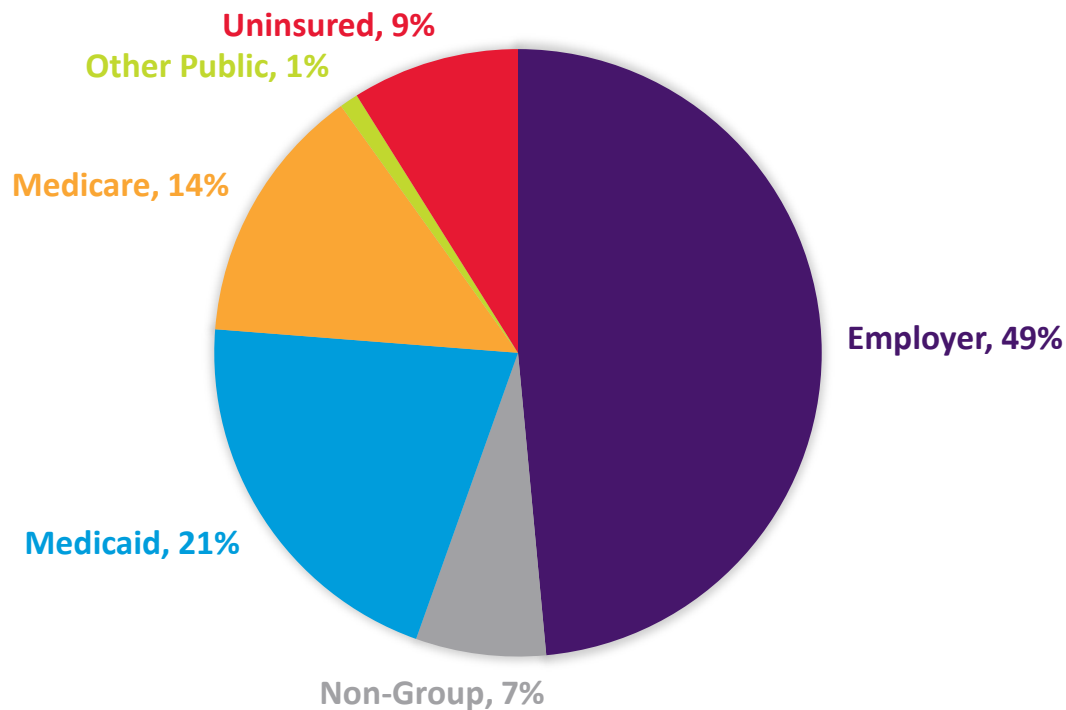




U.S. Health Care Reform - Diving into the Economic, Physician, and Patient Aspects of Proposed Health Care Plans

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Health Insurance Coverage of the Total Population, 2017

