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# Affordable Health Care for All: An American Solution to High Costs and Coverage Gaps

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## INTRODUCTION

**America's sprawling health care economy faces many vexing challenges. But the root of the problem is simple: Medical care in the United States costs too much. Our overpriced health care system leaves too many uninsured, eats into workers' wage growth, strains public budgets, and keeps families in fear that one medical emergency will leave them bankrupt. Health care costs are the top financial concern of families – greater than taxes, housing, or college expenses.[1,2]**

President Donald Trump and the Republican Party have aggravated public anxieties by failing to produce a credible plan for controlling health care costs and covering the uninsured. Instead, they have waged a partisan crusade to kill the Affordable Care Act (ACA), which protects Americans with preexisting conditions and has enabled 17 million people to get insurance coverage. Even after suffering a clear rebuke from voters in the 2018 midterm elections, Trump Republicans persist in trying to sabotage the ACA in the courts.[3] Thus it is no wonder Americans trust Democrats more than Republicans to address their health care anxieties.[4]

Democrats, however, could squander that trust by overreaching. That's the danger posed by several leading 2020 presidential candidates endorsing the abolishment of private insurance and replacing it with a government-funded, national health care system. It would require a staggering $32 trillion in new government spending over ten years and would massively disruptive coverage for the 155 million

Americans forced to give up their employer sponsored insurance, risking a public backlash of seismic proportions.[5]

Furthermore, without transforming the delivery and payment system structure, a fee-for-serviced based Medicare-for-All program would not necessarily improve outcomes or restrain cost growth over time. Without reform, it would likely entrench fee-for-service medicine and limit the spread of accountable care arrangements that pay for prevention, wellness and healthier outcomes for patients.

The United States spends 18 percent of its gross domestic product on health care – almost one and a half times more than Switzerland, the country with the second-highest rate of health care spending.[6] Yet outcomes here are worse than in other advanced countries. Compared to the health care systems of 10 other high-income countries, the United States ranks last in access, equity, and overall health status.[7]

With increasing premiums, co-pays, drug costs, and surprise bills, it's not hard to see why middle-class families are feeling the squeeze. Americans spend more on medical services because prices here are higher than elsewhere. Our system is fraught with waste, our providers (physicians and hospitals) are paid more, and goods like biopharmaceuticals and medical devices are more expensive.[8] On average, U.S. hospital prices are 60 percent higher than countries in Europe[9] and physicians make twice as much as their counterparts in other advanced countries.[10]

Americans shell out an average of $10,739 per person per year on medical care.[11] Families pay $5,547 annually toward their employer-sponsored coverage, which costs roughly $22,885 for a family of four.[12] [13] Out-of-pocket costs have grown from $601 per person in 1970 (in 2017 dollars) to $1,124 per person on average in 2017.[14] Over the next decade, the Centers for Medicare and Medicaid Services (CMS) predicts that half of the estimated 5.5 percent average annual growth in health care spending will come from price increases, while just a third of the spending growth will come from greater consumption of health care services, even as the huge baby boomer generation ages and needs more care.[15]

For too long, however, the health care debate has been focused on who pays for care and what is covered rather than on why health care costs so much in the first place. Republicans routinely push to move the cost of care onto individuals and away from government subsidies, while Democrats go after short-term junk health insurance policies, huge drug price increases, and surprise health care bills. As former Oregon Gov. John Kitzhaber, MD illustrates, this framing presents Americans with a false choice between cost and access.[16]

Medicare-for-All may be bold, but in essence it's just a financing mechanism and without necessary delivery reform will not improve America's flawed health care system. In this report, PPI offers a progressive alternative to Medicare-for-All aimed at lowering the overall cost of medical care and creating stronger incentives for reform and better health outcomes.

Affordable Health Care for All is a comprehensive plan to discipline medical prices, plug gaps in coverage and bring Medicare and Medicaid into

the 21st century. It would cap medical costs and encourage insurers to pay for the value, not the volume, of medical services. By reducing the overall cost of medical care in America, this plan also would free up resources that can be invested in housing, nutrition, public safety and other social initiatives that improve public health and keep people from needing medical care in the first place.

Progressives don't need to import "single payer" plans from other countries to solve our health care problems. PPI's plan offers a distinctively American solution to high costs and coverage gaps. It would leave room for choice and competition; promote more efficient use of health care resources; and, put America in the vanguard of medical research and innovation – all while protecting Americans from outrageous health care prices.

**Affordable Health Care for All has five key components:**

- Cap out-of-network provider prices in the private insurance market
- Build on the ACA's coverage gains and insurance reforms
- Allow older Americans to buy into Medicare
- Update and streamline the Medicare program
- Move Medicaid from fee-for-service to value-based payments

## I. CAP OUT-OF-NETWORK PROVIDER PRICES IN THE PRIVATE INSURANCE MARKET

Our plan starts by protecting consumers from "surprise" out-of-network bills by capping out-of-network rates. Initially the cap would be set at 200 percent of Medicares rates, then phase down gradually to 120 percent. A cap would prevent hospital chains and large physician groups from using their regional or local monopoly power to boost prices beyond a reasonable level. Although patients may have a choice of hospital, they rarely have a say in which anesthesiologist or emergency room physician treats them, and often don't know if they are out-of-network.

Crucially, a cap on out-of-network provider prices also would cut in-network prices. This dynamic works because providers (including hospitals) have no incentive to remain outside of networks if the price they can charge is capped at levels comparable to what they would receive for delivering services to patients in-network anyway.

Researchers at Yale recently found that even a modest effort to control out-of-network surprise bills also reduced in-network rates.[17] Capping out-of-network bills more broadly would have a much larger impact on rates over all. It would place a de facto limit on all health care prices, related to Medicare rates, and would thereby create a stronger incentive for hospitals and doctors to negotiate value-based reimbursement arrangements with insurers. Over time, this would push private insurances away from fee-for-service medicine to capitated models and other forms of accountable care.

