**Total allowed: 5,000 words (including references), 4 exhibits**

**Word count: 6093 (missing discussion)**

**Title:** Individuals, Children, Aged 55+, Risk-Equalization, and Equity (ICARE): A Feasible US Transition to a Better Health Insurance System

**Abstract**

The United States healthcare system continues to incur higher costs for worse outcomes than other developed nations; hence, major health reforms are long overdue. We propose and evaluate a politically feasible transition from the current patchwork insurance system to one with publicly-subsidized, privately-insured coverage. Our proposal, ICARE, emphasizes individual contracts, uniform coverage for children, using managed competition to promote efficiency, and standardized coverage. We utilize a dynamic simulation framework that incorporates behavioral responses and institutional frictions to estimate the increase in public spending associated with ICARE. Our baseline simulations predict incremental public spending to be $513 billion annually, roughly 1/6 of the spending increase necessary to fund more ambitious proposals such as Medicare For All. Results suggest that our proposal is a politically and financially more viable option for healthcare reform in the United States.

**Keywords:** US health care reform, public option, managed competition

Introduction

**(1,425 words; goal: ~1250)**

Major health reforms in the United States are long overdue. For decades, the US health care system has incurred much higher costs than other high-income countries with worse outcomes. The current patchwork system of coverage leaves large, inequitable gaps resulting in underinsurance, crippling health expenses, and medical debt. In addition, the US is an outlier in its unequal coverage across income, geography, and race; and ineffective insurance market competition leading to inflated costs.1–3 Although health reforms like the 2010 Affordable Care Act (ACA) have improved delivery and financing, serious problems remain; indeed, following a sidelining during the COVID-19 pandemic, discussions of healthcare reform are due for a resurgence.

Some approaches have been suggested that replace or augment private, employer-sponsored insurance (ESI) to extend coverage through publicly-funded options. Often presented with taglines such as “Medicare for All”, “Medicare public option”, and “Medicaid buy in”, these proposals walk a tightrope of advancing multiple aims: lowering costs, increasing affordability of insurance and health services, and promoting greater equity across the population.

These reforms are not costless, however. Many proposals fall well short of political viability by proposing sweeping, overly costly changes to the healthcare system.4 Furthermore, proposals fail to adequately “fold in” existing coverage options or discuss how reforms should evolve over time. Many Americans, including those in ESI and Medicare, report wanting to reserve the right to choose coverage.5

We propose a politically moderate reform which broadens existing coverage while resolving underlying distortions and inequities. Our proposal—which we term ICARE—constitutes a “constrained optimal reform” subject to political feasibility. ICARE relies on multiple, competing private insurance companies and federal subsidies to expand coverage availability and generosity. The proposal has five components: individual health contracts; universal, subsidized insurance for children; early opt-in to public coverage for individuals aged 55-64; risk equalization to ensure plan portability across markets; and equitable financing options for all individuals.

Critically, these five components represent incremental shifts which could be implemented separately or holistically, subject to political feasibility. ICARE is more moderated than a leap to a single-payer system but focuses on reforms where potential gains are the largest. Additionally, ICARE incorporates funding methods with growing bipartisan appeal, such as value-added taxation, to achieve reform.

ICARE addresses three critical problems with US health insurance. First, the transition to portable, individual-level contracts resolves the segmented, patchwork system of coverage currently in place. Individual contracts minimize interruptions in coverage from labor-market disruptions or adverse life events and encourage competition across insurers. Second, we eliminate barriers to accessing care for particularly at-risk populations, children and the near-elderly.6,7 Finally, we propose reforms to plan financing to make payments more equitable for all individuals.

We simulate ICARE’s costs using a microsimulation framework incorporating individual behavioral responses and institutional frictions. We adopt a flexible framework that allows for comparisons across different proposals, including potentially more politically attractive ones. Our results suggest that ICARE requires $513 billion annually in additional public spending once fully implemented. This is considerably more politically attractive than costlier proposals; the most recent estimate of Medicare For All required a spending increase of $2.8 to $3.2 trillion annually.8 Similar to Medicare For All, ICARE allows this spending to be offset by generating savings in reducing administrative costs,9 or by incorporating additional cost-containment mechanisms (e.g., quality controls or coverage mandates).

