



#ACTUARIES2019

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Expanding Access to Public Plans



Panel

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Linda Blumberg, Urban Institute

Agenda

- Background—potential goals and key design issues for proposals to extend public insurance eligibility
- Federal proposals to expanding eligibility
- State approaches to expanding eligibility
- Modeling various health care reform options

Potential goals

- Reduce the number of uninsured
- Increase access to affordable coverage
- Exert downward pressure on provider prices, especially in areas with high prices or little provider competition
- Increase plan availability, especially in areas with few private insurance options
- Reduce health care spending

General public plan expansion approaches

- Public plan option in the ACA marketplaces
- Medicaid buy-in
- Medicare buy-in
- Medicare for more or for all

How the design elements are specified will affect program outcomes

- Access to coverage and access to care
- Premiums and out-of-pocket costs
- Viability of public plan expansion
- Viability of existing individual and group markets

Key design elements

- Who is the eligible population?
- What benefits would be covered and what patient cost-sharing would be required?
- Mandatory vs. optional: Would coverage in the plan be the sole coverage source available or an option among other coverage choices?
- How would premiums be set? Would they be self-supporting or would they be subsidized by state or federal government?

Key design elements (cont.)

- Would private plans (e.g., Medicare Advantage, Medicaid managed care) be available?
- How would provider payment rates be set? Would the plan have a provider network?
- Who would administer the program?
- How would the program be financed?
- How would the transition be handled?

Congressional Proposals

--Public Plan Option--

- S. 3 Keeping Health Insurance Affordable Act (Cardin)
- S. 489/H.R. 1277 State Public Option Act (Schatz/Lujan)
- S. 981/H.R. 2000 Medicare-X Choice Act (Bennet&Kaine/Delgado)
- S. 1033/H.R. 2085 The CHOICE Act (Whitehouse/Schakowsky)
- S. 1261/H.R. 2463 Choose Medicare Act (Merkley/Richmond)

Proposals would create federal public plan option to be offered in individual market exchanges. Some would extend option to employers, enhance premium and cost-sharing subsidies, and/or impose prescription drug or other cost containment measures. Proposals would use Medicare or Medicaid providers and base provider payment rates on Medicare rates.

Congressional Proposals

--Medicare Buy-in--

- S. 470 Medicare at 50 Act (Stabenow)
- H.R. 1346 Medicare Buy-In and Health Care Stabilization Act (Higgins)

Proposals would allow adults age 50+ to buy into Medicare (including Medicare Advantage).

Congressional Proposals

--Public Program with Employee Option--

- H.R. 2452 Medicare for America (DeLauro & Schakowsky)

Would automatically enroll individuals in the individual market, Medicaid, and Medicare into public program. Employers can continue to offer qualified coverage; workers can opt for employer coverage or public program.

Congressional Proposals

--(Enhanced) Medicare for All--

- S. 1129 Medicare for All (Sanders)
- H.R. 1384 Medicare for All (Jayapal)

Proposals would replace most health insurance with single federal program. Comprehensive benefits with no premiums and no or limited cost sharing.

Democratic Candidate Proposals

- Public option in conjunction with ACA improvements
 - Joe Biden, Pete Buttigieg, Amy Klobuchar
- Public program with employee option
 - Beto O'Rourke—backs Medicare for America legislation
- Medicare for All
 - Bernie Sanders—enhanced Medicare, elimination of private insurance
 - Kamala Harris—retains Medicare Advantage
 - Others showing general support include: Cory Booker, Tulsi Gabbard, Elizabeth Warren, Andrew Yang

For more information

- American Academy of Actuaries
 - Expanding Access to Public Insurance Plans
<https://www.actuary.org/files/publications/PublicInsurancePlans.pdf>
- Other resources
 - Comparison of Medicare-for-All and Public Plan Proposals, Kaiser Family Foundation
<https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/>
 - Where Do the Democratic Candidates Stand on Health Reform? Kaiser Family Foundation
<https://www.kff.org/slideshow/where-do-the-democratic-candidates-in-the-september-12th-debate-stand-on-health-reform/>
 - The “Medicare for All” Continuum, The Commonwealth Fund
<https://www.commonwealthfund.org/blog/2019/medicare-all-continuum>

Expanding Access to Public Plans: State Perspective

PRESENTED BY
Michael Cohen, PhD

Agenda

- Definitions
- History
- Recent Policy/Political Changes
- State Activities
 - Case Studies
- Towards the Future

Issue and Definitions

Multiple states have expressed interest in exploring or implementing a public option to improve affordability and access for certain populations

Target Population

- Uninsured and/or underinsured (affordability)
 - Those ineligible for cost-sharing protections, those ineligible for subsidies under current ACA (non-citizens, family glitch, too high income, etc.)

Definitions

- Public Plan (includes both Public Options and Medicaid Buy-In)
 - Number of other activities occurring
- Unit of Activity
 - States increasingly locus of policy-making
 - What resources can a state bring to improve coverage and affordability

History

Pre-ACA

- Initial concept to offer a public plan in competition with private issuers first made waves in the United State in 2001 in the form of the CHOICE Model in California (Halpin and Harbage 2010)
- Public Option part of House bill version (2009) of the ACA but not the Senate (and therefore final) version of the ACA (2010)

Post ACA

- Vermont (Green Mountain Care)
 - Law passed in 2011 to implement single payer system
 - Initial goal was to achieve a universal health care via 1332 waiver
 - Governor Shumlin ended the attempt in 2014
 - Costs cited as main roadblock

