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Progressives and health care: What comes next?

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INTRODUCTION

“Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.” –
President Harry Truman, 1945

President Truman’s words remind us that the arc of social progress is long. Progressives have worked to prevent Americans from being financially ruined by illness or injury for the better part of the past century. Key milestones include the 1960s push for Medicare and Medicaid, passage of the Children’s Health Insurance Program (CHIP) in the late 1990s, and, most recently, President Barack Obama’s Affordable Care Act (ACA). At nearly every stage, the Republican Party has fought to stymie the progressive drive to make sure that all citizens have access to affordable health care.

That battle, of course, continues to this day. Throughout his presidential campaign, President Donald Trump promised to replace the ACA with something better and cheaper.¹ After failing repeatedly to repeal “Obamacare” and coalesce around any serious alternative, President Trump and congressional Republicans have waged a relentless campaign to sabotage the law. They have killed the individual mandate, made cheap plans more available to lure young and healthy

people out of risk pools, ceased cost-sharing reduction payments and supported gutting protections for people with preexisting medical conditions.

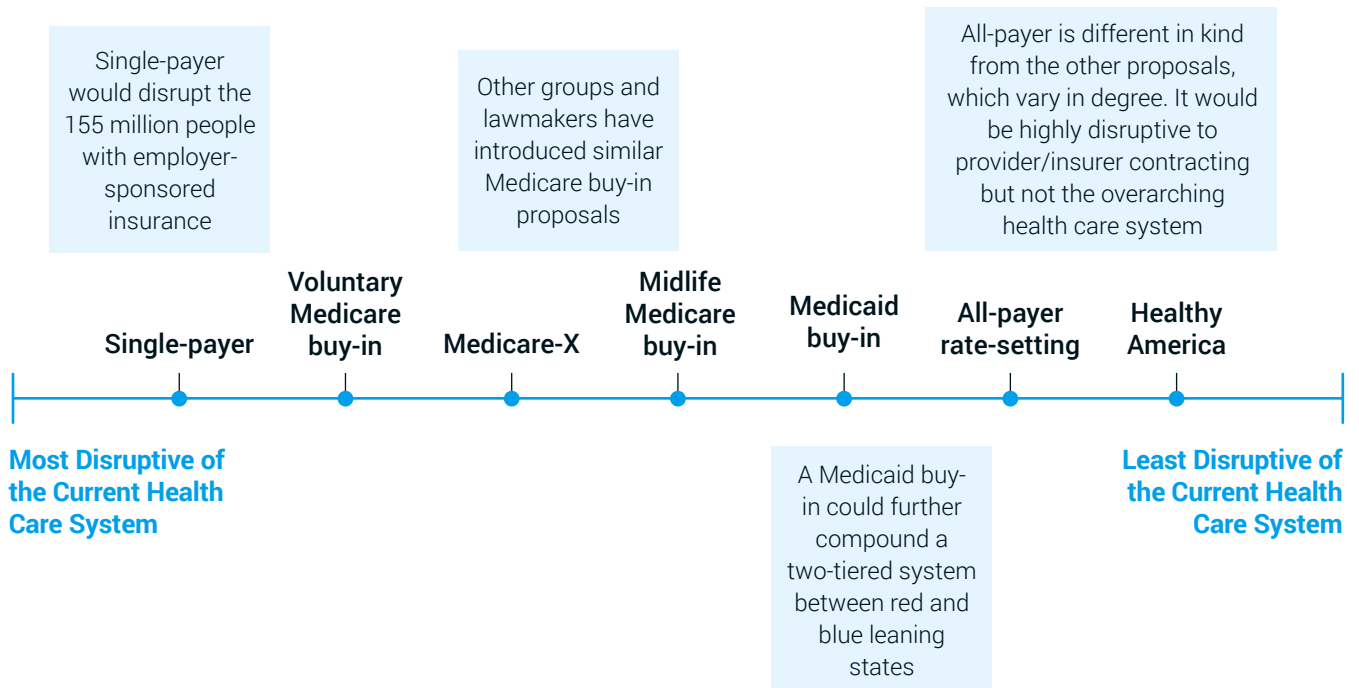
President Trump and congressional Republicans have waged a relentless campaign to sabotage the law.

Though average premiums remained stable nationally² due to the enormous premium increases in 2018,³ some states are still seeing premiums soar into 2019 (12 percent in Washington state, 21 percent in Washington, D.C., and a whopping 23 percent in Vermont).⁴ In fact, mounting public anxiety about health care costs and access is putting the issue

front and center in the 2018 midterm elections. Ironically, the GOP’s blindly partisan animus against “Obamacare” has done what Obama and the Democrats had failed to do – make the ACA popular.⁵ Polls show a majority began supporting the law in 2017 and now 75 percent of Americans want to keep the ACA’s provisions that prevent health plans from discriminating based on health status.⁶

There’s no doubt that the ACA represented a vital step toward universal coverage but much remains to be done: More than 30 million remain uninsured, costs remain out of reach for many, and GOP efforts to sabotage the law have undone many of its protections.

