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**Status of U.S. Health Insurance Coverage and the
Potential of Recent Congressional Health Reform Bills
to Expand Coverage and Lower Consumer Costs**

Sara R. Collins, Ph.D.
Vice President, Health Care Coverage and Access
The Commonwealth Fund
One East 75th Street
New York, NY 10021
src@cmwf.org

Invited Testimony

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EXECUTIVE SUMMARY

Thank you, Mr. Chairman, members of the Committee, for this invitation to testify today on current proposals to reform the U.S. health care system. My comments will focus on the national gains in health insurance coverage since the passage of the Affordable Care Act (ACA), the problems people continue to report affording health insurance and health care, and the potential of recent Congressional health reform bills to address these problems.

The ACA brought sweeping change to the U.S. health system, expanding comprehensive and affordable health insurance to millions of lower- and middle-income Americans, and making it possible for anyone with health problems to buy health insurance by banning insurers from denying people coverage or charging them more because of preexisting conditions.

The number of uninsured people in the United States has fallen by nearly half since the ACA was signed into law, dropping from a historical peak of 48.6 million people in 2010 to 29.7 million in 2018. There was also a decline in the share of people who reported financial problems associated with medical bills or who had problems getting health care because of cost. A large body of research on the effects of the ACA shows that the overall impact of the legislation on people's ability to afford health insurance and get needed health care has been positive.

However, three distinct, yet interrelated, problems remain: millions of people are still uninsured, millions of people with insurance have plans that are leaving them underinsured, and health care costs are growing faster than median income in most states.

After dropping significantly through 2015, the national uninsured rate has held steady at around 9 percent, with ominous upticks in 14 states in 2017. These stalled gains stem from four primary factors:

- Seventeen states have not yet expanded Medicaid, including the heavily populated states of Florida and Texas.
- People with incomes just over the marketplace subsidy threshold (about \$48,560 for an individual and \$100,000 for a family of four) and many in employer plans have high premium contributions relative to income.
- Congressional and executive actions regarding the individual market and Medicaid have reduced potential enrollment in both.

- Undocumented immigrants are ineligible for subsidized coverage under the ACA.

In addition to the 29.7 million people who lack insurance, an estimated 44 million working-age adults with insurance are underinsured because they have high out-of-pocket costs and deductibles relative to their income. This is up from 29 million in 2010, according to Commonwealth Fund survey data. The greatest growth in the share of underinsured adults is occurring among those in employer health plans. However, people who buy plans on their own through the individual market — including the ACA marketplaces — are underinsured at the highest rates.

The growth in underinsurance is attributable to two primary factors:

- Growth in cost-sharing, particularly deductibles, in the individual market and employer plans
- Sluggish growth in U.S. median income; out-of-pocket health care costs and deductibles comprise a growing share of income among low- and moderate-income families.

Leaving millions of people uninsured or underinsured has implications for families and the nation's general prosperity. Commonwealth Fund surveys have consistently found that people who lack health insurance even for short periods of time, or those who are underinsured, avoid or delay needed health care and are at risk of accumulating medical debt. Many adults with medical bill or debt problems report serious financial problems including using all their savings to pay their bills or receiving a lower credit rating as a result of their debt. Other research has demonstrated that people who don't have adequate health insurance all their lives have fundamentally different life experiences and less economic opportunity than those who are adequately insured. This includes lower educational attainment, lifetime earnings, and life expectancy.

A major factor underlying trends in both uninsured and underinsured rates is the overall rate of growth in U.S. health care costs. Health care costs are the primary driver of premium growth in private insurance. To temper premium growth, insurers and employers have increased deductibles, exposing enrollees to growing out-of-pocket risk. This means that health care costs ultimately drive consumers' decisions to buy insurance (via premiums) and whether to get health care (via cost-sharing). Income-based subsidies and risk-reduction strategies like reinsurance can lower premiums and consumers' out-of-pocket costs, but they will not address the underlying cost drivers. Moreover, the federal and state costs of those policies also will be affected by overall cost growth. It is therefore critical that such policies be paired with strategies to lower U.S. health care costs.

There is growing evidence that prices paid to providers — especially hospitals — rather than use of health care services, are the primary driver of health care cost growth. There is also considerable evidence that prices explain the wide health care spending gap between the United States and other wealthy countries.

Recent research also indicates that per capita costs in U.S. private insurance are rising faster than those in public insurance programs. Medicare sets prices for providers, while prices in commercial plans are usually the result of negotiation between providers and insurers or employers. Gerard Anderson and colleagues note that the difference between prices paid by public and private insurers ballooned from 10 percent in 2000 to 50 percent in 2017. They argue that to lower the rate of growth in U.S. health care costs, we need increased scrutiny of private insurer payments to providers.

Congressional Democrats have introduced several bills aimed at addressing the interrelated problems of uninsurance, underinsurance, and rising health care costs. The bills are similar in that they expand the public portion of our mixed private–public health care system. They fall along a continuum that ranges from adding public plan features to private insurance to Medicare-for-All proposals. The bills may be broadly grouped into three categories:

- **Adding public plan features to private insurance.** These bills include provisions to enhance the premium and cost-sharing subsidies for marketplace plans, fixing the so-called family coverage glitch in employer plans, adding reinsurance, and addressing the Medicaid coverage gap for low-income people in nonexpansion states.
- **A choice of public plans alongside private plans.** In addition to enhancing ACA subsidies and providing reinsurance, the bills in this category also give consumers a choice of a public plan, based on either Medicare or Medicaid, for employers and people in the ACA marketplaces. The bills use the leverage of the federal government’s buying power in setting premiums for the public plan, establishing provider payment rates, and negotiating prescription drug prices. Some bills also improve benefits for people currently enrolled in Medicare.
- **Making public plans the primary source of coverage in the U.S.** Bills in this category are single-payer or Medicare-for-All bills in which all residents are eligible for a public plan that resembles the current Medicare program, but is not the same program we have today. The bills limit or end premiums and cost-sharing and end most current forms of insurance coverage, including most private coverage, with the exception of HR 7337, which retains employer coverage as an option. Benefits are comprehensive and include services not currently covered by Medicare such as dental, vision, and long-term care. The approach brings substantial federal leverage to bear in setting premiums and lowering provider and prescription drug prices.

While these bills would create different degrees of change, all have the potential to make the following general changes in the U.S health care system:

- Improve the affordability, benefit coverage, and cost protection of insurance for many or all U.S. residents
- Lower the rate of cost growth in hospital and physician services, prescription drugs, and health plan and provider administration

- Reduce the number of uninsured people, in some bills to near zero
- Reduce the number of underinsured people, in some bills to near zero.