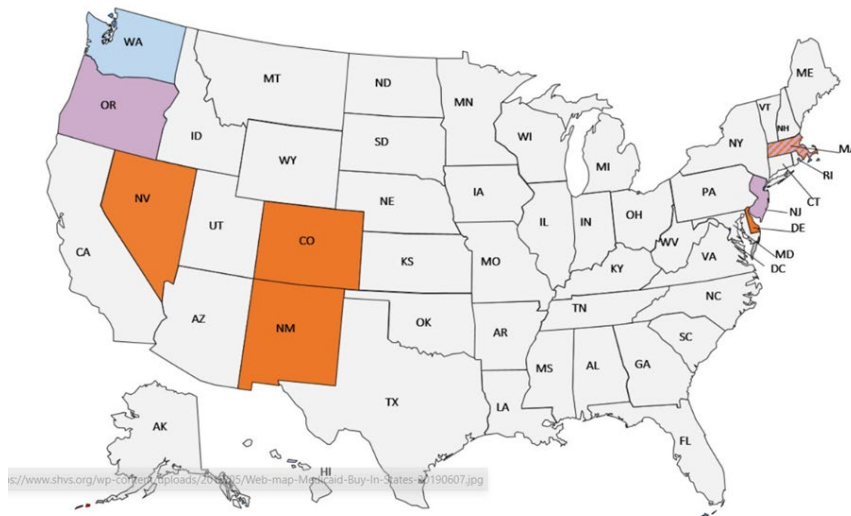
Changes to Political/Policy Landscape

- State Actions
 - What changed between 2014 and 2019
- Landscape Changes
 - Insurance participation increases (relative to 2017)
 - Premium increases in 2017 and 2018
- Political/Economic Changes
 - 2016 and 2018 elections
 - State budgets

State Activities

View of State Activities of April 2019

From SHVS (<https://www.shvs.org/state-efforts-to-develop-medicaid-buy-in-programs/>)



Blue – Passed Explicit Law

Orange/Purple – Was Considered in 2019

Overall Activity

Large push by state legislatures and advocates for public plans

One state (WA) currently planning on a public option starting in 2021

One state (CO) actively working on a plan for 2022

Other states still studying the issue

Note several states focused on other activities (reinsurance, subsidies, etc.) to improve affordability

Washington

May 2019 – state of Washington passed first “public option”

Public Option Model

- State contracts with at least one insurer who offers a bronze, silver, and gold plan.
- Overall provider contracting cannot exceed 160% of Medicare
 - Primary care service payments must be at least 135% of Medicare
 - State has flexibility to alter caps if carriers are unable to form provider network
- Report to legislature in 2022 on how system is working and if changes are needed
- Also includes subsidies for those 400% to 500% FPL
 - Caps net premiums at 10% of household income

Technical Details Forthcoming

Colorado

Colorado's legislation passed a law directing state agencies to develop a public plan for the legislature to consider in 2020 (due in November 2019).

Proposal By Agencies

- Start in 2022
- Issuers, over a certain size, will be required to offer public option plans on and off-Exchange.
- Issuers will be limited to 85% MLR
- Providers reimbursed as a rate benchmarked to Medicare rates (175% to 225%) for inpatient and outpatient facility
- Option sold on and off-Exchange with consumers eligible for APTCs
- Includes a 1332 component (recoup less APTCs)
- Does not use Medicaid Infrastructure (different populations, state financial risk/cost, etc.)

Other States

Other States Highlight Difficulty of Getting Public Plan Passed

CT

- Initial proposal similar to WA
- Threat of issuer exit ended the bill

NM

- Considering Medicaid Buy-In
- Currently studying impact of different models

CA

- All-payer system shelved
- Subsidies and mandate implemented instead

Towards the Future



Potential Cost Effects
of a

Single-Payer Health Option for New York State

Christine Eibner



Interest in single-payer arrangements has spiked at the state and national levels