FIGURE 1: Seven Progressive Proposals Arranged From Most Disruptive To Least



The rate of uninsured has fallen from its peak in 2010, when 18.2 percent of Americans lacked coverage; however, people remain uninsured for a variety of reasons:

- **The cost is too high:** In 2016, of those who said they were uninsured, 45 percent cited cost as the driving reason.⁷
- **Republican obstruction of Medicaid expansion:** 17 states have not yet expanded Medicaid under the ACA and the rate of uninsured remains almost twice as high compared to states that have expanded Medicaid.⁸
- **Immigration status:** There are 23 million noncitizens in the U.S., including those here legally and illegally. Noncitizens are much more likely than citizens to be uninsured. Among those under age 65, 17 percent of legal immigrants and 39 percent of undocumented immigrants are uninsured. Undocumented immigrants are not eligible for Medicaid or exchange coverage and only those who received qualified immigration status more than five years prior can qualify for Medicaid.⁹

The 2018 midterm elections present progressives with an opportunity to hold the Trump Republicans accountable for undermining the individual market, putting Americans with preexisting conditions at risk, and refusing to expand Medicaid to more low-income workers.

Polls show likely voters say that health care is their top concern, even edging out jobs and the economy.¹⁰ What's more, voters trust Democrats over Republicans on health care by an 18-point margin.¹¹

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No doubt the Democrats' advantage reflects their staunch defense of the ACA since Trump took office. Nonetheless, many Democrats aren't content to simply defend the ACA and are proposing their own ideas to "repeal and replace" Obamacare with more ambitious – and costly – plans to achieve universal coverage.

Progressive lawmakers and policy analysts have introduced a variety of proposals that range from nationalizing health care with a single government payer to building on the ACA framework to expand coverage and control costs. In part, this reflects impatience with the status quo and a commendable desire to speed up progress toward the long-sought progressive goal of universal coverage. But it also entails significant political risks.

Democrats have a strong hand on health care but could misplay it if the midterm debate centers on their disunity and internal ideological cleavages rather than the issue on which most voters agree with them – the need to ensure that all Americans have access to affordable health coverage. It's also possible swing voters will be hesitant to support health care proposals that sound hugely disruptive and expensive.

In an op-ed, President Trump charged that Democrats have united around a plan to end Medicare as we know it by embracing "Medicare for all." In what is clearly an effort to distract

from voter anger over GOP attempts to repeal the ACA, scam patients with junk insurance and take away protections for people with preexisting conditions, Trump is using classic fear mongering to rally his base. Democrats shouldn't take his bait. Instead of getting bogged down trying to explain what "Medicare-for-all" really means, they should focus on what unites them — the moral imperative of universal coverage. If, as seems increasingly likely, the midterm elections go in their favor, there will be ample time to debate what comes next in health care.

This report compares and contrasts the leading progressive proposals for achieving universal coverage. Its purpose is to help progressives evaluate the menu of options for universal health care from the standpoints of cost, competition, and the division of responsibility between government and the private sector. We have arrayed the proposals along a continuum (see Figure 1) that runs from the most interventionist and costly to more targeted reforms aimed at closing coverage gaps, curbing high costs, and preserving incentives for medical innovation.

Rather than picking winners and losers, the aim of this paper is to help progressives and policy makers make informed decisions.

That's not because PPI lacks strong convictions about health care policy. We have long advocated for a distinctively American approach to universal health care that covers everyone, uses choice and competition to discipline costs, and stimulates robust innovation. To curb costs, we favor moving away from fee-for-service medicine to new payment methods that reward value and outcomes. PPI also supports a decentralized system that relies on a mix of public and private coverage to allow Americans a wide spectrum of choices.

This report presents a comparative analysis of seven leading health proposals. These include a single-payer option, three voluntary Medicare buy-in options, a Medicaid buy-in option, all-payer rate-setting, and a proposal to build upon the ACA by merging the Medicaid population into its health care exchanges.

FIGURE 2: Progressive Proposals For What Comes Next

	WHO RUNS THE PLAN?	WHO IS ELIGIBLE?	CAN PEOPLE CHOOSE PLANS?	WHAT DO ENROLLEES PAY?	WHAT IS COVERED?	WHAT ARE PROVIDERS PAID?	ARE THERE OUT-OF-POCKET PRICE CAPS?
Single-payer	Medicare	All people	No	Taxes (no premiums)	Enhanced ACA benefits with low cost sharing	Medicare payment rates	✓
Voluntary Medicare buy-in	Medicare	All non-elderly people except those Medicaid- or Medicare-eligible' employers	Depends: Employers choose for workers; yes for others	Federal gov't-set premiums based on costs, decreased for low-income enrollees and employer contribution (current law)	Enhanced ACA benefits with gold-plan-level cost sharing	Negotiated rates between Medicare and average private rates	✓
Medicare-X	Medicare	People buying on their own and small businesses in undeserved areas initially	Yes	Federal gov't-set premiums based on costs, decreased for low-income enrollees (current law)	ACA benefits and cost sharing reductions (current law)	Medicare payment rates (with adjustments for rural areas)	✗
Midlife Medicare buy-in	Medicare	People ages 50 to 64 without access to employer coverage	Yes, initially, but not once in Midlife Medicare, except in limited cases	Federal gov't-set premiums, decreased for low-income and increased for high-income enrollees	Similar to Medicare benefits and cost sharing	Medicare payment rates	✓
Medicaid buy-in	States	All non-elderly people in states that opt in	Yes	State-set premiums, decreased for low-income enrollees	ACA benefits and reduced cost sharing	Medicare rates	✗
All-payer rate-setting	Individual market plans but with prices set by the federal government	All non-elderly people	Yes (although Medicare rates apply to all plans)	Private insurance-set premiums, decreased for low-income enrollees	ACA benefits and cost sharing reductions (current law)	Medicare payment rates	✓
Healthy America	Federally-administered public health insurance plan, alongside private plan option	All those currently eligible for Medicaid or the ACA exchanges	Yes, between a public option and a private market	Premiums depend on income, though no one will pay more than 8 percent of income	ACA's essential benefits, along with supplemental benefits for low-income children and people with disabilities	Medicare payment rates	✓