- **Why Price Caps Now?**
  The U.S. health system has never had perfect price competition and purely free markets. Since the 1960s, it has been a hodgepodge of public insurance like Medicare and Medicaid alongside private employer-based coverage and, as a last resort, individually purchased coverage. Historically, physician practices were small and hospitals were usually non-profit, independent, and community-oriented. Health costs rose continuously, and health providers

were paid generously, but, at least until the mid-1970s, medical costs were not viewed as a top national problem.

But in that high-inflation era, health costs began to soar. In the face of economic stagnation and budget shortfalls, Medicare introduced a new rate schedule that controlled prices and stopped rewarding hospitals for overly long inpatient stays. After the economic downturn in the early 1990s, insurers and employers switched to managed care plans, which tightly restricted patients' choice of providers while simultaneously clamping down on providers' fees. By "steering" patients to one hospital or physician group over others, insurers used their leverage to reduce prices dramatically.

These cost control efforts succeeded, perhaps too well. When the economy improved, consumers revolted against overly restrictive managed care plans. The "managed care backlash" caused employers to switch to broader networks and prices started rising again. Hospitals started consolidating into chains that often dominated entire regions. Many hospital chains bought physician groups; some either converted to for-profit status or behaved that way – maximizing profit margins began to take priority over community stewardship and charity care.

Over the last decade, the public side of the U.S. health system has had some successes in controlling medical inflation. Medicare costs moderated a little, as price increases were held down and hospital utilization stabilized. Seeking better benefits and lower out-of-pocket costs, Medicare beneficiaries increasingly switched from Medicare's traditional fee-for-service program to private Medicare Advantage plans, which, in turn, often use innovative, value-based reimbursement and seek to better coordinate care, particularly for patients with chronic or long-term health conditions.[18]

Medicare Advantage plans are succeeding precisely because of Medicare's out-of-network price cap.[19] Based on data from the mid-2010s, the Congressional Budget Office (CBO) reported that while commercial payment rates for hospital care averaged nearly 190 percent of Medicare's rates, Medicare Advantage plans' in-network rates were very close to those of Medicare, because Medicare Advantage plans' rates are capped at Medicare rates for out-of-network care.[20]

While Medicare Advantage has flourished, the on-going battle to keep costs down for private employer-based and individual coverage has largely been lost. Hospitals have continued to consolidate into large regional chains, often purchasing physician groups in the process. As a result, hospital prices faced by private insurers have risen to at least 200 percent of Medicare rates, and physician rates have also risen toward unsustainable levels.[21] [22] To hold down premium increases in the face of continually higher prices, employers have raised deductibles, co-pays and premiums.

That's why PPI believes it is time to learn from the Medicare Advantage experience and extend price caps to private health care markets.[23] In theory, today's large integrated health systems can improve quality by reducing unnecessary and duplicative care. In practice, however, the potential efficiency gains from integration have been swamped by the concentration of providers' pricing power.

Private insurers pay widely varying prices both across and within local health care markets, which suggests that they have little leverage with providers.[24]

Our plan would give employer-based and individual health plans the same sort of price backstop that Medicare price caps give to Medicare Advantage plans. Over time, the out-of-network price cap would save consumers billions by lowering premiums and out-of-pocket costs. The cap would also indirectly save billions for the federal budget through the employer coverage tax exclusion – if you bring down employers' health care cost, the tax exclusion dollar-value gets smaller.

Medicare Advantage plans have worked to distinguish themselves from traditional Medicare by better managing patient care, providing ancillary benefits, and providing a better customer experience. We believe that with fixed prices, private plans will have the same incentive to compete by offering a better insurance product at lower cost.

We estimate that capping out-of-network bills would cut health care costs in the commercial market by almost half.[25] Thanks to the ACA's medical-loss ratio, which caps the share of premiums that health plans can spend on administration costs rather than medical services, lower prices for those services would also lower premiums. In turn, lower premiums would reduce government spending on ACA premium subsidies and reduce employer spending on health coverage.

## II. BUILD ON THE ACA'S COVERAGE GAINS AND INSURANCE REFORMS

Due to reforms and coverage expansions under the ACA, 17 million more Americans now have health insurance who otherwise would not.[26] In addition to ensuring that the majority of premiums are used to pay for health care, not marketing or CEO salaries, the ACA provided much needed subsidies to those who don't get insurance through work, barred insurance companies from charging people with "preexisting" medical conditions astronomical premiums, encouraged experimenting with new ways of delivering and paying for care, and closed the "donut hole" in the Medicare Prescription Drug Program.

Nonetheless, Republicans have waged an all-out war against the ACA since it passed Congress in 2010. Backed by President Trump, they have been able to eliminate the individual mandate penalty, make skimpy health insurance plans more available, and cancel the federal government's enrollment and outreach efforts. Combined, these efforts make insurance more expensive for those who need it most – those in the individual market.

In that market, people whose earnings put them at or above 400 percent of the federal poverty level (roughly $49,000 for an individual) pay the full price of their insurance premiums. On average, this means that a 40-year-old making $50,000 would pay $340 a month (8 percent of their income) for a low-tiered bronze plan with high out-of-pocket costs. And older enrollees would pay even more: a 60-year-old making $50,000 would pay 17 percent of their income toward premiums for the average lowest cost plan.[27] These plans often have high deductibles as well, which can make medical care cost prohibitive.