The NYHA would extend comprehensive coverage to all



**Cover all
New York
residents**



**Replace
existing
insurance**



**Provide wide
scope of
health benefits**



**Eliminate
cost sharing**

Financing would rely on redirected health care funding and new taxes

Current NYHA



**Federal, state,
and local taxes
redirected**



**Insurance
premiums**



**Out-of-pocket
payments**

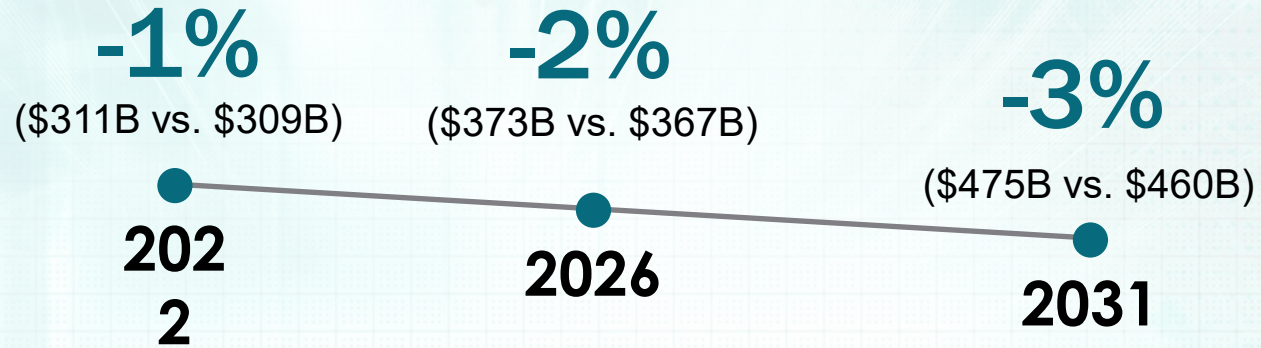


**New payroll and
nonpayroll taxes**

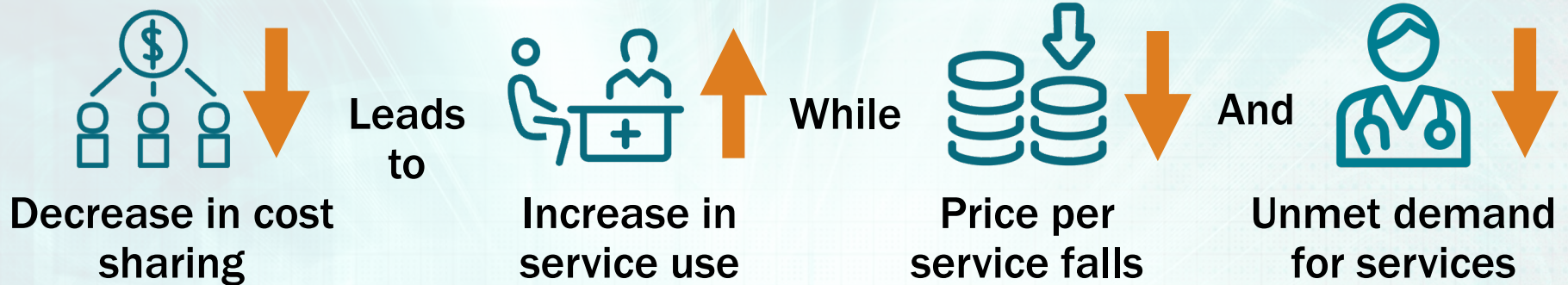
RAND analyzed the effects of the NYHA on coverage and costs

- **Used a microsimulation approach to estimate the effects on demand for health care, supply of health care, and spending**
- **Conducted an environmental scan, reviewed the literature, and interviewed stakeholders to assess feasibility**
- **Key assumptions**
 - **Federal waivers obtained**
 - **No migration on the part of residents, businesses, or providers**
 - **No tax avoidance**

Under our base assumptions, NYHA spending would decline slightly



Use of health care services would increase



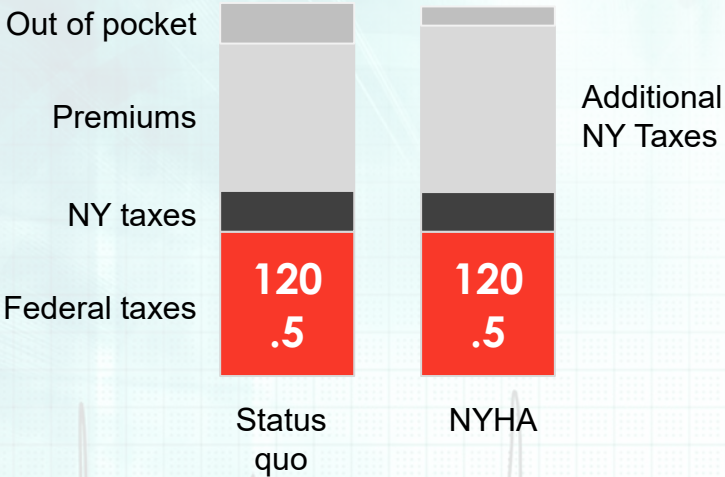
Bottom line
Overall spending falls over time

These results assume things go very smoothly for the state. But our feasibility study revealed many potential barriers.

- **The need to obtain federal waivers**
- Residential migration and tax avoidance
- Businesses' response
- Providers' response



Baseline analysis assumes state can recapture \$120.5 billion in federal funds



43%
of program would be
federally funded in
2022

2022

States would need at least three types of federal waivers

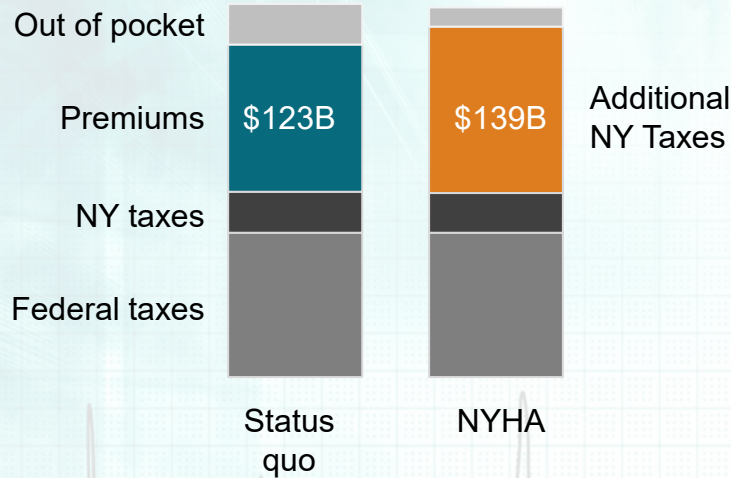
- Medicaid (1115 Waiver)
 - Must be budget neutral to the federal government
 - How will state show eligibility over time
 - Shadow eligibility system?
 - Block grant/per capita cap?
 - What about mandatory benefits like transportation that are not part of single payer?
- Medicare (402(b) or 1115a Waiver)
 - Must be budget neutral to the federal government
 - Unprecedented
 - Subject to challenge?
- Marketplaces (1332 Waiver)
 - Must be budget neutral to federal government
 - Implications for employers who offer across states
- Seema Verma announced that CMS will not approve; but could change with a different administration

These results assume things go very smoothly for the state. But our feasibility study revealed many potential barriers.

