HEALTH REFORM 2020

Towards Affordable, Quality Care for All Americans

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From History to Strategy:

Health Reform's Past, Health Reform's Future

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Component Parts and Challenges

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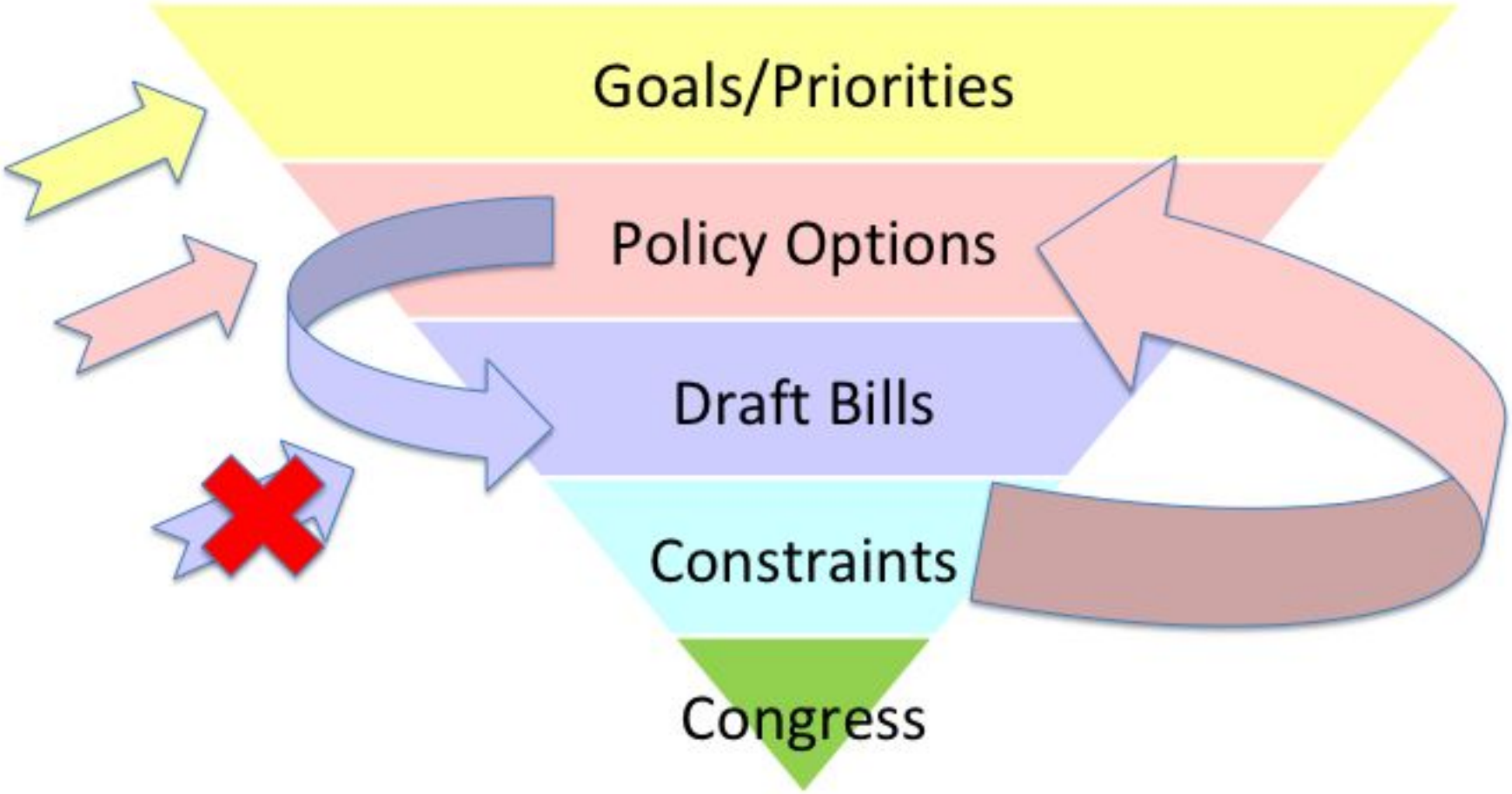
Health Reform 2020: More Options Needed

January 11, 2018

Sherry Glied

How Health Reform Seems to Happen



Our Review: Common Features of Current Proposals

- Unified structure (national or state)
- Single tier (no alternative coverage)
- Broad benefit package (often including LTC)
- Very limited out-of-pocket payments
- Global budgets (especially hospitals)
- System-wide budget

Multiple Complex and Challenging Constraints

- Pragmatic
  - Congress
  - CBO
  - Interest groups
- Political
  - Polarization
  - Checks and balances
  - Federalism
  - Judicial protections
  - Bureaucratic
- Nature of sector
  - Path dependence – historical patterns of use
  - Ecosystem of social welfare
  - Rapid innovation
- Economic
  - Current costs and budget implications
  - Efficiency costs of taxation
  - Incentives generated by prices, regs
  - Underlying income distribution
  - Variations in practice patterns and structures

Framing Choices: Goals and Priorities should Inform Options

Goals and Priorities

- Coverage
  - Remaining uninsured under ACA
- Financial security
  - Coverage affordability, OOP affordability
- Health outcomes
  - Deteriorating life expectancy, disparities
- Innovation, quality

Options

- "Medicare" (or "Medicaid")
- Global budgets
- Insurer administrative costs
- Care free at point of service
- Single tier

- All high income countries except the USA have universal health insurance

There has been a consistent shift toward more universal, broader coverage across countries
  - Universal health insurance appears to be institutionally optimal
- No two high income countries operate their health systems in the same way
  - There is no tendency toward convergence in how most components of health systems are organized
    - No specific health system organization appears to be universally optimal

Identifying Options: International Lessons

- National regulatory framework, considerable sub-national autonomy ↑
  - Australia, Canada, Germany
    - Medicaid option proposals
- Intentionally two (or multi)-tier system ↔
  - Australia, England, Germany, Switzerland
    - Private insurance backstop proposals/ACA +
- Narrower universal benefit + means-tested ↔
  - Australia, Canada, Singapore
    - Conventional Medicare buy-in + Duals
- Out-of-pocket payments
  - France, Germany, Sweden, Switzerland ↗
    - Medicare +, ACA +
- Combined budget and activity-based financing for hospitals
  - Australia, England, Norway ↑
    - ?
- Aggressive regulation of provider pricing in public system ↔
  - Most countries
    - Medicare

Questions?

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Where To Start:
Options for Phasing In Public Plans

Jeanne Lambrew, PhD
Senior Fellow, The Century Foundation

- Challenges of “big bang” approach:
  - Size of the system
  - Vested interests
  - Fear of change
- Why phase-ins matter:
  - Could lead to retrenchment
  - Could stall

1. Where Private Plans End

- **Options**: Start in underserved areas with few to no choices (e.g., Medicare X, fallback options)

- **Pros**:
  - Fills gaps in affordable options
  - Previously embraced by Republicans (Part D, Snowe trigger in 2009)
  - Could create support for more general availability

- **Cons**:
  - May be more work than is needed – could, for example, have private plans pay providers at Medicare rates
  - Could prevent private plans from entering these areas
  - Would introduce a public plan in mostly red states

2. Less Old Next

- **Options**: Midlife Medicare

- **Pros**:
  - Lowers age eligibility for a popular program to 50
  - People age 50 to 64 have lower average costs than seniors but higher average costs than private plan enrollees
  - Allows more of a pure Medicare extension

- **Cons**:
  - Highlights differences in benefits in Medicare and private coverage,
  - forcing hard choices
  - Helps the least uninsured and highest average income age group
  - Could be subject to the scare tactics of “messing with Medicare”

3. Make It A Choice

- **Options**: House version of the ACA,
  Medicare Part E Medicaid buy-in

- **Pros**:
  - Lets individual and/or employers choose rather than setting eligibility rules
  - Could stimulate competition and value in private plans
  - Allows for a natural rather than forced transition

- **Cons**:
  - Hard to design to allow for unbiased choice without undermining benefits of public plan
  - Could result in private insurers pulling out of markets
  - Requires regular policy adjustments (which are difficult in a polarized political environment)

4. Go Where The Money Is

- **Options**: Medicare for people with disability, public reinsurance for private plans

- **Pros**:
  - Helps make ACA's integration of people with pre-existing conditions into private plans more affordable
  - Allows people to "keep their plans"
  - Builds on a respected role for government: helping those with extreme needs

- **Cons**:
  - Public benefits are invisible, undermining political sustainability
  - Replaces private reinsurance which some employers may prefer
  - Use of Medicare payment rates here (as in other plans) could engender opposition from physicians and hospitals

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Understanding what's "public" in a public health reform plan

The Century Foundation: Health Reform 2020

January 11, 2018

Larry Levitt

Kaiser Family Foundation

@larry_levitt

What makes a public insurance plan public?

1. Accessibility of coverage is guaranteed and not dependent on business decisions.
2. The plan does not earn profits (though there may still be profits in the underlying health system).
3. Reimbursement rates are regulated in some way.
4. The plan is accountable to elected officials, and ultimately to the public.

Medicare is a public plan

- A government-sponsored plan is available to all eligible beneficiaries, with provider reimbursement rates (mostly) regulated.
- For-profit private plans participate through Medicare Advantage and Part D, but under constrained rules and with set payments from the government.

The ACA Marketplace is not a public plan

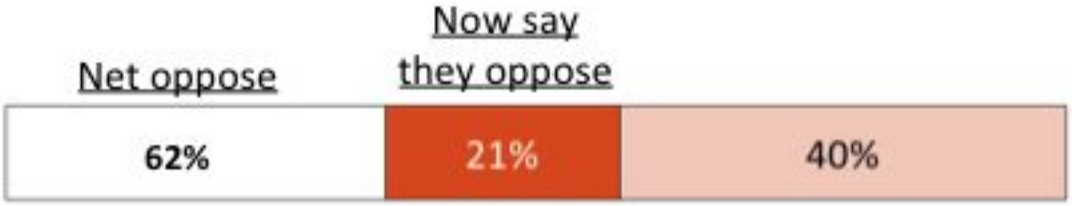
- The Marketplace is government-operated, with substantial government financing through premium subsidies.
- However, there is no guarantee of coverage availability (no public fallback) and no regulation of reimbursement rates.