To undo the damage done by Trump and the Republicans, and to ensure that the ACA can cover more uninsured Americans, PPI's health proposal would:

### 1. Restore reinsurance

Reinsurance is essentially insurance for insurers. With reinsurance, the government helps pay for the cost of exceptionally high-cost claims, which helps bring down the premiums for everyone. PPI proposes restoring the transitional reinsurance program, which was in operation for ACA plans between 2014 and 2016. A $15 billion reinsurance program would bring down premiums in the individual market by roughly 15 percent. The Congressional Budget Office projects that about 60 percent of the cost of a federal reinsurance program would be offset by the savings – mainly stemming from premium subsidy reductions in the individual market.[28] The Commonwealth Fund projects that a generous reinsurance program without an individual mandate would increase coverage by roughly two million people.[29]

### 2. Expand ACA coverage by raising the subsidy threshold

Despite coverage gains, 28 million people still have no insurance coverage at all – and 45 percent of them cite cost as the main reason.[30] Lifting the subsidy threshold from 400 to 600 percent of the federal poverty level would enable roughly 1.2 million additional middle-earners to get coverage.[31] In effect, this change would create parity between people in the individual market and those who get their coverage through their employer, since the latter receive what amounts to a 30 percent subsidy through the federal tax exemption of employer health spending.[32]

### 3. Replace the individual mandate with auto-enrollment

Health insurance premiums are based on the average cost of care for consumers in a covered population. If younger and healthier people decline to buy insurance, the covered population will on average be older and sicker and have higher medical bills. Prior to the passage of the ACA, insurers charged higher premiums to cover people with more expensive health care needs and declined to cover pre-existing conditions.[33] The ACA banned this practice and people now pay similar premiums for similar coverage regardless of their health status.[34]

To cover the additional costs of enrolling more people with preexisting conditions, insurers needed a larger, healthier population in the pool. The ACA sought to address this with the individual mandate: requiring that everyone obtain health insurance or face a tax penalty. But in the 2017 tax bill, President Trump and the Republicans eliminated the individual mandate penalty, which will intensify "adverse selection" and lead to higher premiums. Rather than try to reinstate the unpopular mandate, PPI proposes using auto-enrollment to bring more healthy people into insurance markets to lower costs.

By automatically enrolling people in insurance plans instead of requiring them to act to enroll themselves, policymakers can create a dynamic which requires less effort to be insured than uninsured. Auto-enrollment has proved a successful tool in retirement plans, where it has led to about a 40 percent increase in coverage.[35] Here are some auto-enrollment options for policymakers to consider:

- As with many Medicaid plans, state governments could designate a "default" health insurance plan on their exchange.[36] All uncompensated care claims by providers would be charged to this insurance plan. Uninsured individuals would pay a premium to cover the costs of this plan through their tax returns whether or not they took advantage of the insurance benefits during the past year.

People who had other insurance coverage for part of the year would have their premium for this default program pro-rated accordingly. Alternatively, policymakers could create a voluntary opt-out for consumers who truly want to be uninsured. This would reduce the benefits of auto-enrollment but would also mitigate the elements of the individual mandate that made the policy so unpopular in the first place.

- Uninsured individuals could be nudged to enroll when filing their taxes by the IRS and tax preparers. In the same way that filers receiving refunds are encouraged to direct those refunds into an IRA, uninsured taxpayers should be urged to enroll in an ACA plan and direct their refunds to covering a portion of their premiums.
- Health care providers could be permitted to enroll people into private plans. Under current law, health care providers often act as enrollment facilitators for low-income patients eligible for Medicaid.[37] Health care providers could also be permitted to auto-enroll people whose incomes are too high for Medicaid, but who are eligible for coverage in ACA health exchanges. Operationally, providers would act as de-facto exchange navigators for uninsured people.

Auto-enrollment likely will work best for the millions of people who are eligible under the ACA for free or low-cost coverage but are not yet enrolled. The Kaiser Family Foundation estimates about a quarter of the eligible population, roughly 4.2 million people, could purchase a bronze plan with fully subsidized premiums.[38] An additional 7.5 million uninsured people are eligible for Medicaid/CHIP. Finally, 2.5 million poor adults could be enrolled in Medicaid if the 14 states that have not yet expanded eligibility under the ACA did so.[39] Successfully enrolling these three groups would reduce the uninsured rate by more than a third.[40]

### 4. Limit the use of short-term health insurance plans

The Trump administration expanded access to short-term health plans and made them renewable for up to 36 months. Short-term plans are intended for people who have a gap in coverage. They typically have a maximum benefit amount and do not have to abide by the ACA's market regulation – such as covering preexisting conditions and having an out-of-pocket maximum. Expanding them hurts consumers in two ways: 1) People may think they have a regular, comprehensive coverage plan, when in fact they have one with limited benefits; and, 2) If young and healthy people opt for cheaper short-term plans outside the ACA's individual market, those left in it would be sicker and pay higher premiums. To avoid such adverse selection, PPI's plan would limit use of short-term plans to three months.

Taken together, we estimate these four steps would reduce the uninsured rate by half. Combined with the price cap, which will lower prices in the private insurance market, and changes in Medicare and Medicaid described in the following sections, we are confident the PPI health care plan will put coverage within reach for all Americans.

## III. ALLOW OLDER AMERICANS TO BUY INTO MEDICARE

One segment of the U.S. population that is particularly vulnerable to high health costs is middle-age Americans who are not yet eligible for Medicare and make too much money to

receive subsidies in the individual market. That is why we propose allowing people aged 55 and older to buy Medicare coverage.[41]

A "Midlife Medicare" buy-in – conceived by health care historian Paul Starr – would respect the traditional understanding of Medicare as a program for the elderly by allowing the not-quite retired the chance to buy their benefits early. And by taking many high-cost people out of the individual market, Midlife Medicare would lower premiums for those who remain.[42]

Buy-in enrollees' benefits would be no different from the current program for the Aged and Disabled, and payments to providers and Medicare Advantage plans would be the same as the traditional program rates. Buy-in enrollees would pay premiums based on the cost of their coverage minus the income-based subsidy they may be eligible for in the individual market. (The increase in the subsidy cap from 400 to 600 percent of poverty would apply to them as well). Most traditional Medicare enrollees buy supplemental coverage or Medigap plans to cover services, like vision and dental care, that Medicare doesn't cover. Like people 65 and older, Midlife buy-in enrollees could choose the traditional fee-for-service plan with a supplemental plan or a Medicare Advantage plan.