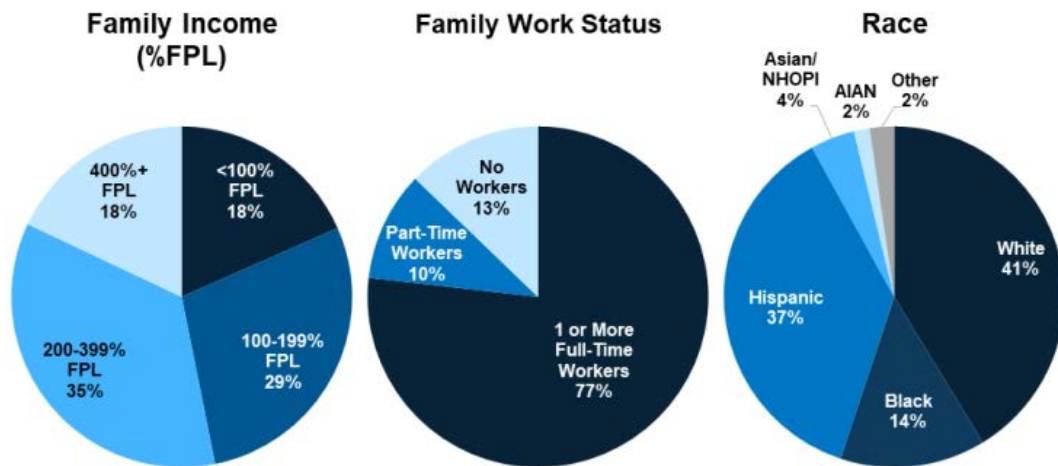


Source: KFF State Health Facts

Where We Are Now: Who Remains Uninsured

Figure 6

Characteristics of the Nonelderly Uninsured, 2017

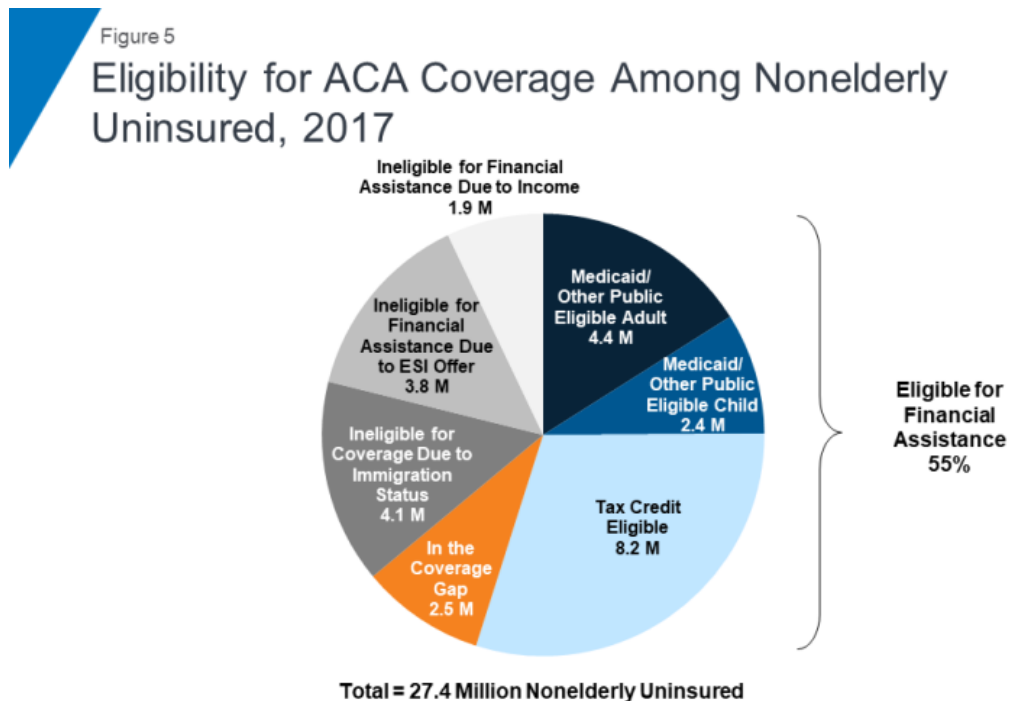


NOTE: Includes nonelderly individuals ages 0 to 64. The US Census Bureau's poverty threshold for a family with two adults and one child was \$19,730 in 2017. Data may not sum to 100% due to rounding. NHOPI refers to Native Hawaiians and Other Pacific Islanders. AIAN refers to American Indians and Alaska Natives. Persons of Hispanic origin may be of any race; all other race/ethnicity groups are non-Hispanic.

SOURCE: Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.



Where We Are Now: Who Remains Uninsured



NOTES: Numbers may not sum to totals due to rounding. Tax Credit Eligible share includes adults in MN and NY who are eligible for coverage through the Basic Health Plan. Medicaid/Other Public also includes CHIP and some state-funded programs for immigrants otherwise ineligible for Medicaid.

SOURCE: Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.



AMA Policy: How to Cover the Remaining Uninsured Eligible for Financial Assistance to Obtain Coverage

- 6.8 million eligible for Medicaid or CHIP
 - Increase and improve outreach and enrollment
 - Oppose Medicaid work requirements
- 8.2 million eligible for premium tax credits
 - Increase the generosity of premium tax credits
 - Expand eligibility for and increase the size of cost-sharing reductions
 - Provide enhanced premium tax credits to young adults
 - Support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits

AMA Policy: How to Cover the Remaining Uninsured Currently Ineligible for Financial Assistance

- 2.5 million in the coverage gap
 - Advocate for state-level Medicaid expansion
- 1.9 million ineligible due to income
 - Eliminate the subsidy “cliff”
 - Implement state/federal reinsurance program
- 3.8 million ineligible due to ESI offer
 - Fix the ACA’s family glitch
 - Lower the threshold that determines whether an employee’s premium contribution is “affordable”



Where Do We Go From Here? Issues to Consider in Evaluating Proposals to Expand Coverage