Government control is the virtue, as well as the potential Achilles heel, of a public plan

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

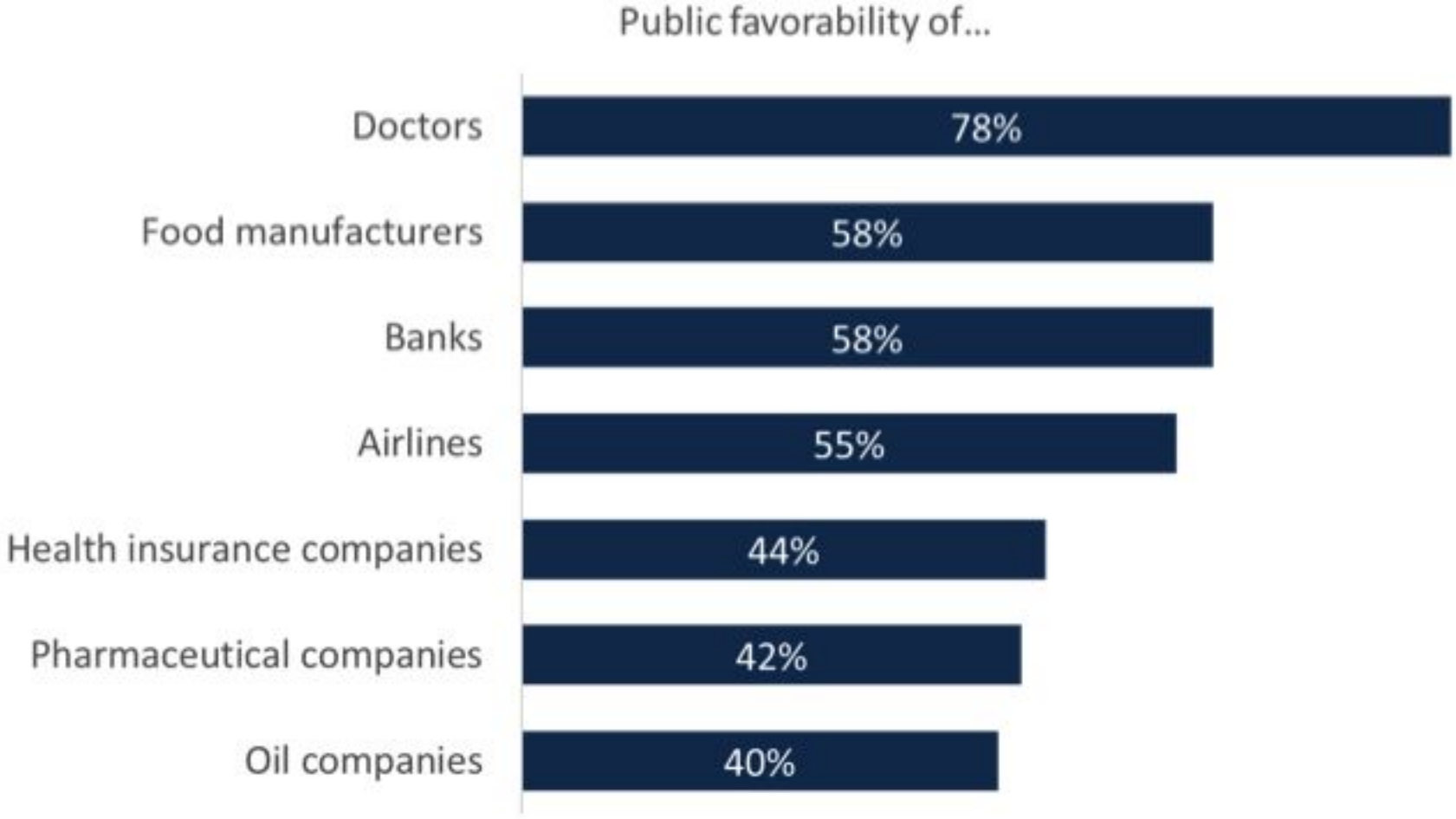
ASKED OF THE 55% WHO **FAVOR**:

What if you heard that OPPONENTS say guaranteed universal coverage through such a plan would give the government too much control over health care?



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)

Health insurance companies are not exactly popular



Source: Kaiser Family Foundation Health Tracking Poll (conducted August 6-11, 2015)

Governing a public plan

- How to balance political accountability and political independence?
  - Administration through an agency vs. a quasi governmental institution.
  - The role of boards or commissions.
  - Legislative vs. delegated authority.
- Is there dedicated financing?
- What is the role of states?

The challenge: A health reform plan that is…

Simple

Sustainable (politically and financially)

Not scary

(P.S. Every other high-income country has figured out a way to do this, if not perfectly.)

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Medicare for All, Medicare for More

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Medicaid for More and State-Based Reforms

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Woodrow Wilson
School of Public & International Affairs
In the Nation's Service
and in the Service of All Nations

Health Reform 2020:
Medicaid for More and State-Based Reforms

Heather Howard
Woodrow Wilson School
of Public and International Affairs
Princeton University

January 11, 2018

Agenda: Promise and Peril of State-Based Reforms

- Pre-ACA reforms
- Post-ACA reforms
- Looking ahead – potential of Section 1332 waivers?
- Key takeaways – ingredients for success

Pre-ACA Efforts:

Hawaii, Minnesota and Massachusetts

- Hawaii's Prepaid Health Care Act enacted in 1974
  - Employer Mandate, highly standardized plans that undergo rigorous state review
  - State secured ERISA exemption and ACA Section 1332 waiver to protect program
- MinnesotaCare enacted in 1992: provides coverage for persons above Medicaid up to 275% FPL without access to ESI
  - Comprehensive benefit package (but $10,000 limit on hospital inpatient)
  - Program managed, and plans procured, by Department of Human Services (Medicaid Agency)
- Massachusetts reforms (mandate, subsidies, Connector) enacted in 2006 drove uninsured rate down to 3%, provide basis for structure of ACA

Post-ACA State Efforts

Comprehensive

- Vermont – effort to achieve single-payer

Targeted

- Minnesota – Basic Health Program (MinnesotaCare), 400-500% FPL rebates, Public Option/Buy-In Proposals
- New York – Basic Health Program
- California – expand coverage for undocumented residents
- Nevada – Medicaid Buy-in (legislation vetoed)
- Potential of 1332 waivers?

1332 Waivers: What's in it for States?

- Flexibility to waive major ACA coverage provisions and try out solutions tailored to the state's specific needs
- Opportunity to stabilize insurance market and reduce premiums
- Access to federal funds that would otherwise be coming into the state through ACA programs

Types of 1332 Waivers

Narrow/targeted

- Hawaii fix for pre-ERISA employer mandate
- California proposal to allow undocumented residents to purchase on Covered California (waiver withdrawn)

Reinsurance program (AK, IA, MN, OK, OR)

- Alaska stabilizes individual market through state-funded reinsurance program for high cost claims
  - 2017 rates expected to be +40% and ended up being +7%
- 1332 waiver allows state to recoup ("pass-through") some of the savings that would accrue to the federal government due to lower premiums
- HHS specifically encourages state consideration of reinsurance programs

Broader waivers

- Iowa proposal would have fundamentally reshaped subsidy structure, included elements of AHCA (waiver withdrawn)
- Other possibilities: public option or Medicaid buy-in

1332 Waiver Activity: Latest Developments

Approvals

- Oregon reinsurance waiver approved
- Minnesota waiver approved but pass-through funding for BHP denied ($258m/2 years loss)

Withdrawals

- Oklahoma withdraws waiver due to lack of timely approval
  - ". . . lack of a timely waiver approval will prevent thousands of Oklahomans from realizing the benefits of significantly lower premiums in 2018."
- Iowa waiver withdrawn
  - "Section 1332 waivers in the Affordable Care Act are unworkable."
  - Public reports that President Trump directed CMS to disapprove Iowa waiver

On Hold

- Massachusetts waiver deemed incomplete
  - State can amend and attempt to move forward for plan year 2019

Looking Ahead: the Future of 1332 Waivers

- Federalism vs. actions that could be seen to support the ACA
- Will the Trump Administration issue new guidance relaxing rules?
- Prospects for Section 1332 waiver reforms in bipartisan fix legislation
- States planning for 2018 submissions (for plan year 2019)?

Key Takeaways on State-Based Reforms

- Energy at the state level, but . . .
  - Inherent structural challenges
  - Ongoing efforts to degrade coverage create speed bumps for states
- Ingredients for success
  - Commitment from leadership in state
  - Federal assistance
    - Dollars
    - Support for policy flexibility (or benign policy apathy)
  - Effective advocacy partners
  - Budget and regulatory stability

Thank you!

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Medicaid for More and State-Based Reforms

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Health Care Reform's Disability Blind Spot

Harold Pollack

University of Chicago School of Social Service Administration

Century Foundation

Roadmap

- Recent tragedies
- Some reasons and signs that American disability policy as a complicated mess
- ACA's blind spots
- What next for 2020?
  - The case for ambition
  - The case for caution
  - Senator Sanders' interesting move
- Incremental improvements
- The long game

Imagine you were Mariam Pare

A window into America's disability mess.

- Disability barriers
  - SSI $2,000 countable asset limit
  - SSDI two-year Medicare waiting period
  - SSDI SGA restrictions on gainful employment
- ACA tried to help
  - Medicaid expansion, which assists many people with disabilities who do not/cannot participate in SSI or SSDI
  - Money Follows the Person, Balanced Incentive Program, etc.
  - Failed CLASS Act
  - Lost opportunity on many incremental fronts

What next?

- Disability community
  - Rather peripheral to original ACA fight, with distinctive political interests not universally shared in ACA coalition
  - Played central role in defending ACA and Medicaid, earned seat at the table
- But…disability policy as costly and complicated as the rest of ACA.
  - Looming LTC issue
  - What to do with fifty years of Medicaid wiring
  - Money and complexity
- Sanders' plan addresses SSDI waiting period, leaves state Medicaid disability services surprisingly intact. So do others.
- Administrative simplicity, programmatic boldness
  - Specific, simple, and important measures such as SSI limits. ABLE Act.
  - Setting stage for what is to come.