How many people aged 55-64 would switch to the Medicare buy-in? Likely fewer than you think. Of the 41 million Americans between the ages of 55-64, roughly 10.8 percent have coverage in the relatively high-cost individual market and 7.9 percent are uninsured. These groups would have the strongest incentive to buy into Medicare. It's also possible that some middle-age workers with job-based coverage might choose to retire early if Medicare buy-in were an option. However, Medicare benefits are often less generous than employer-sponsored plans or silver and platinum (the middle and high-tiered) plans on the individual market.

**TABLE 1: SOURCE OF HEALTH INSURANCE COVERAGE, AMERICANS AGED 55-64**

| PRIVATE | PUBLIC | INSURED | UNINSURED | EMPLOYER | INDIVIDUAL | MEDICARE | MEDICAID |
|---|---|---|---|---|---|---|---|
| 73.1% | 19.0% | 92.1% | **7.9%** | 62.3% | **10.8%** | 9.7% | 9.3% |
| 30,456,502 | 7,915,472 | 38,371,974 | **3,282,775** | 25,970,177 | **4,486,325** | 4,038,907 | 3,876,565 |

**MOST LIKELY TO BUY-INTO MEDICARE**

*Adapted from State Health Compare*[43]

On the other hand, Medicare premiums likely would be lower than those in the individual market. Middle-aged people in the individual market are subsidized by younger enrollees under the ACA's 3-1 rule: premiums for the oldest enrollees cannot be more than three times those for the youngest. Older enrollees typically incur greater health costs, but the market seeks to make coverage affordable to all by spreading those costs across the population. The 3-1 rule ends up discounting older enrollees' premiums by roughly 12-15 percent.[44] Middle age workers who buy into Medicare would join an insurance pool – Medicare – that is older and has higher

medical costs. But Medicare payment rates to doctors are substantially less than what private health insurance plans pay. Thus, on net, we expect premiums to be lower in the Medicare market than in the individual market.

Of course, any kind of Medicare buy-in would falter if medical providers are unwilling to accept more patients with the lower Medicare payment rates. But we expect the system to be able to absorb the relatively small number of people likely to make the switch from an individual or employer plan to Medicare. In this sense, Midlife Medicare operates as a fallback public option for older working Americans most likely to have high medical costs.

## IV. UPDATE AND STREAMLINE THE MEDICARE PROGRAM

Medicare was created in 1965 to provide health insurance coverage for the elderly and disabled. Since then, it has been revamped and updated several times, notably by the addition of Medicare Advantage in 1997 and Part D, a prescription drug benefit, in 2006. The ACA also included provisions for testing new payment and delivery models as an alternative to the program's original fee-for-service method. Today, traditional Medicare needs another update. Its alphabet-soup benefit structure (Parts A, B and D) is needlessly complex and confusing. There are no caps on out-of-pocket spending, and its fee-for-service payment method encourages overutilization and inefficiency because it rewards the volume, not quality, of health care delivered.

We propose fundamental changes in both traditional Medicare and Medicare Advantage to promote efficiency, better value for money, and better health outcomes.

### MEDICARE ADVANTAGE IS AN ALTERNATIVE TO TRADITIONAL MEDICARE

People who choose Medicare Advantage select from a menu of government-approved private health insurance plans. These plans typically are health maintenance organizations (HMOs) and preferred provider organizations (PPOs), which require members to receive care from a specific network of hospitals and doctors. To be included in these smaller networks, health plans demand more accountability – either for better quality care or utilization management—from providers. Medicare Advantage plans provide the same benefits offered through traditional Medicare (coverage for care from hospitals, physicians, home health care agencies, etc.). Medicare caps prices in both the traditional plan and the Medicare Advantage market at the same level. This provides a "benchmark" that Medicare Advantage plans can negotiate from, promising providers more patients in exchange for lower prices.

Medicare Advantage began as a demonstration program in the 1970s as a way to give beneficiaries more choice from the one-size-fits-all health plan and to move away from fee-for-service health care. By putting private health plans on the hook for the cost of unnecessary medical care or poor health outcomes, Medicare Advantage created strong economic incentives for those plans to actively manage health care services for their beneficiaries to improve outcomes. Since it was formally codified as an alternative to the traditional program in the 1990s, Medicare Advantage has become immensely popular, today covering more than a third of all Medicare beneficiaries.[45] Medicare Advantage created space for innovation, enabling health plans to test new ways to deliver and pay for care – such as with value-based reimbursement models.

- **Merge Parts A, B and D into a single benefit package — Medicare One**

  Traditional Medicare beneficiaries today pay multiple premiums for Part A (hospital care), Part B (doctors and outpatient care) and Part D (prescription drugs). To further complicate matters, each Part requires beneficiaries to pay different deductibles, co-pays and co-insurance – with no limit on out-of-pocket spending. Beneficiaries enrolled in Medicare Advantage, however, have one combined benefit with easy-to-understand premiums and co-pays and an out-of-pocket cap. We propose that traditional Medicare follow suit.

  We propose consolidating Parts A, B, and D into a streamlined "Medicare One" benefit with one premium, one annual deductible, one co-pay rate for spending above that deductible, and an out-of-pocket cap like the one that exists in Medicare Advantage plans. From the enrollees' perspective, they would have one consolidated benefit just like they would receive from Medicare Advantage. Administratively, Medicare Parts A and B would become one program within CMS that has one set of reimbursement rates (as opposed to the current system, where reimbursement rates differ between Parts A and B). The combined AB plan would then be paired with the private prescription drug plan which enrollees select. Enrollees' premiums and deductibles for Medicare One would be set based on the package of prescription drug benefits they choose.