Estimates of the potential effects of these provisions include:

- By lifting the top income eligibility threshold for marketplace premium tax credits, we could insure 1.7 million more people and lower silver plan premiums by 2.7 percent, at a net federal cost of \$10 billion in 2020.¹
- Reinstating the ACA’s reinsurance program could increase insurance coverage for up to 2 million people, lower silver plan marketplace premiums by as much as 10.7 percent, and result in net deficit savings of as much \$8.8 billion in 2020.²
- Enhancing premium tax credits and lifting the income eligibility threshold could reduce annual marketplace premium contributions by enrollees from \$356 to as much as \$9,434.³
- Funding and extending the cost-sharing reduction payments and pegging premium tax credits to the gold plan could decrease marketplace deductibles by \$1,650 for people with incomes at 250 percent of poverty (\$30,350 for an individual) and above.⁴
- Allowing HHS to negotiate prescription drug prices under a Medicare-for-All approach could lower drug prices by 4 percent to 40 percent.⁵
- Replacing most private insurance with public insurance under a Medicare-for-All approach could lower insurance and provider administrative costs from a current 13.9 percent of spending in commercial plans to 6 percent to 3.5 percent of all spending.⁶

¹ Jodi Liu and Christine Eibner, [Expanding Enrollment Without the Individual Mandate: Options to Bring More People into the Individual Market](#) (Commonwealth Fund, Aug. 2018).

² Liu and Eibner, [Expanding Enrollment](#), 2018.

³ Assumes individual mandate and funding for cost-sharing reductions are reinstated. Linda J. Blumberg et al., [A Path to Incremental Health Care Reform: Improving Affordability, Expanding Coverage, and Containing Costs](#) (Urban Institute, Dec. 2018).

⁴ Assumes individual mandate and funding for cost-sharing reductions are reinstated. See Blumberg et al., [Path to Incremental](#), 2018.

⁵ Jodi Liu and Christine Eibner, [National Health Spending Estimates Under Medicare for All](#) (RAND Corporation, Apr. 2019); Robert Pollin et al., [Economic Analysis of Medicare for All](#) (Political Economy Research Institute, University of Massachusetts Amherst, Nov. 2018); Charles Blahous, “[The Costs of a National Single-Payer Healthcare System](#),” Mercatus Working Paper, Mercatus Center at George Mason University, July 2018; John Holahan et al., [The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending](#) (Urban Institute, May 2016); and Kenneth E. Thorpe, [An Analysis of Senator Sanders’ Single Payer Plan](#) (Emory University, Jan. 2016, unpublished paper).

⁶ Liu and Eibner, [National Health Spending Estimates](#), 2019; Blahous, “Costs of a National,” 2018; Holahan et al., [Sanders Single-Payer](#), 2016; and Thorpe, [Analysis of Senator Sanders’](#), unpublished.

- Setting provider prices at Medicare rates under a Medicare-for-All approach could reduce U.S. health spending by \$384 billion in 2022, or \$5.3 trillion over 10 years.⁷
- Recent estimates of the effects of a Medicare-for-All proposal on U.S. national health care expenditures range from: declines of 9.6 percent (Pollin) and 2.1 percent (Blahous) to increases of 1.8 percent (RAND), 9.8 percent (RAND), 12.6 percent (Thorpe) and 16.9 percent (Urban Institute).⁸

In the area of costs, what has captured the greatest attention in the emerging debate around Medicare for All is the significant shift in the how national health spending would be financed. With the exception of HR 7339, which retains employer coverage as an option for employers and employees, all the bills in this category would shift most U.S. health care spending from households and employers and state and local governments to the federal budget.⁹ This shift raises important questions about financing sources, in particular the incidence of taxation.

What is notable about the range of national health expenditure estimates under a Medicare-for-All approach is that the increase in expenditures is often less than the increase in demand for health care induced by providing comprehensive coverage to everyone. The range of spending estimates is very wide. This is because the degree of potential savings and efficiencies depend on certain assumptions, particularly the ability of a single-payer plan to lower provider payments, prescription drug costs, and administrative costs. The mechanisms for achieving slower health care cost growth in these proposals could be considered, refined, and applied not only in single-payer approaches but in other health reform strategies as well. For example, as part of a set of incremental ACA reforms, the Urban Institute estimated that capping provider payments at a level just above Medicare rates in the individual market could lower federal spending on the ACA's premium tax credits by \$11.8 billion and household spending on premiums by \$1.7 billion in 2020.¹⁰

Conclusion

Since the ACA was passed in 2010, Congress has not passed further legislation to insure more people or make private plans more affordable or cost-protective. Many states have stepped up by promulgating regulations, passing legislation, and establishing programs like reinsurance to secure insurer participation, inform consumers of their coverage options, and lower consumer costs. But people living in states that did not embrace the coverage expansions (i.e., the Medicaid expansion or choosing to operate a state-based marketplace) are lagging those who live in more

⁷ Blahous, "Costs of a National," 2018.

⁸ None of these estimates include the potential effects of HR 1334's proposal to establish regional global budgets for institutional providers and separate budgets for capital projects.

⁹ HR 7339 requires employers to meet the new coverage requirements of the public program and gives them and their employees the option to elect the public plan.

¹⁰ Assumes individual mandate and funding for cost-sharing reductions are reinstated. See Blumberg et al., *Path to Incremental*, 2018.

actively engaged or resourced states. Some states that have taken actions like establishing reinsurance programs are struggling to finance them long term.

Improving coverage for all U.S. residents will require federal legislation. The bills recently introduced are an amalgam of provisions that individually or collectively have the potential to make small to large improvements in coverage and increase the ability of people to get the health care that they need. Lowering premiums, limiting out-of-pocket cost exposure, and lowering the overall rate of health care cost growth are achievable goals. These bills provide mechanisms to move forward on each. Some ideas — like enhancing the ACA’s subsidies — won’t completely solve the U.S.’s significant affordability problem, but will provide a step toward providing targeted relief to several million people.

Many of these ideas can be implemented without a major reorganization of the health care system. For example, paying providers in commercial insurance plans at prices closer to Medicare’s or allowing the Secretary of Health and Human Services to negotiate prescription drug prices have potential to slow health care cost growth and would not require an immediate shift to a single-payer system. The Medicare-for-All bills feature some of the proposed approaches in less sweeping bills, such as enhancing marketplace subsidies or as transitional coverage improvements during a multiyear transition to a single-payer system. On the other hand, moving piecemeal also involves trade-offs. Based on the experience of the ACA, it appears possible or even likely that additional steps may take some time to achieve.

The committee is to be commended for taking on the issue of health reform. Hearings like these allow for fact-based consideration of policy options, their potential implications, and their trade-offs. I look forward to your questions.

Thank you.

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Thank you, Mr. Chairman, members of the Committee, for this invitation to testify today on current proposals to reform the U.S. health care system. My comments will focus on the national gains in health insurance coverage since the passage of the Affordable Care Act (ACA), the problems people continue to report affording health insurance and health care, and the potential of recent Congressional health reform bills to address these problems.

The ACA Brought Sweeping Change to the U.S. Health Care System

The ACA brought sweeping change to the U.S. health system, expanding comprehensive and affordable coverage options to lower-and middle- income Americans through a newly regulated and subsidized individual market and expanded eligibility for Medicaid. The law's provisions also made it possible for people with health problems at all income levels to buy health insurance on their own by banning insurers from denying people coverage or charging them more because of preexisting conditions.

