

Strategies for Improving Health Coverage and Reducing Costs: Major Proposals and Key Considerations

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Introduction

Good morning, Chairman Neal, Ranking Member Brady, and Members of the Committee. Thank you for inviting me to testify about pathways to universal health coverage, and major proposals for achieving this goal.

I am Tricia Neuman, a senior vice president at the Kaiser Family Foundation and director of the Foundation's Program on Medicare Policy. The Kaiser Family Foundation is a non-profit organization providing non-partisan health policy analysis, and journalism (Kaiser Health News) for policymakers, the media, the health policy community and the public. We are not associated with Kaiser Permanente or Kaiser Industries.

During the past few years, a range of proposals have been introduced that aim to achieve two primary goals: broadening health insurance coverage and making health care more affordable. Some of these proposals build on the current mix of employment-based coverage, marketplace and other private insurance, and public programs such as Medicare and Medicaid. Others would fundamentally change the way in which health coverage is provided and financed by establishing a national public program for all U.S. residents.

My testimony will describe the range of proposals on the table, describe similarities and differences among them, and highlight policy choices and trade-offs that could have significant implications for coverage and costs.

Health Coverage Today

Health insurance helps people get the medical care they need, when they need it, and often leads to better health outcomes. Most people living in the U.S. have health insurance. In 2018, more than 150 million people had health insurance from an employer, more than 120 million people had health coverage from a public program, such as Medicare, Medicaid and the Children's Health Insurance Program (CHIP) and about 14 million people had non-group coverage, including 11 million who purchased insurance through the marketplace.¹ Yet, about 30 million Americans are uninsured.²

With the implementation of the major coverage provisions in the Affordable Care Act (ACA), the number of non-elderly uninsured people living in the U.S. has substantially declined (**Figure 1**). However, between 2016 and 2018, the number of Americans without health insurance increased by nearly 2 million people mainly due to recent policy changes that have affected both the individual market and Medicaid. Uninsured adults are more likely to have problems paying

medical bills, delay or forego medical care, use up their savings, and have difficulties paying for other necessities.³

The cost of coverage is the main reason that people find themselves without health insurance. Many people who are uninsured are ineligible for financial assistance under the ACA, either because their income is too high or they have access to employer coverage (even though they still might find coverage unaffordable). Others are without health insurance because they live in one of the 14 states that have not expanded Medicaid or because their immigration status makes them ineligible for coverage. Just over half of the uninsured are eligible for Medicaid or premium tax credits but are not enrolled in coverage. Some in this category may still perceive coverage is unaffordable, even with subsidies (**Figures 2 and 3**).

Health costs are also a concern for people with health insurance, and often are a barrier to care. According to the latest KFF poll released earlier this week, about one-fourth of all insured Americans report difficulty paying their premiums, deductibles, and copays for doctor visits and prescription drugs (**Figure 4**). According to KFF's annual survey of employers, annual deductibles have increased 8-times as fast as wages since 2008 – a trend that poses particular challenges for people with low incomes and significant health needs (**Figure 5**). Low-income families with employer-based coverage spend as much as 14 percent of their income, on average, on premiums and other health expenses.⁴

The health insurance marketplaces established by the ACA have provided a much-needed source of health insurance, especially for people who qualify for premium tax credits and cost-sharing reduction subsidies. However, for those who do not qualify for premium assistance, health insurance sold on the marketplace can be prohibitively expensive, especially for older adults in their late 50s and early 60s. The Administration recently expanded the availability of short-term health plans that offer lower premiums for people not eligible for ACA premium tax credits, but did so by allowing plans to exclude certain benefits required of ACA-compliant plans and by allowing insurers to deny or restrict coverage to people with pre-existing conditions.⁵

And, while much of the focus in recent years has been on coverage and costs for the non-elderly population, the 60 million seniors and younger beneficiaries with disabilities covered by Medicare also face high out-of-pocket costs relative to their income (**Figure 6**).