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- **Residential migration and tax avoidance**
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Taxes would replace premiums as key source of health care financing



156%

increase in total state
tax revenue in 2022

2022

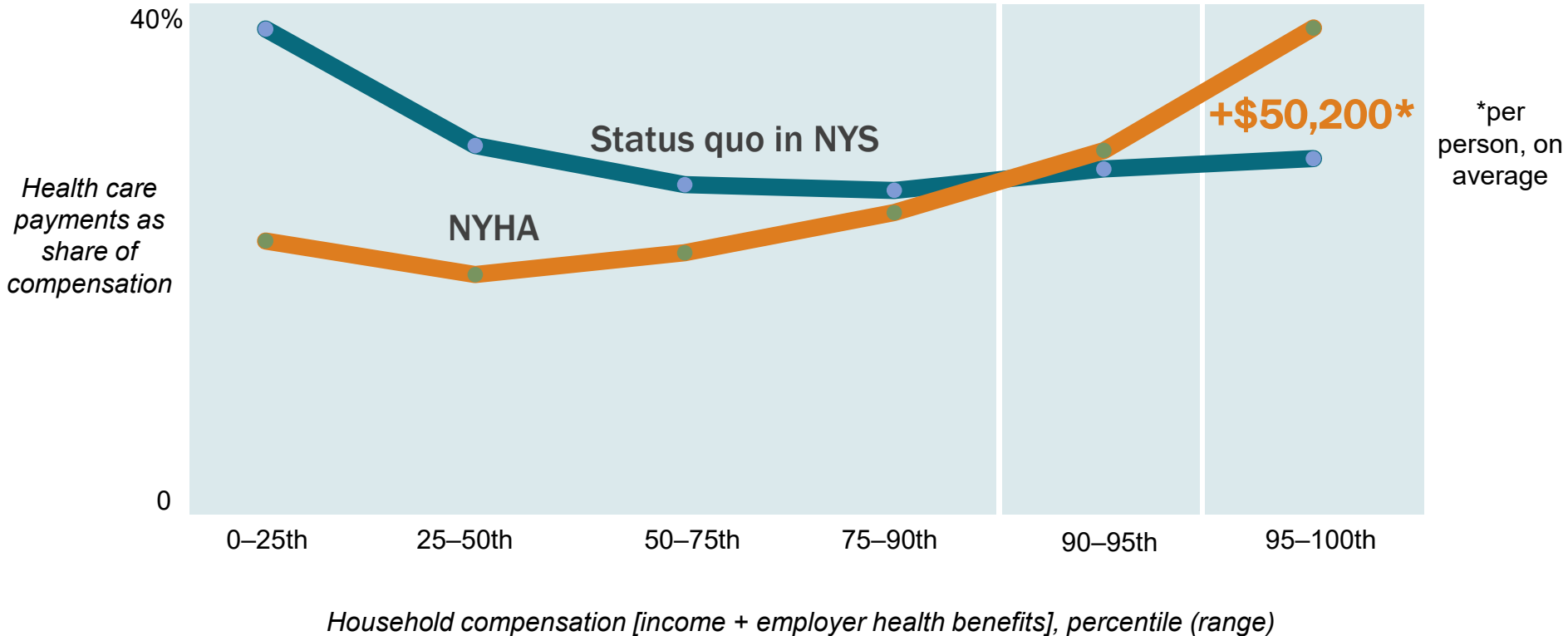
We estimated one possible tax schedule that raises \$139B in financing for 2022

Income	Tax Rate (%) Payroll / Nonpayroll
≤\$27,500	6.1 / 6.2
\$27,501–\$141,200	12.2 / 12.4
>\$141,200	18.3 / 18.6