S. 1129, the Medicare for All Act of 2019

- Medicare-for-All would replace employer-sponsored insurance, individual market coverage, and most public programs, including Medicaid (for most services) and Medicare
- Medicare-for-All would have no premiums, and in general no cost-sharing, with the exception of giving the Secretary of HHS the authority to allow for cost-sharing for prescription drugs, up to \$200 per year
- Medicare-for-All would cover all medically necessary services in outlined benefit categories, dental and vision services, and home and community-based long-term services and supports
- Under Medicare-for-All, a global budget would be established for all health spending
- A fee schedule would be established for physicians, guided by Medicare rates

ACA 2.0 Proposals

- Increase the amount of and expand eligibility for premium tax credits, including removing the “subsidy cliff”
- Provide “enhanced” tax credits to young adults
- Increase amounts of cost-sharing reductions received by individuals who qualify for them
- Extend eligibility for cost-sharing reductions beyond 250 percent FPL
- Establish a reinsurance program
- Fix the ACA’s “family glitch”
- Establish a state individual mandate and/or auto-enrollment program
- Restrict the availability of short-term limited duration insurance (STLDI) plans and association health plans

Public Option Proposal of Vice President Biden

- Provide Americans with a public health insurance option like Medicare
- The Biden public option would be available to individuals covered by ESI, individually purchased coverage and the uninsured
- The Biden public option would negotiate lower prices from hospitals and other health care providers
- Premium-free public option would be available to uninsured who fall in the coverage gap

The Republican Study Committee Health Care Plan

- Repackage existing funding for ACA premium subsidies and Medicaid expansion to fund state-administered flex-grants to subsidize health insurance for low-income individuals
- Establish federally-funded, state-administered Guaranteed Coverage Pools to ensure individuals with high-cost illnesses have access to quality and affordable coverage
- Extend HIPAA portability and pre-existing condition protections for Americans with employer-sponsored insurance to people moving into the individual marketplace
- Reform the tax code to provide equal tax treatment in the employer and individual health insurance markets
- Allow HSA dollars to be used to cover more health-related expenses including insurance premiums, direct primary care service fees, and health sharing ministry dues
- Increase allowable, pre-tax contributions to HSAs from \$3,500 to \$9,000 for individuals and from \$7,000 to \$18,000 for families
- Eliminate ACA coverage mandates
- Similarities to provisions of 2017 repeal-and-replace bills, including the American Health Care Act of 2017

Coverage and Scope of Benefits

- How many people would become insured/lose coverage as a result of the proposal?
 - Would the proposal lead to universal or near-universal coverage, or be more incremental in nature?
 - Are people able to opt out of the coverage option(s) available?
 - What mechanisms are included to maximize coverage rates?
- Will new coverage options align with ACA-required essential health benefits, current Medicare benefits, or be more comprehensive in nature?
- What level of cost-sharing would be required of patients?

Impacts on Patient Access

- How will cost-sharing levels required of patients under the proposal impact the utilization of medical services?
- Will demand for medical services increase or decrease?
- At what rate will providers participate in any newly established plan?
- Will provider supply increase, decrease, or remain relatively consistent?

Other Impacts on Physician Practices

- How will payment rates outlined in the proposal impact the ability of physician practices to cover their costs of care?
- How will the proposal impact ongoing delivery reform efforts?
- Will physicians have the same amount of choices in their practice of medicine?
- What impact will the proposal have on physician practice payer mix? How would that impact practice efficiency?
- Will administrative burdens and hassles increase or decrease under the proposal?

Cost and Financing

- Medicare-for-All proposals are expected to incur the largest increases in federal spending
 - \$25 trillion to \$40 trillion over 10 years
- Urban Institute estimate of proposals to build upon and fix the ACA on federal spending on acute health care for the nonelderly in 2020:
 - Reinstating the ACA's individual mandate penalties and cost-sharing reduction payments and prohibiting the expanded availability of STLDI plans: Savings of \$11.4 billion;
 - Expanding Medicaid eligibility in all remaining states, with full federal financing of the Medicaid expansion for all states (when added to the previous bullet): \$68.1 billion; and
 - Improving marketplace assistance, including enhancing the ACA's premium tax credit and cost-sharing subsidy schedules; tying ACA financial assistance to gold instead of silver level coverage; and establishing a permanent federal reinsurance program (added to the two previous bullets): \$131 billion.
- How will proposals be paid for?
 - Will premiums and cost-sharing be required?
 - Will provider payment rates serve as a vehicle to help limit proposal costs?
 - Will tax changes be required?
 - Will the tax exclusion for employment-based health insurance be impacted?