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KEYNOTE

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THE CENTURY FOUNDATION

THE AMERICAN PROSPECT

GREENBERG QUINLAN ROSNER

STRATEGY + RESEARCH

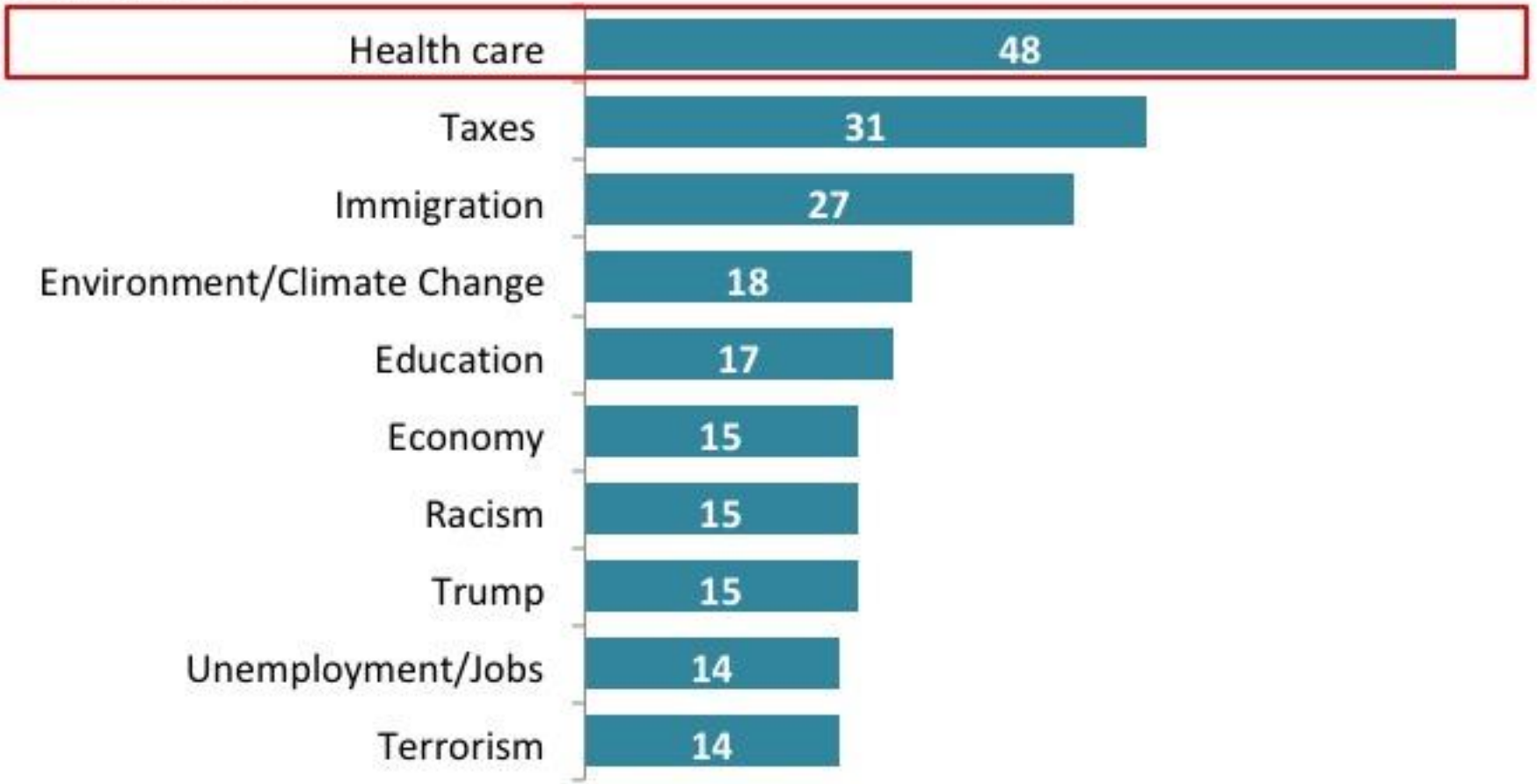
Health Care 2020

Anna Greenberg

CAMPAIGNS | CORPORATIONS | ADVOCACY | WORLDWIDE

Health care is top of mind for most Americans, but could be result of recent debates

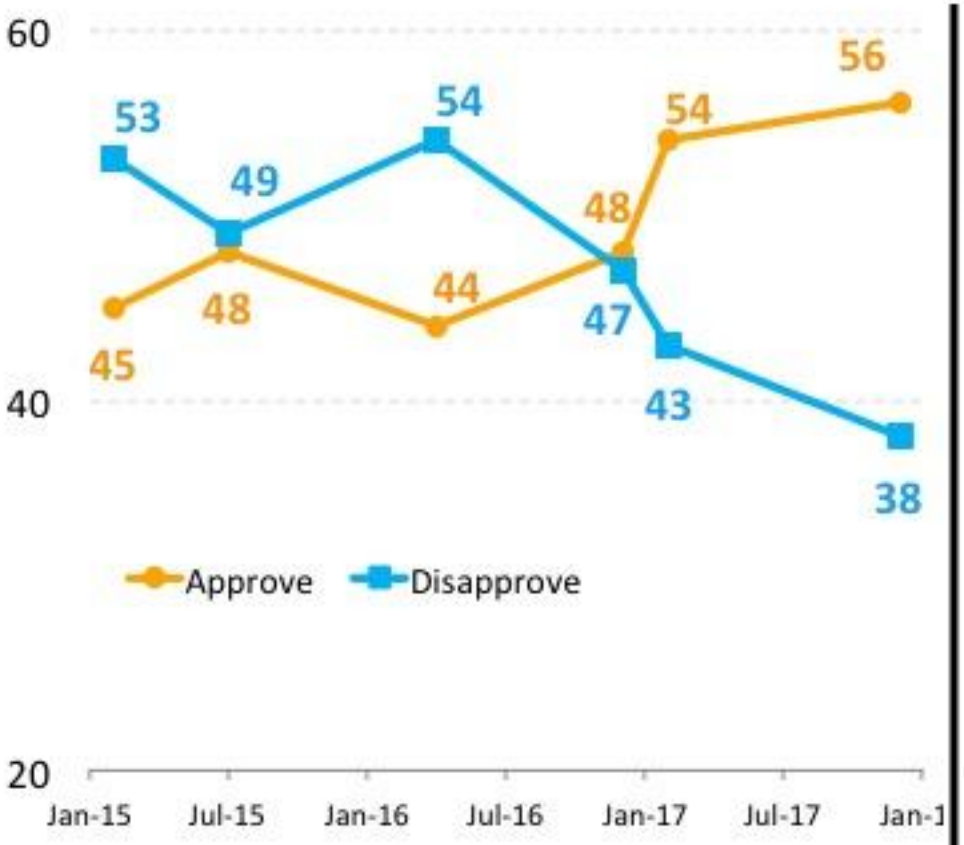
Thinking about the problems facing the United States and the world today, which problems would you like the government to be working on in the year 2018? Please list up to five problems.



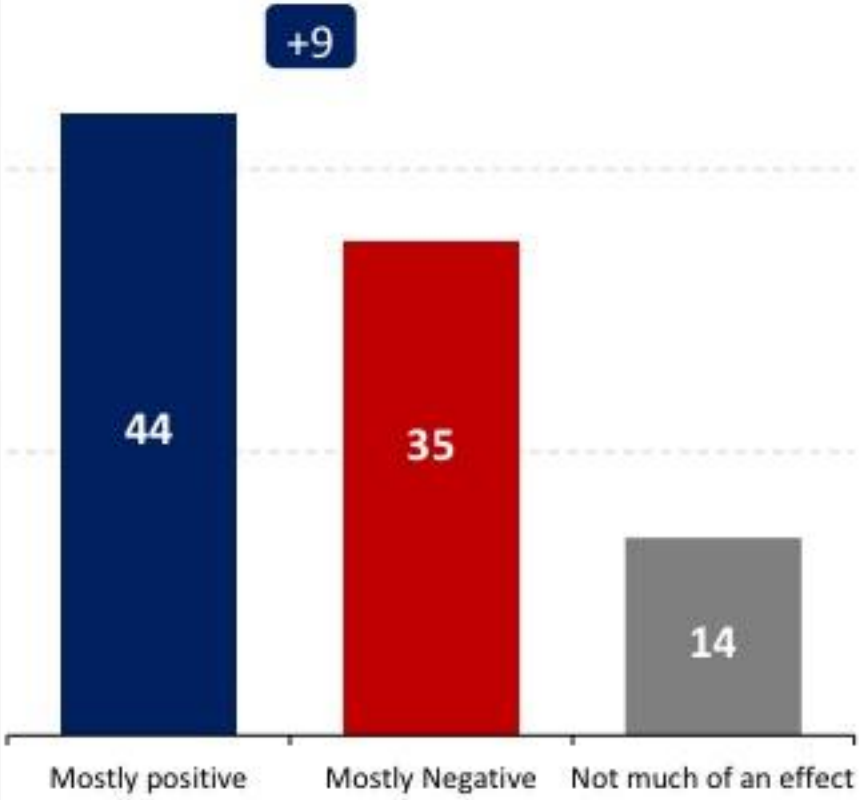
AP-NORC, December 2017

ACA viewed positively, and more adults say law has had a positive impact than a negative impact on US

Do you approve or disapprove of the health care law passed by Barack Obama and Congress in 2010?



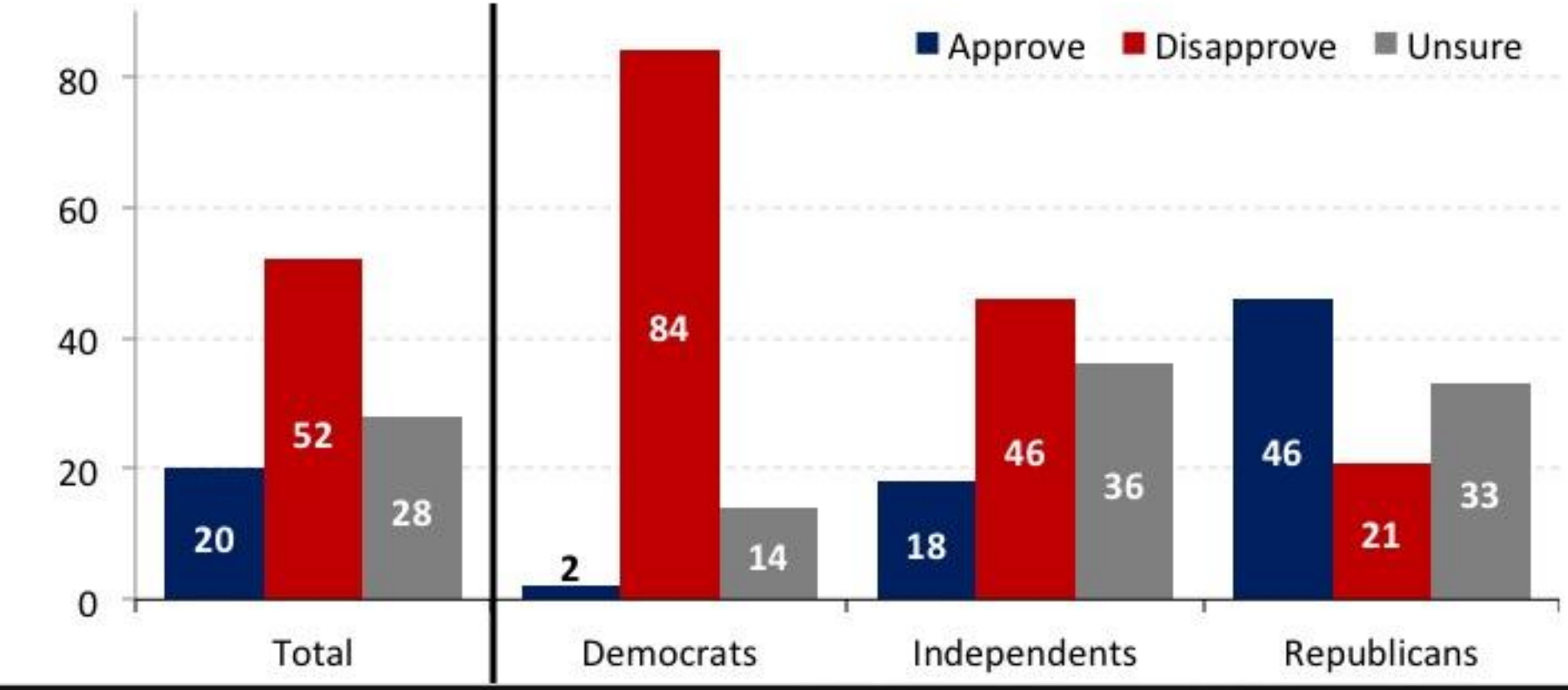
So far, that is up until today, has the health care law had a mostly positive, mostly negative, or not much of an effect on the country as a whole?