The number of uninsured people in the United States has fallen by nearly half since the ACA was signed into law, dropping from a historical peak of 48.6 million people in 2010 to 29.7 million in 2018 (Exhibit 1).¹¹ Cost-related problems gaining access to health care and financial problems associated with medical bills care also declined (Exhibits 2 and 3).¹² And while people still experience gaps in coverage, those gaps have shortened considerably in duration (Exhibit 4). A large body of research on the effects of the ACA show that the overall impact of the legislation on people's ability to afford health insurance and get needed health care has been positive.¹³

¹¹ Emily P. Terlizzi, Robin A. Cohen, and Michael E. Martinez, [Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2018](#) (National Center for Health Statistics, Feb. 2019).

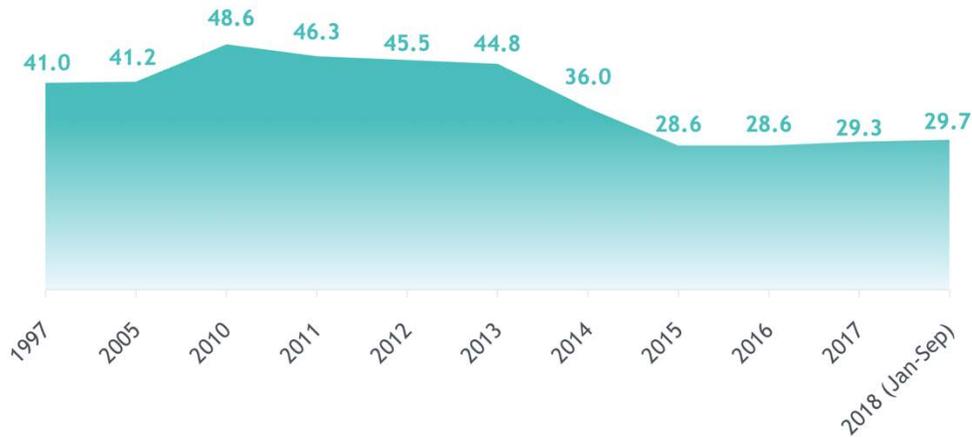
¹² Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, [Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured](#) (Commonwealth Fund, Feb. 2019).

¹³ Benjamin D. Sommers et al., [“Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults,”](#) *Health Affairs* Web First, published online May 17, 2017; Olena Mazurenko et al., [“The Effects Of Medicaid Expansion Under The ACA: A Systematic Review,”](#) *Health Affairs* 37, no. 6 (June 2018): 944–50; Munira Z. Gunja, Sara R. Collins, and Herman K. Bhupal, [Is the Affordable Care Act Helping Consumers Get Health Care?](#) (Commonwealth Fund, Dec. 2017); Sara R. Collins et al., [Americans' Experiences with the ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction](#) (Commonwealth Fund, May 2016); and Sara R. Collins, Petra W. Rasmussen, and Michelle M. Doty, [Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period](#) (Commonwealth Fund, July 2014).

EXHIBIT 1

The Number of Uninsured People in the United States Fell by Nearly Half, from 48.6 Million in 2010 to 29.7 Million in 2018

Number of people uninsured at the time of the survey (millions)



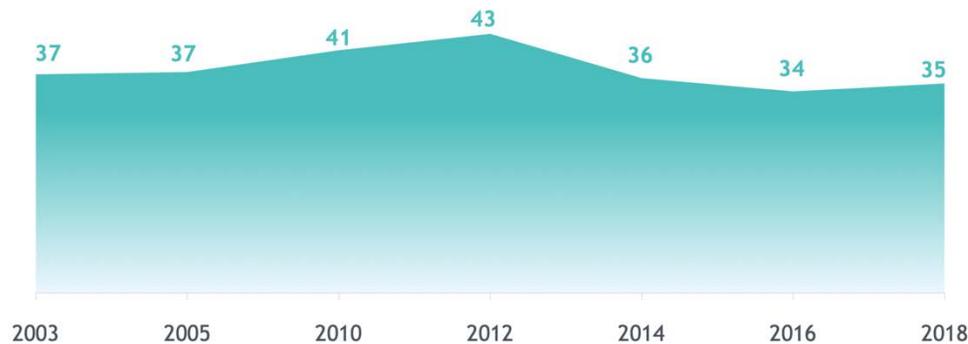
Note: Data are for all ages.
Source: Emily P. Terlizzi, Robin A. Cohen, and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-September 2018* (National Center for Health Statistics, Feb. 2019).

EXHIBIT 2

Fewer Adults Report Not Getting Needed Care Because of Costs, but Gains Have Stalled in Recent Years

Percent of adults ages 19-64 who reported any of the following cost-related access problems in the past year:

- Had a medical problem but did not visit doctor or clinic
- Did not fill a prescription
- Skipped recommended test, treatment, or follow-up
- Did not get needed specialist care



Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).
Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured – Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Feb. 2019).

EXHIBIT 3

Fewer Adults Have Difficulty Paying Their Medical Bills, but the Improvement Has Stalled

Percent of adults ages 19-64 who reported any of the following medical bill or debt problems in the past year:

- Had problems paying or unable to pay medical bills
- Contacted by a collection agency for unpaid medical bills
- Had to change way of life to pay bills
- Medical bills/debt being paid off over time

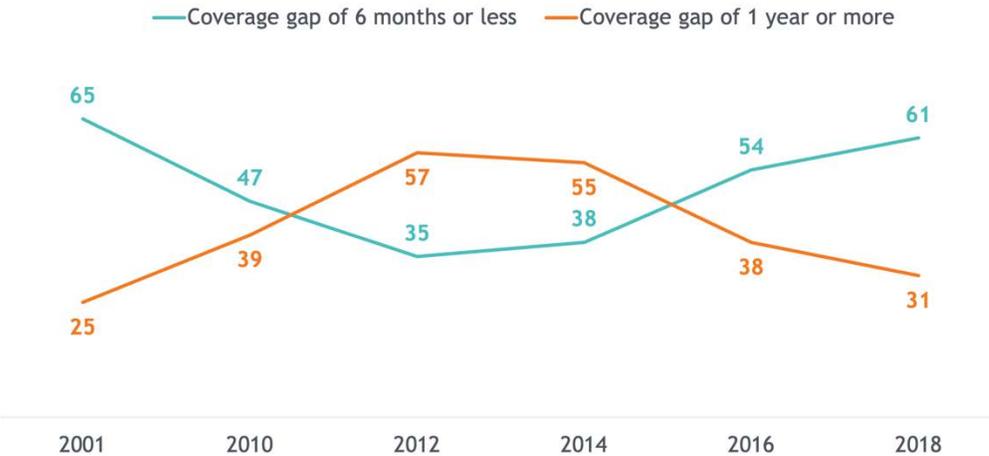


Data: Commonwealth Fund Biennial Health Insurance Surveys (2005, 2010, 2012, 2014, 2016, 2018).
Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured – Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Feb. 2019).

