BHP in five additional states beyond those that have already implemented a BHP or received federal approval to do so (figure 1) under our assumptions. BHP results for West Virginia were published earlier (Buettgens and Ramchandani 2023a). We summarize the results for the remaining four states in table 1.

FIGURE 1

### Current and Potential BHP States



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Source: Urban Institute Health Insurance Policy Simulation Model 2023.

Notes: BHP = Basic Health Program.

## Health Coverage

We find that most of the uninsured are not eligible for BHP (table 1). The share of the nonelderly uninsured that would be eligible for BHP ranges from 4.4 percent in Illinois to 12.5 percent in

Wisconsin. Much larger segments of the uninsured include those eligible for Medicaid/CHIP and not enrolled, those with offers of employer coverage deemed affordable under the ACA, and those not eligible because of immigration status (Buettgens and Ramchandani 2023c).

Nonetheless, the BHP population is important because of the large “benefits cliff” between Medicaid and Marketplace coverage at 138 percent of FPL. Marketplace coverage generally has higher cost sharing and generally higher premiums as well, even with enhanced PTCs. Some are concerned this could disincentive workers from increasing their household income above Medicaid eligibility.<sup>4</sup> BHP would provide coverage with lower premiums and cost sharing, saving those currently enrolled in Marketplace coverage who switch to BHP between \$685 a year in Wisconsin to \$1,640 a year in Wyoming. This represents a reduction in spending on premiums and other health care of between 60.8 percent and 87.4 percent. However, BHP would create a benefit cliff at 200 percent of FPL.

BHP would substantially reduce the number of eligible uninsured people. With high take-up, this would range from a 39.5 percent reduction in Illinois to a 71.5 percent reduction in Wyoming.

## Churn and BHP

Low-income families often have volatile incomes, causing them to gain or lose eligibility for health coverage programs during a year, called “churn.” Churn can lead to coverage gaps from enrollment procedures and to challenges with maintaining providers and completing courses of treatment (MACPAC 2021).

A BHP can help mitigate these challenges for the population that currently churns between eligibility for Medicaid and Marketplace PTCs. BHP recipients renew their coverage every 12 months. With BHP, plans nearly identical to existing Medicaid plans could be offered by existing Medicaid managed care organizations. These organizations could be required to use the same provider networks that serve existing Medicaid enrollees, so the transition could be smoother and not require changing health care providers. This and the lack of a tax reconciliation requirement make it more straightforward for states to seamlessly shift consumers back and forth between Medicaid and the BHP. Aligning BHP plan offerings to those in Medicaid can help address concerns about continuity of care.

We find that a majority (54 percent) of adults gaining PTC eligibility after losing Medicaid eligibility would immediately become eligible for BHP and thus could be automatically transferred (table 2). We find that among adults transitioning from Medicaid to BHP eligibility, 22 percent would be younger than age 25, 40 percent would be age 25 to 44, and 38 percent would be older than age 45.

TABLE 2

**Medicaid Beneficiaries Becoming Eligible for BHP After Losing Medicaid Eligibility, 2024**

<b>Among those gaining Marketplace PTC eligibility after losing Medicaid eligibility,</b>	
Share who immediately become eligible for BHP:	54%
Age distribution of those who immediately become eligible for BHP:	
Younger than 25:	20%
Age 25 to 44:	40%
Older than age 45:	38%

Source: Urban Institute Health Insurance Policy Simulation Model 2023.

Notes: BHP = Basic Health Program; PTC = premium tax credit.

Although many of those in the churn population will initially have incomes above 200 percent of FPL, we find that nearly all would become eligible for BHP at some point in the year following their loss of Medicaid. If a state runs its own Marketplace, enrollees currently in the Marketplace could be automatically transferred to BHP. Thus, nearly all those gaining PTC eligibility after losing Medicaid could enroll in BHP sometime the following year. BHP has an additional advantage for those whose incomes fluctuate because, unlike Marketplace PTCs, there is no individual income reconciliation at tax time. BHP recipients will never have to pay premium subsidies back to the Internal Revenue Service.