Pew Research Center, December 2017

Intense opposition from Dems on repealing ACA, less than 1 in 5 independents support repeal

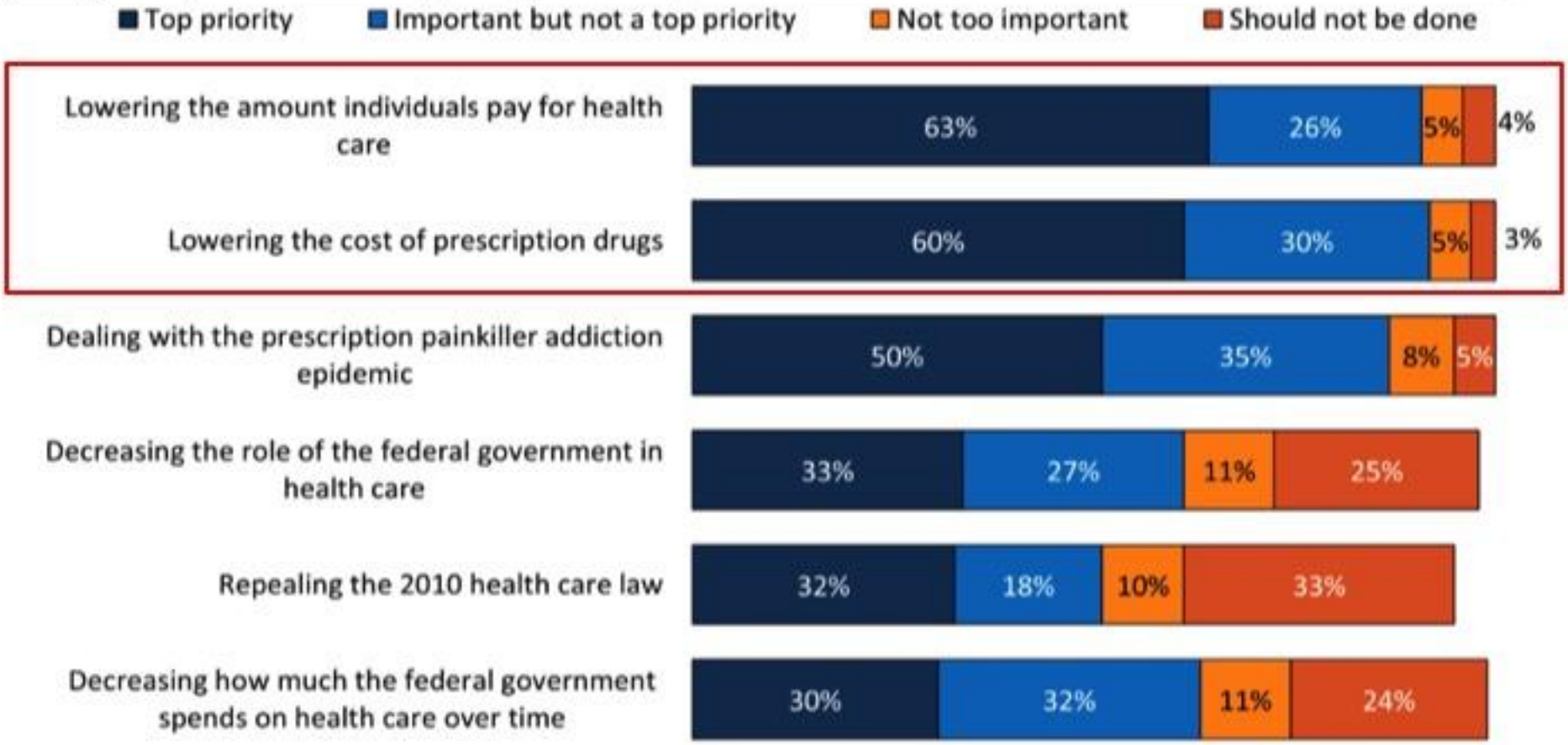
As you may know, Republicans in the Senate recently put forward a new plan, called Graham-Cassidy, that would repeal and replace the Affordable Care Act of 2010. From what you have heard or read, do you approve or disapprove of Graham-Cassidy, the new Republican plan?



CBS News, September 2017

But voters focused on lowering out-of-pocket costs lead health care priorities

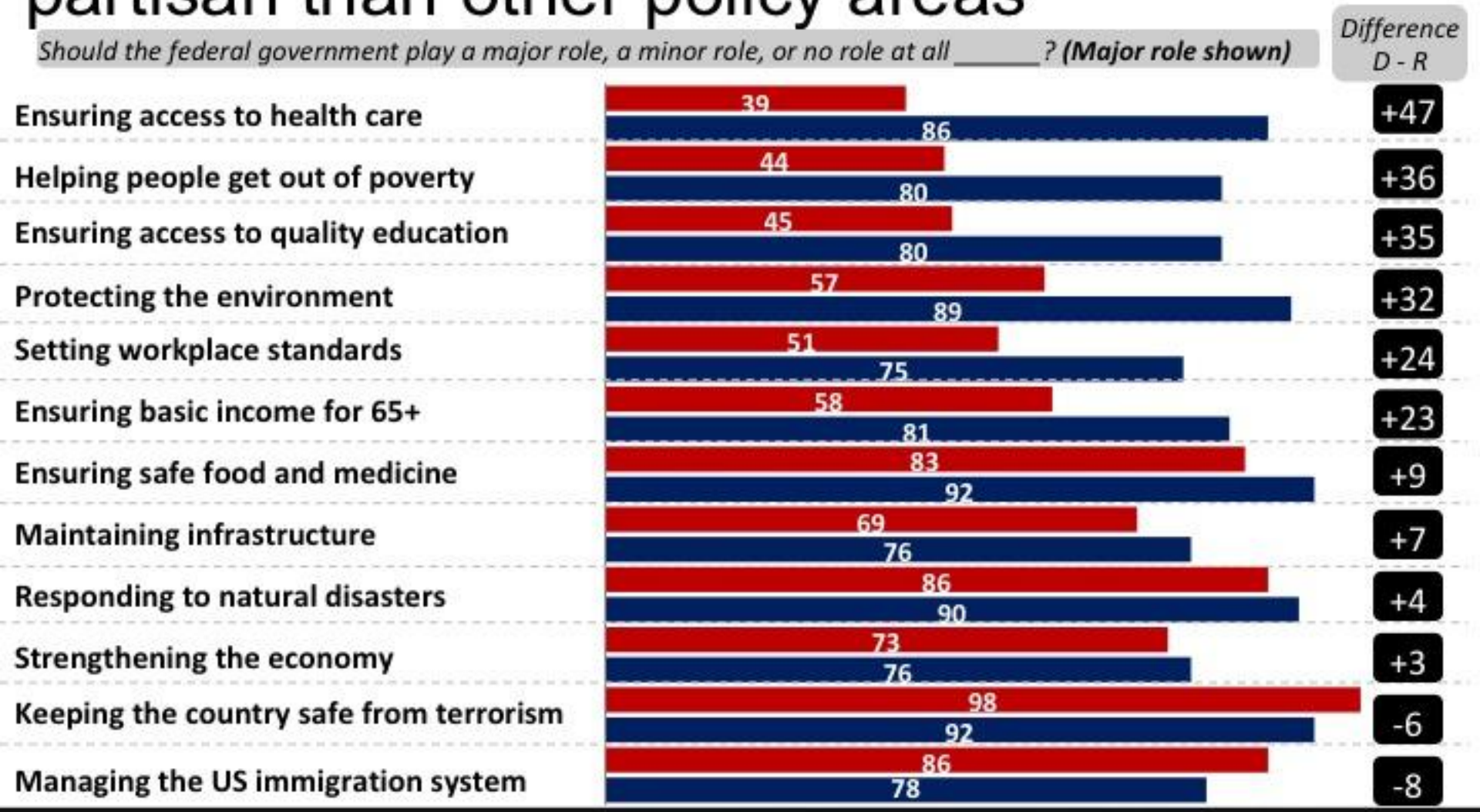
Should each of the following things President Trump and Congress might do when it comes to health care be a top priority, an important but not top priority, not too important or should it not be done?