EXHIBIT 4

Since the ACA, Gaps in People’s Coverage Have Been Shorter

Percent of adults ages 19-64 insured now but had a coverage gap in past year



Data: Commonwealth Fund Biennial Health Insurance Surveys (2001, 2010, 2012, 2014, 2016, 2018).
Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured – Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Feb. 2019).

Millions of People Remain Uninsured or Are Underinsured

However, three distinct, yet interrelated, problems remain: millions of people remain uninsured, millions of people with insurance have plans that are leaving them underinsured, and growth in health care costs is outstripping growth in median income in most states.

29.7 million people remain uninsured. After dropping significantly through 2015, the national uninsured rate has held steady at around 9 percent, with ominous upticks in 14 states in 2017 (Exhibit 5).¹⁴ The share of working-age adults who are uninsured is about 13 percent; about 5 percent of children are uninsured. (Exhibit 6).¹⁵ These stalled gains stem from four primary factors:

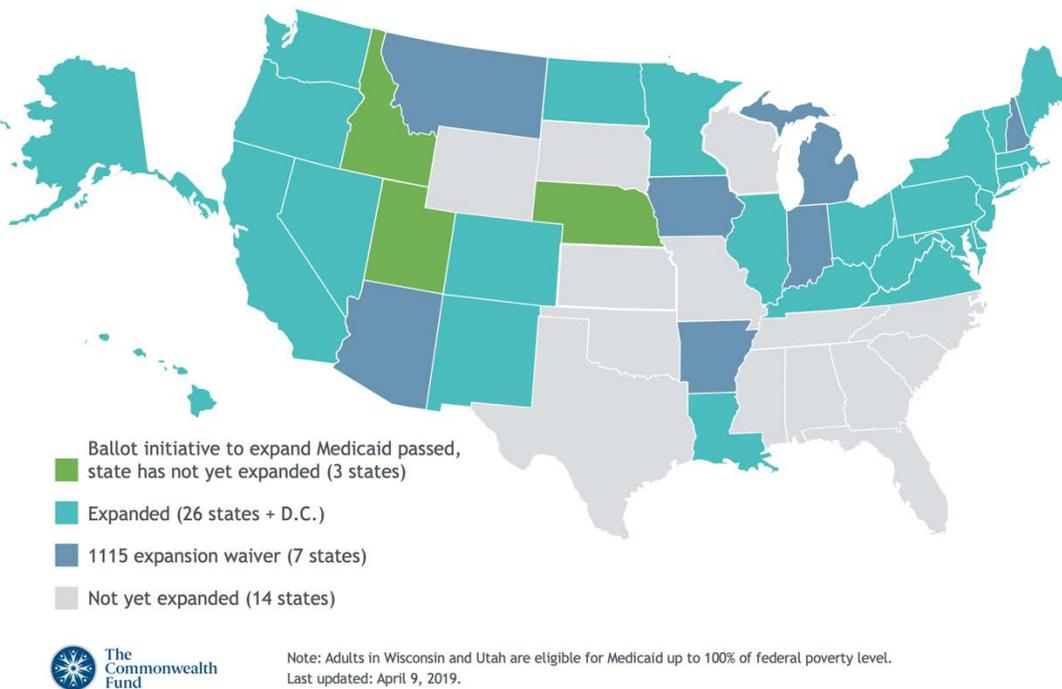
- Seventeen states have not yet expanded Medicaid, including the heavily populated states of Florida and Texas (Exhibit 7).
- People with incomes just over the marketplace subsidy threshold (about \$48,560 for an individual and \$100,000 for a family of four) and many in employer plans have high premium contributions relative to income.
- Congressional and executive actions regarding the individual market and Medicaid have reduced potential enrollment in both.
- Undocumented immigrants are ineligible for subsidized coverage under the ACA.

¹⁴ Emily P. Terlizzi, Robin A. Cohen, and Michael E. Martinez, [*Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2018*](#) (National Center for Health Statistics, Feb. 2019); Edward R. Berchick, Emily Hood, and Jessica C. Barnett, [*Health Insurance Coverage in the United States: 2017*](#) (U.S. Census Bureau, Sept. 2018).

¹⁵ Emily P. Terlizzi, Robin A. Cohen, and Michael E. Martinez, [*Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2018*](#) (National Center for Health Statistics, Feb. 2019).

EXHIBIT 7

Status of Medicaid Expansion Across the States



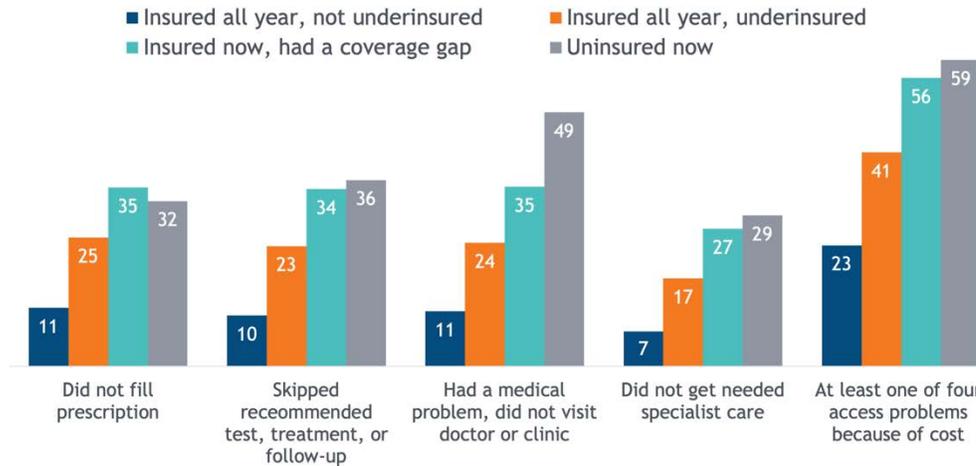
Why it matters. Commonwealth Fund surveys have consistently found that people who lack health insurance — even for short periods of time — avoid or delay needed health care and are at risk of accumulating medical debt. In the 2018 Commonwealth Fund Biennial Health Insurance Survey, more than 55 percent of people who spent any time uninsured in the past year reported not getting needed health care including not filling prescriptions because of cost (Exhibit 8).¹⁶ More than half said that they had problems paying medical bills, including paying off medical debt over time (Exhibit 9). People who are uninsured are much less likely to report getting recommended preventive care like flu shots and cancer screens like mammograms and colon cancer screens (Exhibits 10 and 11).

¹⁶ Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, [Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured](#) (Commonwealth Fund, Feb. 2019).