The principles in ICARE are reflective of “managed competition” frameworks used globally. Similar to the German and Dutch systems, ICARE proposes that private care delivery be funded by many competing private plans, each offering generous, largely standardized benefits and financed via income or consumption taxes.10,11 Similar to Columbia, XXX.

Our ICARE proposal is made up of five key components:

I: Individual, rather than family, contracts for all insured

C: Children receive fully subsidized care

A: (Near)-aged individuals may choose to opt into public care

R: Risk-equalization across employers ensures plan portability

E: Equitable financing linked to ability-to-pay

*Individual Contracts*

Many current coverage options leave individuals vulnerable to disruptions, whether from labor-market disruptions, mobility limitations, or adverse life events. Spouses and dependents are especially vulnerable to disruptions due to a policy-holder’s job loss, divorce, or death.12 Furthermore, individuals currently face wide variation in both the availability and generosity of available coverage, variation which is inequitable and possibly welfare-reducing.13 These problems are exacerbated by a high degree of market fragmentation in the US, resulting in diminished competition among insurers.14 ICARE proposes a transition to individual, portable contracts, and subsidies for contracts with an average cost-sharing level at or above 80%. Providing stabilizing forces in the level of plan generosity and shifting to individual contracts will eliminate inequities across states, labor markets, and households.

An indirect effect of increasing and standardizing plan generosity is that some individuals who are currently uninsured will opt into purchasing health insurance, which may also reduce premiums by decreasing the average risk of the insured. Although premium subsidies will reduce the number of consumers choosing to be uninsured, ICARE’s proposed subsidies may not be enough to achieve universal coverage without more explicit insurance mandates, as originally specified in the ACA.15

*Expanded Private Coverage and a New Public Option*

Individual contracts on their own may be insufficient to reach vulnerable populations, however. This includes children, who are currently overwhelmingly either through the Children’s Health Insurance Program (CHIP) or Medicaid or uninsured altogether. Current coverage varies widely across states, restricts provider networks, and pay providers lower fees, all reducing access to high-quality care.16 Similarly, individuals approaching age 65 (who do not yet qualify for Medicare) are at high risk of underinsurance.17,18 As the US population ages, protecting this group (projected to constitute over 10% of the US population by 2035) becomes increasingly important.

ICARE will fully bear the health care costs of children aged 18 and younger, including costs that were previously paid out-of-pocket (OOP) by families. All costs will be borne at the federal level to eliminate state variation in access and quality. In addition, ICARE will introduce a public option that competes directly with private insurers for the near-aged population (aged 55 to 64). In both public and private coverage, enrollees will pay a partially-subsidized premium for gold-level coverage, providing a bridge between private insurance and Medicare coverage while retaining individual choice.

Recent evaluations of proposals to lower the Medicare eligibility age suggest that this expansion would provide an important avenue of coverage to many Americans, with as many as 7.3 million more Americans enrolling in Medicare were the eligibility age lowered to 60.8 In addition to expanding eligibility, we propose standardizing coverage and enhancing physician reimbursement rates above traditional Medicare rates.

One commonly cited risk of implementing a mixture of public and private coverage options is that the public option may struggle to stay viable due to the “cream skimming” tactics of private insurers, who attempt to entice the least risky enrollees into their plans. Research using German health care data finds little evidence of such behavior.19 These risks can be mitigated through standardized coverage levels, which lends itself to horizontal differentiation of private and public contracts. This differentiation could include competition on dimensions other than generosity, including network, brand, and premium costs. Additionally, ICARE proposes protections against cream-skimming through employer subsidies (designed to increase take-up of private coverage for even risky enrollees) and risk equalization.