Kaiser Health Tracking Poll, April 2017

Government's role in health care more partisan than other policy areas

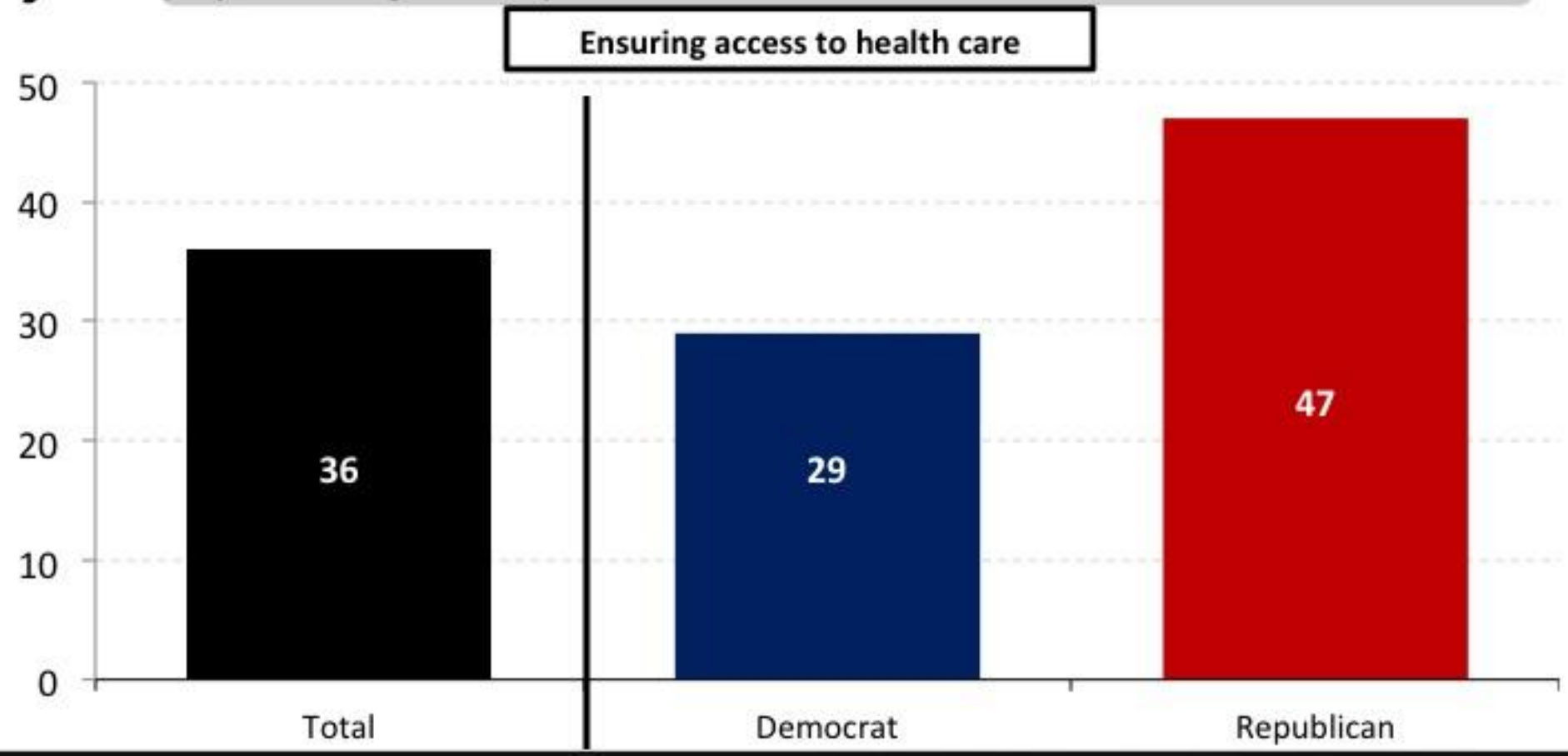
*Should the federal government play a major role, a minor role, or no role at all _____? **(Major role shown)***



Pew Research Center, December 2017

Reflecting the occupant in the White House, GOP more likely to think gov't doing a good job

Is the federal government doing a very good, somewhat good, somewhat bad or very bad job _____?
(Very/somewhat good shown)

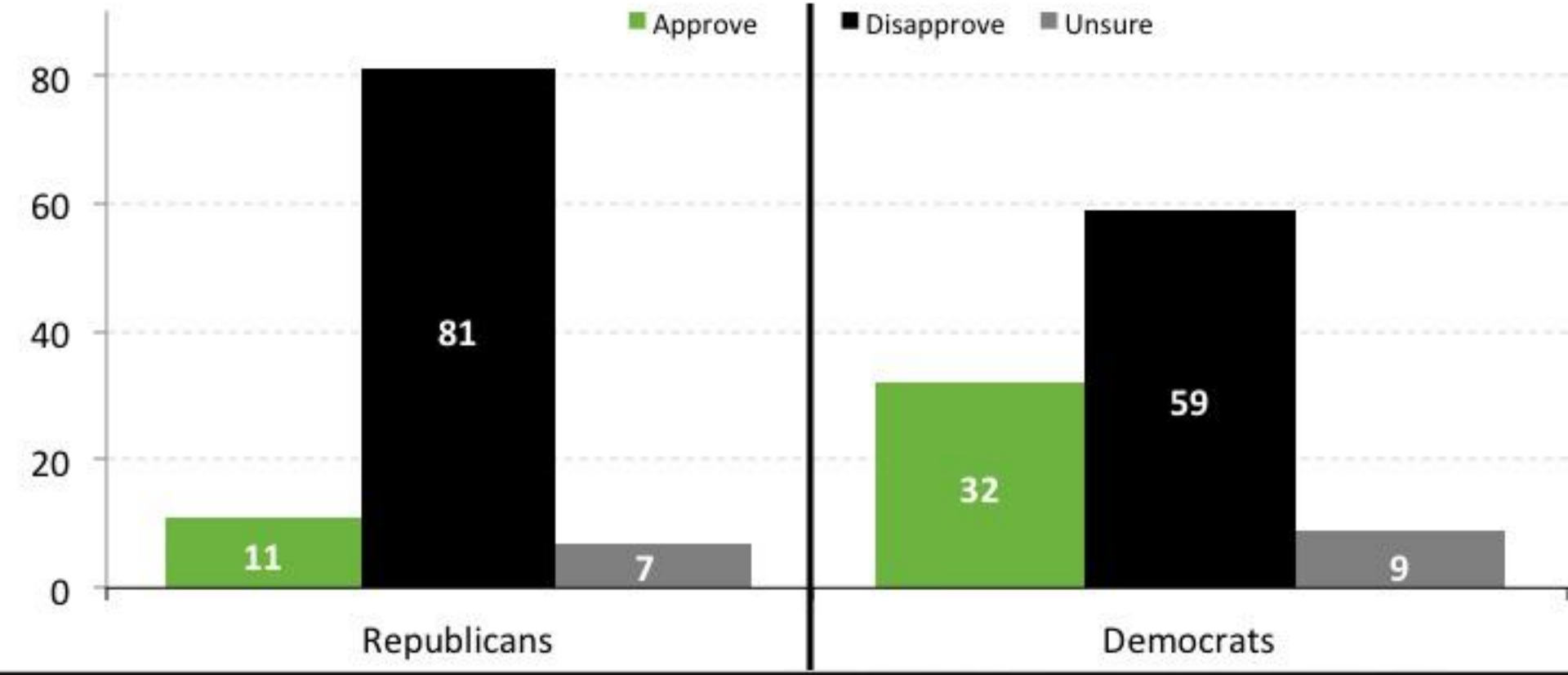


Pew Research Center, December 2017

But, overwhelming disapproval for congressional GOP on health care

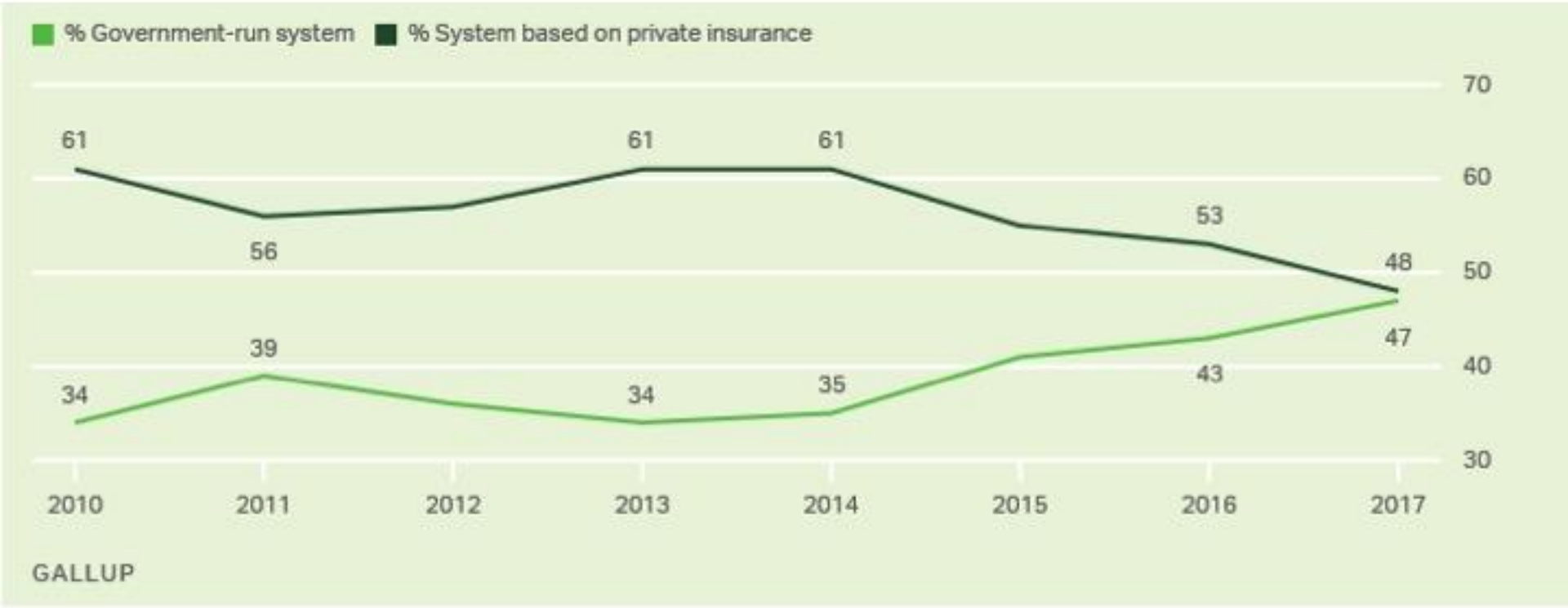
Do you approve or disapprove of the way the **Republicans in Congress are handling health care**?

Do you approve or disapprove of the way the **Democrats in Congress are handling health care**?



Increasing support for a government-run health system

Which of the following approaches for providing health care in the United States would you prefer – replacing the current health care system with a new government-run health care system, or maintaining the current system based mostly on private health insurance?