Medicare-for-all and Other Approaches Involving a Public Program or Plan

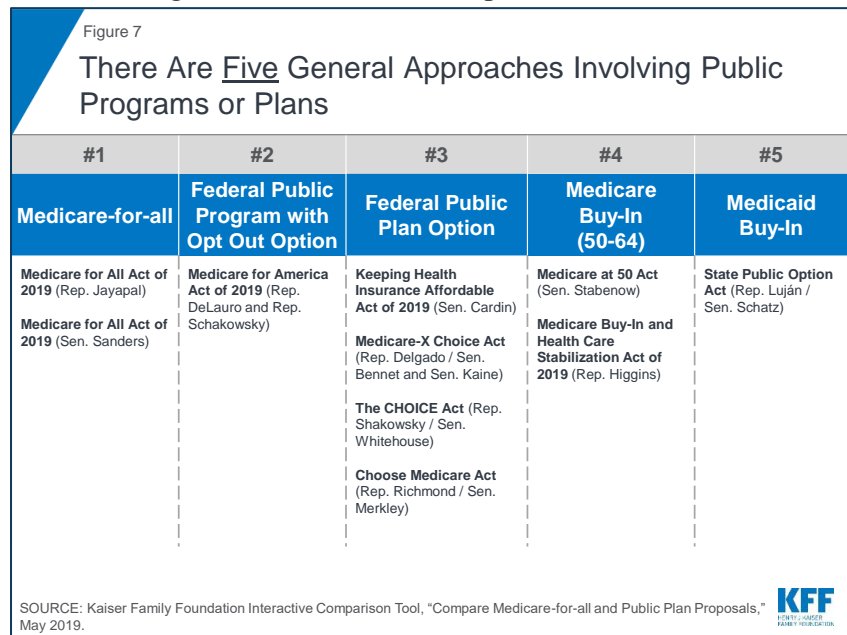
Since the start of the 116th Congress, a number of bills have been introduced in the House and the Senate to address ongoing coverage and affordability cost challenges. The proposals reflect a range of approaches from fundamental reforms of the U.S. health care system, such as Medicare-for-all, to more incremental strategies that build on the current system.

Five Approaches Involving a Public Program or Plan

To help make sense of the many proposals that would establish a public program or plan, we’ve categorized legislation into five distinct categories that fall across a spectrum, in terms of their comprehensiveness and likely impact (Figure 7).⁶

1. Medicare-for-all

Among these proposals, Medicare-for-all is clearly the most ambitious. It would replace nearly all current forms of public and private health insurance with a new federal program that would guarantee health coverage for all U.S. residents regardless of age. The new program would replace employment-based coverage, private insurance, Medicare and Medicaid.



Medicare-for-all would cover comprehensive medically necessary or appropriate services, including dental, vision, institutional and community based long-term services and supports, along with transportation and other services needed by people with low incomes and disabilities.⁷ Benefits would be far more comprehensive than those that are typically offered by most private insurance plans and the current Medicare program – with no premiums, deductibles or cost sharing.

To help constrain health care cost growth, Medicare-for-all would establish payment rates for hospitals, physicians, and other providers, in contrast to the current system in which fees are negotiated separately by private insurers and public programs. Payments would be subject to a

global budget process and negotiation. The Secretary would also negotiate prescription drug prices. In addition, replacing private insurance with a public program would likely reduce administrative expenses and insurer profits.⁸

Medicare-for-all would require a major change in the way in which health coverage and care is organized and financed in the U.S. Such a sweeping change would involve trade-offs. On the one hand, it would substantially reduce health care costs paid directly by individuals, employers and states (because they would be relieved of Medicaid spending under the [House bill](#)). It would provide comprehensive benefits, including long-term services and supports (not currently covered by Medicare) with no premiums, deductibles or cost sharing. On the other hand, it would disrupt current coverage arrangements, at least initially, eliminate all private insurance, including employer coverage, change how and how much providers are paid, and increase federal spending and taxes.

2. Federal Public Program with Opt Out Option

This second approach, reflected in the Medicare for America proposal, would establish a federal public program with an opt out option for people who choose qualified coverage under an employer plan. This approach is similar to Medicare-for-all in several ways, although it retains a defined role for employers and private insurance. Like Medicare-for-all, Medicare for America would establish a new federal public program for all U.S. residents, which would ultimately replace many public and private sources of coverage. Once fully implemented, people with Medicare, Medicaid, CHIP or private insurance (other than qualified employer health plans) would be in Medicare for America.

The public program would provide comprehensive benefits, including long-term services and supports, with no deductible, and no premiums or cost sharing for people with incomes below 200 percent of poverty.