Single-payer

Sen. Bernie Sanders (VT) is advocating for the most sweeping change in U.S. health care policy: Replacing the ACA – and, indeed, all private health insurance – with a Canada-style national health insurance system. He, along with other left-leaning policy makers, want “Medicare-for-all” to be central to the Democratic Party’s 2018 and 2020 message.¹²

Sanders’s single-payer plan would cover almost all Americans – rolling in those from traditional Medicare, Medicare Advantage, Medicaid, and employer-sponsored coverage – into a single public system. Though he has branded it as “Medicare-for-all,” it is actually quite different from how Medicare works now. Medicare provides a marketplace where seniors can shop for traditional Medicare or comparable private plans (Medicare Advantage). Although this fact is not widely known, even traditional fee-for-service Medicare is administered through a private insurance company that manages claims. Under Sanders’s proposal, private insurance companies would be outlawed. It would allow the Veterans Affairs health system and the Indian Health Services to continue to provide care outside the new national system.

In addition to covering almost everyone, Sen. Sanders’s single-payer bill, endorsed by one-third of Democratic Senators, would expand Medicare’s coverage to include all hospital visits, primary care services, devices, lab testing, maternity care, prescription drugs, vision care and dental benefits.¹³ Unlike Medicare and most countries with single-payer systems, the new government-run plan would not require co-pays or cost sharing (except for prescription drugs). It would bar employers and private insurance companies from offering separate plans, which often are used in conjunction with Medicare and

in other countries to fill in the gaps in coverage.

Unlike Medicare and most countries with single-payer systems, the new government-run plan would not require co-pays or cost sharing (except for prescription drugs).

For all these reasons, the Sanders plan would be enormously expensive. The liberal-leaning Urban Institute estimates it would cost about \$32 trillion over 10 years.¹⁴ Sen. Sanders has proposed funding his single-payer plan with a new 7.5 percent payroll tax on employers, a 4 percent income tax hike and an array of taxes on wealthier Americans and corporations. However, the revenue generated by these new taxes would fall short of what’s needed to cover the \$32 trillion tab. Single-payer advocates argue that Americans would come out ahead over time, since the tax hikes they’d face would be lower than the premiums they would no longer have to pay. The experience of the Trump-GOP tax bill, however, suggests another possibility: Employers who would no longer have to contribute to their workers’ health care premiums might pass on those savings to their shareholders rather than workers.¹⁵

Finally, the politics of single-payer are by no means clear. Sanders has pushed Democrats to make “Medicare-for-all” the centerpiece of their midterm campaign, saying that “...this is not a radical idea...for decades, every man, woman and child in Canada has been guaranteed health care through a single-payer, publicly funded health care program.” Additionally, advocates point to polls purporting to show most Americans favor “Medicare-for-all.” However, those positive feelings quickly dissipate when voters are faced with arguments against single-payer. Once asked if they realize that Medicare for all would require

tax increases, 60 percent say they oppose a single payer model (see chart below). What's more, single-payer has not fared well in ballot initiatives. In Colorado, for example, 80 percent of voters voted against a recent single-payer ballot referendum.¹⁶

Alexandria Ocasio-Cortez (D-NY) used a strong Medicare-for-all message in her successful bid to upset Rep. Joe Crowley, but the idea hasn't played well in other areas of the country. In states like Iowa, Texas, and Kansas, candidates

that made Medicare-for-all a centerpiece of their campaigns generally lost their primaries.¹⁷ The path for Democrats to take back the House runs through states like these. In another more conservative district, Rep. Conor Lamb (D-PA) won on a health care message – but, instead of Medicare-for-all, he promised to protect Medicare and build on the successes of the ACA.¹⁸

Arguments against single-payer plan sway some initial supporters

Do you favor or oppose having national health plan, or (single-payer/Medicare-for-all) plan, in which all Americans would get their insurance from a single government plan?

Favor

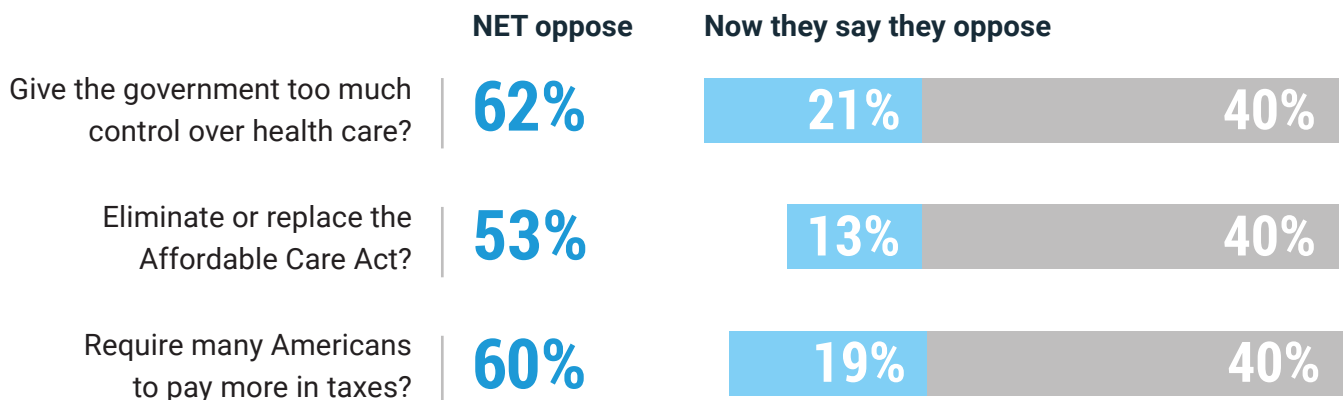


Oppose



Asked of the 55% who favor

*What if you heard the **opponents** say guaranteed universal coverage through such a plan would...*