EXHIBIT 8

Inadequate Coverage Is Associated with More Cost-Related Problems Getting Needed Care

Percent of adults ages 19-64 who had any of four access problems in past year because of cost*



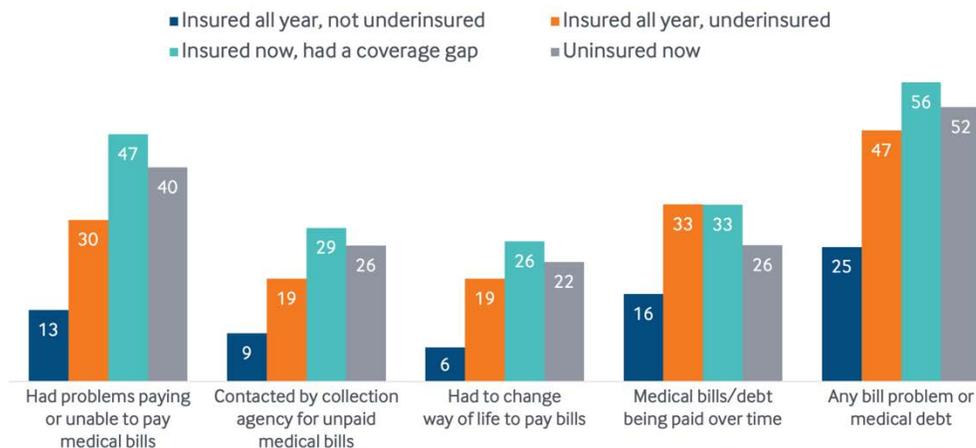
Notes: * Includes any of the following because of cost: did not fill a prescription; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic; did not see a specialist when needed. "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equalled 10% or more of income; out-of-pocket costs, excluding premiums, equalled 5% or more of income if low-income (<200% of poverty); or deductibles equalled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey.
 Data: Commonwealth Fund Biennial Health Insurance Surveys (2018).
 Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured – Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Feb. 2019).



EXHIBIT 9

Inadequate Coverage Is Associated with More Problems Paying Medical Bills

Percent of adults ages 19-64 who had medical bill or debt problems in past year*



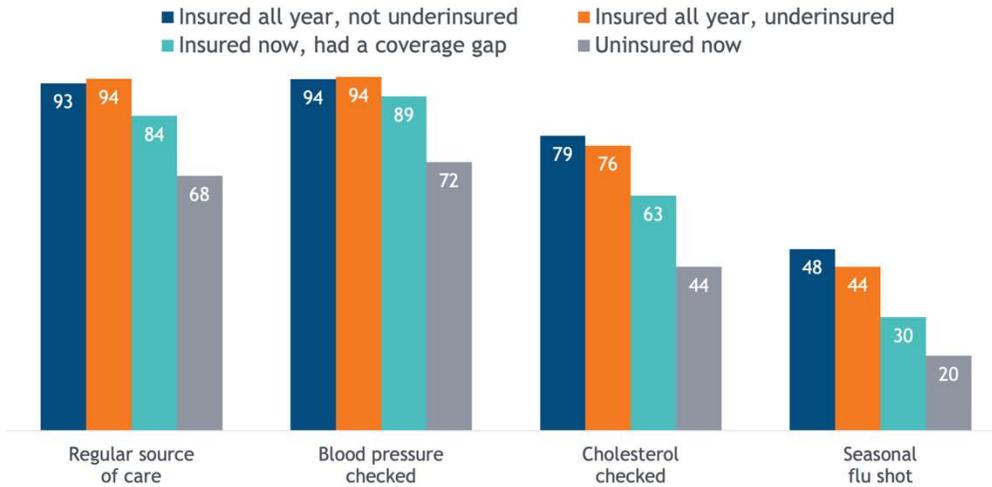
Notes: * Includes any of the following: had problems paying or unable to pay medical bills; had to change way of life to pay bills; medical bills/debt being paid over time. "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equalled 10% or more of income; out-of-pocket costs, excluding premiums, equalled 5% or more of income if low-income (<200% of poverty); or deductibles equalled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey.
 Data: Commonwealth Fund Biennial Health Insurance Surveys (2018).
 Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured – Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Feb. 2019).



EXHIBIT 10

Continuously Insured Adults Are More Likely to Get Preventive Care

Percent of adults ages 19-64

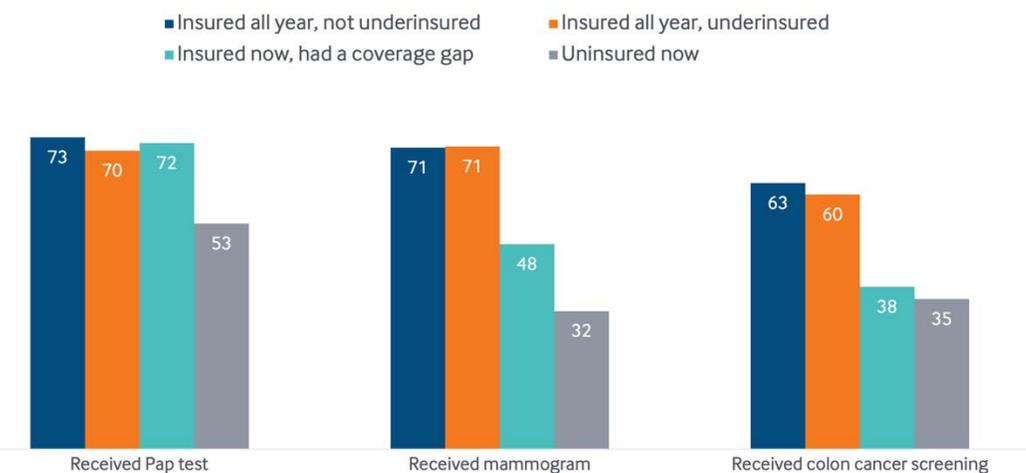


Notes: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date. "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey. Respondents were asked if they: had their blood pressure checked within the past two years (in past year if has hypertension or high blood pressure); had their cholesterol checked in past five years (in past year if has hypertension, heart disease, or high cholesterol); and had their seasonal flu shot within the past 12 months.
 Data: Commonwealth Fund Biennial Health Insurance Surveys (2018).
 Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured – Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Feb. 2019).

EXHIBIT 11

Continuously Insured Adults Are More Likely to Get Cancer Screenings

Percent of adults ages 19-64



Notes: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date. "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey. Respondents were asked if they: received a Pap test within the past three years for females ages 21-64, received a mammogram within the past two years for females ages 40-64, and received a colon cancer screening within the past five years for adults ages 50-64.
 Data: Commonwealth Fund Biennial Health Insurance Surveys (2018).
 Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured – Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Feb. 2019).

In its landmark 2003 study, the Institute of Medicine (IOM) concluded that people who lack adequate health insurance all their lives have fundamentally different life experiences and less economic opportunity than those who are adequately insured, including lower educational attainment, lifetime earnings, and life expectancy.¹⁷ At the time of the study, the IOM estimated that the aggregate, annualized cost of uninsured people's lost capital and earnings from poor health and shorter lifespans fell between \$65 billion and \$130 billion annually.

44 million people are underinsured. In addition to the 29.7 million people who lack insurance, an estimated 44 million working age adults with insurance, or 29 percent, are underinsured because they have high out-of-pocket costs and deductibles relative to their income (Exhibit 12).¹⁸ This is up from an estimated 29 million, or 22 percent, in 2010. People who buy plans on their own through the individual market — including the ACA marketplaces — are underinsured at the highest rates. However, the greatest growth in the share of underinsured adults is occurring among those in employer health plans. The growth in underinsurance is attributable to two primary factors:

- Growth in cost-sharing, particularly deductibles, in private health plans
- Little or no growth in U.S. median income; out-of-pocket health care costs and deductibles comprise a growing share of income among low- and moderate-income families.