Medicare for America differs from Medicare-for-all in several ways. First, employers would have the option of providing qualified private coverage or purchasing coverage for their employees in the public plan, an approach historically known as “pay or play.” Employees could choose between the employer plan, if offered, or Medicare for America. Second, this approach retains a role for private insurers to offer so-called Medicare Advantage for America plans, and qualified employer-sponsored coverage. Third, unlike Medicare-for-all, people with incomes above 200 percent of poverty would be required to pay premiums and cost sharing on a sliding-scale basis up to a limit.

To constrain costs, while making adjustments for health care providers of underserved populations and in underserved areas, the Secretary would establish payment fees based on rates paid by Medicare or Medicaid (whichever is higher), pay hospitals at least 110 percent of either Medicare or Medicaid rates (whichever is higher), increase payments in underserved areas, and negotiate prices with drug manufacturers.

Like Medicare-for-all, this approach would put the country on a fast track toward universal coverage; it could also reduce costs associated with administrative efficiencies, private insurers' profits, and the change in provider fees. However, it would also disrupt current coverage arrangements during the phase-in period. It would also increase federal spending, which would be offset by employer contributions, state maintenance of effort (MOE) payments in lieu of Medicaid spending, new taxes, and other revenue sources.

3. Public Plan Option

The public plan option approach is more incremental than either Medicare-for-all or the approach establishing a federal public program with an opt out option. Each of the four bills that have been introduced so far would retain current sources of public and private coverage, and offer a new federal public plan option in the marketplace, with premiums set to cover costs. People who choose this option would be able to apply cost-sharing subsidies to coverage under the public plan, as they would with other marketplace plans. Medicare (and in some cases, Medicaid) providers would participate in the public plan. These proposals aim to improve coverage by offering a lower-cost option to marketplace-eligible individuals.

Among these bills, there are a number of differences that could have significant implications for coverage and affordability in the public plan and marketplace. For example, one of the proposals would allow large and small employers to buy into the public plan, while the others would limit eligibility to marketplace-eligible individuals.⁹ Three of the four bills would expand premium tax credits to cover more people, and one of the proposals would also enhance cost-sharing reduction subsidies.¹⁰

The public plan option bills also vary in how they would establish provider payment rates. One proposal, for example, would allow the Secretary to establish payment rates for the public plan that would be no less than the amount paid under the current Medicare program and no higher than rates paid by private insurers in the marketplace. Others rely more directly on Medicare rates, with some flexibility to adjust rates, for example, in rural areas.

In general, these bills leave the Medicare and Medicaid programs intact, although one proposal would add an out-of-pocket limit to traditional Medicare, and three of the bills would authorize the Secretary to negotiate drug prices for the current Medicare program and all four would do so for the public plan.

4. Medicare Buy-In for Older Adults

The fourth approach – a Medicare buy-in option for people between the ages of 50 to 64 – would reach a more limited number of people because it restricts eligibility to older, marketplace-eligible adults. This approach focuses on older adults because they face relatively high premiums in the marketplace, particularly if their incomes are just above the limit for tax credits.

For example, a 60-year-old non-smoker making \$50,000 a year would pay about \$8,500 in premiums in 2019 for the lowest-cost marketplace plan, accounting for 17 percent of their income, whereas a 27-year-old with the same income would pay about \$3,400 in premiums, or 7 percent of their income.¹¹ Even if they can afford the premium for the lowest-cost plan, they still may face high deductibles and additional cost-sharing requirements.

The Medicare buy-in option would cover Medicare benefits (Parts A, B and D), rather than the essential health benefits typically covered under the federal public plan option bills, with premiums set to cover 100 percent of costs. In some ways, the new Medicare buy-in program would be a hybrid of the current Medicare program and marketplace coverage; it would cover Medicare benefits, but allow individuals to apply marketplace premium tax credits and cost-sharing subsidies toward their Medicare buy-in coverage. To address affordability concerns, the [House bill](#) would also enhance cost-sharing subsidies for both marketplace and Medicare buy-in enrollees.

The Medicare buy-in proposals would use Medicare rates to pay hospitals, physicians and other health care professionals to reduce costs and premiums, rather than the higher rates typically paid by private insurers.¹² This contrasts with other proposals that give the Secretary more flexibility in setting provider payment rates.