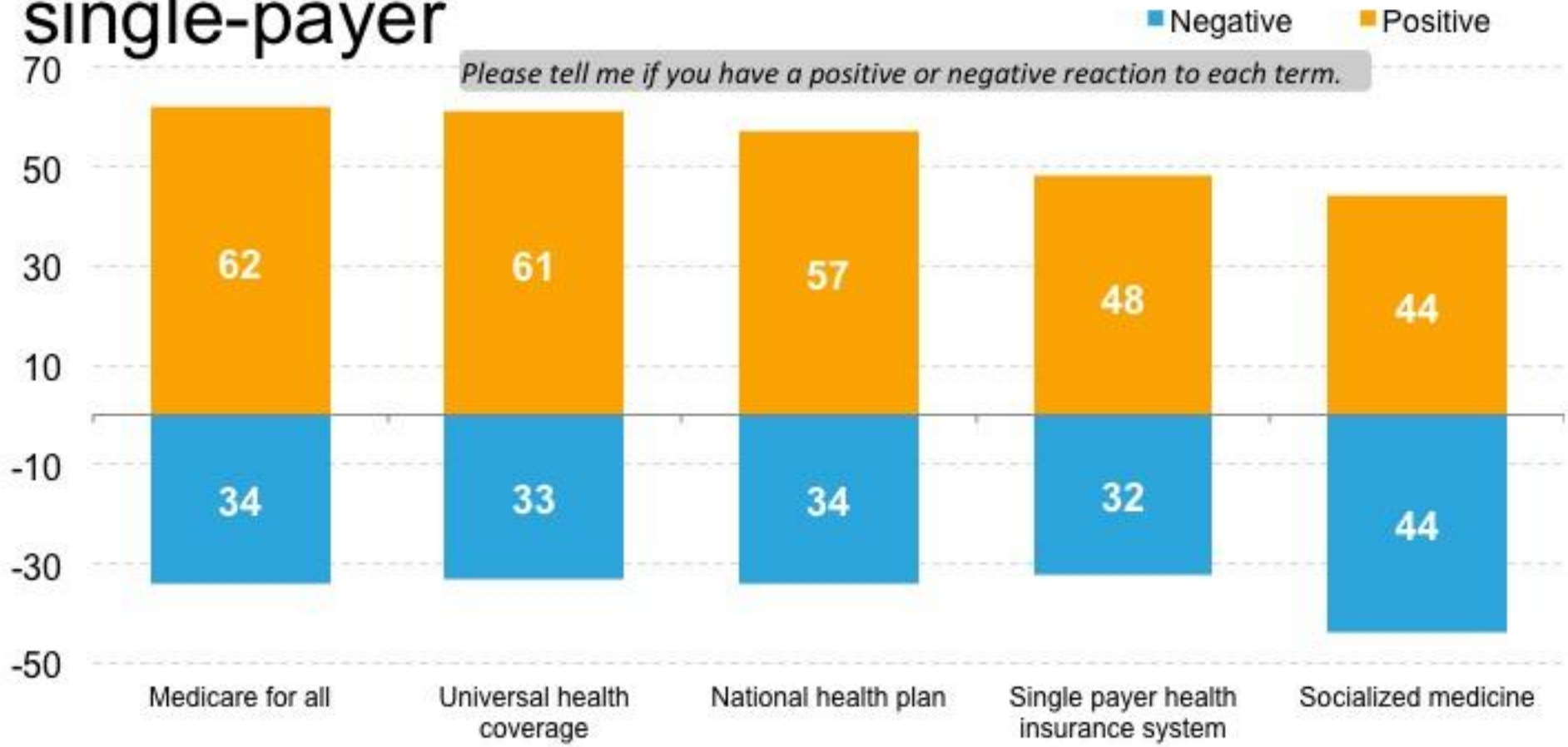
Despite high water mark for Republican support for a gov't run system, there is a predictable partisan split

Which of the following approaches for providing health care in the United States would you prefer – replacing the current health care system with a new government-run health care system, or maintaining the current system based mostly on private health insurance?

	Gov't-run system	System based on private insurance
Republicans/leaners	22*	76
Democrats/leaners	67	29

***22 percent is the highest Republican support Gallup has recorded for a government run health care system in 7 years of asking the question**

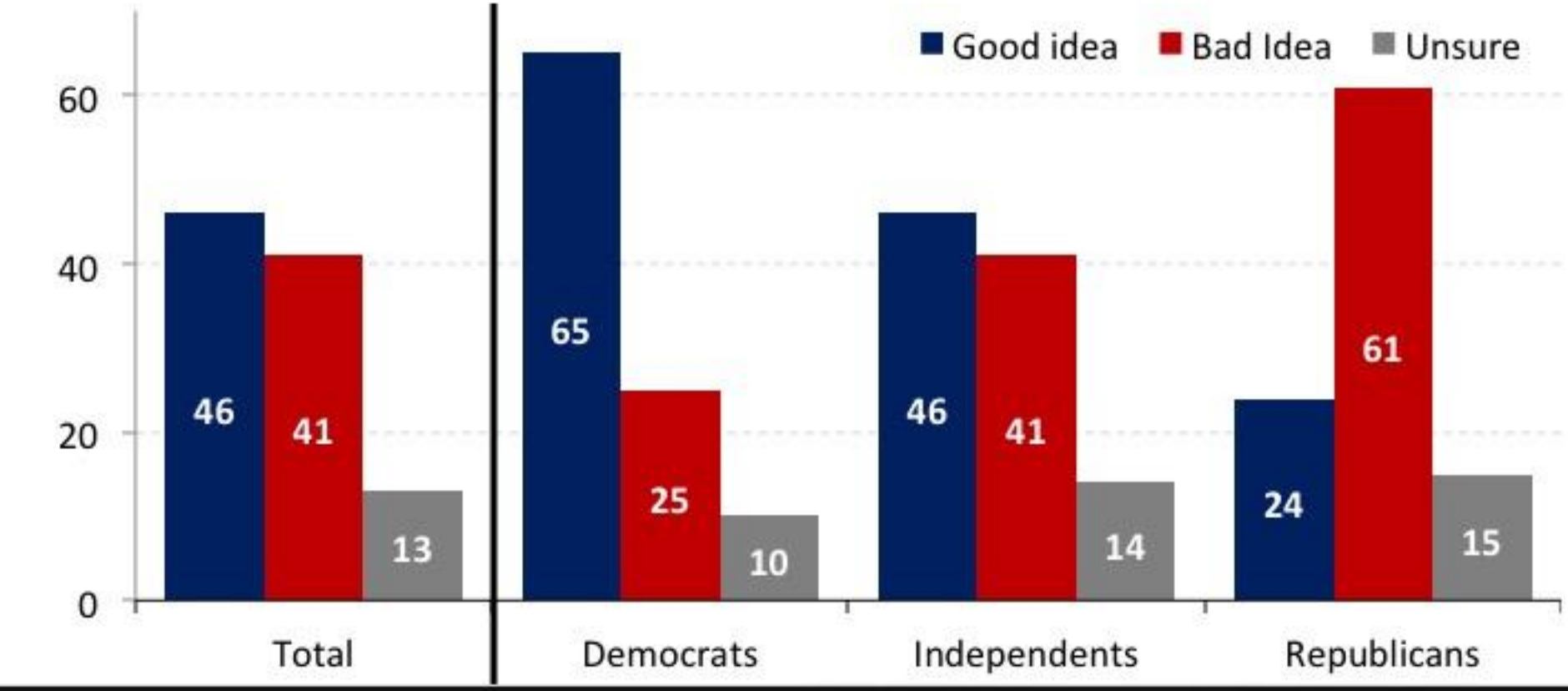
Terminology matters: Medicare for all and Universal coverage more popular than single-payer



Kaiser Health Tracking Poll, November 2017

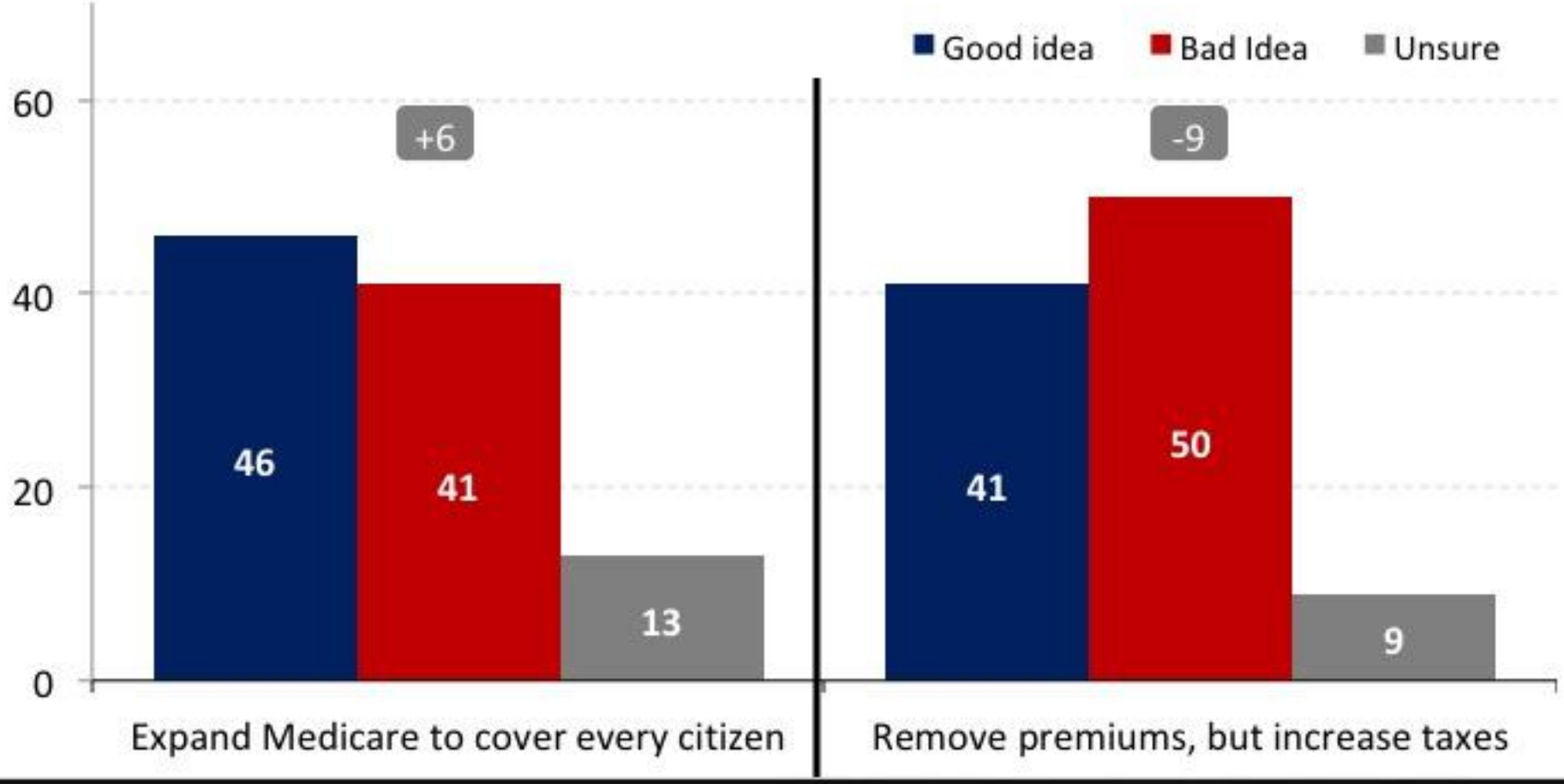
Single-payer system that 'expands Medicare to every citizen' falls along partisan lines

Do you think that removing the current health care system and replacing it with a single-payer system, in which the federal government would expand Medicare to cover the medical expenses of every American citizen, is a good idea or a bad idea?



And loses support if taxes increase

Would you think that a single-payer system is a good idea or a bad idea if it removed all health insurance premiums, but also increased your taxes?



Final thoughts

- It is hard to predict if healthcare will be an issue in 2020, as so much depends on people's experiences (i.e., does the repeal of individual mandate disrupt in a way that affects people who get PRIVATE insurance).
- How it will play out will depend on whether people blame Trump/GOP or Obama/Dems for disruptions, costs, etc.
- Did we bomb North Korea?