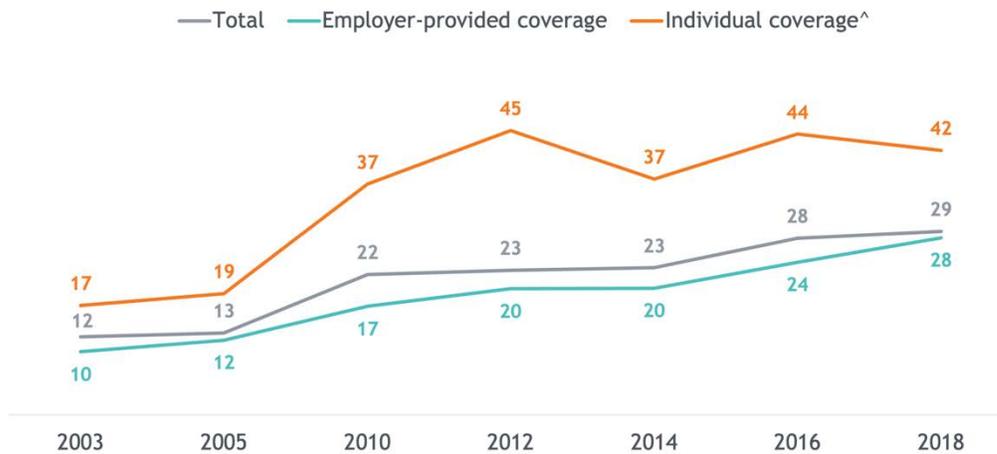
¹⁷ Institute of Medicine, Committee on the Consequences of Uninsurance, [*Hidden Costs, Value Lost: Uninsurance in America*](#) (National Academies Press, 2003).

¹⁸ Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, [*Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured*](#) (Commonwealth Fund, Feb. 2019).

EXHIBIT 12

More Adults Are Underinsured, with the Greatest Growth Occurring Among Those with Employer Coverage

Percent of adults ages 19-64 insured all year who were underinsured



Notes: "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. Total includes adults with coverage through Medicaid and Medicare. Respondents may have had another type of coverage at some point during the year, but had coverage for the entire previous 12 months. ^ For 2014 and 2016, includes those who get their individual coverage through the marketplace and outside of the marketplace.
 Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).
 Source: Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, [Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured](#) (Commonwealth Fund, Feb. 2019).

Greater cost-sharing, especially higher deductibles, has been the predominant tool used by private insurers and employers to temper premium growth over the last several years. Deductibles have grown in both proliferation and size. In 2017, 87.5 percent of single-person health plans offered by employers had deductibles, compared to 70.7 percent in 2008.¹⁹ Over that period, average deductibles more than doubled in size, from \$869 to \$1,808.²⁰

Why it matters. Commonwealth Fund surveys consistently find that underinsured adults are much more likely to skip needed health care, like filling prescriptions or going to the doctor when they are sick, than are those who are not underinsured. In 2018, 41 percent of underinsured adults reported not getting needed health care because of the cost (Exhibit 8).²¹

In addition, people who are underinsured are much more likely to report problems paying medical bills or say they are paying off medical debt over time. In 2018, 47 percent of underinsured adults reported problems paying medical bills, nearly twice the rate of adults who

¹⁹ Commonwealth Fund analysis of the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), 2017.

²⁰ Sara R. Collins and David C. Radley, [The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families](#) (Commonwealth Fund, Dec. 2018).

²¹ Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, [Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured](#) (Commonwealth Fund, Feb. 2019).

were insured all year but not underinsured. One-third reported they were paying off medical debt over time, twice the rate of adults who were not underinsured (Exhibit 9).

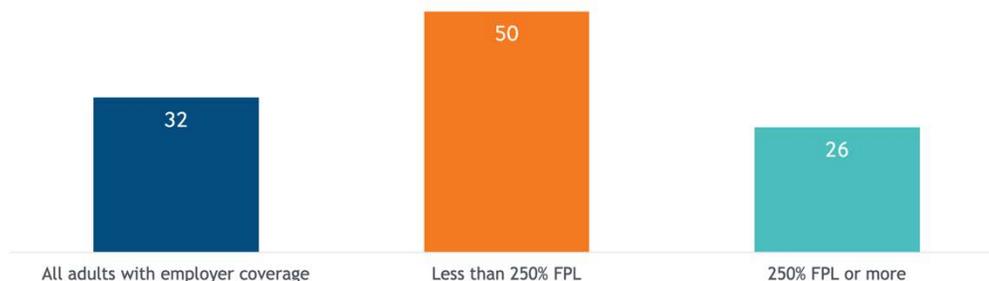
Many moderate- and low- income families who have high-deductible health plans simply do not have the assets or savings to pay for an unexpected medical bill — an emergency room visit resulting from an accident or acute illness, for example. A recent Commonwealth Fund survey found that half of moderate- and low-income adults with employer coverage said they would not have the money to pay for an unexpected \$1,000 medical bill in a month’s time (Exhibit 13).²²

EXHIBIT 13

One-Third of Adults with Employer Coverage Say They Would Not Have the Money to Pay an Unexpected \$1,000 Medical Bill Within 30 Days

 If you were to experience an unexpected medical event in 2018 that left you with a bill for \$1,000, would you have the money to pay the bill within 30 days?

Percent of adults ages 19-64 with employer coverage who responded “no”



Data: Commonwealth Fund Affordable Care Act Tracking Survey, Feb.-Mar. 2018.

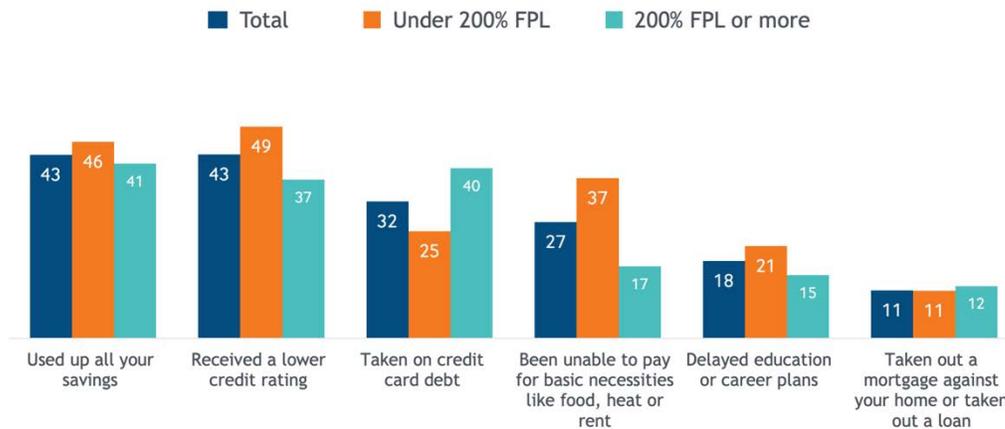
The Commonwealth Fund Biennial survey found that many adults with medical bill or debt problems reported serious financial problems: 43 percent had used all their savings to pay their bills, 43 percent had received a lower credit rating as a result of their debt, 32 percent racked up debt on their credit cards, 18 percent said they had delayed education or career plans (Exhibit 14). People with lower incomes were particularly affected: 37 percent said they were unable to pay for basic necessities like food, heat, or rent as a result of their bills.

