URBAN
INSTITUTE · ELEVATE · THE · DEBATE

US Health Care Reform: What Have We Done and Where are We Headed?

Linda J. Blumberg, Ph.D.

Institute Fellow

February 5, 2019

A few terms I'll use:

- Medicare: the federal health insurance program for people age 65 and older plus some people with disabilities;
- Medicaid: the state and federal health insurance program for certain low-income people;
- Nongroup Insurance: health insurance purchased by individuals and families independently, not through an employer;
- Payment Rates: prices that insurers (public or private) pay to hospitals and physicians for the care they provide.

The Affordable Care Act, 2010

- Expanded Medicaid eligibility
  - Ultimately at state discretion (+/-37, ID,NE,UT)
- Subsidized private nongroup coverage for those with low and moderate incomes through new marketplaces
- Individual mandate (tax penalty for being uninsured)
- Requirements on employers
- New federal floors for regulation of private insurance, providing a broad array of consumer protections.

Set of changes necessary to protect people with health problems (pre-existing conditions, etc.)

- Guaranteed issue and renewability for all products [NG/SG]
- No lifetime or annual benefit maximums
- Modified community rating (premiums can't vary on factors other than age, tobacco use, geography, and those variations are limited), [NG/SG]
- Prohibition on exclusions of pre-existing conditions (NG/SG)
- Requirements to cover essential health benefits (NG/SG)
- Cost-sharing limits and tiers (NG/SG)

Other insurance regulations, including:

- Coverage of preventive care with no cost-sharing;
- Medical loss ratio requirements that limit share of premiums that go to insurers' administrative costs (including profit);
- Dependent coverage up to age 26 on parents' policies;

Plus, a whole bunch of other stuff that I don't have time to go into.

So how did this work out?

- By the end of 2016, an additional 20 million people were insured;
- Uncompensated care decreased, especially in states that expanded Medicaid;
- Insurance market competition thrived in many nongroup markets (especially high population density areas) with low premium increases in many areas;
- Eliminated discrimination by health status in NG and SG markets;
- Slow down in national health spending;
- Decrease in unmet medical need due to cost;
- No adverse employment effects & no loss of employer coverage;

But gaps remained

- Some areas, particularly rural areas and some others with little insurer and/or hospital competition had high premiums and premium increases in the private nongroup market;
- Some states did not expand Medicaid eligibility, leaving a significant coverage gap among the poor in those states;
- While coverage was much higher, many others still faced large financial burdens to obtain coverage or receive care;
- Thus, many still remained uninsured. Important to remember, that the ACA was not designed to achieve universal coverage.

- And then came the election of 2016…

Changes since 2017

- Elimination of the individual mandate penalties beginning in 2019, will reduce coverage and increase premiums for those not receiving subsidies;
- Elimination of direct reimbursement for cost-sharing subsidies;
- Expansion of availability of “short-term” policies which provide fewer benefits, are not guaranteed issue, and can vary premiums with health status. These will draw people out of ACA coverage and leave it more expensive for those who remain;
- Virtual elimination of federal money for outreach and dramatic reductions in funds for enrollment assistance;
- Encouragement of states to apply for waivers to implement work requirements for Medicaid coverage;
- Encouragement of states to apply for waivers to change structure of reforms while weakening requirement that they still provide equivalent benefits, affordability, or coverage levels;
- Other stuff.

So now what?

- Wholesale repeal efforts by the Republican Congress and the President failed in 2017;
- Democrats and policy experts are proposing and discussing an array of reforms, ranging from (1) improvements to the ACA to remedy gaps and reverse recent Administrative and legislative efforts to undermine it, to (2) wholesale reforms that would completely remake the nation's insurance system;
- Some Republicans continue to hold out hope that they can reduce federal investment in health care, probably most popularly by block granting funds to the states and reversing many of the ACA's regulatory changes;
- Meanwhile, the latest in a series of federal court challenges has the potential to completely undermine the ACA. So stay tuned for that.

Medicare-for-All, Medicare Buy-In, Medicaid Buy-In, Public Options, etc.

- Many progressives are centering their proposed reforms around some type of government health insurance option.
- The terms being used are not very helpful at understanding what they mean or how they differ.
- How to make sense of all of this?

Lesson Number 1: Why do so many of them use the term Medicare?

- Medicare is the federal insurance program for people age 65 and over;
- It is quite popular (despite its flaws), and so lots of proposals incorporate this name in theirs;
- Just because Medicare is in the name, does not mean the plan would enroll you in the existing Medicare program.
- In fact, doing so would be extremely hard and not necessarily desirable.
  - The financing is complicated
  - The coverage doesn't look like traditional insurance.

Lesson 2: So what are these proposals actually suggesting?