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Building on the Affordable Care Act

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Strengthening Non-Group Markets

John Holahan and Linda Blumberg

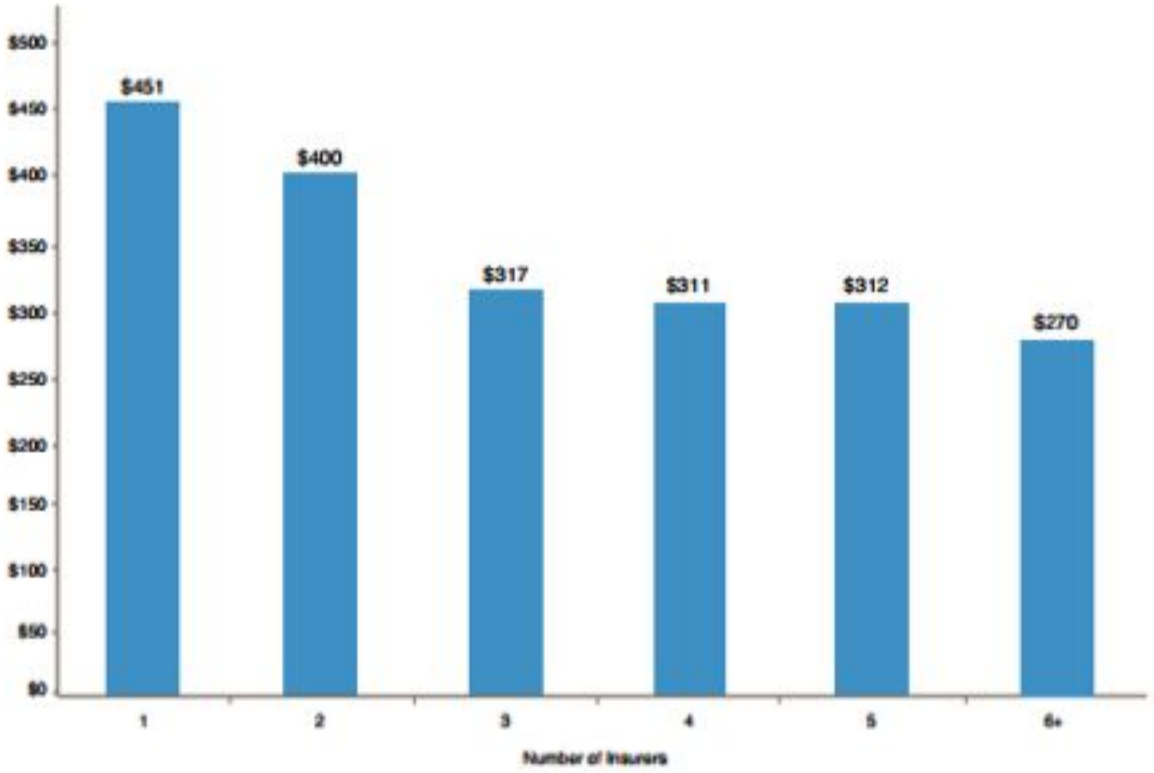
January 11th, 2018

Strengthening Non-Group Markets

- Issues in the Non-Group Market – pre 2018
  - High Deductibles and Narrow Networks
  - High and Rising Premiums
  - Insurer Exits and the Threat of Bare Counties

- Policy Responses — Increase Insurer Participation and Marketplace Competition
  - Increase Enrollment to Make Marketplaces Larger
    - Improve affordability, increase coverage and reduce insurer risk
  - Address insurer and provider market power
    - More choices, more competition, lower premiums

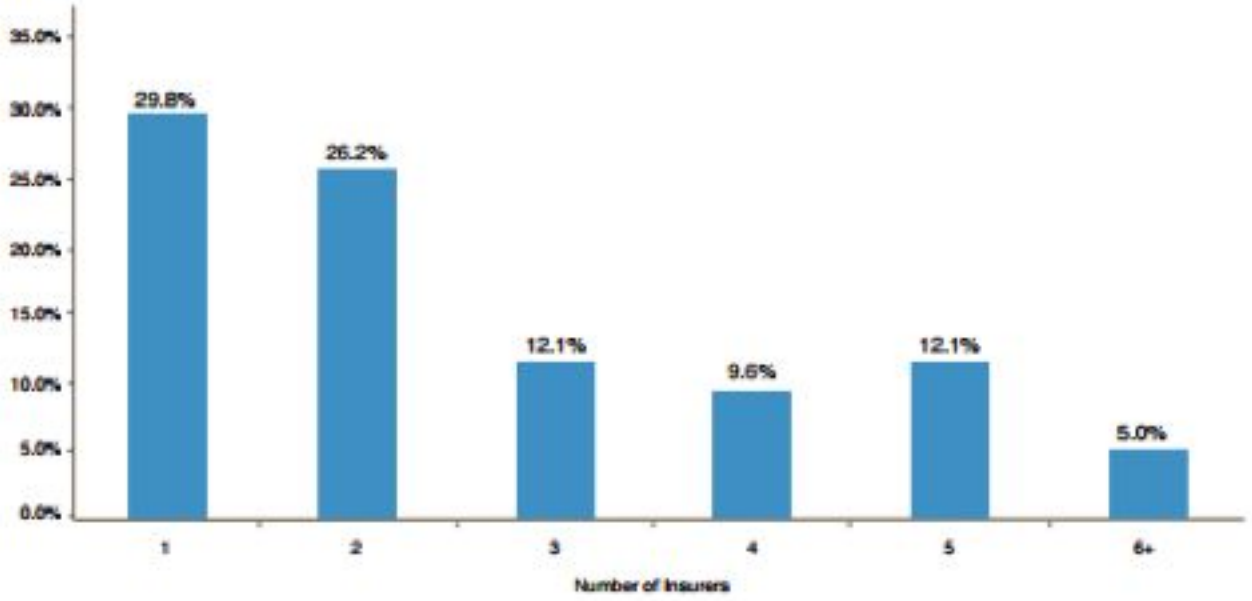
Figure 1. 2017 Median Benchmark Monthly Premium Levels by Rating Region Insurer Participation



Note: The benchmark premium is the second-lowest-cost silver premium in the rating region's marketplace.

Source: Urban Institute analysis of premium and insurer participation data taken from Healthcare.gov public use files and relevant state marketplace websites

Figure 2. Median Percent Change in Benchmark Premium by Number of Insurers Participating in Rating Region, 2016–2017



Note: The benchmark premium is the second-lowest-cost silver premium in the rating region's marketplace.

Source: Urban Institute analysis of premium and insurer participation data taken from Healthcare.gov public use files and relevant state marketplace websites.

Increasing Enrollment –
Many Markets are Too Small to Support Competition

- Improve Premium and Cost Sharing Subsidies, including ending premium cliff at 400% FPL
- Fix Family Glitch
- Prohibit Sale of Non-Compliant Plans
- Allow Medicaid Expansion to 100% FPL
- Adopt Permanent Reinsurance Program

Increasing Insurer Participation and Marketplace Competition - The Problem

- Competition in marketplaces is much more cut-throat than Medicare Advantage
  - Intense Pressure to be Second Lowest Cost Plan (or close to it)
- Insurer and Provider Concentration Drives Up Premiums
  - Provider Market Power Limits Insurer Bargaining Ability
  - Insurer Market Power Inhibits Entry by New Insurers, Weakens Incentive for Insurers to Negotiate Aggressively with Providers

Insurer Participation and Market Competition: Policy Options

- Limit Number of Cost Sharing Designs at Each Metal Level
- Link Tax Credits to Higher of Median or Weighted Average Premium Rather than Second Lowest Cost

Insurer Participation and Market Competition: Policy Options, Continued

- Cap Provider Payment Rates, as in Medicare Advantage, at or close to Medicare Levels

- Medicare Advantages does not allow balance billing by out of network providers; which affects payment rates to in-network providers; this has allowed commercial insurers to compete with traditional Medicare

- Adopting similar polices in Marketplaces would
  - Constrain provider market power by limiting payments
  - Insurers can more easily enter new markets because they would not be disadvantaged in provider rate negotiations
- As with most cost containment strategies, likely to be provider opposition

Public Option is an Alternative to Capping Rates

- It would be a major effort to establish a new plan that would have to perform many functions; can't just adopt Medicare
- There would be serious opposition from insurers in addition to providers
- Caps on provider payment rates would be an easier path to achieving most of the same objectives

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Building on the Affordable Care Act

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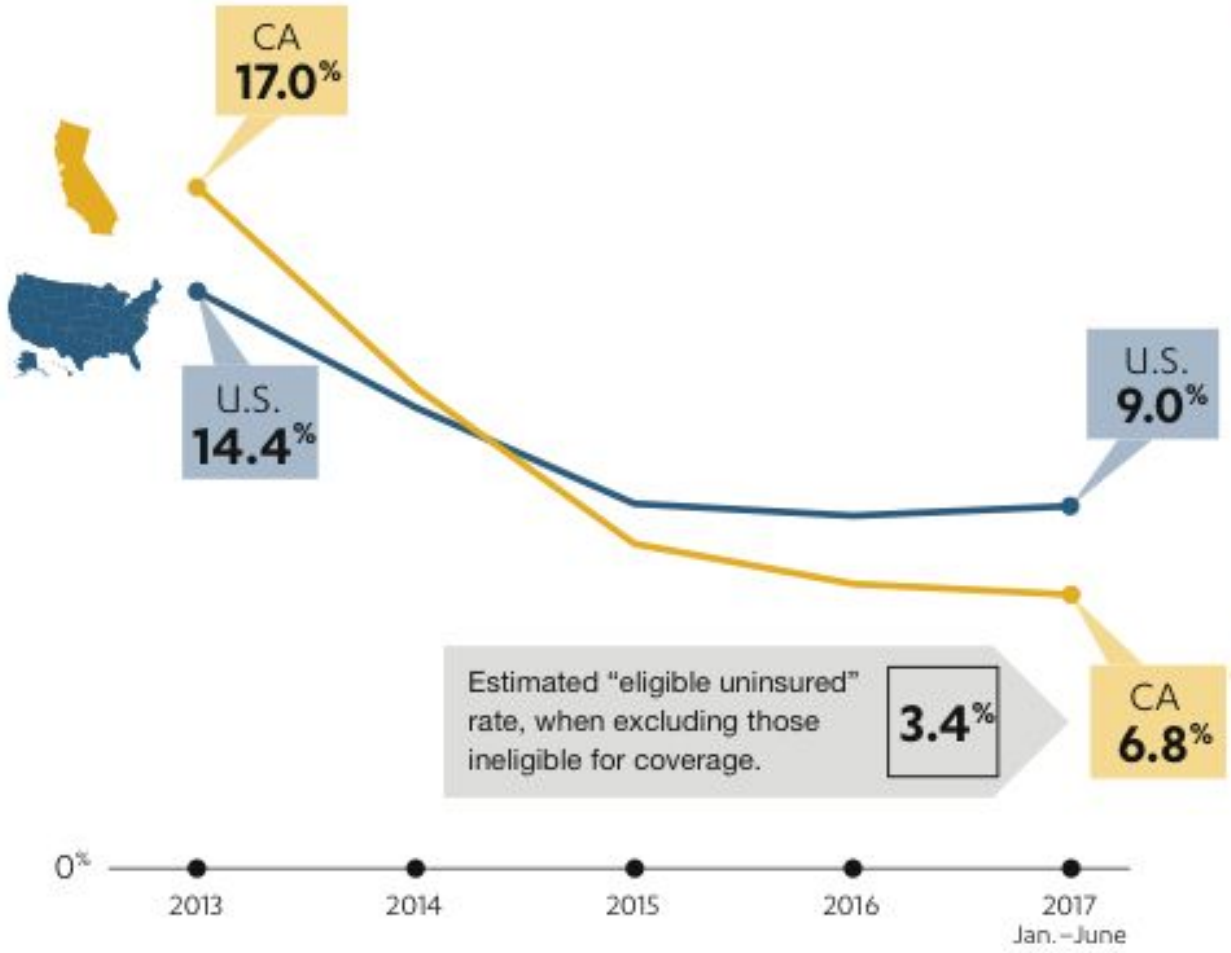
Building Affordability – Role of Marketplaces in Helping Shape the Delivery System