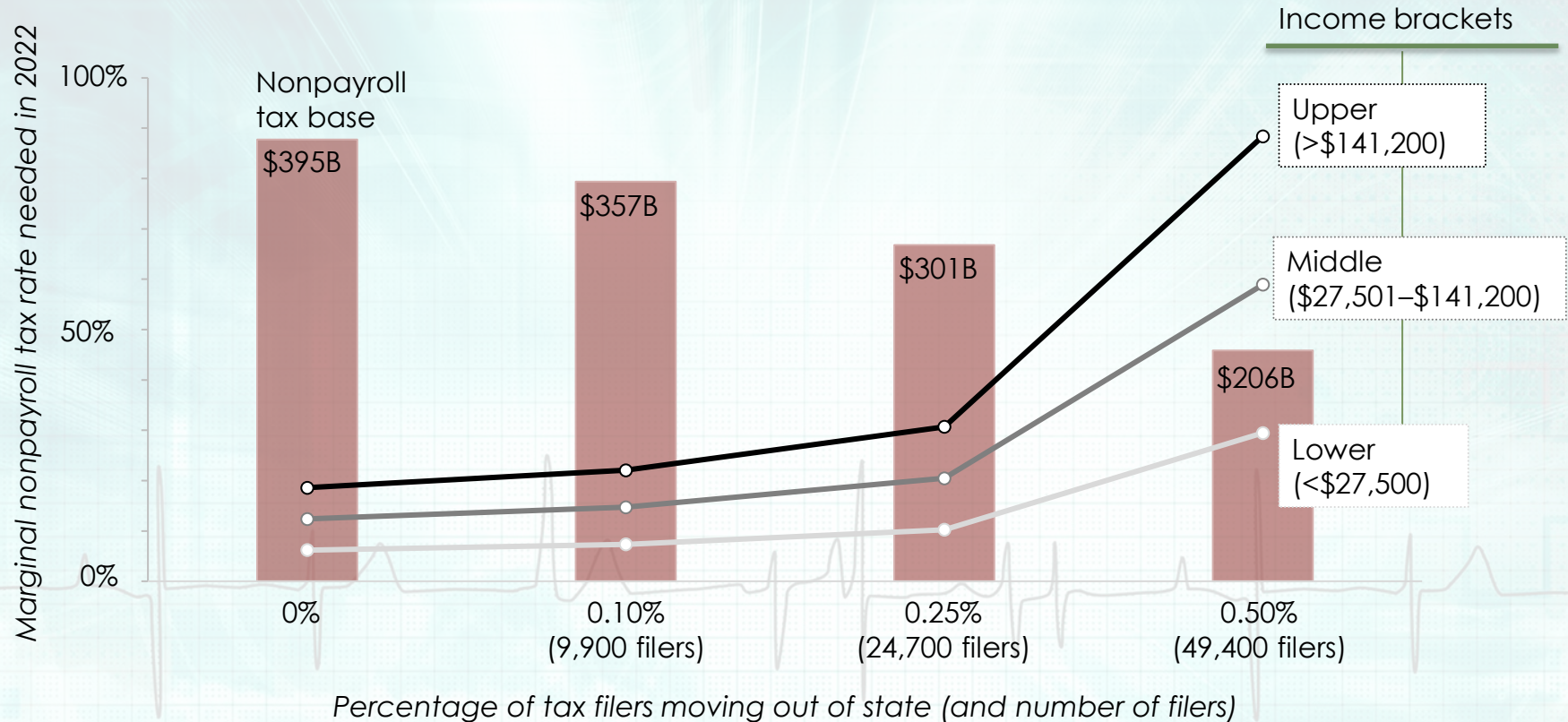


**Employer pays
80% of payroll tax**

Health care payments by households would fall for lowest-income residents, rise for highest in 2022



Wealthiest residents leaving the state could substantially reduce the funding base



These results assume things go very smoothly for the state. But our feasibility study revealed many potential barriers.

- The need to obtain federal waivers
- Residential migration and tax avoidance
- **Businesses' response**
- Providers' response



Whether employer payments would increase depends on current health insurance offerings

Employers currently offering health insurance would pay...

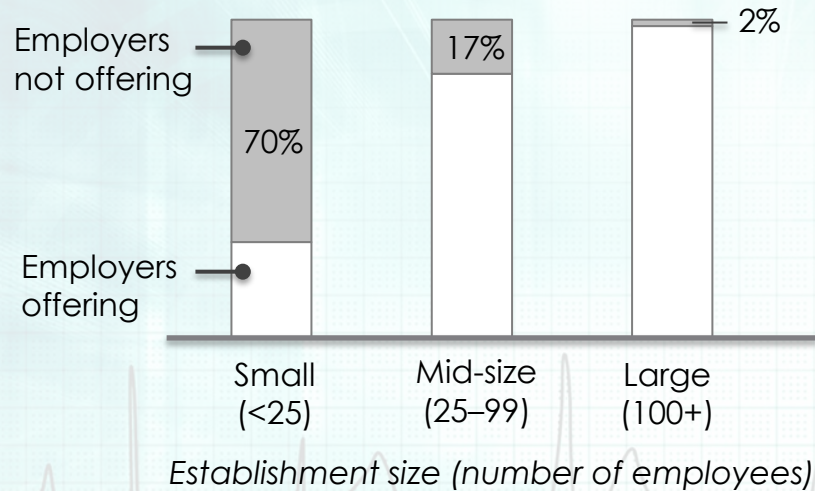


Employers **not** currently offering health insurance would pay...



...per worker, on average, in 2022

The new payroll tax would increase payments primarily by small businesses



Employers **not** currently offering health insurance would pay...

\$1,200–
\$1,800
more

...per worker, on average, in 2022

Possible responses by businesses

- Leave state
- Shut down
- Attempt a legal challenge
 - ERISA preempts state regulation of self-insured insurance plans
 - Prior case law is ambiguous as to whether a state single payer could result in a successful ERISA challenge
 - Maryland “pay or play” struck down under ERISA
 - San Francisco “pay or play” upheld (by a different court)

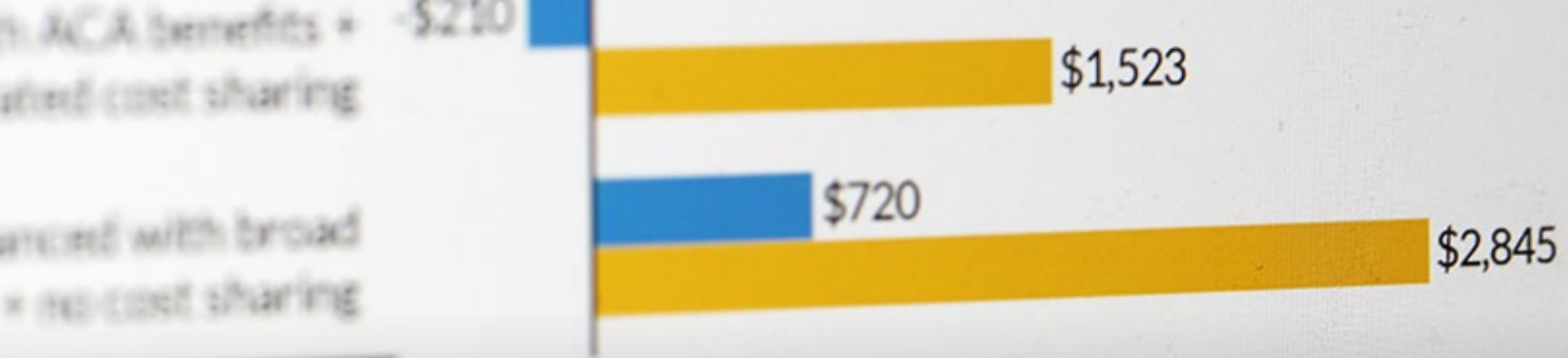
These results assume things go very smoothly for the state. But our feasibility study revealed many potential barriers.