Note: Top bars show results for combined question wording. Don't know/Refused responses not shown. Source: Kaiser Family Foundation Health Tracking Poll (conducted June 14-19, 2017)

Voluntary Medicare Buy-in

Senators Jeff Merkley (D-OR) and Chris Murphy (D-CT) have introduced a “Choose Medicare” bill that would allow anyone – including employers – to buy into the Medicare program. This proposal for a voluntary Medicare buy-in would essentially create the public option that liberals tried and failed to include in the ACA. It would allow those who want a government-issued health plan to buy one without disrupting the 155-million-person employer market. “Medicare is consistently rated the most popular and efficient health insurance system in the United States,” they note. They call for a new “Medicare Part E” that would be self-sustaining because it would be fully paid for by premiums.

The idea is to use Medicare’s massive leverage in health care markets to lower prices and reduce costs in the individual market. Medicare uses price controls and has generally done a better job than private insurance companies at controlling costs. Medicare caps prices in both the traditional plan and the Medicare Advantage market. Even if patients go out-of-network to get medical attention, providers can only charge them what Medicare allows. This provides a “benchmark” that Medicare Advantage plans can negotiate from, promising volume to providers in exchange for lower prices.

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The bill sponsors say that premiums from those buying-in would cover the cost of the program. However, responding to concerns that the individual market is still not affordable for many people, the proposal would expand ACA subsidy eligibility to those up to 600 percent of the federal poverty level (from 400 percent) and tie the subsidy to the “gold tier” plan rather than the “silver tier.” There are no cost estimates yet for this proposal, but the expansion of tax subsidies would be the most expensive provision and would require general revenue funding.

Like Senator Sanders’s proposal, Medicare Part E would provide more comprehensive benefits than the traditional Medicare program. This includes what the ACA defines as “essential health benefits” – ambulatory patient care, emergency services, and reproductive benefits and others. To further reduce costs to consumers, the Choose Medicare Act would impose out-of-pocket caps for those with Medicare coverage. Additionally, it would have Medicare negotiate on the price of prescription drugs.

While reducing costs to consumers through more generous subsidies and less cost sharing is clearly needed in the individual market, it would be very expensive to provide without any new revenue. Currently there are no formal cost estimates for the proposal.

Medicare Public Option

Senators Tim Kaine (D-VA) and Michael Bennet (D-CO) take a more gradualist approach to creating a public option with a Medicare buy-in. “The [ACA] is imperfect [and] doesn’t go far enough to reduce costs and increase competition,” they note. Their “Medicare-X” plan offers a public option under Medicare that would be phased into health care exchanges in counties with one or fewer private options

before eventually expanding nationally and including employers. Like the Choose Medicare Act, Medicare-X would reimburse providers at the same rates as traditional Medicare and be financed by premiums (not by tapping the Medicare Trust Fund). It would offer premium subsidies for those who qualify but it would not increase subsidies or cap out-of-pocket costs.

In 2016, former President Obama endorsed this sort of a Medicare “fallback” plan, which would operate like the fallback provisions in the Medicare Part D Prescription Drug Program. If there is a shortage of drug plans (less than two), the Department of Health and Human Services (HHS) has the authority to contract with private entities to offer public option-like “fallback” plans. However, there has been ample supply of prescription drug plans to date and HHS has never used this authority.

Last year, out of a total of 3,143 counties, only 44 counties were “at risk” of being bare according to the Kaiser Family Foundation.¹⁹ State policy makers and insurance commissioners were able to work with plans and, in the end, no counties were bare for the 2018 plan year. However, with the Republican sabotage of the ACA, the threat of bare counties could resurface later this year. The problem is, many high-cost areas will have only one or two insurers or a limited number of providers, or both.²⁰ This happens most often in rural areas where there is little competition and providers can essentially set their rates without negotiating with insurers. There is evidence that a lack of competition in the exchanges drives up prices. In 2017, counties with one insurer had 9.6 percent higher premiums than those counties with two participating insurers, and 15.3 percent higher premiums than those counties with three or more participating insurers.²¹

The ACA’s experience has demonstrated that private insurers don’t find certain areas of the country profitable.

Though state insurance commissioners and exchanges worked to increase participation – and every county had at least one insurer in 2018 – roughly 30 percent had only one.²² This problem is likely to get worse with the Republican efforts to sabotage the individual market. Repealing the individual mandate, allowing more plans that do not meet ACA coverage requirements, and ending cost-sharing reduction payments will all reduce plan participation in certain areas. A public option would provide a safety net plan in these areas as well as increase competition in more counties and encourage greater efficiency and quality.

The ACA’s experience has demonstrated that private insurers don’t find certain areas of the country profitable.