Sources: Kenneth Thorpe, Urban Institute, Mercatus Center, KFF



Looking Ahead: The Impact of ACA-Related Court Cases



Supplemental materials

Vice President Joe Biden's [D] Affordable Care Act 2.0

Policy

- Biden's healthcare plan aims to preserve the ACA, and to take it a step further by adding a public option styled after Medicare

Enrollment

- Public option (such as Medicare) will be offered on the Affordable Care Act (ACA) marketplace
- Eliminates the 400% income cap on tax credit eligibility and lowers the limit on the cost of coverage from 9.86% of income to 8.5%
- Set tax credits based on gold plan rather than silver plan
- Offer premium-free access to the public option for qualifying individuals in states that did not expand Medicaid under the ACA and to those in states that did expand Medicaid as long as those states continue their current cost sharing with the federal government
- Automatic enrollment of qualifying individuals into the premium-free public option when they interact with public institutions and welfare programs

Financing

- Close capital gains tax loopholes
- Increase income tax cap to 39.6%

Implications for Patients and Physicians

- **Physicians**
 - **Community Health** – double the federal investment in Community Health Centers
 - **Mental Health** – implement mental health parity law
 - **Global Health** – rescinding the Mexico City Policy (AKA global gag rule) to allow the U.S. to support global health initiatives
 -
- **Patients**
 - Under the public option, patients will have no co-pay to see a primary care physician
 - **Pre-existing condition** – keeping these protections for all
 - **Women's health** – expanding access to contraception (restore federal funding to Planned Parenthood) and protecting the constitutional right to an abortion (reversing TRAP laws)
 - **Maternal Health** – follow California's steps in halving maternal mortality by adopting the California Pregnancy-Associated Mortality Review, for the whole nation
 - **LGBTQ+ Health** – defending healthcare protections for the LGBTQ+ population to ensure no one is discriminated against based on their gender, gender identity, or sexual orientation
 - **Surprise medical billing** - Aim to reduce the cost of health care by banning surprise medical billing and increasing market competition

- ***Prescription Drug Pricing*** – reduce prescription drug prices by allowing Medicare to negotiate drug prices, external reference pricing (comparing costs of a drug in other countries), limiting price increases, allowing consumers to buy from other countries, termination of pharmaceutical corporation tax breaks for advertisement spending, and investing more in generic brand drugs

What is “Buy-in?”

- An option that states can opt for, to expand access to current Medicaid/Medicare health insurance plans, thus effectively increasing the number of citizens who are covered

Medicare at 50 Act, S. 470 by Senator Stabenow

- S. 470 aims to lower the eligibility age to 50 to increase access to care for older adults.

Enrollment

- Will cover all United States citizens and residents between the ages of 50 to 64 who choose to buy-in to Medicare
 - Individuals in this age range will be able to opt-in to Medicare Parts A, B, and D as well as Medicare Advantage plans
 - These individuals are available to enroll in private coverage if they choose to do so
- Enrollment is for one year at a time
- Enrollment coordinated with marketplace and Medicare enrollment periods

Financing

- Premiums for the Medicare buy-in plan will cover costs, by being deposited into the Medicare Buy-In Trust Fund

Implications for Patients and Physicians

- Patients
 - Increased access to health insurance, with the change in eligibility requirements allowing for enrollment at an earlier age
- Physicians
 - Largely unaffected; would abide by the Medicare procedures already currently in place, so would have a larger subset of patients covered by Medicare

Medicare Buy-in and Health Care Stabilization Act of 2019, H.R. 1346 by Representative Higgins

- H.R. 1346 is very similar to S. 470 (Medicare at 50 Act), with the key difference being that of enhanced marketplace cost sharing subsidies for all participants.