It is important to note that the Medicare buy-in proposals for 50-64 year olds do not simply lower the age of Medicare eligibility – an option that would result in a significant increase in the number of people with primary coverage under the current Medicare program. In fact, the proposals keep separate the financing of the new Medicare buy-in program and the current Medicare program, and explicitly prohibit the new program from having any impact on premiums and benefits in the current Medicare program.

5. Medicaid Buy-In

A fifth and very different approach would give states the option to establish a Medicaid buy-in plan that would be offered in the marketplaces. Under this proposal, in states that elect this option, individuals eligible to purchase coverage in the marketplace could choose the Medicaid buy-in plan. States, rather than the federal government, would set premiums for the Medicaid buy-in plan; individuals would be able to apply their marketplace premium tax credits and cost sharing subsidies to the Medicaid buy-in plan, and pay no more than 9.5 percent of household incomes in premiums (extending subsidies to people with incomes above 400 percent of poverty).

The Medicaid buy-in plan would rely on Medicaid participating providers and would use Medicaid payment rates, except that states would be required to pay primary care providers no less than the Medicare payment rate for both the buy-in plan and the current Medicaid program. In addition, the federal government would pay a 100 percent match rate for states newly adopting the Medicaid expansion.

Because states may or may not pursue a Medicaid buy-in, the impact of this approach on coverage would vary across states.

Some states have moved forward on their own to consider a Medicaid buy-in or public-plan option as one strategy among many to lower the cost of health insurance in the marketplace for people in their state. At this time, however, only Washington State has enacted legislation to create a public option offered by private insurers in the marketplace, with payments to providers capped at 160 percent of Medicare rates.

Other Approaches: Proposals to Broaden Coverage without a Public Plan

Other proposals aim to broaden coverage and make health insurance more affordable by building on the ACA, but stop short of creating a new federal program or public plan option.¹³ These proposals include provisions, such as: raising eligibility for premium tax credits, expanding cost-sharing subsidies, increasing funding for outreach and enrollment assistance, prohibiting balance billing for emergency services, establishing a federal reinsurance program, and prohibiting the sale of short-term policies that typically do not cover all essential benefits and often apply dollar caps on coverage.

These proposals aim to address some of the shortcomings in the ACA that lead some people to forego health insurance or delay care, even if insured. Enhanced premium subsidies, for

example, have the potential to expand coverage by making health insurance more affordable for people with incomes above and below 400 percent of poverty. However, while these incremental approaches would strengthen the marketplace, they would not address more systemic issues that the more comprehensive proposals aim to address.

And, what about Medicare?

While the debate about coverage and costs has mainly focused on the non-elderly population, an unexpected but important outcome of current policy discussions is the renewed interest in Medicare itself. Many of the proposals invoke the Medicare name, because Medicare is a popular and successful national public health insurance program. Medicare gets high marks from seniors, the general public, and across party lines (**Figure 8**). Several of the public plan options adopt key features of the current Medicare program, such as its approach to provider payments, balance billing protections (no surprise medical bills) and its roster of participating providers.

Yet, Medicare has gaps in coverage that can result in significant out-of-pocket costs. Perhaps that is why some of the proposals would strengthen Medicare, by providing more comprehensive benefits and coverage, or more incrementally, adding an out-of-pocket limit¹⁴ (which Medicare currently lacks) or establishing a public Medigap option.¹⁵ Under the Medicare-for-all and Medicare for America proposals, the current Medicare program would evolve into a new Medicare, with low or no premiums, low or no cost sharing, and far more comprehensive benefits, such as dental, vision and long-term services and supports (which are currently not Medicare-covered benefits). And, virtually all of these bills would authorize the Secretary to negotiate lower drug prices, including for people covered under the current Medicare program.

Conclusion

A broad range of policy options are on the table that aim to move the country down a path toward universal coverage and more affordable health care. Some of these proposals are far reaching and would involve a major reorganization of the health care system and its financing, while others take a more incremental approach. These proposals vary in a number of ways that are not trivial. As of now, the effect of these proposals on coverage and costs has yet to be estimated by the Congressional Budget Office. Key questions to address as these conversations continue:

- How many people would gain health insurance coverage?
- How would the introduction of a public program or plan affect coverage under employer plans, the marketplace, Medicaid and Medicare?

- How would these proposals address the unique challenges facing children and adults with special needs and disabilities?
- What would be the effect on the underlying cost of care, and spending by key stakeholders (individuals, employers, states and the federal government)?
- What would be the impact on patient care?
- How would new costs be financed?