One weakness of this proposal, according to Paul Starr, a leading health policy analyst and historian, relates to “balance billing.” Balance billing is the practice of providers billing a patient the difference between what the payer pays and the provider charges. Medicare does not allow balance billing, in either the traditional program or in Medicare Advantage. The Medicare-X plan does not include these protections for patients in the individual market.

There are no cost estimates to date.

Midlife Medicare Buy-in

Starr has proposed what he regards as a more politically feasible way to stabilize the ACA individual market – an age-limited Medicare buy-in option.²³ Starr proposes offering a Medicare buy-in to those 50 and older, removing

the oldest and sickest from the individual market risk pool, and using the Medicare program to provide a robust public option.

Starr notes that major health care changes pushed by the past two Democratic Presidents provoked a major public backlash that cost the party many seats in the 1994 and 2010 midterm elections. His Midlife Medicare buy-in seeks to steer a middle course between a massively disruptive single-payer plan and an ACA weakened by serial GOP assaults – one that would bring down health insurance premiums without requiring huge tax subsidies.

Starr proposes offering a Medicare buy-in to those 50 and older, removing the oldest and sickest from the individual market risk pool, and using the Medicare program to provide a robust public option.

Aside from political sabotage, premiums in the ACA's individual market stay high because the population ended up a little sicker and older than many actuaries predicted. Starr's proposal would allow people aged 50-64 to buy into traditional Medicare or the Medicare Advantage program. It also would eliminate the two-year waiting period for Medicare for those deemed eligible for Social Security Disability Insurance. By pulling 50- to 64-year-olds, as well as those that qualify for disability out of the individual insurance pool, premiums for those 49 years of age and under in the individual market would go down.

Medicare fee-for-service sets a price for each health care service. The price caps also apply to Medicare Advantage. If doctors and insurance companies cannot agree on a price or if a service is out-of-network, it is capped at the fee-for-service price set by the government. These caps create a price ceiling and give private plans

leverage to negotiate better deals with providers – in exchange for volume guarantees, the plans get cheaper prices. This allows for competition between Medicare Advantage plans and traditional Medicare. Starr seeks to replicate this type of market for older but not yet retired Americans.

The ACA individual markets don't have price controls for out-of-network services. Starr's proposal would provide a strong Medicare plan that also could be used to set rates for comparable Medicare Advantage plans in the Midlife Medicare market. To overcome providers' resistance to serving the new Medicare enrollees at lower prices, providers would be required to accept Midlife Medicare in order to keep seeing regular senior Medicare patients. Put simply, Starr's proposal would expand the Medicare market – where seniors shop for traditional or Medicare Advantage plans – to the 50-64 group.

Depending on how premiums were priced, this could lower costs for Medicare overall. Evidence suggests that those who are healthy at age 70 are better positioned for longer and healthier life with no additional costs to Medicare. By offering those 50-64 more comprehensive and preventative care, they are less likely to be a part of the 10 percent of Medicare patients who account for 70 percent of Medicare's \$91 billion in acute care spending.²⁴

Many U.S. seniors see Medicare as an earned entitlement. After working and paying taxes for years, they become eligible for a program that provides them with mostly free medical care when they need it most. Starr's proposal reinforces that view of Medicare. Rather than opening the program up to all, it limits Medicare to those who have been working and paying into the system most of their adult life, while letting the not-quite-retired buy into the program before

they become fully eligible for benefits. Though proponents of Medicare for all may regard it as insufficiently generous, Starr's alternative would increase competition in the individual market by removing the most expensive patients. Increasing competition, providing a new option for older and more expensive patients, paying Medicare prices, and ensuring more comprehensive preventative care could all lower costs for consumers and the health care system as a whole.

This proposal covers a smaller number of beneficiaries than the other proposed Medicare buy-ins. Though there are not any formal cost estimates, presumably it would cost much less than a single-payer or Medicare-for-all bill.

Medicaid Buy-in

Amid all the attention on Medicare, Sen. Brian Schatz (D-HI), and Reps. Ben Ray Lujan (D-NM) and John Delaney (D-MD) have offered a novel twist: Enable people to buy into Medicaid, the federal-state program that provides health insurance to low-income Americans. Sen. Schatz says the goal of the bill is "...to expand the availability of low-cost, high-quality health plans to all Americans by establishing a state public option through Medicaid. [The] bill builds on a system that already works – a system that is already in place in every county in every state in the country; and a system that has built-in efficiencies." The bill would also increase all Medicaid reimbursement to match the rates of Medicare and encourage more provider participation.

Under this proposal, states could choose to offer Medicaid as a public option on their ACA exchange. State Medicaid and insurance agencies would work together to set benefits

(omitting benefits specifically tailored to low-income people like transportation to appointments) and set premium rates. The costs of the insurance would be paid by individuals through premiums and by the federal government through premium tax credits, the refundable credit that helps eligible individuals and families cover the premiums for their health insurance purchased on the exchanges.

Because it is a program designed for low-income people, Medicaid typically has no copayments or coinsurance. A Medicaid buy-in plan, however, would likely have to incorporate both to cover the cost of providing care. That being said, the most expensive part of the Schatz-Delaney proposal stems from increasing Medicaid reimbursement from about 72 percent on average, to parity with Medicare reimbursement rates.²⁵

Many states use Medicaid managed care organizations (MCO) to manage services for Medicaid beneficiaries. These private organizations are paid a capitated rate – meaning a flat rate per beneficiary – to manage the benefits of enrollees. If more states integrated MCOs into the individual market, it could help restrain cost growth and provide more holistic care to patients than they'd get from a fee-for-service system like Medicare.