Enrollment

- Will cover all United States citizens and residents between the ages of 50 to 64 who choose to buy-in to Medicare
 - Individuals in this age range will be able to opt-in to Medicare Parts A, B, and D as well as Medicare Advantage Prescription Drug plans
 - These individuals are available to enroll in private coverage if they choose to do so
- Enrollment is for one year at a time
- Enrollment during ACA enrollment periods; marketplace procedures apply

Financing

- Premiums for the Medicare buy-in plan will cover costs, by being deposited into a new and separate Medicare Buy-In Trust Fund, for the sole financing of the buy-in population

Implications for Patients and Physicians

- Patients
 - Increased access to health insurance, with the change in eligibility requirements allowing for enrollment at an earlier age
- Physicians
 - Largely unaffected; would abide by the Medicare procedures already currently in place, so would have a larger subset of patients covered by Medicare

State Public Option Act, S. 489 by Senator Schatz and H.R. 1277 by Representative Lujan

- The State Public Option Act would allow patients to buy-into the already existing Medicaid program in order to increase the number of persons with affordable and high quality health insurance.

Enrollment

- Enrollment is for one year at a time
- If the state elects the option, enrollment would occur in the ACA marketplace
- Enrollment during ACA enrollment periods; marketplace procedures apply

Financing

- States would have to first use their premium revenues and Advanced Premium Tax Credits

- Following the above, if the state has any excess expenses related to the program, the federal government and the state in question will share the expenses at the normal FMAP rate.
- Following the above, if the state has any excess revenues related to the program, the state in question and the federal government will share the revenues at a rate of 50%

Implications for Patients and Physicians

- Patients
 - Increased access to health insurance, with the change allowing all patients to buy-into access to Medicaid assuming the state has opted-into the program
- Physicians
 - Largely unaffected; would abide by the Medicaid procedures already currently in place, so would have a larger subset of patients covered by Medicaid
 - States required to pay Medicare rates to primary care physicians, Medicaid rates paid to all other physicians

Medicare for All Act of 2019 S. 1129 (Sponsor: Senator Bernie Sanders [D-VT])

Single Payer Health Insurance

- Medicare for All, run by the Secretary of Health and Human Services (HHS), will cover all United States residents and will replace all other publicly offered insurance
- Benefits will begin four years after the Act is enacted for most residents. However, all newborns will be automatically enrolled at the time of their birth in the US or when they establish residency in the US, and benefits for individuals under the age of 19 will begin one year after the Act is enacted.
- The benefits provided in this Act include: 1. hospital services (inpatient and outpatient), 2. ambulatory patient services, 3. primary and preventative services, 4. prescription drugs, medical devices, and biological products (including outpatient), 5. mental health and substance abuse treatment services, 6. laboratory and diagnostic services, 7. comprehensive reproductive (repealing the Hyde amendment), maternity, and newborn care, 8. pediatrics (including early and periodic screening, diagnostic, and treatment services), 9. oral health, audiology, and vision services, 10. short-term rehabilitative and habilitative services and devices, 11. emergency services and transportation, 12. necessary transportation to receive health care services for individuals with disabilities and low-income individuals, and 13. home and community-based long-term services and supports
- Private health insurers are prohibited from selling health insurance that duplicates the benefits provided in this Act, but they may provide additional benefits beyond the scope of this Act.

Transition

- In the four years before full implementation, a Medicare buy-in option will be established with decreasing age requirements each successive year, 55 after the first year, 45 after the second year, and 35 after the third year. This coverage will constitute the minimum essential coverage required under the Affordable Care Act.
- This Medicare buy-in option will have an annual premium as established by the Secretary, which shall be equal to the average, annual per capita expenditure for Medicare benefits and administrative expenses.
- In states that do not expand Medicaid, cost sharing subsidies will be applied to the Medicare Transition plan.

Payments

- This Act establishes fee schedules and benefit payment amounts that are consistent with processes for determining payments currently under Medicare with new processes for updating payment amounts.
- Prescription drug prices will be negotiated annually by the Secretary, while emphasizing the use of generic drugs when possible.

Financing

- This Act establishes the Universal Medicare Trust Fund and appropriates current federal health spending offsets into it.
- Logistics of how to raise the increased revenue necessary to finance this Act has not been finalized, but proposals include, but aren't limited to, restructuring the tax code to close loopholes, a 4% income-based premium paid by employees, a 7.5% income-based premium paid by employers, and a wealth tax.

Implications for Patients and Providers

Patients

- All residents of the US will have access to comprehensive health care
- Patients will no longer have out of pocket expenses for medical care (premiums or deductibles), leading to fewer people going into debt due to medical costs
- Patients may have increased taxes

Physicians

- Lower administrative costs due to only having to navigate a single insurance system
- Physicians may be reimbursed less per patient

H.R. 1384, Medicare for All Act of 2019 (Sponsor: Rep. Pramila Jayapal [D-WA-7])

The basic structure of H.R. 1384 mirrors that of S. 1129, with several key differences which are highlighted below.