- The need to obtain federal waivers
- Residential migration and tax avoidance
- Businesses' response
- **Providers' response**



Providers may reduce supply or leave state if payment rates fall

- Model assumes payment set at all-payer average, increases over time at Medicare rates
 - Leads to reduction in payment over time
 - We estimate that providers will reduce supply as a result
 - Only about half of the new demand for health services is met
- Some single payer approaches call for more significant reductions in provider payment, with unknown consequences
 - Providers may reduce hours, shut down, or leave state if payment falls substantially
- Provider leverage may preclude substantial payment reductions
 - WA state example—providers currently paid ~174% of Medicare
 - Public option negotiations settled on 160% of Medicare (<10%↓)



November 5, 2019, American Academy of Actuaries Annual Meeting

Comparing Health Insurance Reform Options: From “Building on the ACA” to Single Payer

Linda J. Blumberg, John Holahan, Matthew Buettgens, Anuj Gangopadhyaya, Bowen Garrett, Adele Shartzter, Michael Simpson, Robin Wang, Melissa M. Favreault, and Diane Arnos



Context for Analysis

- ACA Reforms
 - Medicaid expansion, subsidized private nongroup coverage, private insurance regulatory reforms, etc.
 - Increased insurance coverage ~ 20 million people; reduced uncompensated care; eliminated explicit discrimination against sick in private insurance markets; new insurer competition in many areas, etc.
- However, gaps remained:
 - Many still found coverage/out-of-pocket costs unaffordable; Supreme Court decision left 17 states without Medicaid expansion; provider/insurer consolidation keeps premiums high in some markets
- Policy changes since early 2017 created new problems and exacerbated others:
 - Repeal and repeal/replace efforts introduced confusion and uncertainty for consumers and insurers; reduced regulations decreased consumer protections & exacerbating risk selection problems; made enrollment harder in multiple ways; eliminated individual mandate penalties

Ensuing Policy Debate

- Many Republicans, including the president, continue to support full repeal, being pursued currently through the courts
 - Many support an array of policies designed to revert to greater risk segmentation and reduced federal funding for health care
- Most Democrats are pursuing policies designed to improve greater sharing of health care risk and improved affordability either through
 - building on the ACA (e.g., lower cost-sharing requirements, higher subsidies, filling Medicaid gap, public option) or
 - by revamping the entire system (single payer)

Analysis of 8 reform options

- 4 reforms add incrementally to the ACA in steps:
 - Improve premium & cost-sharing subsidies and expand eligibility for assistance
 - Bring healthier people back into the insurance pool
 - Cost containment through introduction of public option
- Reforms 5-6: builds on 1-4, but also
 - Auto-enrollment which leads to universal coverage for US residents legally present
 - Further improve affordability, including for more workers
- Reforms 7-8: single payer “lite” and single payer “enhanced”
 - single government health insurance plan for all, no private coverage
 - the two approaches differ in benefits and cost-sharing and coverage for undocumented immigrants

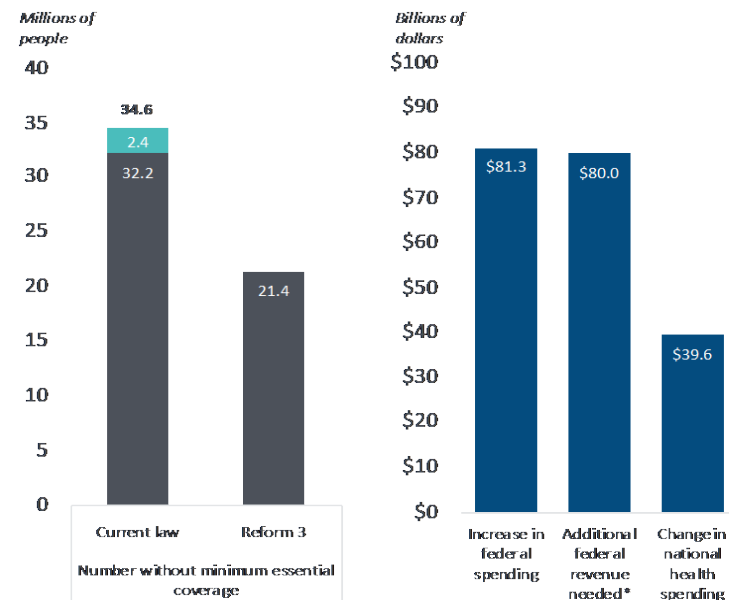
Overview

- Results compare reform to current law:
 - The uninsured
 - The change in federal spending = federal budget effects
 - The change in national health spending = households + employers + state governments + federal government
- We include different ways to achieve universal coverage
- Reforms estimated as if fully in place in 2020
- Estimated government revenues needed, but not how to get them

Reforms 1-3: In 3 steps

- More generous premium & cost-sharing subsidies
- Permanent reinsurance program
- Restored individual mandate & prohibition on substandard plans
- Filling in the Medicaid gap in nonexpansion states
- uninsured fall by 10.8 million with all pieces; filling Medicaid gap is critical
- *National* spending increases modestly by \$39.6 billion, 1.1%
- *Federal* spending increases with more assistance, \$81.3 billion in 2020, \$1.0 trillion over 10 years for reform 3).