- Most often, the new plans would create a government run insurance plan that pays doctors and hospitals in a way similar to the way Medicare pays them:
  - Based on a payments system that reimburses at levels significantly below what most commercial insurers pay them.
  - If doctors and hospitals are paid less, that means that insurance premiums will be lower.

Why are policymakers looking to Medicare's Payment System (and sometimes Medicaid's)?

- On average, commercial insurers pay hospitals 89 percent more than Medicare.
  - This varies considerably by geographic area, by hospital, by insurer, and by the type of care provided.
  - Medicaid, the public insurance program for the low-income, pays hospitals similarly to Medicare.
- For physicians, depending upon the service, commercial insurers pay from 11 percent more than Medicare to 139 percent more than Medicare.
  - Medicaid pays less than Medicare for physician care.
- Health care spending per Medicare enrollee has grown significantly slower over time than health care spending for people privately insured.

Lesson 3: So how do all of these plans differ?

- The level of payments to hospitals and doctors
- Who would be allowed to enroll in the plan? Would anyone be required to enroll in it?
- Would private plans still be permitted as alternatives?
- What benefits would be covered by the plan?
- What premiums would people pay to enroll in the plan?
- What would people in the plan have to pay out-of-pocket when they access care?
- How would the new federal costs be paid for?

Lesson 4: How should we evaluate the different options?

- More benefits covered, the lower the cost-sharing requirements, the higher the costs associated with the plan but the greater the access to care when needed;
- The lower the provider payment rates, the lower the costs of the program, but the more disruptive to current health care delivery systems (supply, quality);
- The lower the premiums to consumers, the greater the level of coverage, but the higher the government costs (i.e, need more taxes).

Pros and Cons of Incremental Reforms Compared to Sanders-like Single Payer

Pros:

- Less disruptive to insurance people like;
- Less disruptive to the health care delivery system;
- Income-related assistance targets help to those most in need;
- Lower federal costs, means fewer taxes to raise;
- Allows more choice for consumers.

Cons:

- Some inequities likely to remain in system;
- Requires value judgments as to who needs how much help and some may not get enough;
- Maintains more system complexity;
- Allows for less control over system-wide levels of payments (i.e., cost containment).

What does Sanders/Harris Medicare-for-All Look Like?

- Payments to all doctors and hospitals at Medicare payment rates;
- All US residents, including undocumented immigrants enrolled;
- No private insurance plans, either employer or nongroup;
- All medically necessary benefits, including dental and long term services and supports (this is more generous than Medicaid, Medicare, and current private insurance);
- No premiums;
- No out-of-pocket costs at point of service (except possibly limited for some prescription drugs);
- Financed entirely through tax system, but bill does not specify sufficient funding sources.

Example of an incremental approach

- Reversing Trump-era policies and re-instating individual mandate penalties, prohibiting short-term policies, outreach and enrollment assistance, and restoring cost-sharing subsidies;
- Federal funding to ensure Medicaid expansion in remaining states and use proven strategies to auto-enroll more eligible people;
- Enhance premium and cost-sharing subsidies to make coverage more affordable;
- Restore a federal reinsurance program to increase insurer participation and lower premiums for the unsubsidized;
- Cap provider payment rates (at Medicare rates or somewhat above) for any insurer selling coverage in the nongroup market to lower government and consumer costs;
    - Alternatively could offer a public plan option tied to Medicare rates for those purchasing in the nongroup market.

How would these two examples compare on coverage and federal spending?

- Coverage (2020):
  - Medicare-for-All: theoretically would eliminate all uninsurance in the country (although I'm not clear how the undocumented piece would actually work (roughly 3% of current uninsured));
  - Incremental approach: would reduce the uninsured in the US to about 20 million people, about 7% of the nonelderly, down from estimated ~12% under current law. However,
    - Excluding the undocumented and those eligible for Medicaid, about 3% of the nonelderly population would remain uninsured.
- Increase in federal government costs (2020):
  - Medicare-for-All: over $3 trillion per year
  - Incremental: $119 billion per year

Health Reform Forces Difficult Political/Social Decisions

- How much do we spend societally to increase access to necessary care for people with lower incomes? At what incomes should we provide assistance? How will we raise the revenues necessary?
- How much do we pool insurance risk in order to increase access to care for people with significant health problems, regardless of incomes?
  - Greater pooling of risk, the lower the costs of care for people when needing health care services, but the higher the costs placed on people when they are healthy.
  - Minimum levels of covered benefits, limits on cost-sharing requirements, guaranteed issue, prohibitions on pre-existing condition exclusions, prohibitions on health status rating in premiums, individual mandates are all ways to force pooling of risk.
- How much inequity are we willing to accept and how much central control will we tolerate in an effort to contain costs?