Although states cannot merge their Medicaid and ACA populations without a federal Medicaid waiver, some state lawmakers in Nevada, Minnesota, and Massachusetts have introduced Medicaid buy-in bills.²⁶ Without additional federal funds, however, it is unlikely that states would dramatically increase Medicaid reimbursement rates to encourage providers to take on Medicaid patients.

Medicaid buy-in faces formidable obstacles. First, not all states are committed to the goal of using Medicaid to expand coverage. As we've seen with Medicaid expansion under the ACA, a Medicaid buy-in option could become a two-tiered system. In blue and blue-leaning states, legislatures may choose to expand the program to include a buy-in. However, this is less likely to happen in GOP-led states, 17 of which have rejected federal funding under ACA to expand their Medicaid programs. Second, this proposal boosts reimbursement rates to attract more providers to Medicaid, increasing costs for both the states and the feds. Anyone interested in buying into the program would see premiums rise to cover higher reimbursement rates.

If more states integrated MCOs into the individual market, it could help restrain cost growth and provide more holistic care to patients than they'd get from a fee-for-service system like Medicare.

There are no formal cost analyses to date but the increased reimbursement of the Medicaid program would likely be quite expensive. As currently written, the proposal does not include a financing mechanism to pay for this increase.

"All-payer" Rate Setting

In contrast to the other proposals examined here, "all-payer" rate setting aims only indirectly at expanding coverage. It is designed to put a ceiling on health care costs. Instead of making government the single payer of everyone's health bills, "all-payer" requires all providers to accept the same payment rates for medical treatment, regardless of whether their patients have public or private insurance.

In the 1970s, many states implemented "all-payer" rate setting models, in which an

independent commission decided the rates for health care services regardless of who was paying the bills. At the time, there was not a large difference between commercial and Medicare reimbursement rates, so health care providers did not face a huge cut when shifting to an all-payer system. In exchange for set prices, they received a predictable revenue stream more conducive to long-term planning and consumers were able to buy more affordable health care coverage.

As time went on, all-payer rate setting began to falter because fee-for-service payment systems allowed providers to compensate for price controls by delivering more services. If a doctor or hospital can only charge a set price per services, they then have an incentive to increase the number of services to earn more money. During the 1990s, managed care organizations appeared, promising that, by better managing care and demonstrating value, they would reduce costs more effectively than price controls. Managed care had mixed results: Though they did reduce health care costs and consumption, they limited choice and consumers were concerned that for-profit managed care health plans were more interested in saving money than providing health care.

Today, in the United States, Maryland is the lone state operating an all-payer system for hospital services. Maryland's rate setting applies to all hospital inpatient and outpatient services. In 1976, the cost per hospital admission in Maryland was 26 percent above the national average. However, 30 years later, in 2007, the average hospital cost admission was approximately 2 percent below the national average, due to the structure of the all-payer system.²⁷

Other countries, including France, Germany, Japan, and the Netherlands, use elements of rate setting. In Germany, tightly regulated “sickness funds,” comparable to non-profit insurance companies, compete on quality rather than price because of strict price controls. The comparative success of these countries in controlling costs is spurring renewed interest in the all-payer system.

California legislators, for example, are considering a proposal that would replicate Maryland’s all-payer system. Rather than lumping all consumers into a uniform, single-payer plan, insurers would have their prices set by a commission and compete on cost and quality to get customers and contract with providers.

The payments would be based on a multiple of Medicare rates in an effort to restrain and standardize prices. It would then require providers to apply for adjustments to the base amount.

The challenge of moving to an all-payer rate setting model today is twofold: First, the payment differential between Medicare and commercial payers is substantial. This means that hospitals would see huge budget decreases if commercial payers were brought inline with Medicare rates. Second, it is founded on a fee-for-service model. Maryland has continued to modify its program because its utilization remained too high under the program. It wasn’t until global budgets were implemented that costs began to fall. Per capita Medicare costs still remain higher than the national average, even if per-visit costs are low.²⁸

Rather than lumping all consumers into a uniform, single-payer plan, insurers would have their prices set by a commission and compete on cost and quality to get customers and contract with providers.

The Maryland model had been based on fee-for-service and thus had encouraged increased admissions and overall costs to the Medicare program remain higher than the national average. In 2014, however, the state negotiated a waiver with the Centers for Medicare and Medicaid Services (CMS) to include global budgets beginning in 2014. Based on past utilization, hospitals receive a population-based budget for all services for state residents, regardless of payer. Maryland committed to keep per-capita hospital expenditure growth below 3.58 percent and pledged to save Medicare \$330 million over five years. The program has demonstrated early success in its first few years.

Rate setting acknowledges a truth in health care: There is often limited competition in sparsely populated areas, and therefore less incentive to hold prices down. Additionally, medical loss ratio (MLR) rules passed under the ACA mandate that insurers use 85 percent of premiums on health care services, limiting the amount that goes toward profits and administrative costs. However, if insurers get paid more in premiums, they have more to allocate to profits and administrative costs, even if the ratio remains constant. This has created a perverse incentive to limit negotiated prices with providers because their revenues increase as the amount spent on care increases.