Coverage and Changes in Spending Compared to Current Law, 2020



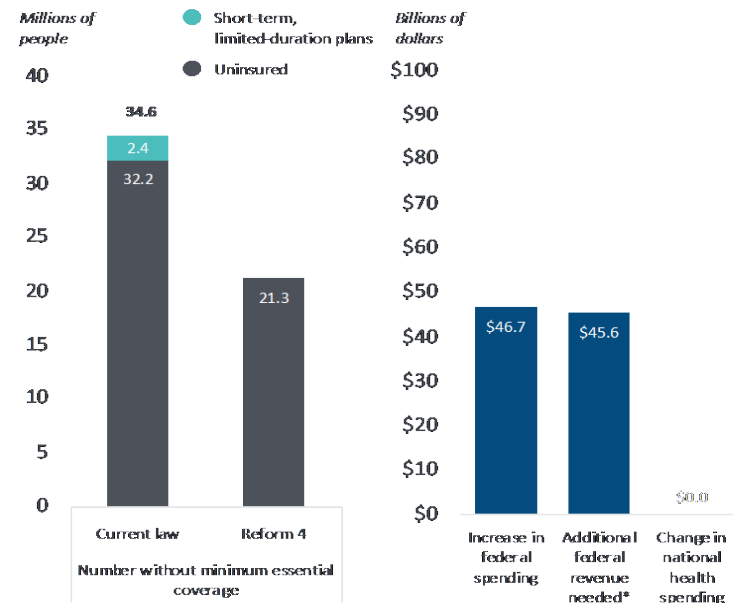
* Increase in federal revenue needed to finance reform, net of additional income tax receipts resulting from reduced employer spending on health insurance passed back to workers as wage increases.

Data: Urban Institute analysis.

Reform 4: Reform 3 *plus*

- Public option and/or capping of private insurers' provider payment rates in the nongroup market
- uninsured fall by 10.9 million
- Keeps *national* spending constant due to public option
- Federal* spending increases, but is lower than otherwise would be with public option: \$46.7 billion in 2020, \$590 billion over 10 years (versus \$1.0 trillion over 10 years)

Coverage and Changes in Spending Compared to Current Law, 2020



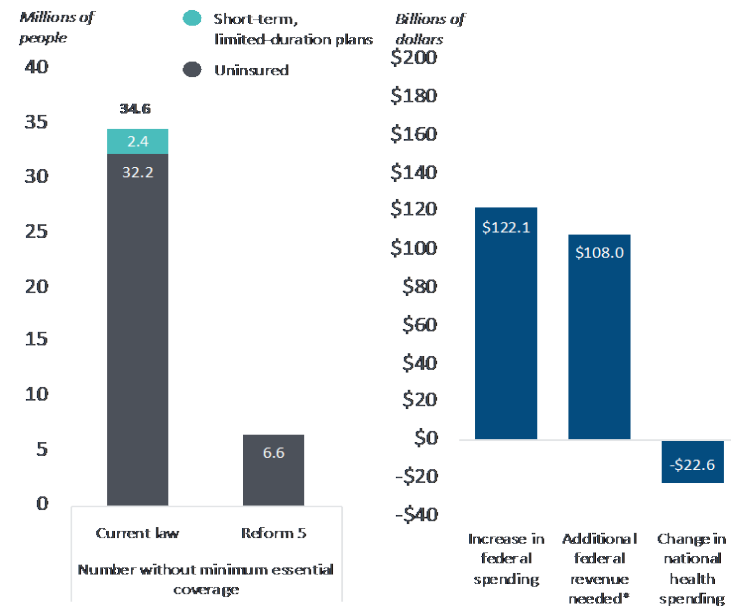
* Increase in federal revenue needed to finance reform, net of additional income tax receipts resulting from reduced employer spending on health insurance passed back to workers as wage increases.

Data: Urban Institute analysis.

Reform 5: Reform 4 *plus*

- Continuous auto-enrollment with retroactive enforcement (CARE)
- Eliminates ESI “firewall”
- Requires public option
- Universal coverage for people legally present in US; reduces uninsured by 25.6 million (80%)
- Employer coverage drops by 15.0 million, 10.2%
- *National* spending decreases modestly (\$22.6 billion or 0.6%)
- *Federal* spending increases by \$122.1 billion in 2020, \$1.5 trillion over 10 years

Coverage and Changes in Spending Compared to Current Law, 2020



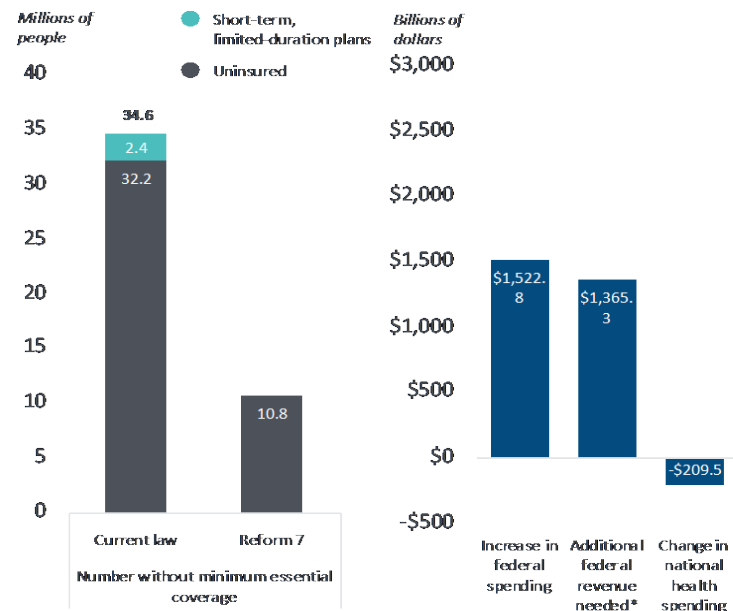
* Increase in federal revenue needed to finance reform, net of additional income tax receipts resulting from reduced employer spending on health insurance passed back to workers as wage increases.