- **Use average bids to calculate the share of Medicare government subsidies**

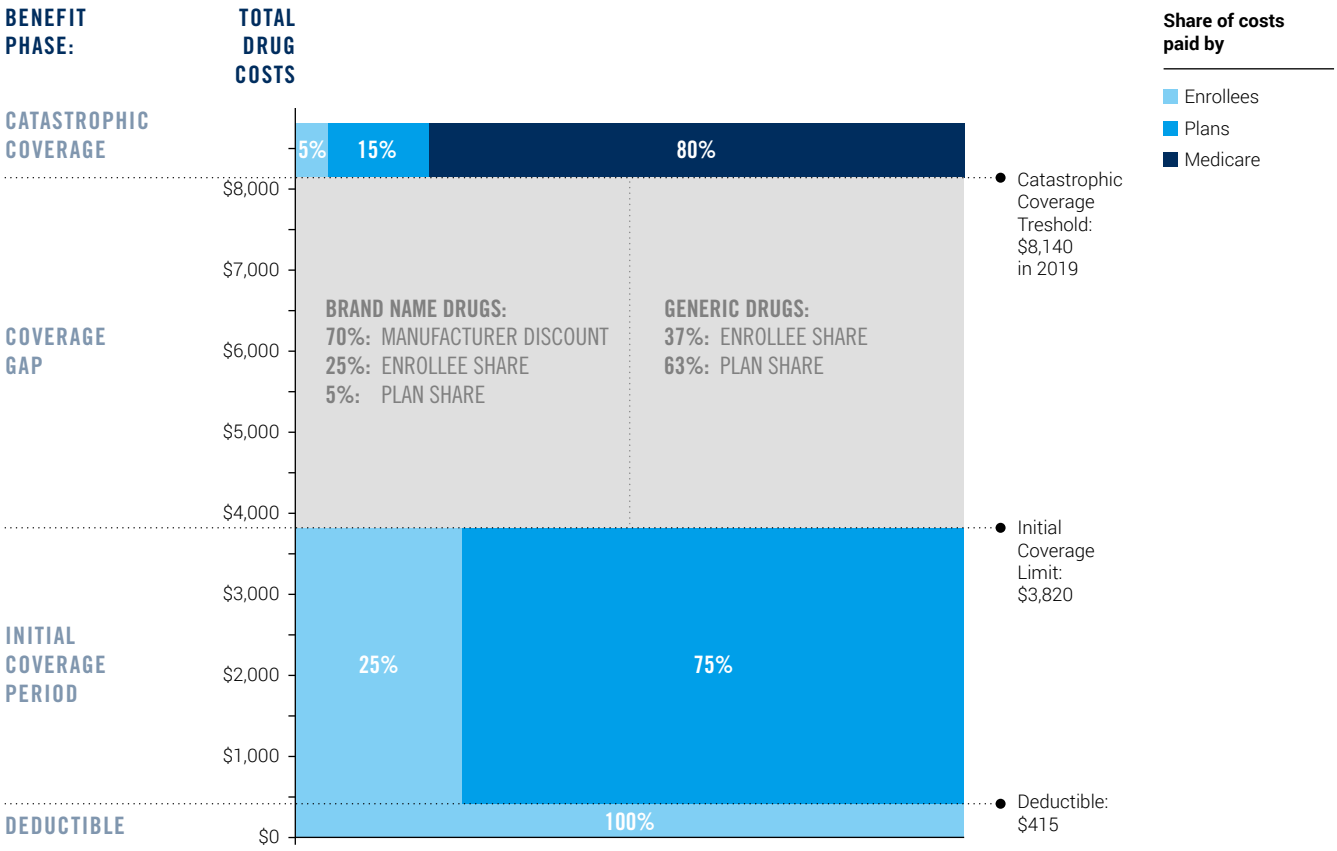
  PPI proposes to base Medicare subsidies on the average bid of health plans in a given region rather than a statutory benchmark, as occurs today. Beginning in 2022, CMS would pool the bids from Medicare Advantage plans in each region, as well as the cost of covering a beneficiary under Medicare One, and calculate an average bid based on the number of enrollees in each plan. Every plan, whether it be Medicare One or Medicare Advantage, would receive a taxpayer subsidy for each enrollee that covers 80 to 84 percent of the average-bid benchmark (with appropriate risk adjustments for health status). Enrollees would then pay a premium equal to the difference between the government subsidy and the full premium value of the plan they've selected.

  In the aggregate, all plans in the system would be rewarded for increasing efficiency and managing care better and consumers would choose efficient plans because those plans would have lower premiums. However, using the average of bids to set subsidy levels would not penalize plans that succeeded in managing care more efficiently and lowering their premiums as they would likely gain market share. Additionally, Medicare Advantage plans could not cut benefits because they would be required to offer benefits comparable to Medicare One. This model will encourage value-based care and bring down costs throughout the system, thereby slowing the growth of the benchmark over time.[46]

- **Medicare Prescription Drug Benefit Reform**

  The federal government covers 74.5 percent of the cost of the Part D program, with insurance plans and beneficiaries paying the rest.[47] Unfortunately, the way that the benefit is designed encourages drug companies to price drugs high, hurting both taxpayers and consumers.

## FIGURE 1: MEDICARE PART D STANDARD BENEFIT DESIGN IN 2019




**Note:** Some amounts rounded to nearest dollar.

*Adapted from The Kaiser Family Foundation*[48]

Once Part D beneficiaries have reached a certain out-of-pocket spending threshold, known as the catastrophic coverage threshold, Medicare picks up the lion's share of their bills. This encourages the use of high-price drugs so that beneficiaries quickly reach the catastrophic benefit and start paying less for their drugs while Medicare pays more. To ease the resulting burden on taxpayers, the Medicare Payment Advisory Commission (MedPAC) recommends that Medicare reduce its catastrophic spending from 80 percent to 20 percent of drug costs and have Part D drug plans cover the difference.

Though Medicare covers 80 percent of the costs above the catastrophic threshold – with Part D plans paying 15 percent of the costs and enrollees paying the last 5 percent – the 5 percent coinsurance can be cost-prohibitive for beneficiaries with very high-price drugs. When drug costs are too high, beneficiaries will ration or stop taking drugs they need.[49] Our proposal would introduce an out-of-pocket maximum of approximately $3,000 for patients, above which their coinsurance would be zero.