*Fairness and Financing Features*

The proposed changes may differentially affect both individuals (e.g., based on preexisting coverage) and employers (e.g., based on industry and firm size). To even this playing field, ICARE proposes a risk-equalization program across public and private coverage, paralleling the structure used by the ACA Marketplace. This greatly reduces the incentive for insurance plans to disproportionately attract lowest risk enrollees, and ensures true portability of individual contracts.20

The development of an optimal risk adjustment scheme will ultimately depend on the ways in which individual contracts and public coverage are implemented.21,22 ICARE’s proposed risk pooling will combine individual premiums and risk-adjusted regulator payments, similar to programs used in Medicare Advantage programs and the ACA Marketplaces.21 Expanding these models will have strong political and economic viability given their successful use over the last decade. Risk adjustment also provides a powerful regulatory tool for cost-containment: more aggressive regulator payments may help control premium costs.21

Finally, ICARE calls for more equitable financing options for health insurance. Currently, employers pay a fixed premium per enrollee regardless of their income, and individuals can claim tax deductions for their coverage only when enrolled in ESI.23 These policies are both regressive, benefitting higher-earning workers over those with lower compensation.24,25 ICARE proposes progressive financing through a proportional tax on either income or consumption.

**Simulation Methods and Data**

(current: 1,066 words)

*ICARE Timeline*

ICARE will be phased in over an extended period, (here, modeled as eleven years) in order to prioritize taking important steps while minimizing overall disruption. Exhibit 1 provides details on the simulated timeline across all five ICARE components. New public coverage options for children and the near-aged gradually become more available until 2035, when everyone eligible can enroll. In addition, we designate the phasing in of individual contracts and our risk adjustment plan within the first three years, and the implementation of employer subsidies gradually over the first five years.

*Methodology*

We employ a flexible simulation framework based on externally calibrated parameters that incorporate multiple institutional frictions and behavioral responses to reforms. This approach has several advantages. First, simulations are easily compared a range of proposed policies, even those using more extreme assumptions. These comparisons are critical in a setting where political viability is a key constraint. Second, calibrations can be easily updated based on up-to-date research on parameters of interest, such as how employer savings from reform are passed on to increases in employee wages. This can be done even in real time as ICARE is phased in. Finally, our model doesn’t rely on modeling assumptions for health production or household budget constraints and utilization; instead, exogenous parameters can be used to match the model to observed data on utilization and enrollment.

Our framework incorporates individual and institutional responses along three dimensions. First, we estimate how individuals will transition across coverage options, including ESI, Medicaid, Medicare, and ICARE. This allows for adverse selection effects, where risky patients opt into generous. Second, we allow for increased plan generosity to spur increased utilization (moral hazard effects).26,27 Finally, we incorporate how institutional savings from ICARE (e.g., for employers) will affect wages and financing. We link our model to macroeconomic variables such as the GDP growth rate and overall population growth following the methodology of the NHE.28

*Data*

Our simulations incorporate data from multiple sources. First, to simulate ESI spending, we use the IBM MarketScan Research Data from 2007 to 2019. These claims data contain detailed, representative information for spending within the ESI population, including how the cost of coverage was shared between individuals and employers. We binned observed enrollees by age and calculated annualized rates of average OOP and plan spending. We placed a spending cap of $250,000 on high-cost individuals, and augmented claim costs by 15% to approximate administrative costs of plans.

Second, we estimated spending for uninsured individuals and individuals covered by Medicaid, CHIP, and Medicare. We used the most recent Medical Expenditures Panel Survey (MEPS) to obtain estimates of annual spending for uninsured individuals and CMS reports to estimate costs of other publicly-funded programs. We also incorporated reports from the MAC Stats Data Book and Kaiser Family Foundation reports to identify the breakdown of Medicaid spending and enrollment by age group.5 We estimate that children covered by Medicaid and CHIP account for about 45% of all US children, but that this is not evenly distributed across ages. In particular, about 48.5% of children aged 3 years or younger have public coverage, as opposed to about 42% of those 4 years old and older.29 Finally, based on enrollment reports, we assume that 25% of the covered children are on CHIP and 75% are covered through Medicaid.

Spending on children constitutes 18% of national Medicaid spending, yielding a projected total of $2,837 per child-year. Based on institutional reports, we assume that 65% of this spending is met by the federal government and 35% is left to states. Similarly, we estimate an annual cost of $2,000 per child enrolled in CHIP, with 93% covered by the federal government and 7% by states.