²² Sara R. Collins, [The Growing Cost Burden of Employer Health Insurance for U.S. Families and Implications for Their Health and Economic Security](#), Invited Testimony, U.S. House of Representatives Committee on Ways and Means, Subcommittee on Select Revenue Measures, Hearing on “How Middle-Class Families Are Faring in Today’s Economy,” Feb. 13, 2019.

EXHIBIT 14

Adults with Medical Bill Problems Had Lingering Financial Problems

Percent adults ages 19-64 who reported the following happened in the past two years because of medical bill problems[^]



[^] Base: Respondents who reported at least one of the following medical bill problems in the past 12 months: had problems paying medical bills, contacted by a collection agency for unpaid bills, had to change way of life in order to pay medical bills, or has outstanding medical debt.
Data: Commonwealth Fund Biennial Health Insurance Survey (2018).

Health care cost growth is outpacing growth in U.S. median income. A major factor underlying trends in both uninsured and underinsured rates, is the overall rate of growth in U.S. health care costs, particularly relative to growth in median income. Health care costs are the primary driver of premium and deductible growth in private insurance. This means that health care costs ultimately drive both consumer decisions to buy insurance and whether to get health care.

Over 2014 to 2016, U.S. health care spending rose at an annual rate of 5.3 percent and is projected to grow by 5.5 percent per year over the next decade, to nearly \$6 trillion by 2027, or about 19.4 percent of GDP.²³ Median household income is growing at comparatively slower pace: 3.2 percent in 2016 and 1.8 percent in 2017.²⁴

Health care costs are the primary driver of premium growth in private plans, comprising 80 to 85 percent of premiums. In 2017, the annual rate of growth in employer premiums ticked up by 4.4 percent for single person plans and 5.5 percent for family plans (Exhibit 15).²⁵

²³ Andrea M. Sisko, et al. "[National Health Expenditure Projections, 2018-27: Economic and Demographic Trends Drive Spending and Enrollment Growth](#)," *Health Affairs*, March 2019.

²⁴ U.S. Census Bureau, *Income and Poverty in the United States, 2016 and 2017*.

²⁵ Sara R. Collins and David C. Radley, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families* (Commonwealth Fund, Dec. 2018).

EXHIBIT 15

Premiums for Employer Health Plans Climbed in 2017

Average growth from previous year



Data: Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), 2008-2017.
Source: Sara R. Collins and David C. Radley, [The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families](#) (Commonwealth Fund, Dec. 2018).

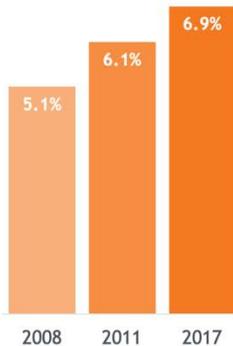
While the employee share of premium costs has stayed relatively constant over time, as employer premiums have grown, so has the dollar amount employees contribute to their premiums. Between 2016 and 2017, average annual employee premium contributions nationally rose by 6.8 percent to \$1,415 for single-person plans and by 5.3 percent to \$5,218 for family plans (Exhibit 16).²⁶ The average employee premium cost across single and family health plans amounted to nearly 7 percent of U.S. median income in 2017, up from 5.1 percent in 2008. In 11 states (Arizona, Delaware, Florida, Georgia, Louisiana, Mississippi, Nevada, New Mexico, North Carolina, Oklahoma, Texas), premium contributions were 8 percent of median income or more, up to a high of 10.2 percent in Louisiana.

²⁶ Sara R. Collins and David C. Radley, [The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families](#) (Commonwealth Fund, Dec. 2018).

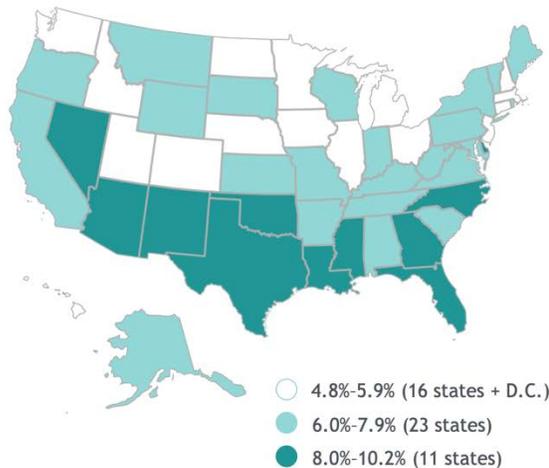
EXHIBIT 16

Worker Payments for Employer Coverage Are Growing Faster than Median Income

Employee premium contribution as share of median income



Average employee premium contribution as percent of median state income in 2017



Notes: Estimates of median household income used in the denominator for this ratio come from the Current Population Survey (CPS), which revised its income questions in 2013. The denominator in our ratio estimates prior to 2014 is derived from the traditional CPS income questions, while ratio estimates from 2017 are estimated from the revised income questions. Household incomes have been adjusted for the likelihood that people in the same residence purchase health insurance together.

Data: Employee premium contribution: Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), 2008, 2011, 2017; Median household income: Current Population Survey, 2008-09, 2011-12, 2017-18.

Source: Sara R. Collins and David C. Radley, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families* (Commonwealth Fund, Dec. 2018).

Because employers and insurers increase cost-sharing to temper premium growth, health care cost growth is also a key driver of the ballooning size of deductibles. In 2017, the average deductible for single-person policies rose by 6.6 percent to \$1,808 (Exhibit 17). Average deductibles increased in 35 states and the District of Columbia. Deductibles ranged in size from a low of \$863 in Hawaii to a high of about \$2,300 in Maine and New Hampshire. Among families who spend enough on health care during the year to meet their deductibles, those at the midrange of the income distribution would spend 4.8 percent of their income on average before their coverage kicked in.²⁷ This is up from 2.7 percent of income in 2008.