These ongoing discussions also provide an important opportunity to educate the public about the range of proposals under consideration, and the potential trade-offs involved with different strategies that could move toward universal coverage and make health care more affordable for people across the country.

Figures Referenced in Text

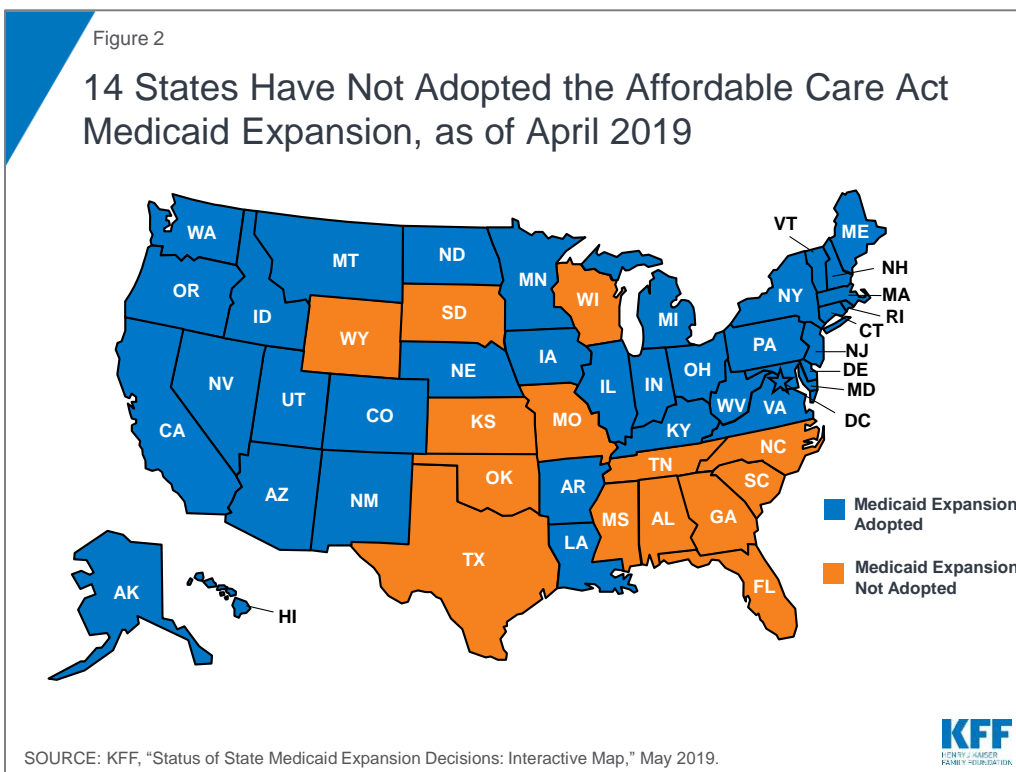
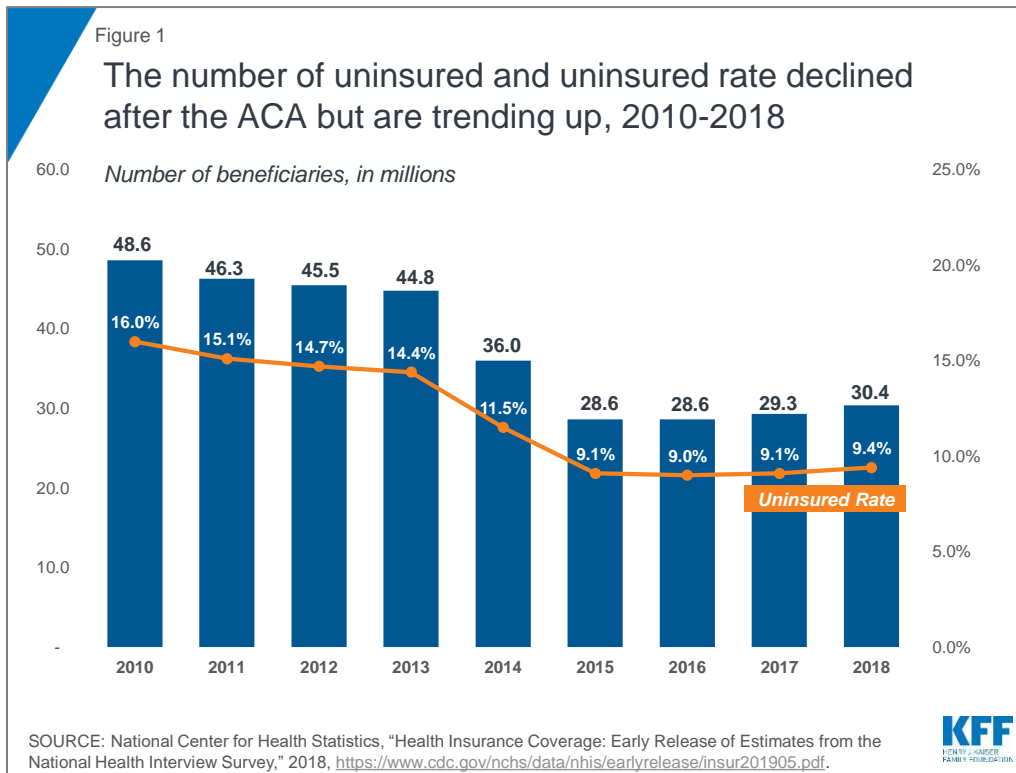
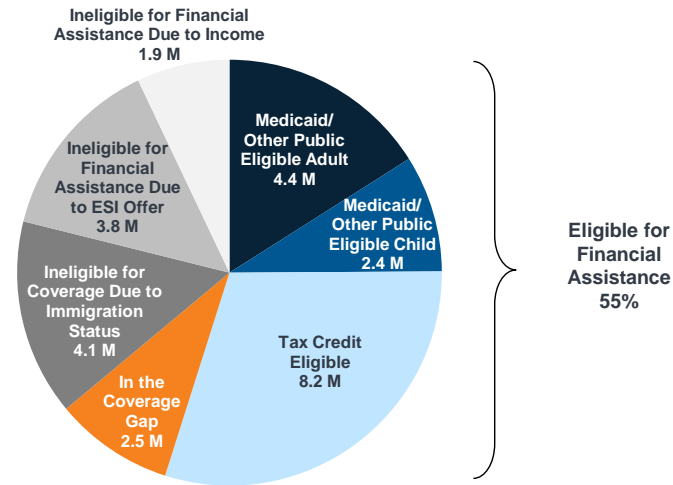