*Calibrated Parameters*

Exhibit 2 lists the exogenously calibrated choice parameters used in our baseline simulations. These include generous estimates of individual adverse selection and moral hazard. Even though ICARE is designed to mitigate adverse selection among the near-aged, we allow for those who opt into ICARE to cost 35% more conditional on age. Additionally, based on previously estimated age differences in moral hazard effects, which show that children have relatively inelastic demand for health services, we incorporate a 5% spending increase for all publicly-covered individuals aged 6 and older.30

We also allow for the possibility that some previously uninsured individuals will opt into either ESI or ICARE. Given that ICARE also proposes standardizing the generosity of coverage across ICARE and ESI plans, baseline simulations assume that only 30% of eligible near-aged individuals opt into ICARE coverage. Additionally, we assume no switching out of the Medicaid/CHIP program into private insurance or switching into uninsurance for anyone who is ICARE-eligible.

We also define premium subsidies for adults on ESI and ICARE coverage. Those with private contracts faced reduced premiums from ICARE subsidies and any residual employer contributions; however, near-aged individuals on ICARE pay a subsidized premium of 45% of average per-enrollee plan payments.

We also specify parameters to capture other important features of the healthcare system omitted by our data collection. These include overhead costs (base: 15% of claims) not included in individual claims-level data, an inflation rate of health costs surpassing overall inflation (base: 1%), and ICARE physician reimbursement rates. We model the latter as a weighted average of private and public rates (base: 100% commercial plan rates); this is particularly relevant for those transitioning from Medicaid/CHIP to ICARE and represents additional costs that need to be accounted for in funding ICARE.

We also directly model employer behavior using two key parameters. Employers discount future healthcare obligations at a fixed 10% rate. We also propose that of the amount employers would have spent on insuring individuals now covered by ICARE, a fixed fraction is passed on to employees as wage increases; we conservatively estimate this value at 30%.

Finally, to estimate funding options for ICARE, we specify a set of taxable goods and services for a value-added tax (VAT). In contrast to earlier calculations which use a relatively narrow base of goods (roughly 20% of GDP), the typical tax base for OECD countries ranges between 30–50% of GDP, excluding only goods and services whose value are hard to measure.31 In our baseline simulations, we use a taxable base of 40% of US GDP. To estimate payroll tax increases, we utilize IRS data on the distribution of adjusted gross income for US citizens, and simultaneously estimate how earnings change in response to simulated ICARE policies.

**Results**

(current: 1,025 words; goal: ~750 words)

Our simulations allow us to estimate the total change in public spending needed to finance ICARE. In addition to existing public health spending, additional funds allow the expansion of public coverage, subsidies to private contracts, and increased coverage quality and physician reimbursements.

Exhibit 3 illustrates the estimated spending on ICARE over the transition period. During the program’s first five years, ICARE gradually introduces coverage for the youngest children and those closest to Medicare eligibility and phases in employer subsidies for sufficiently generous private plans. Following this, risk equalization programs and transitions to individual contracts ensure a smooth transition of costs as ICARE expands until it is fully implemented.

We estimate that after ten years, combined spending on the ICARE public option will be about $715.4 billion annually. Of this, only $289 billion needs to be accounted for in additional revenue. We also estimate the cost of subsidies needed to incentivize 75% of post-ICARE private plans to be sufficiently generous (e.g., 80% cost-sharing). In the final year of implementation, ICARE subsidies will cost about $224 billion, bringing the total cost of the ICARE program up to just over $513 billion per year.

Appendix Figure A.1 shows how ICARE fits into national healthcare trends for both costs and enrollment. By 2035, ICARE will enroll about 36% of the population while constituting just under one quarter of total health spending. The Appendix further illustrates how enrollment can be broken down by age and dependency status.

*Financing ICARE*

We examine two alternative methods to finance ICARE: a proportional credit-invoice value-added tax, and an adjustment to the payroll tax. A value-added tax (VAT), like retail sales taxes popular in the US, is a tax levied on goods and services; the key difference is that VATs are levied at each stage in a good’s development, rather than only at the final sale. This shifts the relative incidence of a tax from consumers to businesses but need not overly complicate existing US tax structures. VATs are increasingly popular across the globe: all 35 OECD countries have had substantial VATs since 2005, with rates averaging 19.3% of final sales price in 2019. In these countries, VATs constitute the third largest source of revenue after social security and personal income taxes; previous research has suggested that a US-based VAT would also generate significant revenue.32,33

A VAT also constitutes a politically feasible option for generating revenue for public health spending, for several reasons. First, they are easier to enforce than wealth taxes or typical retail sales taxes, avoiding tax evasion among wealthier groups.33 VATs also do not distort saving or investment decisions, making them healthier for economic growth than wealth or income taxes.31 Finally, the VAT enables revenue collection from non-citizens who still consume goods and services in the US, including tourists and other nonresidents. VATs hence occupy a political middle ground between liberal pushes for tax increases on high incomes and conservative moves to reduce entitlement spending.