### **Nongroup Market Size**

BHP would be separate from the Marketplaces and the nongroup health insurance market more generally. As a result, the number of covered lives in the nongroup market would decline by 22.3 percent in Iowa and 45.1 percent in Wyoming. The share in Wyoming is larger than in other states because Wyoming has not expanded Medicaid. This means that people with incomes between 100 and 138 percent of FPL are enrolled in Marketplace coverage rather than Medicaid (Buettgens and Ramchandani 2023b).

We estimate that the health risk of the nongroup market would not change much under BHP, with the five states in table 1 seeing premiums change by only about 1 percent in either direction because of changes in the risk pool (data not shown). However, a large loss of covered lives may make the market less attractive to insurers, who may reconsider participation. Neither New York nor Minnesota saw any change, but a state's individual circumstances should be considered.

### **Silver Loading and Changes in Marketplace Premiums**

After the Trump administration ceased reimbursing insurers for the cost of the ACA CSRs, those costs were covered in most states by increasing premiums for silver premiums, either in the Marketplace or across the entire nongroup market. Calculations that determine federal PTCs are based on these higher premiums and result in higher PTCs. Silver loading thus increases federal spending on PTCs but allows people to apply larger tax credits to lower the cost of bronze or gold plans, whose premiums were unaffected.



With BHP, those with incomes up to 200 percent of FPL would no longer get CSRs. This covers most of CSR spending, as CSRs are very small for those with incomes between 200 and 250 percent of FPL, and there are no CSRs at higher incomes. Silver loading would largely end, so silver premiums and PTC amounts would decline. As a result, those with incomes above 200 percent of FPL who purchase bronze or gold coverage with PTCs would face higher premiums because their PTCs would shrink. Some gold purchasers might respond to smaller PTC amounts by switching to bronze or now-cheaper silver plans, which would mean higher cost sharing. We estimate that PTC recipients with incomes too high to qualify for BHP would pay hundreds of dollars more on average, ranging from \$434 in Wisconsin, \$460 in Iowa, \$497 in Illinois, and \$1,409 in Wyoming. The impact in Wyoming is particularly large because it has not expanded Medicaid, as noted above. There is currently a much larger share of low-income Wyoming enrollees in the nongroup market getting the largest CSRs than in expansion states. These would switch to BHP, lowering silver premiums by much larger amounts than in other states.

## Government Spending

Federal government spending will generally increase under BHP if take-up is high. Although per capita federal PTCs will be lower because of the near elimination of silver loading and the federal government would only pay 95 percent of PTCs for BHP enrollees, more people will enroll in BHP and receive federal subsidies because it offers more affordable coverage. The increase would be small in all states. As we discuss below, BHP has no federal deficit neutrality requirement, so the change in federal spending has no impact on the approval of a BHP plan.

We selected potential BHP states based on the criteria that federal payments would fully cover projected state BHP costs; in our projections, the BHP trust funds would run an annual surplus in all these states. But there is always some degree of uncertainty in our projections. Future changes in Marketplace premiums and state spending on BHP enrollees—or expiration of enhanced Marketplace PTCs—could lead to a BHP deficit, forcing the state to reduce provider payment rates, increase premiums and/or cost sharing, or contribute state funds. On the other hand, we project that Illinois would have a sizeable surplus, and could further raise provider reimbursement and/or reduce premiums and cost sharing.

## Discussion

We find that adopting a BHP with the parameters described would significantly improve the affordability of health care over Marketplace coverage for people gaining eligibility, primarily by reducing out-of-pocket health spending. As a result of these benefits, BHP would increase enrollment among people gaining eligibility and slightly reduce the number of uninsured. However, only a fraction of uninsured people would become eligible for BHP since most uninsured people either are undocumented or have incomes below the income eligibility threshold for the BHP. Other policies, such as enrolling more people currently eligible for Medicaid and Children's Health Insurance Program, could further reduce the number of uninsured people.