Healthy America

Because of the beating the ACA has taken, many lawmakers are under the impression that it’s more politically feasible to start from scratch rather than build on the successes of the ACA. Challenging that logic, analysts at the Urban Institute have produced a health reform blueprint that stabilizes and expands the ACA framework. Specifically, they propose combining the ACA individual market and

Medicaid-eligible population, a step that would dramatically expand the risk pool in the individual marketplace, increase competition and coverage, and reduce costs. It would be far less complicated than a Medicare buy-in or single-payer model, and far less costly.

Their approach simplifies and stabilizes the individual market by absorbing beneficiaries of Medicaid and CHIP and uses Medicare payment rates to keep down costs.²⁹ Rather than a buy-in proposal that keeps separate risk pools between the individual market and those on a public plan, the Medicaid population joins the individual market.

Essentially, the Urban Institute analysts contend that the ACA has everything we need if we can fix its weak spots.

- First, it would fold the Medicaid population into the individual market to better spread risk, particularly in sparsely populated geographic areas
- Second, to encourage competition and lower prices, it would set prices at Medicare levels for both the public plan and the private plans offered on the exchanges
- Third, it would increase the benchmark plan to cover 80 percent of health care costs, compared to the current 70 percent (moving up from the silver tier to the gold)
- Finally, it would penalize a share of a person's standard tax deduction if they did not enroll in coverage

Very low-income beneficiaries, children, and the disabled would pay nothing and have supplemental benefits targeted at their needs (such as transportation), and would benefit from a sliding scale of subsidies and cost-sharing.

The states would contribute a portion of Medicaid funding – keeping the program dually funded through the federal government and the states. People with income above 138 percent of the federal poverty level would pay premiums based on income, and long-term care would remain a Medicaid benefit managed by states outside of the exchanges. Employer-based insurance, the traditional Medicare program, the Veterans Administration health care program, and the Indian Health Service all would be left in place.

The Institute's default plan would be more generous than the ACA's current benchmark plan. Lower-income people could select a plan that covered a higher share of their costs. Those with incomes below 138 percent of the federal poverty level or under (\$27,000 for a family of three) would pay no premiums for the gold plan, and premiums would rise slightly with the more income a person makes. There would be no upper limit for subsidies as they would be structured to ensure no one would pay more than 8.5 percent of their income on premiums.

The Healthy America proposal also would resurrect the ACA's individual mandate, axed by the Trump administration. The percent of the standard deduction lost would increase with income. The idea would be to encourage all people to enroll and therefore reduce adverse selection in the market.

The Healthy America plan has two great advantages – affordability and political realism. It is based on current law and expectations of the insurance market and does not entail shifting millions of Americans from private to public health plans. By bringing rate setting into the individual market, expanding the risk pool, and providing more generous subsidies, it helps

make individual coverage affordable. However, it does not disrupt Medicare or the employer insurance market. Urban Institute estimates that it would reduce the uninsured rate from about 11 percent to about 6.7 percent – 4 percent of non-elderly legal U.S. residents would remain uninsured and 63 percent of undocumented non-elderly U.S. residents would remain uninsured.

The Urban Institute estimates that some new tax financing would be needed: approximately \$98 billion in the first full year of implementation. They estimate “that over 10 years of the Healthy America program, federal spending would increase by \$1.2 trillion and state government spending would decrease by \$422 billion, resulting in a net increase in total government spending of \$790 billion, or roughly 0.025 percent of GDP.” They suggest that this could come from increases in payroll, income, sin taxes (e.g., on alcohol and tobacco) and shift the federal share of Medicaid DSH funding to the program (\$12 billion annually).

CONCLUSION

Progressives are understandably impatient with the status quo in health care. It leaves 30 million Americans uninsured – a number likely to go up as the Trump Republicans continue their unconscionable campaign to eviscerate the ACA.

And, for those with coverage, high premiums continue to eat into wage gains working Americans would otherwise get. It’s no wonder the mood among Democrats is to stop playing defense and go on the offensive with new proposals for expanding coverage and making health care more affordable.

Progressives are understandably impatient with the status quo in health care. It leaves 30 million Americans uninsured – a number likely to go up as the Trump Republicans continue their unconscionable campaign to eviscerate the ACA.

As this comparison of leading health proposals shows, there are many roads that lead to the long-sought progressive goal of universal health coverage. They range from a massively disruptive and expensive public takeover of health care markets to the kind of incremental progress Democrats have been making since President Lyndon B. Johnson signed Medicare and Medicaid into law in 1965. The strategic challenge progressives face today is to choose the path most likely to command majority support.

PPI will lay out its preferred course in future reports. For now, as we approach a crucial midterm election, we urge progressives to focus on where they agree – the economic and moral imperative of universal health coverage – rather than splitting into sectarian camps over the best way to achieve it. That will best align progressive candidates with public sentiment and maximize the prospect for the sweeping gains progressives will need to put an effective check on the Trump Republicans. After the midterms, as the 2020 presidential cycle starts, there will be an opportunity for progressives to debate what should come next in health care.