Figure 3

Eligibility for ACA Coverage Among Nonelderly Uninsured, 2017



Total = 27.4 Million Nonelderly Uninsured

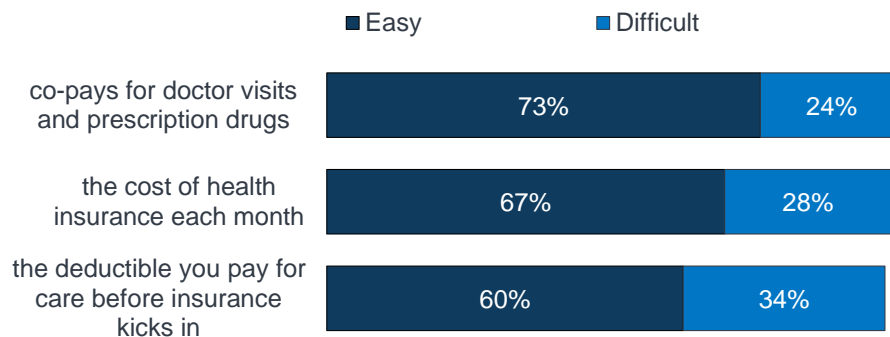
SOURCE: KFF estimates based on the 2017 American Community Survey, one-year file. See KFF, "The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act," January 2019.



Figure 4

Some Insured Americans Report Difficulty Affording Health Care

In general, how **easy** or **difficult** is it for you to afford to pay...?