Obviously these two changes together would prompt plans to raise premiums. However,

because Medicare subsidizes beneficiaries' premiums, Medicare would make larger payments to private health plans to cover the costs on the premium front rather than the catastrophic end. On net, consumers would not face higher costs but the incentives would be better aligned to encourage the use of lower cost drugs and more negotiation with manufacturers. Over time, MedPAC believes this approach would be much more efficient, creating savings to the federal government as plans negotiate discounts from drug makers and direct patients to use lower cost drugs.

- **Sever doctors' fees from the cost of the drug** PPI proposes that doctors receive a flat fee for administering drugs rather than a percentage of the drug price under Medicare Part B. Doctors often administer drugs to their patients, particularly in the oncology and ophthalmology fields where treatments are injected into the body for cancer or macular eye degeneration. For these types of therapies, Medicare reimburses doctors for the cost of the drug plus 6 percent of the average sales price (ASP). This open-ended formula encourages physicians to administer the more costly of two drugs because they will receive a higher fee per injection. Such perverse incentives have led Medicare to pay double what other developed countries pay for similar drugs administered by physicians.

## V. MOVE MEDICAID FROM FEE-FOR-SERVICE TO VALUE-BASED PAYMENTS

State Medicaid programs are well positioned to move rapidly away from the inefficient and inflationary fee-for-service payment method. Because states already have a fixed budget to spend on health care for Medicaid enrollees, they already operate in a global budget type of model. To encourage more preventative and outcomes-based care, states should look for ways to use "capitated" models with providers. This means that a provider or hospital would take a set amount of funding each year to manage the care for a fixed number of patients – providing incentives for providers to deliver better services more efficiently.

Oregon has pioneered the use of Medicaid waivers under former Governor John Kitzhaber to move away from fee-for-service to a system of fixed, per capita payments. The state has contracted with Coordinated Care Organizations (CCOs), a network of health care providers that includes social services agencies, hospitals, and dentists, to actively manage care for its roughly one million Medicaid beneficiaries. Instead of reimbursing each provider for each service rendered, as Medicaid normally does, Oregon's CCOs receive a set dollar amount for each patient (adjusted to reflect their particular health risks). They are encouraged to coordinate with care providers and social service or community organizations to address a patient's medical needs holistically.

Like Medicare Advantage, CCOs operate within a global budget while requiring compliance with rigorous metrics around quality outcomes and patient satisfaction (Medicare Advantage has a 5-Star Rating from CMS). A key difference, however, is that Medicare Advantage is not indexed to a sustainable rate of growth; its budget is recalculated each year based on the previous year's spending. This means that costs can continue to grow exponentially if not checked. In contrast, Oregon's CCOs have expanded access and constrained medical inflation while maintaining quality and outcomes under a capitated growth rate.

With the waiver Oregon received in 2012 to implement the CCO model, the federal government included a one-time, five-year investment of $1.9 billion in exchange for commitments around cost reduction and quality – specifically a commitment to bend down Medicaid's cost curve by two percentage points by the end of the second year of the waiver (from 5.4 to 3.4 percent per-person per-year). The state was not allowed to reduce benefits or eligibility and had to meet strong quality, health outcomes and patient satisfaction metrics.

During the first five-year waiver period, the state successfully operated within the constraints of the per-capita growth cap, enrolled over 385,000 more people under the ACA Medicaid expansion, and all the CCOs met the outcome and quality metrics stipulated under the waiver. The state returned the initial federal investment and realized a cumulative total funds savings of over $1 billion.[50]

PPI urges other states to follow the trail blazed by Oregon to modernize Medicaid. We propose that U.S. lawmakers authorize CMS to grant more waivers that move away from fee-for-service health care delivery and capitate their annual Medicaid budget. States that develop rigorous plans to follow Oregon's lead should find it easy and quick to get waivers from the U.S. Department of Health and Human Services.

The federal government should also encourage states to experiment with ways to bend the cost curve while maintaining quality and addressing upstream social determinants of health. This could come in the form of grants, flexibility between social service agencies (such as allowing health care dollars to be spent on housing), and pilot projects.

## CONCLUSION

The Trump Republican's reactionary push to return to a world where people with preexisting conditions can't get coverage, low-income people are ineligible for Medicaid, and young adults cannot stay on their parents plans, creates an opportunity for Democrats to repeat their 2018 success by being the party that defends health care. And voters trust them by roughly a 2 to 1 margin over Republicans.[51]

The five pillars of PPI's health plan– capping out-of-network prices; buttressing the ACA's efforts to control costs and expand coverage; authorizing Americans nearing retirement to buy into Medicare;  modernizing Medicare, and moving Medicaid away from fee-for-service – build on America's hybrid, public-private health care system. Each segment of the health insurance market – commercial, Medicare, and Medicaid – has distinctive strengths to bring to this uniquely American architecture for health care delivery.

This proposal is a starting point for a two-pronged attack on the high costs that plague the U.S. health care economy. It uses a declining price cap to push the health care system toward a more efficient and accountable model. The savings from lowering prices paid by both public and private insurers should be reinvested into programs that improve social conditions – poverty, nutrition, underperforming schools, poor housing – that have a big influence on peoples' health. In this way, we can begin to replace a system that merely insures against sickness or accidents after the fact with one that promotes better health in the first place.

As the 2020 election cycle gets underway, progressive candidates should keep in mind that, in general, one-size-fits-all approaches are increasingly at odds with a society that prizes choice, innovation, and diversity. We can achieve the goals of universal coverage and less expensive health costs by embracing a hybrid system that encourages high quality, comprehensive, and cost-effective health care.