Health Reform 2020: Towards Affordable, Quality Care for All Americans
Building on the Affordable Care Act

Peter V. Lee
January 11, 2018

Coverage Expansion Having Dramatic Effects in California



With California's expansion of Medicaid and the creation of a state-based marketplace, the rate of the uninsured has dropped to historic lows. Almost four million new enrollees are in the Medi-Cal program and 1.3 million people are enrolled through Covered California.

Source: U.S. Centers for Disease Control and Prevention's National Health Institute Survey

Covered California is Promoting Improvements in the Delivery of Care

Covered California contract requirements to promote the triple aim of improving health, delivering better care and lowering costs for all Californians include:

Promoting innovative ways for patients to receive coordinated care, as well as have immediate access to primary care clinicians

- All Covered California enrollees (HMO and PPO) must have a primary care clinician.
- Plans must promote enrollment in patient-centered medical homes and in integrated healthcare models/Accountable Care Organizations.

Reducing health disparities and promoting health equity

- Plans must "track, trend and improve" care across racial/ethnic populations and gender with a specific focus on diabetes, asthma, hypertension and depression.

Changing payment to move from volume to value

- Plans must adopt and expand payment strategies that make a business case for physicians and hospitals.

Assuring high-quality contracted networks

- Covered California requires plans to select networks on cost and quality and in future years, will require exclusion of "high cost" and "low quality" outliers — allowing health insurance companies to keep outlier providers, but detailing plans for improvement.

Note: for detailed information about improvements in the delivery of care, Covered California requires health insurance companies to abide by Attachment 7 of the model contract. To view Attachment 7, go to http://hbex.coveredca.com/stakeholders/plan-management/PDFs/Attachment_7_Individual_7-5-2016_Final_Clean.pdf

Covered California Board presentation slides on Attachment 7: http://www.coveredca.com/news/pdfs/CoveredCA-Board-QualitySummary-04-07-16.pdf

MOVING THE NEEDLE ON PRIMARY CARE: COVERED CALIFORNIA'S STRATEGY TO LOWER COSTS AND IMPROVE QUALITY

Four Inter-related Elements

1. **Benefit Design**
   From the beginning, Covered California has made sure consumers can seek ambulatory care without needing to meet the deductible
2. **A Primary Care Physician for Every Enrollee**
   As of March of this year, 99% of Covered California enrollees have a doctor who can serve as their advocate
3. **Payment Reform**
   Moving away from Fee for Service
4. **Patient Centered Medical Home Recognition**
   Support PCPs in adopting accessible, team-based, data-driven care

Click here to view complete report.


HealthAffairsBlog

Moving The Needle On Primary Care: Covered California's Strategy To Lower Costs And Improve Quality

COVERED CALIFORNIA SEEKING TO ALIGN WITH PUBLIC AND PRIVATE PURCHASERS

Covered California's Contractual Requirements (Attachment 7) provides opportunities for alignment and to learn from private and public purchasers best practices. Opportunities include:

- 1.02: Fostering networks based on value – Quality AND Cost:
- 1.02(3) & 1.03(3): Excluding high cost/low quality hospitals (or explain why keeping them)
- 1.04(1): High cost pharmaceuticals – detail application of value practices and independent validation
- 1.06: Participate in collaboratives – CalSIM Maternity and Statewide Workgroup on Overuse
- 3.01 & 3.02: Reducing health care disparities – track, trend and reduce health disparities
- 4.01 & 4.02 & 4.03: Primary and coordinated care – track, trend and improve enrollment in and payment to primary care, PCMH and ACOs/IHMs
- 5.01: Hospital payments – by 2019 at least 2% of hospital payments at-risk or value-based (6% by 2023)
- 7.01: Patient/Consumer Information – tools on quality and price

Note: for detailed information about improvements in the delivery of care, Covered California requires health insurance companies to abide by Attachment 7 of the model contract. To view Attachment 7, go to http://hbex.coveredca.com/stakeholders/plan-management/PDFs/Attachment_7_Individual_7-5-2016_Final_Clean.pdf

The Individual Market as Driver of Disruptive Innovation at the Plan and Provider Level?

As incumbents focus on improving their products and services for their most demanding (and usually most profitable) customers, they exceed the needs of some segments and ignore the needs of others. Entrants that prove disruptive begin by successfully targeting those overlooked segments, gaining a foothold by delivering more suitable functionality – frequently at a lower prices. Incumbents, chasing higher profitability in more demanding segments, tend not to respond vigorously. Entrants then more up market, delivering the performance that incumbents' mainstream customer require, while preserving the advantages that drove their early success. When mainstream customers start adopting the entrants' offerings in volume, disruption has occurred.

What Is Disruptive Innovation, Clay Christensen, Harvard Business Review, Dec. 2015

Successful Plans in the Individual Marketplaces	Big Name Plans that Tried the Individual Market…Failed…and Retrenched
• Blue Shield of California (and SOME other BC/BS Plans) • Centene/HealthNet • Kaiser • Molina • Regional Plans: Sharp, WHA, Oscar, etc.	• Aetna • Anthem (?) (and SOME others BC/BS plans) • Cigna • Humana • United

Covered California/Marketplace Strategies: Value Proposition for Other Purchasers

Covered California's Strategies with Potentially "Disruptive" Value Propositions	Annual Premium Savings Compared to "Standard" and "Generic" Large Employer offerings of National Plans and TPAs
1. **Narrower Networks/Better Rates**	**30% to 45%**
2. **Exclusion of "Pricing Bandits"** (e.g., market dominant academics)	**5% to 10%**
3. **Alternative Payment Methods** (APMs) (e.g., ACOs, PCMH, aggressive moves to risk-based payment, episodes)	**0 to 10%**
4. **Benefit Design** (Covered California Actuarial Value of 77% -- WITH income-based designs providing 94% to lower income; compared to average large employer designs of 85% AV)	**5 to 10%**
Total Potential Savings	**40% ++**

Note – strategies are complementary and overlapping

Information for consumers

CoveredCA.com

Information on exchange-related activities

hbex.CoveredCA.com

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PANEL

Building on the Affordable Care Act

THE CENTURY FOUNDATION

THE AMERICAN PROSPECT

Where To Start:
Options for Phasing In Public Plans

Jeanne Lambrew, PhD
Senior Fellow, The Century Foundation

- Challenges of "big bang" approach:
  - Size of the system
  - Vested interests
  - Fear of change
- Why phase-ins matter:
  - Could lead to retrenchment
  - Could stall

Eligible and Enrolled

Addressing Non-Financial Barriers to Coverage

Ellen Montz

THE CENTURY FOUNDATION

Will Lower Premium/Higher Quality Options Generate Full Insurance Coverage?

Evidence suggests that even at zero premium, uninsured will remain

- 27% of the uninsured are eligible for Medicaid or CHIP (KFF 2016)
- 70% of subsidy eligible-uninsured able to purchase a Bronze plan at zero premium or less than the cost of the individual mandate penalty (KFF 2017)

Does going uninsured despite financial accessibility suggest individuals do not want insurance?

- Evidence suggests individuals value insurance
  - Take-up in employer market and Medicare Part B is high
  - Outreach and education efforts improve enrollment

Policy Options– Active Enrollment

Outreach and Education
(e.g., advertising campaigns, enrollment assistance)

- Pros: Promotes informed decision-making by consumers, proven effective
- Cons: Diminishing returns to investment

Administrative Simplification (e.g., greater data sharing, eligibility simplification)

- Pros: Reduces hassle costs of eligibility determinations for consumers
- Cons: Could require large administrative/programmatic investments with limited information on impact

Individual Mandate and Individual Mandate Penalty

- Pros: Administrative infrastructure exists, evidence for effectiveness, scalable
- Cons: Has been unpopular

Policy Options– Passive Enrollment

Automatic Enrollment-- uninsured individuals are identified through data and automatically enrolled

Pros:

- If implemented and administered effectively, could provide insurance protections for the greatest number of individuals with risk pool improvements
- Successfully used for health insurance enrollment outside the United States and for other benefit enrollment in the US (e.g., retirement accounts, Medicare)

Cons:

- Difficult to administer, even for the federal government
- To prevent imposing unexpected premiums, the default enrollment plan could either require high consumer cost-sharing or taxpayer funding

Policy Options–
Active and Passive Hybrids

Program Synergies (e.g., use of existing and expansion of express lane and presumptive eligibility options)

- **Pros:** Relies on existing program structures and/or eligibility determinations, proven effective in Medicaid/CHIP, often provides insurance to those most in need

- **Cons**: Relies on sometimes unpredictable interactions with public programs or the health care system, not easy to adapt to Marketplace coverage given different eligibility rules and income ranges

Conclusion

- Expanding public plans or hybrid public-private plans alone will not eliminate the uninsured
- Meaningful policy options for decreasing the non-financial barriers to enrollment exist and are not mutually exclusive
- Policy makers should consider:
  - Balancing scope with administrative feasibility
  - Balancing consumer protections with consumer and government costs
  - Promoting market risk stability
  - Giving individuals the opportunity to make active choices
- Recognize that policies to increase enrollment will likely increase federal/state budget costs, despite some offsetting savings

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Political Prospects

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HEALTH REFORM 2020

Towards Affordable, Quality Care for All Americans

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