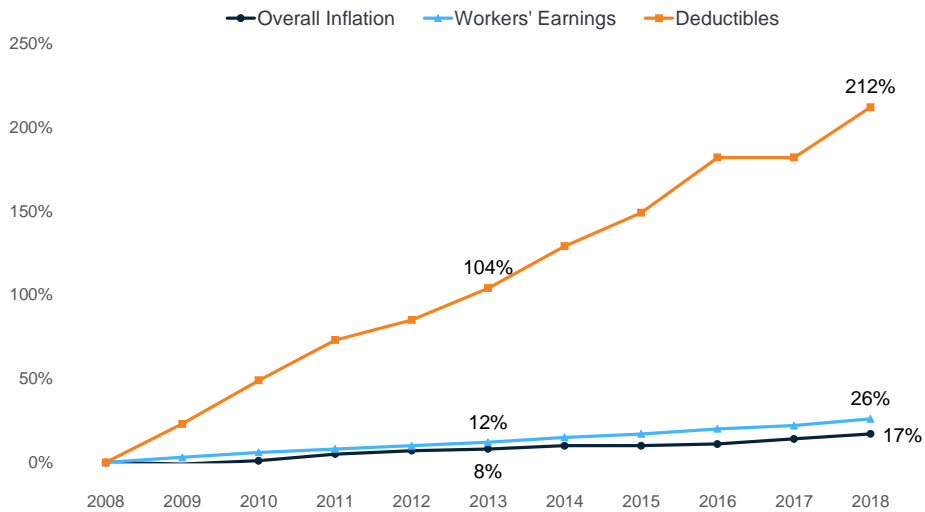
NOTE: Among insured adults.

SOURCE: KFF Health Tracking Poll (conducted May 30-June 4, 2019). See topline for full question wording and response options.



Figure 5

Since 2008, General Annual Deductibles for Covered Workers have Increased Eight Times as Fast as Wages

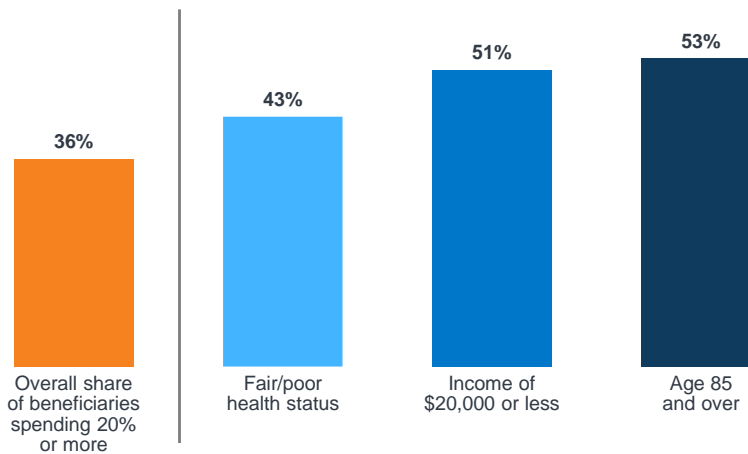


SOURCE: KFF and KFF/HRET Employer Health Benefits Surveys. Consumer Price Index, U.S. City Average of Annual Inflation (April to April); Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April). See KFF, "2018 Employer Health Benefits Survey," October 2019.



Figure 6

More Than One-Third Of Traditional Medicare Beneficiaries Spent At Least 20% Of Per Capita Total Income On Out-of-pocket Costs In 2013



SOURCE: Kaiser Family Foundation analysis based on CMS Medicare Current Beneficiary Survey 2013 Cost and Use file and The Urban Institute's DYNASIM3. See "Medicare Beneficiaries' Out-of-Pocket Health Care Spending as a Share of Income Now and Projections for the Future," January 2018.



Figure 7

There Are Five General Approaches Involving Public Programs or Plans

#1	#2	#3	#4	#5
Medicare-for-all	Federal Public Program with Opt Out Option	Federal Public Plan Option	Medicare Buy-In (50-64)	Medicaid Buy-In
Medicare for All Act of 2019 (Rep. Jayapal) Medicare for All Act of 2019 (Sen. Sanders)	Medicare for America Act of 2019 (Rep. DeLauro and Rep. Schakowsky)	Keeping Health Insurance Affordable Act of 2019 (Sen. Cardin) Medicare-X Choice Act (Rep. Delgado / Sen. Bennet and Sen. Kaine) The CHOICE Act (Rep. Shakowsky / Sen. Whitehouse) Choose Medicare Act (Rep. Richmond / Sen. Merkley)	Medicare at 50 Act (Sen. Stabenow) Medicare Buy-In and Health Care Stabilization Act of 2019 (Rep. Higgins)	State Public Option Act (Rep. Luján / Sen. Schatz)

SOURCE: Kaiser Family Foundation Interactive Comparison Tool, "Compare Medicare-for-all and Public Plan Proposals," May 2019.