Enrollment

- Benefits will begin two years after the enactment of this Act.
- Benefits for individuals under the age of 19 and above the age of 54 will be eligible starting one year after the enactment of the Act.

Payments

- Each year the Secretary will establish a national health budget for the total health expenditures for health care items and services.
- Each quarter, the Secretary will pay institutions and providers a lump sum for the items and services provided in that time frame, with quarterly reviews.
- Annual negotiations will take place between institutions and Regional directors to determine the amount of payments, taking into account historical expenditures, data on costs, changes in volume, and other factors.

Prescription Drug Prices

- The Secretary will negotiate with pharmaceutical manufacturers annually the prices that may be charged to Medicare for All, taking into account: clinical effectiveness, budgetary

impact of providing coverage of such drug, similarly effective or alternate treatment regimens, and total revenue from global sales of the drug by the manufacturer.

- If the Secretary is not able to negotiate an appropriate price for a covered drug, the Secretary may authorize the use of the patent for purposes of manufacturing the drug for sale under Medicare for All, while reasonably compensating the patent holder. The Secretary may procure a drug directly.

Transition

- One year after enactment of this Act, a transitional Medicare buy-in plan will be offered through the ACA marketplaces, with the same benefits available under Medicare for All.
- The premium of that plan will be determined by the Secretary.
- Tax credits will be available to individuals above 400% of the federal poverty line and those below 100% of the federal poverty line in states that haven't expanded Medicaid.

Medicare for America Act of 2019 H.R. 2452

(Sponsors: Rep. DeLauro[D-CT] and Rep. Schakowsky [D-IL])

Public Option with Buy Out

- The public health insurance option “Medicare for America” (MFA), run by the Secretary of Health and Human Services (HHS), will be offered in the market alongside private health insurance companies.
- MFA will be available to residents of the United States and its territories, individuals who are lawfully present, and individuals eligible for Medicaid.
- Automatic enrollments and employer-mediated enrollments will facilitate the transition to MFA, while individuals that have qualified health care coverage will have the option to opt out.
- Benefits of MFA include coverage of essential health benefits (as defined by the Affordable Care Act) and comprehensive coverage of reproductive health services.
- The premium is determined by a linear scale for families earning greater than 200% of the poverty line but will not exceed 8% of their adjusted gross monthly income.
- There is no premium imposed on families earning less than 200% of the poverty line.
- HHS will determine rates for reimbursing providers based on title XVIII of the Social Security Act and will establish rates for services not covered under the Act.

Provisions

No surprise billing: For non-emergent and emergent services, the out-of-pocket expense for patients will not exceed the amount that would be charged by an in-network provider. Out of network providers may bill the HHS for reimbursement at the rate established under the MFA.

Eliminating waiting periods: The 24-month waiting period for Medicare coverage for individuals with disabilities and the waiting period for State Medicaid coverage will be eliminated.

Abortion coverage: Federal funds can be used for providing abortion services.

Student loan forgiveness: The HHS and Secretary of Education will erase 10% of the Federal Loan and accrued interest (for that year) for each year that a health care provider participates in MFA. This applies to any eligible Federal Loan issued within 20 years before the enactment of MFA.

Safe staffing: Hospitals must provide adequate staffing to optimize patient care. Notably, minimum nurse-to-patient ratios must be upheld.

Financing

- Federal funds will be used to finance the public health insurance option.
- A 5% tax will be imposed on adjusted gross income if income exceeds \$500,000.
- Medicare payroll tax will be increased from 0.9% to 4%.
- Investment income tax will be increased from 3.8% to 6.9%
- Other increases will be in excise taxes on tobacco products, alcohol and sugary drinks.

Implications for Patients and Physicians

Patients

- MFA would be an affordable alternative to the private health insurance plans that currently exist in the market.
- MFA is similar to social security in that it is funded through taxes on income and the benefits are received in older age or disability.
- Premiums will likely decrease as there is no focus on profits, administrative costs are lower and the government has increased bargaining power compared to private companies.
- Patients will be able to change jobs and move without compromising their health insurance.

Physicians

- MFA may drive down costs of services provided by physicians.
- Physicians may be reimbursed less than they are currently.