

EW RISINGER

Excelsior Springs, Missouri

Phone: 816-674-1686 | Email: ernie@ewrisinger.com

Week 25

Federal Health Insurance Option — The Public Option

"The public option that should have existed twenty years ago."

1. The Problem

Approximately 28 million Americans were uninsured in 2025 — 8.3% of the population — confirmed from CDC National Health Interview Survey data published May 2026. An additional estimated 23 million adults are underinsured, meaning they have coverage but cannot afford to use it due to high deductibles and out-of-pocket costs per Commonwealth Fund analysis. Combined: approximately 51 million Americans lack meaningful access to healthcare. ACA benchmark silver plan premiums increased an average of 26% in 2026 — confirmed from KFF analysis — the largest increase since 2018. The expiration of enhanced ACA subsidies at end of 2025 is driving approximately 5 million fewer marketplace enrollees in 2026 compared to 2025 per KFF projections. The public option was stripped from the ACA in 2010 by insurance industry lobbying. What passed instead was a regulated private marketplace where the government subsidizes private insurers who still generate shareholder profits, pay executive compensation, fund lobbying, and deny claims to protect margins.

2. The Governing Principle

The public option that should have existed twenty years ago. The federal government operates a health insurance plan available to any American who wants it — not a mandate, a choice. Three cost components only: actual claims cost, 3-5% federal administration overhead, and a fixed \$40 per enrollee per month to deficit reduction. Not to a shareholder. Not to an executive. Not to a lobbying budget. To the American people.

3. The Specific Policy

The Administrative Cost Case

- **Private health insurer administrative overhead:** 15-20% of premiums — the ACA Medical Loss Ratio requires insurers to spend at least 80% of premiums on claims for large group plans and 85% for individual and small group plans. The remaining 15-20% covers administration, executive compensation, shareholder returns, and lobbying. Source: ACA MLR requirements, 45 CFR 158.

- **Medicare traditional administrative overhead:** approximately 1.4-2% of total program costs —

confirmed from CMS Trustees Reports and PNHP analysis of CMS data. Note: some analysts argue this understates true administrative costs by excluding costs borne by other federal agencies. The 1.4-2% is the CMS-reported

for Medicare's

ownernie@ewrisinger.com

administrative cost.

Phone: figure

816-674-1686

| Email:

- **The federal option overhead target:** 3-5% — between Medicare's administrative floor and private insurers' ceiling. Achievable because the federal option does not fund lobbying, shareholder returns, or executive compensation above civil service rates.

The Coverage Crisis — Verified Figures

- **Uninsured Americans 2025:** 28 million — 8.3% of total population. Source: CDC National Health

Interview Survey early release data, May 2026.

- **Underinsured Americans:** approximately 23 million working-age adults — defined as insured but spending more than 10% of income on out-of-pocket healthcare costs or having a deductible exceeding 5% of income. Source: Commonwealth Fund Biennial Health Insurance Survey.

- **Combined uninsured and underinsured:** approximately 51 million Americans lack meaningful access to affordable healthcare. The platform uses this figure — not the 28 million uninsured alone

— because coverage without affordability is not coverage.

- **2026 ACA premium increase:** 26% average increase in benchmark silver plan premiums — confirmed from KFF analysis of second-lowest-cost silver plan for a 40-year-old weighted by county plan selections. States using Healthcare.gov: approximately 30% increase. State-run marketplaces: approximately 17% increase. Largest single-year increase since 2018. Source: KFF, October 2025.

- **ACA subsidy expiration impact:** enhanced pandemic-era premium tax credits expired end of 2025. KFF projects approximately 5 million fewer marketplace enrollees in 2026 as a result.

Unsubsidized enrollees face the full 26% premium increase.

The Federal Health Insurance Option Structure

- **Government owned, professionally operated, market competitive:** available on every ACA marketplace in every state alongside private plans. Rate structure — three components only: (1) actual cost of covered claims for the enrolled population, verified monthly; (2) actual federal administration overhead at 3-5% of claims cost; (3) a fixed \$40 per enrollee per month directly to deficit reduction. At 10 million enrollees: \$4.8 billion per year. At 45 million enrollees: \$21.6 billion per year.

- **Federal health insurance debit card:** every enrollee receives a dedicated payment card. For scheduled care, specialist visits, diagnostic tests, and prescriptions — the plan loads the approved payment amount and the enrollee pays the provider directly at the negotiated or self-pay rate. Providers who accept immediate payment without billing overhead can pass savings directly to the federal option. Every charge visible in real time — an unrecognized charge triggers an immediate flag before payment is released. Emergency care billed after the fact — the debit card model applies to scheduled care only.

- **Provider payment rates:** the federal option pays providers at rates that attract and retain a full network — not artificially suppressed Medicare rates. Administrative savings fund the difference. Rural hospitals and rural physicians receive rate adjustments reflecting higher delivery costs — consistent with Week 12 rural medicine incentives.

Email: ernie@ewrisinger.com

- **What the ACA got Phone:**
right —816-674-1686
preserved and| strengthened:
no denial for pre-existing conditions;
children covered on parents' plans until 26; minimum coverage standards; no lifetime benefit caps;
preventive care without cost-sharing. The federal option operates under all of these standards. The ACA marketplace continues — the government option is an addition, not a replacement.

- **Enhanced ACA subsidy permanence:** pandemic-era enhanced subsidies made permanent by statute, indexed to inflation, funded through the deficit reduction framework. End the annual congressional brinkmanship that leaves millions uncertain whether they can afford health insurance.

4. Estimated Cost

Federal health insurance option startup: approximately \$5-10 billion in Year 1 for systems development, enrollment infrastructure, and initial reserves. At scale the plan is self-funding through premiums set at actual claims cost plus 3-5% administration plus the \$40 deficit reduction contribution. Enhanced ACA subsidy permanence: approximately \$15-20 billion per year, partially offset by reduced uncompensated care costs currently absorbed by hospitals and ultimately the federal government. All figures subject to CBO independent scoring within 90 days of inauguration.

5. Year 1 Implementation and Measurable Result

Year 1 measurable result: Federal Health Insurance Option legislation introduced within 30 days; enhanced ACA subsidies made permanent; enrollment systems contracted within 90 days; plan available on all ACA marketplaces for the following plan year; first monthly cost transparency report published within 180 days showing claims cost, administration cost, and deficit reduction contribution per enrollee. Baseline: CDC NHIS uninsured rate 8.3% in 2025; KFF 2026 benchmark premium increase 26%.