# References

1 Jeffery M. Jones, "Healthcare Costs Top Financial Problem for U.S. Families," Gallup, May 30, 2019. https://news.gallup.com/poll/257906/healthcare-costs-top-financial-problem-families.aspx

2 Ashley Kirzinger, Cailey Muñana, Bryan Wu, Mollyann Brodie, "Data Note: Americans' Challenges with Health Care Costs," The Henry J. Kaiser Family Foundation, June 11, 2019. https://www.kff.org/health-costs/issue-brief/data-note-americans-challenges-health-care-costs/

3 Julie Appleby, "DOJ Lawyers Try New Tricks To Undo Obamacare. Will It Work?" Kaiser Health News, July 12, 2019. https://khn.org/news/doj-lawyers-try-new-tricks-to-undo-obamacare-will-it-work/

4 Steven Shepard, "Poll: Majority of voters don't trust Trump on health care," Politico, April 3, 2019. https://www.politico.com/story/2019/04/03/poll-majority-trust-trump-health-care-1250889

5 John Holahan, Matthew Buettgens, Lisa Clemans-Cope, Melissa M. Favreault, Linda J. Blumberg and Siyabonga Ndwandwe, "The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending, The Urban Institute, May 9, 2016. https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private-spending

6 Bradley Sawyer and Cynthia Cox, "Since 1980, The Gap has Widened Between U.S. Health Spending and That of Other Countries," Peterson-Kaiser Health System Tracker, December 7, 2018. https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-since-1980-the-gap-has-widened-between-u-s-health-spending-and-that-of-other-countries___2018

7 Eric C. Schneider, Dana O. Sarnak, and David Squires, Arnav Shah, Michelle M. Doty, "Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care," The Commonwealth Fund, July 2017, https://interactives.commonwealthfund.org/2017/july/mirror-mirror/

8 Papanicolas, Woskie, and Jha, "Health Care Spending in the United States and Other High-Income Countries," JAMA, March 13, 2018.

9 Francette Koechlin, Luca Lorenzoni, and Paul Schreyer, "Comparing Price Levels of Hospital Services Across Countries," Organisation for Economic Cooperation and Development, July 10, 2010, https://www.oecd-ilibrary.org/social-issues-migration-health/comparing-price-levels-of-hospital-services-across-countries_5km91p4f3rzw-en

10 Miriam J. Laugesen and Sherry A. Glied, "Higher Fees Paid to US Physicians Drive Higher Spending For Physician Services Compared to Other Countries," Health Affairs, September 2011, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0204.

11 "National Health Expenditures 2017 Highlights," Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf.

12 "Premium for Employer Sponsored Family Health Coverage Rise 5% to Average $19,616; Single Premiums Rise 3% to $6,896," The Henry J. Kaiser Family Foundation, October 3, 2018, https://www.kff.org/health-costs/press-release/employer-sponsored-family-coverage-premiums-rise-5-percent-in-2018/

13 Matthew Rae, Rebecca Copeland, and Cynthia Cox, "Tracking the Price In Premium Contributions and Cost-Sharing For Families With Large Employer Coverage," The Henry J. Kaiser Family Foundation, August 14, 2019. https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/

14 Rabah Kamal and Cynthia Cox, "Health Insurance Is a Growing Share of Total Health Expenditures and Out-Of-Pocket Spending is a Smaller Portion Than in 1970," Peterson-Kaiser Health System Tracker, December 10, 2019, https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-health-insurance-represents-a-growing-share-of-total-health-expenditures-particularly-public-programs_2017

15 Andrea M. Sisko, Sean P. Keehan, John A. Poisal, Gigi A. Cuckler, Sheila D. Smith, Andrew J. Madison, Kathryn E. Rennie, and James C. Hardesty, "National Health Expenditure Projections, 2018-27: Economic and Demographic Trends Drive Spending and Enrollment Growth," Health Affairs, February 20, 2019, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05499

16 John Kitzhaber, MD, "Reframing the 2020 Health Care Debate," Progressive Policy Institute, July 22, 2019. https://www.progressivepolicy.org/publications/policy-brief/reframing-the-2020-health-care-debate/

17 Zack Cooper, Fiona Scott Morton, Nathan Shekita, Surprise! Out-of-network billing for emergency care in the United States," National Bureau of Economic Research (NBER) Working Paper 23623, Revised January 2018. http://www.nber.org/papers/w23623.

See also Zack Cooper and Fiona Scott Morton, Ph.D. "Out-of-Network Emergency-Physician Bills — An Unwelcome Surprise," New England Journal of Medicine, November 16, 2016. https://catalyst.nejm.org/out-of-network-physicians-emergency-billing/

18 Susan Morse, "How Medicare Advantage steers the Silver Tsunami into coordinated, value-based care," Healthcare Finance, March 28, 2019. https://www.healthcarefinancenews.com/news/how-medicareadvantage-steers-silver-tsunami-coordinated-value-based-care

19 John Holahan, Laura Skopec, Erik Wengle, Linda J. Blumberg, "Why Does Medicare Advantage Work Better Than Marketplaces? Urban Institute, January 30, 2018. https://www.urban.org/research/publication/why-does-medicare-advantage-work-better-marketplaces/view/full_report.

20 Jared L. Maeda and Lyle Nelson, "An Analysis of Private-Sector Prices for Hospital Admissions," Congressional Budget Office, April 2017. https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/52567-hospitalprices.pdf

21 Chapin White and Christopher Whaley, "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative," RAND Corporation (2019). Available at: https://www.rand.org/pubs/research_reports/RR3033.html.