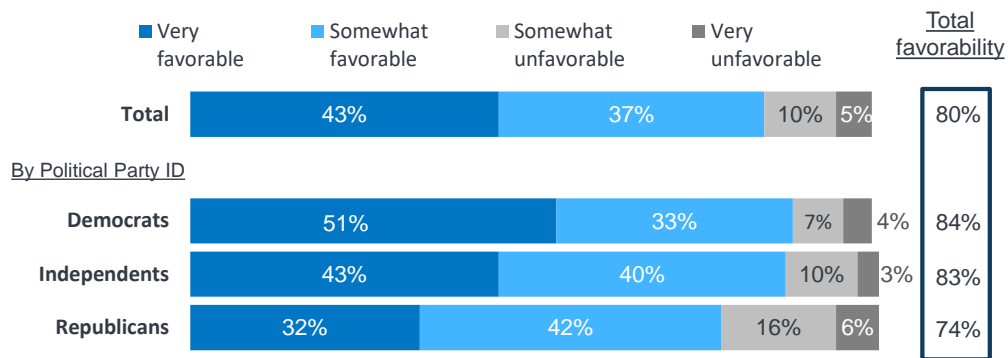


Figure 8

Medicare Is Popular among the General Public and across Party Lines

In general, do you have a favorable or an unfavorable opinion of Medicare?



SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted November 8-13, 2017)



Endnotes

- ¹ KFF analysis of estimates based on the 2018 American Community Survey, one-year file; KFF State Health Facts, “Total Number of Medicare Beneficiaries,” accessed June 2019, <https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/>. KFF State Health Facts, “Total Monthly Medicaid and CHIP Enrollment,” accessed June 2019, <https://www.kff.org/health-reform/state-indicator/total-monthly-medicare-and-chip-enrollment/>. KFF analysis of data from Mark Farrah Associates Health Coverage Portal TM, 2018, and data from the Centers for Medicare and Medicaid Services (CMS).
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- ³ Rachel Garfield, Kendal Orgera, and Anthony Damico, “The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act,” (Washington, DC: Kaiser Family Foundation, January 2019), <https://www.kff.org/uninsured/report/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act/>.
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- ⁶ Kaiser Family Foundation, “Compare Medicare-for-all and Public Plan Proposals,” accessed June 2019, <https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/>.
- ⁷ The specific provisions of the House and Senate bills vary. For example, the Senate bill would maintain a role for states to provide institutional long-term services and supports.
- ⁸ Mark Hadley, “Key Design Components and Considerations for Establishing a Single-Payer Health Care System,” Congressional Budget Office, May 22, 2019, <https://www.cbo.gov/system/files/2019-05/55258-SinglePayerTestimony.pdf>.
- ⁹ H.R. 2463/S. 1261, “Choose Medicare Act,” 116th Cong. (2019), available at <https://www.congress.gov/116/bills/hr2463/BILLS-116hr2463ih.pdf> and <https://www.congress.gov/116/bills/s1261/BILLS-116s1261is.pdf>
- ¹⁰ See for example, the H.R. 2463/S. 1261, “Choose Medicare Act,” 116th Cong. (2019), available at <https://www.congress.gov/116/bills/hr2463/BILLS-116hr2463ih.pdf> and <https://www.congress.gov/116/bills/s1261/BILLS-116s1261is.pdf>; S. 3, “Keeping Health Insurance Affordable Act of 2019,” 116th Cong. (2019), available at <https://www.congress.gov/116/bills/s3/BILLS-116s3is.pdf>; and H.R. 2000/S.981, “Medicare-X Choice Act of 2019,” 116th Cong. (2019), available at <https://www.congress.gov/116/bills/hr2000/BILLS-116hr2000ih.pdf> and <https://www.congress.gov/116/bills/s981/BILLS-116s981is.pdf>.
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- ¹⁴ H.R. 2463/S. 1261, “Choose Medicare Act,” 116th Cong. (2019), available at <https://www.congress.gov/116/bills/hr2463/BILLS-116hr2463ih.pdf> and <https://www.congress.gov/116/bills/s1261/BILLS-116s1261is.pdf>.
- ¹⁵ H.R. 1346, “Medicare Buy-In and Health Care Stabilization Act of 2019,” 116th Cong. (2019), available at <https://www.congress.gov/116/bills/hr1346/BILLS-116hr1346ih.pdf>.