References

- 1 Donald Trump, Twitter, November 2016. <https://twitter.com/realdonaldtrump/status/793769750056677376>
- 2 Alex Azar, "Remarks on Market Stabilization and Lesson for Healthcare Reform," HHS, September 27, 2017. <https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-market-stabilization-and-lessons-for-healthcare-reform.html>
- 3 Daniel Uria, "Health Secretary: ACA 'Benchmark' Plan Premiums to Drop 2 Percent," UPI, September 27, 2018. <https://www.upi.com/Health-secretary-ACA-benchmark-plan-premiums-to-drop-2-percent/2331538080253/>
- 4 KFF, Tracking 2019 Premium Changes on ACA Exchanges, accessed October 10, 2018. <https://www.kff.org/private-insurance/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/>
- 5 "Kaiser Health Tracking Poll: The Public's Views on the ACA", Kaiser Family Foundation, September 2018. <https://www.kff.org/interactive/kaiser-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable--Unfavorable&aRange=twoYear>
- 6 Ashley Kirzinger, et al. "Kaiser health Tracking Poll – Late Summer 2018: The Election, Pre-Existing Conditions, and Surprises on Medical Bills", The Henry J. Kaiser Family Foundation, September 2018. <https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-late-summer-2018-the-election-pre-existing-conditions-and-surprises-on-medical-bills/>
- 7 "Key Facts about the Uninsured Population", The Henry J. Kaiser Family Foundation, November 2017. <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>
- 8 Robin A. Cohen, et al. "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2017", Center for Disease Control and Prevention, May 2018. <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf>
- 9 "Health Coverage of Immigrants", The Henry J. Kaiser Family Foundation, December 2017. <https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/>
- 10 NBC News, June 2018. http://media1.s-nbcnews.com/i/today/z_creative/18416NBCWSJJunePoll6718Release.pdf
- 11 Grace Sparks, "CNN poll: Democrats are fired up and maintain a strong 2018 lead," October 10, 2018
- 12 Eric Bradner, "Progressives Reject 'Phony Moderation' at Netroots Nation, Setting Tone for 2020 Primary", CNN Politics, August 5, 2018. <https://www.cnn.com/2018/08/05/politics/netroots-nation-progressives-democratic-direction-2020/index.html>
- 13 Haeyoun Park, et al. "One-Third of Democratic Senators Support Bernie Sanders's Single-Payer Plan", The New York Times, September 13, 2017. <https://www.nytimes.com/interactive/2017/09/13/us/sanders-medicare-for-all-plan-support.html>
- 14 John Holahan, et al. "The Sanders Single Payer Health Care Plan: The Effect on national health Expenditures and Federal and Private Spending", Urban Institute, May 2016. <https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private-spending>
- 15 Matt Egan, "Tax Cut Triggers \$437 Billion Explosion of Stock Buybacks", CNN Money, July 10, 2018. <https://money.cnn.com/2018/07/10/investing/stock-buybacks-record-tax-cuts/index.html>
- 16 "Colorado Amendment 69 – Create State Healthcare Systems – Results: Rejected", The New York Times, August 1, 2017. <https://www.nytimes.com/elections/results/colorado-ballot-measure-69-state-healthcare-system>

- 17 Paul Demko, "Why Medicare For All is Playing Poorly in Democratic Primaries," Politico, August 21, 2018. <https://www.politico.com/story/2018/08/21/universal-medicare-democratic-primaries-745296>
- 18 Dylan Scott, "Conor Lamb Decisively Won the Health Care Vote in the Pennsylvania Special Election", Vox Media, March 14, 2018. <https://www.vox.com/policy-and-politics/2018/3/14/17120692/conor-lamb-pennsylvania-special-election-health-care-voxcare>
- 19 "Map: Counties at Risk of Zero Insurers Offering Plans in the 2018 Marketplace", The Henry J. Kaiser Family Foundation, June 2017. <https://www.kff.org/health-reform/press-release/map-counties-at-risk-of-zero-insurers-offering-plans-in-the-2018-marketplace/>
- 20 John Holahan, et al. "Capping Provider Payment: An Alternative to a Public Option", The American Prospect, January 5, 2018. <http://prospect.org/article/capping-provider-payment-alternative-public-option>
- 21 Chris Sloan, et al. "Exchange Plans in Counties with the Least Insurer Competition Have the Highest Premiums", Avalere Health, September 2017. <http://avalere.com/expertise/managed-care/insights/exchange-plans-in-counties-with-the-least-insurer-competition-have-the-high>
- 22 Dylan Scott, "There Are No More Counties Without Any Obamacare Plans", Vox Media, August 24, 2017. <https://www.vox.com/health-care/2017/8/24/16199620/voxcare-no-counties-without-obamacare>
- 23 Paul Starr, "The Next Progressive Health Agenda", The American Prospect, March 2017. <http://prospect.org/article/next-progressive-health-agenda>
- 24 Bobby Milstein, et al. "Why Behavioral And Environmental Interventions Are Needed to Improve Health at Lower Cost", Health Affairs, May 2011. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.1116>
- 25 "Medicaid-to-Medicare Fee Index", The Henry J. Kaiser Family Foundation, 2016. <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- 26 Anita Cardwell, "Searching for New Insurance Options, States Consider Medicaid Buy-In and Other Strategies", The National Academy for State Health Policy, December 2017. <https://nashp.org/some-states-consider-medicicaid-buy-in-plans-to-expand-their-coverage-options/>
- 27 Robert Murray, "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience", Health Affairs, October 2009. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.5.1395>
- 28 "Medicare Spending Per Enrollee, by State", The Henry J. Kaiser Family Foundation, 2014. <https://www.kff.org/medicare/state-indicator/per-enrollee-spending-by-residence/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Per%20Enrollee%20Medicare%20Spending%20by%20Residence%22,%22sort%22:%22desc%22%7D>
- 29 Linda J. Blumberg, et al. "The Health America Program", Urban Institute, May 2018. https://www.urban.org/sites/default/files/publication/98432/2001826_2018.05.11_healthy_america_final_1.pdf



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