22 Daria Pelech, "An Analysis of Private-Sector Prices for Physicians' Services," Congressional Budget Office, January 2018. https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/53441-workingpaper.pdf

23 "Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums," Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, March 26, 2018, http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf

24 "Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets," National Academy of Social Insurance, April 2015. https://www.urban.org/sites/default/files/publication/50116/2000212-Addressing-Pricing-Power-in-Health-Care-Markets.pdf

25 Ben Ritz and Brendan McDermott, "Funding America's Future: A Progressive Budget for Equitable Growth," Progressive Policy Institute, July 2019.
https://www.progressivepolicy.org/projects/center-for-funding-americas-future/budgetblueprint/

26 Key Facts about the Uninsured Population," The Henry J. Kaiser Family Foundation, December 7, 2018.
https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

27 Rachel Fehr, Cynthia Cox, Larry Levit, and Gary Claxton, "How Affordable are 2019 ACA Premiums for Middle-Income People?" The Henry J. Kaiser Family Foundation, March 5, 2019.
https://www.kff.org/health-reform/issue-brief/how-affordable-are-2019-aca-premiums-for-middle-income-people/

28 "Bipartisan Health Care Stabilization Act of 2018," Congressional Budget Office, March 19, 2018.
https://www.cbo.gov/publication/53666

29 Jodi Liu and Christine Eibner, "Expanding Enrollment Without the Individual Mandate: Options to Bring More People into the Individual Market," The Commonwealth Fund, August 2018.
https://www.commonwealthfund.org/sites/default/files/2018-08/Liu_expanding_enrollment_without_mandate.pdf

30 "Key Facts about the Uninsured Population," The Henry J. Kaiser Family Foundation, December 7, 2018.
https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

31 Jodi Liu and Christine Eibner, "Extending Marketplace Tax Credits Would Make Coverage More Affordable for Middle-Income Adults," The Commonwealth Fund, July 2017.
https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_jul_liu_extending_marketplace_tax_credits_ib.pdf

32 Kate Zernike, "The Hidden Subsidy That Helps Pay for Health Insurance," The New York Times, July 7, 2017.
https://www.nytimes.com/2017/07/07/health/health-insurance-tax-deduction.html

33 Mary A. M. Rogers, Catherine Kim, Joyce M. Lee, Tanima Basu, and Renuka Tipirneni, "Private Insurance Coverage for Diabetes Before and After Enactment of the Preexisting Condition Mandate of the Affordable Care Act, 2005-2016," American Public Health Association, March 13, 2019.
https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2018.304933?journalCode=ajph

34 "Risk Pooling: How Health Insurance in the Individual Market Works," American Academy of Actuaries, July 2017.
https://www.actuary.org/content/risk-pooling-how-health-insurance-individual-market-works-0

35 John Scott and Andrew Blevins, "Automatic Enrollment Can Boost Retirement Plan Participation," The Pew Charitable Trusts, August 15, 2018.
https://www.pewtrusts.org/en/research-and-analysis/articles/2018/08/15/automatic-enrollment-can-boost-retirement-plan-participation

36 Christian Linke Young, "Three Ways to Make Health Insurance Auto-Enrollment Work," Brookings Institution, 2019.
https://www.brookings.edu/research/three-ways-to-make-health-insurance-auto-enrollment-work/

37 Christine Sebastian, "Presumptive Eligibility: A Step Toward Streamlined Enrollment in Medicaid and CHIP," Families USA, September 2011.
https://familiesusa.org/product/presumptive-eligibility-step-toward-streamlined-enrollment-medicaid-and-chip

38 Rachel Fehr, Gary Claxton, Cynthia Cox, and Larry Levitt, "How Many of the Uninsured Can Purchase a Marketplace Plan for Free?" The Henry J. Kaiser Family Foundation, December 11, 2018.
https://www.kff.org/health-reform/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free/

39 Tricia Brooks, Lauren Roygardner, and Samantha Artiga, "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings from a 50-State Survey," The Henry J. Kaiser Family Foundation, March 27, 2019. https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey/

40 Linda J. Blumberg, John Holahan, Michael Karpman, and Caroline Elmendorf, "Characteristics of the Remaining Uninsured: An Update," Robert Wood Johnson Foundation and the Urban Institute, July 2018. https://www.urban.org/sites/default/files/publication/98764/2001914-characteristics-of-the-remaining-uninsured-an-update_2.pdf

41 Paul Starr, "The Next Progressive Health Agenda," The American Prospect, March 2017. http://prospect.org/article/next-progressive-health-agenda

42 Ibid.

43 State Health Compare, "Health Insurance Coverage Type," Accessed July 2019. http://statehealthcompare.shadac.org/table/4/health-insurance-coverage-type-by-age

44 Joanne Fontana, Thomas Muraski, Sean Hilton, "Impact of Changing ACA Age Rating Structure: An Analysis of Premiums and Enrollment by Age Band," Milliman Research, January 31, 2017. http://us.milliman.com/uploadedFiles/insight/2017/MillimanACAAgeBands_0131_Final.pdf

45 "Medicare Advantage Enrollees as a Percent of Total Medicare Population," The Henry J. Kaiser Family Foundation, 2018. https://www.kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/?currentTimeframe=0

46 "A Premium Support System for Medicare: Updated Analysis of Illustrative Options," Congressional Budget Office, October 5, 2017. https://www.cbo.gov/publication/53077

47 Benedic N. Ippolito, Joseph Antos, James C. Capretta, "Cost-reducing health policies: A response to Chairman Alexander and the Senate Committee on Health, Education, Labor, and Pensions," American Enterprise Institute and the Brookings Institute, March 1, 2019. https://www.aei.org/publication/cost-reducing-health-policies/

48 "An Overview of the Medicare Part D Prescription Drug Benefit," Kaiser Family Foundation, October 2018. https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/

49 Michael T. Eaddy, Christopher L. Cook, Ken O'Day, Steven P. Burch, and C. Ron Cantrell, "How Patient Cost-Sharing Trends Affect Adherence and Outcomes," P&T Community, January 2012. https://www.ptcommunity.com/journal/article/full/2012/1/45/how-patient-cost-sharing-trends-affect-adherence-and-outcomes

50 "Oregon Health System Transformation: CCO Metrics 2016 Final Report," Oregon Health Authority, June 27, 2017. https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2016-CCO-Performance-Report.pdf

51 "Attitudes toward Changing the Health Care Law," The Associated Press-NORC Center for Public Affairs Research, April 2019. http://www.apnorc.org/projects/Pages/Attitudes-toward-Changing-the-Health-Care-Law-.aspx

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