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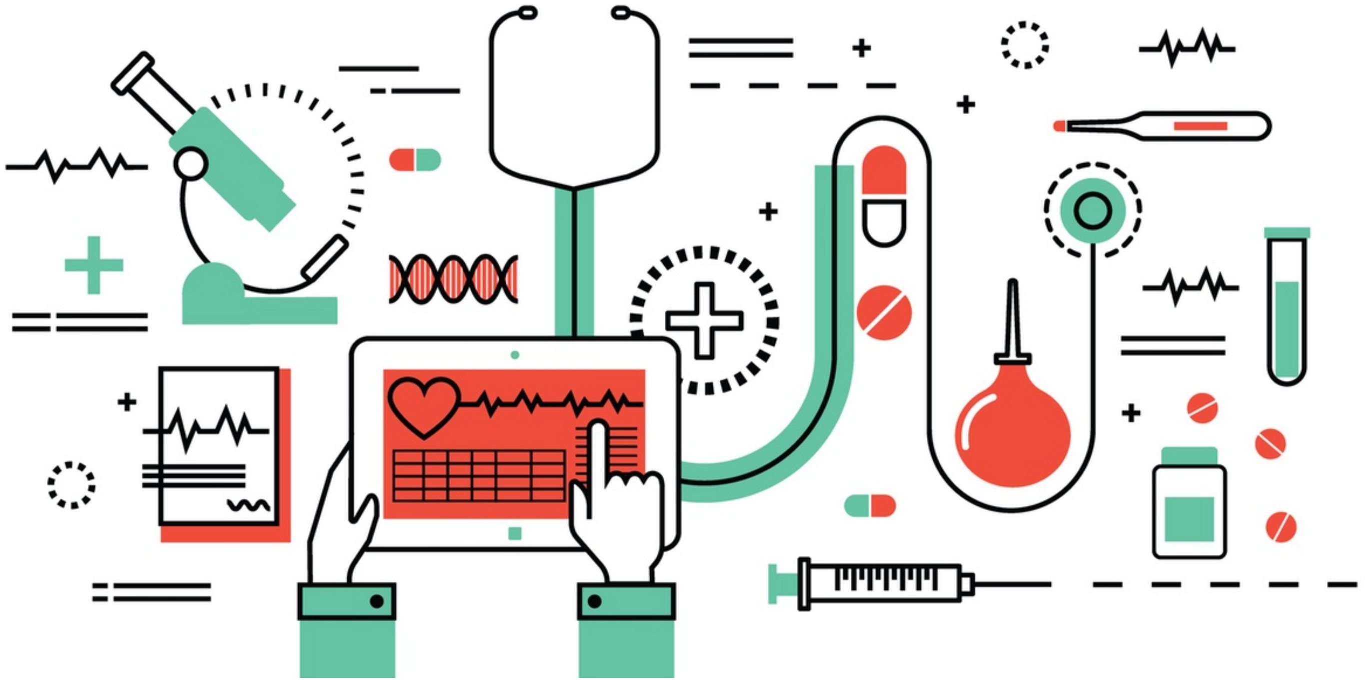

REPORT HEALTH REFORM 2020

The Next Big Thing in Health Reform

Where to Start?

JANUARY 3, 2018 — JEANNE LAMBREW AND ELLEN MONTZ

The next Democratic candidate for president or Democratic Congress will likely embrace some sort of public plan as part of the "next big thing" in health reform. Numerous congressional Democrats have thrown their weight behind Senator Bernie Sanders's "Medicare for All" bill. Support is also growing for various kinds of "public options"—opportunities to expand the role of public programs through Medicare, Medicaid, or the health insurance marketplaces.

These ideas are similar in their goal of providing lower-cost, simpler, and more secure health-care coverage for all Americans through insurance plans that are publicly backed and organized. The proposals reflect frustration with private insurers and a belief in a stronger and more direct role for government, but they differ in how they work. Single-payer plans concentrate health-care finance in the federal government, while Medicare and Medicaid buy-in proposals build on existing programs, payment rates, and relationships with health-care providers.

The proposals also differ in where they start. Barack Obama is among the many who have said that if we could start from scratch, a single-payer system would make the most sense. The U.S. health system, however, is far from a blank slate. It is the largest in the world in spending. Relatedly, it is one of the nation's largest employers, as well as its most lucrative: Nine of the top ten highest-paid occupations are in health care, and both the industry and its employees are likely to resist changes they see as threatening. More than nine in ten Americans now have coverage thanks to the Affordable Care Act (ACA). Changing this entrenched system incrementally has proved daunting; changing it radically may prove impossible. The cliché "don't bet against the house" is safely applied in health policy.

In light of those considerations, we focus here on four major approaches to expanding the public role in achieving the goals of health-care reform. These approaches do not necessitate picking one preferred plan over all others, nor do any of them inevitably lead to a predetermined outcome. The expansion of programs often stalls, as is evident in the long lags between past health reforms. Consequently, the next steps we take are as important as the ultimate destinations that we hope to reach.