Although there are some concerns about implementing VATs, many of these can be allayed by the way the tax base is defined. VATs can be regressive, as lower-income households typically consume a larger fraction of their resources than higher-income households. However, these effects can be mediated by excluding certain basic goods and services from taxation (e.g., food or healthcare) and considering additional policy options, such as adjusting Social Security benefits calculations or implementing universal basic incomes. VATs can also be designed to exempt small, at-risk businesses.

Utilizing our simulated costs for the ICARE phase-in, we estimate that a VAT which caps at 4.4% is sufficient to finance the full ICARE program. The first panel of Exhibit 4 shows a proposed way of gradually increasing the VAT to continuously finance the ICARE program in keeping with rising costs. This phase-in minimizes the distortionary impacts of the tax.31

ICARE could also be funded with a payroll tax increase. This would be consistent with both existing tax structure and previous health care reforms. Additionally, there would be fewer concerns about the regressive nature of the tax (especially if there is no tax cap). However, increasing the payroll tax rate may also discourage savings and investment behavior.

The second panel of Exhibit 4 presents ICARE financing options through a payroll tax increase. We find that an increase of 5.4% is needed to finance ICARE’s implementation. This tax could be borne entirely by taxpayers or split between employers and employees (e.g., as in the Medicare and ACA taxes). These estimates are endogenously determined as ICARE policies affect household wages; we estimate that tax increases could drop to as low as 5.0% should a greater percentage of employer savings be passed on as wages.

*Sensitivity Analysis*

Our results are robust to different specifications of simulation parameters, as presented in Exhibit 5. Each row represents a different simulation, altering a specific simulation parameter and presenting resulting changes in the overall additional costs of ICARE and corresponding tax rates. Changes to public program eligibility (e.g., ages of children or near-aged) have little impact, suggesting flexibility in who ICARE covers publicly. Changes to more critical parameters, such as the fraction of near-aged opting into ICARE and moral hazard effects on utilization, drive up costs. The most sizeable shock to ICARE payments comes from altering the size of employer subsidies, given these constitute half of ICARE funds; however, even providing a 50% subsidy to employer contributions (e.g., roughly one-quarter of ICARE premiums) increases ICARE costs by only 18%. Finally, ICARE costs are substantially reduced if we propose changing physician reimbursement schedules from commercial rates to Medicare rates.

Revenue parameters are also important in our simulations. While these parameters do not change the estimated costs of ICARE, choices such as the taxable base of goods and services for a value-added tax and the fraction of employer savings passed on to employees as wages will influence resulting tax rates. Even if we consider reducing the size of the taxable VAT base by half (e.g., excluding more goods and services), funding ICARE requires a VAT less than half of the OECD average. Additionally, as employers pass on more savings to employees, the necessary increase to the payroll tax similarly falls.

**Discussion**

(current: 428 words; goal: ~750 words)

*Conclusion*

Current discussions of health care reform in the United States typically suffer from two drawbacks: they conflate multiple health policy issues, resulting in convoluted, grandiose policy proposals, and extreme reforms are favored over moderate ones. In this paper, we

have motivated, parameterized, simulated, and evaluated a moderate option to increase access to high-quality health insurance in the US, focusing on structural changes that would remove key frictions and coverage gaps and reduce major inefficiencies and inequities. We view ICARE as a politically attractive transition to individual health insurance contracts, public coverage for all children and for the near-aged who want it, and subsidies and a risk adjustment scheme to promote standardized coverage generosity across private and public plans. Our program preserves and incentivizes the private insurers and providers currently dominating the US health care system while prioritizing equitable coverage and increasing access to care for vulnerable populations.