Data: Urban Institute analysis.

Reform 7: Single Payer “Lite”

- Coverage of all legally present US residents
- ACA essential health benefits
- Income-related cost-sharing
- No private insurance
- 25.6 million legal residents gain insurance, but additional 4.2 million undocumented immigrants become uninsured; net decline of 21.4 million
- *National* spending falls by \$209.5 billion (6%)
- *Federal* spending increases by \$1.5 trillion in 2020, \$17.6 trillion over 10 years
- *Household* spending drops dramatically across income groups (72% overall)

Coverage and Changes in Spending Compared to Current Law, 2020



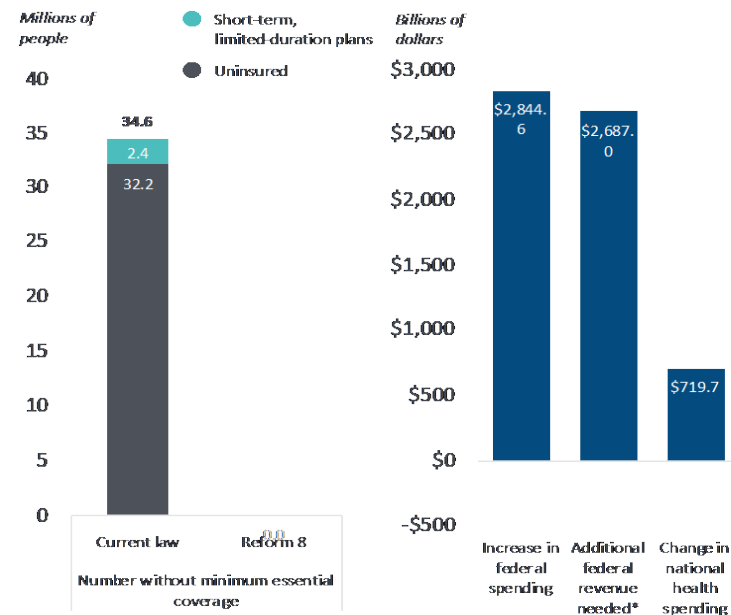
* Increase in federal revenue needed to finance reform, net of additional income tax receipts resulting from reduced employer spending on health insurance passed back to workers as wage increases.

Data: Urban Institute analysis.

Reform 8: Single Payer “Enhanced”

- Coverage of all US residents
- Additional benefits beyond ACA
- No cost-sharing
- No private insurance
- Uninsured eliminated
- *National* spending increases by \$720 billion in 2020.
- *Federal* spending increases by \$2.8 trillion in 2020, \$34.0 trillion over 10 years, roughly double “lite” version
- *Household* spending virtually eliminated

Coverage and Changes in Spending Compared to Current Law, 2020



* Increase in federal revenue needed to finance reform, net of additional income tax receipts resulting from reduced employer spending on health insurance passed back to workers as wage increases.

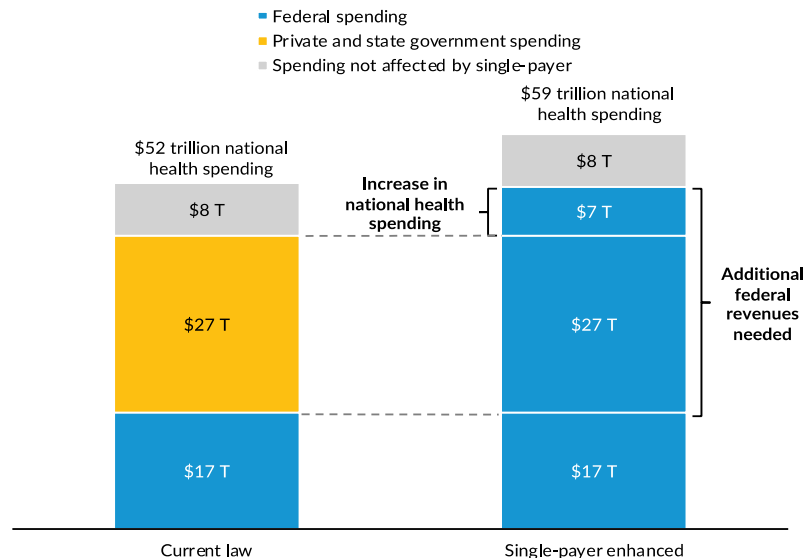
Data: Urban Institute analysis.

- Some advocates believe that, under single payer enhanced, federal spending would increase but national health spending would fall:

Our analysis disagrees.

- \$17 trillion in current federal spending would be repurposed.
- \$27 trillion in state government & private spending would shift to the federal government.
- \$7 trillion more in federal funds would be needed to fully finance it.
- \$8 trillion in spending not affected by reform continues

Ten-Year National Health Expenditures under Current Law and Single-Payer Enhanced, 2020–29



URBAN INSTITUTE

Source: Urban Institute analysis, consistent with estimates presented in *From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs* (Washington, DC: Urban Institute, 2019).

Discussion

- How much payments for hospitals, physicians, and prescription drugs can be reduced and over what period is unknown but has a large effect on government costs;
- How enrollment is phased in and how provider payment rates are reduced has large implications for costs in the 10 year window;
- Changes in employer health care spending are not the same as reducing employer costs;
- Effects on specific households' finances depend upon how benefits are distributed and how reforms are financed; net effects will vary by income

Questions