Start Where Private Insurance Ends

Historically, public coverage has started where private insurance has stopped. The recognition that private insurance would not cover the old, the poor, and people with disabilities contributed to the passage of Medicare and Medicaid in 1965. Nearly five decades later, Democrats designed the ACA to close the remaining gaps, first, by making Medicaid a true safety net for all low-income Americans and, second, by requiring private insurers to cover all people regardless of any pre-existing conditions. The Supreme Court partly undid the first step by making the Medicaid extension optional for the states. Nonetheless, filling the gaps as far as the ACA did led to 20 million more people being covered. The Trump

administration's efforts to undermine the ACA have threatened those gains and led to skyrocketing health insurance premiums for 2018. Additionally, private insurers have balked at offering coverage in the individual market in parts of the country, jeopardizing residents' access to any plan. The prospect of "bare" counties has been one impetus for bills such as "Medicare X," which would offer a Medicare-like plan in counties with no or only one other insurer.

Republicans have previously embraced the concept of a public plan as a gap-filler where no private plan is available. The Medicare prescription drug program, enacted under President George W. Bush, has a government-funded fallback plan for areas with fewer than two private plans. Former Maine Senator Olympia Snowe supported a "triggered" public plan for inclusion in the ACA, a proposal blocked by Senator Joe Lieberman. Depending on its design, a fallback public plan could improve affordability in areas where there is low competition and high prices.

This deployment of public plans, however, may not be necessary to address the problems in these areas, since other responses might suffice. For example, federal law could require urban insurers to serve nearby rural areas, or it could extend Medicare's provider payment rates to private insurance plans in places with no or low competition. A public plan, once it enters an area, may make private insurers less likely to return, potentially replacing private with public plans one county at a time. Most of the areas with few insurers are in red states where governors and legislatures have shown little interest in making their health insurance markets work. While this geographic pattern could make a public option fallback harder to pass through Congress in the first place, it could lessen partisan opposition to public plans in the long run if they succeeded in those areas and built up local support.

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Less Old Next

Another familiar approach is age-based. By far, people under age 18 and over age 65 have the lowest uninsured rates as a result of the programs that America has established for the old and the young. After the passage of Medicare to cover all seniors in 1965, policymakers focused on covering children. Legislation was enacted in 1988 to expand Medicaid to all poor children and in 1997 to create the Children's Health Insurance Program for near-poor children. In addition to extending these programs, the ACA requires that insurers let young adults stay on their parents' plans until age 26, one of the law's most popular provisions.

This year has seen a revival of plans to lower the age of eligibility for Medicare, a proposal first made by President Bill Clinton in 1998 and later debated for inclusion in the ACA. Senator Sanders's Medicare for All bill includes a version of that idea. The Medicare Buy-In Act and the Midlife Medicare program proposed by Paul Starr would extend Medicare as an option for older adults, variously reducing the eligibility age to 55 or 50.

Proponents of lowering the age of eligibility for Medicare point out that expanding a popular program may be the easiest way to expand government insurance. Starting at age 50 aligns with AARP's new definition of "older Americans." This age group tends to have lower average health costs than those already on Medicare yet higher average costs than those in private coverage, so shifting them to Medicare has the potential to lower the average costs both for Medicare and individuals in private insurance. Lowering average premiums in the private market would help attract younger enrollees. And if the goal is to cover all Americans over time in Medicare—literally using it as the foundational health program for people of all ages—this would be the most logical place to start.

The proposals also highlight the differences between Medicare and the ACA marketplace, forcing hard choices. Do these older Americans, for example, get Medicare's lower deductibles or the ACA's annual out-of-pocket limit? Do they get Medicare's social insurance subsidies or the ACA's income-based ones? And, now that the ACA guarantees access to private plans for this group, is providing different coverage for older Americans the top priority? Older adults are much more likely to be insured and have higher income than younger adults, who may object to being left out. Last but not least, even though lowering Medicare's age eligibility is the expansion most similar to the current program, it would likely be subject to the scare tactic often used on senior voters—that it would be "messing with Medicare."

Make it a Choice

Starting about a decade ago, thanks largely to the work of Jacob Hacker, the idea of letting people choose between a public and private insurance plan entered the national debate. Rather than selectively extending public plan eligibility for certain groups, this approach would let people "vote with their feet." The House-passed version of the ACA included a

nationwide public plan (distinct from but resembling Medicare) to be offered alongside private plans to individuals and small businesses. Hacker now proposes that large employers have the choice of a public plan as well. Another option, advocated by Michael Sparer and embodied in a bill introduced by Senator Brian Schatz, would let any eligible individual buy into Medicaid, including those otherwise eligible for individual marketplace or employer coverage.

This approach has appeal in a nation that values the concept of choice. It forces a side-by-side comparison of the different ways to organize coverage, a comparison that proponents believe will dispel myths about public plans. The Congressional Budget Office estimates that proposals such as the one in the 2009 House bill would stimulate competition, improving the value of coverage and reducing its cost. If the public plan "wins" and gets most enrollment, it would be a transition propelled by individuals' decisions rather than a government decree.