Our simulations are novel in that they address multiple dimensions of behavioral response to the ICARE program, relying on a wealth of health economics and health care policy literature. In particular, we accommodate adjustments to utilization, allow for the most expensive enrollees to choose and be subsidized by a public option, and model how employees and employers will respond in heterogeneous ways to the program. Future research on ICARE and other reform proposals may utilize and extend this framework, potentially endogenizing key parameters such as optimal subsidy rates and risk adjustment schemes. This may include more explicit economic modeling linking response parameters to policy features, such as how moving income from tax-preferred insurance coverage to more easily taxable wages may alter household budget constraints and, by extension, healthcare utilization. Additionally, future research may present more refined modeling of how ICARE can be used as a foundation to contain costs, and address “supply-side” issues in the healthcare system, such as profit-oriented physician decision-making, unacceptable wait times for care, and provider consolidation.

We estimate that ICARE will require about $513 billion of additional revenue per year when fully phased in, about 1/6 the expected cost of a full transition to a single-payer system. ICARE’s increased public costs can be funded with a new value-added tax on goods and services of about 4.4% or a payroll tax increase of 5.4%. Perhaps most appealingly, our simulations are flexible and robust to alternative specifications and can be easily adapted by policy makers. It is our hope that this moderate alternative to health care reform could be politically and economically feasible, while achieving major improvements in the quality of health insurance coverage in the United States.

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EXHIBIT 1 (table)  
Caption: Proposed Timeline for the ICARE Transition

Source/Notes: SOURCE [Authors’ simulation proposal.] NOTES [Table shows a feasible transition path from the current US health insurance system to full implementation of the ICARE program. Each row represents one of the eleven years of the implementation, starting in 2024. In each year, progressively more children and near-aged individuals are eligible for ICARE coverage. In addition, over time, other members of population transition to individual contracts, and risk adjustment and employer subsidy programs begin to ensure a smooth transition.]

EXHIBIT 2 (table)  
Caption: Key Parameters Used in Spending Simulations

Source/Notes: SOURCE [Authors’ simulation proposal.] NOTES [Table shows key choice parameters used in baseline simulations. We assume that 30% of the uninsured opt into private insurance—this includes an additional assumption that no uninsured individual eligible for ICARE enrollment remains uninsured. We assume that children covered on ICARE increase their spending by 5% relative to baseline averages in Marketscan data, and that the near-aged enrolled on ICARE are 35% more expensive than the average individual in each age group. When determining physician reimbursement (which impacts the costs of services), we assume that all rates paid are commercial rates, a very conservative estimate. For sensitivity of final projected spending/revenue figures to these parameters, see Table 3 and additional Appendix materials.]

EXHIBIT 3 (figure)  
Caption: Projected ICARE Spending by Age & Former Insurance Status  
Source/Notes: SOURCE [Authors’ simulation results.] NOTES [Figure shows projected spending on ICARE during its phase-in from 2024 to 2035. ICARE spending is broken down into three bars by former insurance coverage (Medicaid/CHIP, ESI, or Unin- sured) and within bars by age (Children, Near-Aged, or Other Adult Subsidies). Note that current funding for existing Medicaid/CHIP programs can be applied to ICARE spending totals, so that the sum of the bars pictured here is more than the amount that needs to be accounted for by a VAT or payroll tax increase. Figures are reported in billions of 2022 USD.]

EXHIBIT 4 (figure)  
Caption: ICARE Financing Options

Source/Notes: SOURCE [Authors’ simulation results.] NOTES [Figure shows the minimum VAT and payroll tax rates needed to fund ICARE enrollment and employer subsidies in panel (a) and (c), and the projected tax revenue raised by the tax in panels (b) and (d). Revenue is projected based on CBO (2018). Revenue is measured in billions of 2022 USD.]

EXHIBIT 5 (table)  
Caption: ICARE Cost and Revenue Estimates: Sensitivity

Source/Notes: SOURCE [Authors’ simulation results.] NOTES [Table shows changes to the results presented in Section 3 based on altering key ICARE parameters. Each row represents a different simulation, comparable to the baseline simulations at the top of the table. All currency is presented in billions of 2022 USD.