There are two main drawbacks to BHP. First, the size of the nongroup market would be considerably reduced. This could potentially affect insurers' willingness to participate in the market. Although neither New York nor Minnesota has seen any reduction in nongroup competition, the situation could differ in other states. Second, people with incomes above 200 percent of FPL who receive PTCs for coverage at metal tiers other than silver would see their costs increase by several hundred dollars a year. This would occur because of the artificially high silver premiums under current law, which are the basis for federal calculations of PTC amounts. Those artificially high silver premiums would fall with the creation of a BHP, and, as a result, so would the PTC amounts. There would be gainers and losers with BHP. BHP eligibles that benefit will see much larger financial savings and have higher incomes than those who would pay more. However, those getting PTCs with incomes just above 200 percent of FPL would generally see the largest cost increases, so silver loading would exacerbate the benefits cliff at 200 percent of FPL under BHP.

## Enhanced PTCs and BHP

Enhanced PTCs are currently set to expire in 2025. These subsidies have led to record-high Marketplace enrollment. In an earlier analysis of this policy, we estimated that 3.1 million more people would be uninsured if they expired (Buettgens, Banthin, and Green 2022).

If enhanced PTCs expire, federal BHP payments would be substantially affected because they are based on the PTCs BHP enrollees would have gotten if they were enrolled in the Marketplace. The applicable percentages of income used to compute Marketplace PTCs and federal BHP payments would be lower. On the other hand, nongroup premiums would be higher because of changes in the risk pool, offsetting part of the reduction in federal payments caused by lower applicable percentages of income. The net result will likely be lower federal BHP payments. If these reduced payments are insufficient to cover state BHP costs, then premiums and cost sharing must be raised and/or provider reimbursement rates lowered unless the state decides to fund the shortfall.

Marketplace enrollment would be notably lower without enhanced PTCs. Fewer people would get CSRs, so the increase in nongroup premiums because of BHP nearly eliminating silver loading would also be smaller.

## Limitations on Available Data

This analysis was based on the standard 50-state HIPSM model, which considers actual Marketplace premiums and publicly available data on Medicaid. A full analysis of BHP feasibility in an individual state would require more specific data provided by a state, as was done for our West Virginia analysis (Buettgens and Ramchandani 2023a). A refined model based on additional data may change feasible payment rates, so we only included states where BHP would be feasible at a minimum payment rate of Medicaid plus 10 percent.

## Conclusion

The feasibility of BHP is highly dependent on state-specific levels of health care spending in the Marketplaces and Medicaid. We find that a BHP would be fiscally feasible while improving affordability and paying providers at least 10 percent above Medicaid rates in only five states in addition to the three states that have already implemented BHP or received federal permission to implement a BHP.

BHP involves important trade-offs. In the five states we've identified, BHP would significantly increase enrollment among those becoming eligible and would reduce the health care spending of enrollees by between 61 and 87 percent. BHP would also improve the continuity of coverage for many who lose Medicaid eligibility. Most of those gaining PTC eligibility after losing Medicaid eligibility would be eligible for BHP and could be automatically transferred. On the other hand, many of those with incomes too high to qualify for BHP but who qualify for PTCs would face higher premiums. BHP would also substantially reduce the size of the nongroup market.

## Notes

- <sup>1</sup> “Marketplace 2023 Open Enrollment Period Report: Final National Snapshot,” CMS.gov, January 25, 2023, <https://www.cms.gov/newsroom/fact-sheets/marketplace-2023-open-enrollment-period-report-final-national-snapshot>.
- <sup>2</sup> Amelia Templeton, “Oregon Becomes 3rd in Nation to Seek Federal Approval for a Basic Health Program,” OPB, September 12, 2023, <https://www.opb.org/article/2023/09/12/oregon-basic-health-plan-insurance-doctor-authority-affordable-care-act/>
- <sup>3</sup> New York recently eliminated all BHP premiums.
- <sup>4</sup> See, for example, State of West Virginia Legislature, House, *Creating the Affordable Medicaid Buy-in Program*, HB 3001, introduced in House March 09, 2021.

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## About the Authors

**Matthew Buettgens** is a senior fellow in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban’s Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington, as well as to the federal government. His recent work includes several research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage. Buettgens was previously a major developer of the Health Insurance Reform Simulation Model—the predecessor to HIPSM—used in the design of the 2006 Roadmap to Universal Health Insurance Coverage in Massachusetts.

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500 L’Enfant Plaza SW  
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