Choice, however, can undermine a system of insurance. People know their health status better than insurers or the government, so it stands to reason that sick people would gravitate to the public plan while healthy people would choose private plans—or vice versa—depending on how the program is designed. That problem can be mitigated behind the scenes through mechanisms such as risk adjustment (compensating health insurers for enrolling a disproportionate percentage of higher-cost enrollees in the market), as is done in Medicare Advantage (although such a system comes at a cost to the federal government). Alternative ways to keep private plans competing alongside a public plan include setting that plan's provider payment rates closer to private plans' rates than Medicare's or requiring Medicare rates for out-of-network providers in private plans, as recently proposed by Zirui Song in *The New England Journal of Medicine*. Failing to adopt measures such as these could result in private insurers pulling out of the markets, in which case people will be deprived of the choice this model promises. For choice models to work, policymakers would need to make periodic adjustments (as has been done for Medicare Advantage), and that kind of calibration may not be feasible in today's politically polarized environment.

Go Where the Money is

Another historical point of entry for public programs has been people with serious health needs. Medicaid covers people with certain disabilities, including, in some states, people whose monthly or quarterly medical bills are so high that the bills impoverish them. Medicare covers people with end-stage renal disease and beneficiaries of Social Security Disability Insurance after a two-year waiting period. Proposals to eliminate Medicare's waiting period have been considered for decades. As Harold Pollack argues, addressing the needs of people with disabilities requires the development of

distinctive capacities in public programs, which some states have done. Building up those capacities nationally would not only improve the care of our most vulnerable but also stabilize private insurance markets. The historical impediment to such an approach has been the cost to the federal government.

Now that the ACA has fully integrated people with pre-existing conditions into private plans, policymakers are considering public means of lowering the cost of private insurance. In 2015, private plans paid more than Medicare for the top 1 percent most expensive Americans. Public reinsurance has become a popular, bipartisan idea to lower premiums and improve the functioning of the individual market. By reimbursing health insurers for high costs (for example, for organ transplants or treatment for hemophilia), reinsurance lowers cost uncertainty for insurers and thus the premiums they charge. Alaska and Oregon are implementing such programs in 2018, and legislation sponsored by Senators Susan Collins and Bill Nelson supports additional state programs. The "Invisible Risk-Sharing Program," a type of reinsurance offered by Republicans in 2017, would pay the costs of people with high-cost conditions like cancer at Medicare provider payment rates. Such a program could, as we have suggested in an article in *Health Affairs*, extend to employer plans as well, efficiently spreading risk to lower premiums for the 175 million Americans with private coverage.

Public reinsurance has the benefit of lowering premiums and allowing people to "keep their plans." It builds on a well-established role for government: helping people who face financial hardship, as the federal government does in floods and other natural disasters. Reinsurance was the only proposal in both the Republicans' 2017 "repeal and replace" bills and Democratic alternatives. And it has the potential of lowering health costs generally depending on its design.

Public reinsurance, however, would primarily replace private reinsurance, and some employers may balk at the strings attached to the money. Because it is a back-end program, employers and insurers rather than the government (and members of Congress who voted for it) would likely get credit for its results. Republicans may reject it as another insurance company bailout, while Democrats may reject it as propping up private insurers rather than expanding "true" public plans. Like other proposals that lower reimbursement, this one could also engender opposition from physicians and hospitals.

Which Path Forward?

It is hard to work out the details of the next advance for affordable coverage when the specter of "Obamacare repeal and replace" still looms. Preventing dramatic reductions in coverage under a Republican-controlled White House and Congress remains a priority.

What the health system looks like at the end of the Trump era will affect future choices. If today's major health programs

are frayed but structurally intact, a future Congress or president may prefer less-dramatic proposals, especially given what else might be on the national and international agenda. Starting with a back-end public reinsurance program to lower costs would build trust and support among employers for a program that could be expanded by making more costs, and thus more people, eligible. A fallback public plan or a public plan choice may be the natural solution for the marketplace. While lowering the age of eligibility for Medicare may be considered a partial solution to private insurance problems, it could be part of larger Medicare reform. And an "all of the above" approach could be taken.

Alternatively, if the health system is in shambles when the next president takes office, the appetite (although not necessarily the ability) to move more rapidly to some type of public plan may be greater. Widespread problems—from few unsubsidized enrollees in the individual market to a watered-down Medicaid program to a return to large annual premium hikes in Medicare and employer-based health plans—could fuel proposals that give all Americans the promise of more affordable, reliable health coverage.

No matter the state of the system, proponents should consider calibrations of various ways to expand public plans in recognition of Americans' distrust of change. We tend to look back before looking forward. Fear of change worked against the ACA's movement of people to reformed private plans; many preferred to "keep their plans," despite their flaws. That same fear worked against Republicans' attempt in 2017 to take away the ACA's Medicaid expansion. A recent survey found that nearly half of Americans do not realize they would have to change plans under a single-payer system. Regardless, ideas across the spectrum we described should be ready since the Trump administration's health policies will almost certainly necessitate a response.

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