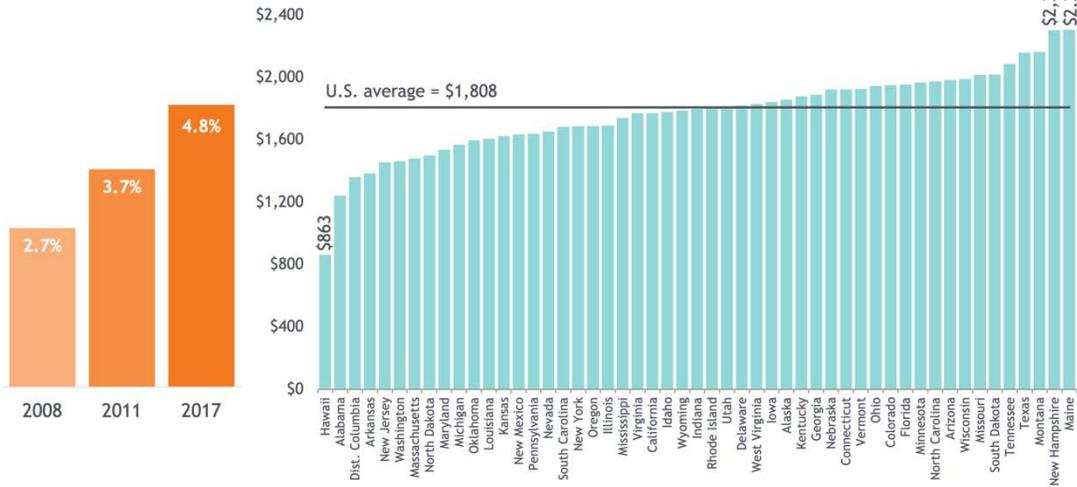
²⁷ Not everyone with a deductible has enough medical expenses in a given year to meet the deductibles; some services are covered by plans before people meet deductibles. By law, preventive care services and many cancer screens must be covered pre-deductible without cost-sharing. And many plans also cover certain prescription drugs and other services before the deductible is met.

EXHIBIT 17

Average Deductibles Are Also Outpacing Growth in Median Income

Deductible as share of median income

Average single-person deductibles for employer coverage, by state, 2017



Notes: Estimates of median household income used in the denominator for this ratio come from the Current Population Survey (CPS), which revised its income questions in 2013. The denominator in our ratio estimates prior to 2014 is derived from the traditional CPS income questions, while ratio estimates from 2017 are estimated from the revised income questions. Household incomes have been adjusted for the likelihood that people in the same residence purchase health insurance together.

Data: Deductible: Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), 2008, 2011, 2017; Median household income: Current Population Survey, 2008-09, 2011-12, 2017-18.

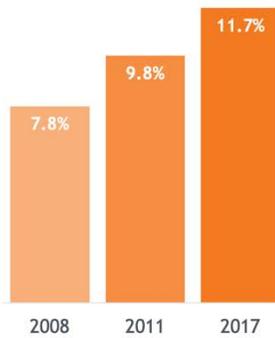
Source: Sara R. Collins and David C. Radley, [The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families](#) (Commonwealth Fund, Dec. 2018).

In employer plans in 2017, total spending on premiums and potential out-of-pocket costs amounted to 11.7 percent of median income in 2017 (Exhibit 18). This is up from 7.8 percent a decade earlier. Costs were 12 percent or more of median income in 18 states. In Louisiana and Mississippi, these combined costs rose to 15 percent or more of median income.

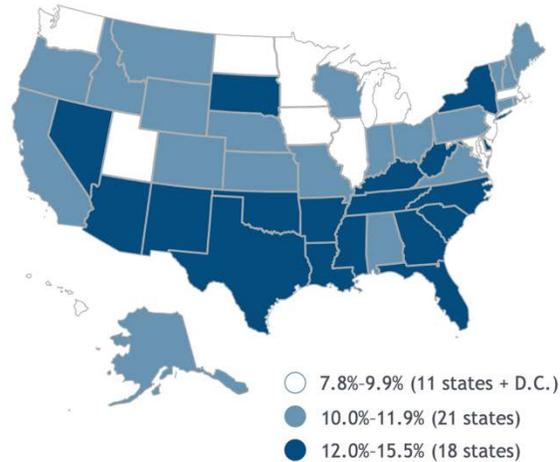
EXHIBIT 18

Premium and Deductible Costs Amounted to Nearly 12 Percent of Median Income in 2017

Combined employee premium contribution and deductible as share of median income



Average employee premium contribution plus average deductible as percent of median state income in 2017



Notes: Estimates of median household income used in the denominator for this ratio come from the Current Population Survey (CPS), which revised its income questions in 2013. The denominator in our ratio estimates prior to 2014 is derived from the traditional CPS income questions, while ratio estimates from 2017 are estimated from the revised income questions. Household incomes have been adjusted for the likelihood that people in the same residence purchase health insurance together.

Data: Employee premium contribution and deductible: Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), 2008, 2011, 2017; Median household income: Current Population Survey, 2008-09, 2011-12, 2017-18.

Source: Sara R. Collins and David C. Radley, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families* (Commonwealth Fund, Dec. 2018).

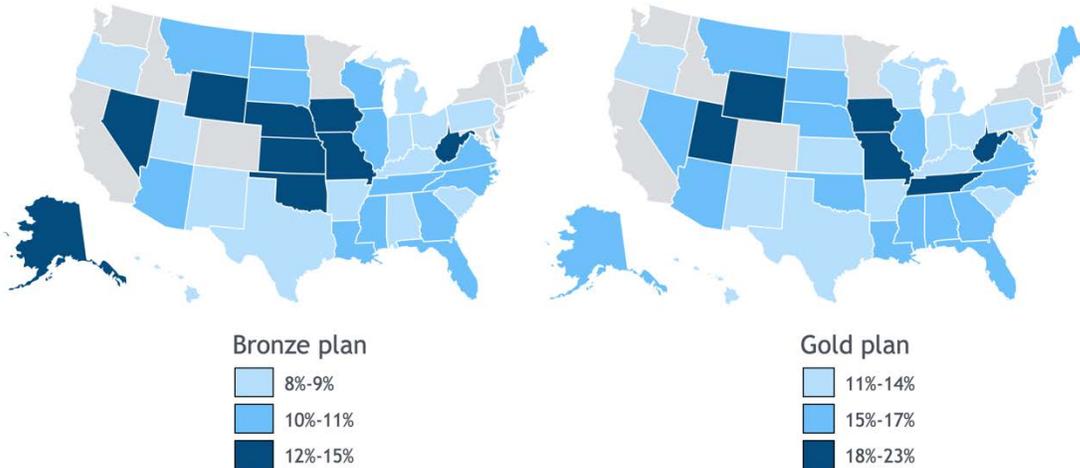
In the individual market, premium growth stabilized in 2019 as insurers adjusted to the ACA market regulations and gained knowledge of their enrollment risk pools. While premiums will continue to be affected by external factors such as uncertainty over congressional, executive, and judicial decisions regarding the ACA's parameters, health care cost growth will be the primary source of premium growth. In contrast to the employer market, lower- and moderate-income people eligible for premium tax credits in the marketplaces are largely protected from premium increases since the ACA capped their contributions as a share of income on a sliding scale. The premium tax credits have been the central stabilizer for the marketplace enrollment. Across the states, 80 to 90 percent of marketplace coverage is subsidized.

However, people whose incomes are just over the income eligibility threshold of 400 percent of poverty (\$100,400 for a family of four and \$48,560 for an individual) are fully exposed to their plan premiums and year-to-year increases (Exhibit 19). For these people, premiums can comprise well over 10 percent of income, even for bronze level plans in many states. Ten percent is an important marker because that is the most people have to pay for their premiums if their income is below the subsidy eligibility threshold.

EXHIBIT 19

Even Bronze Plan Premiums Are High Relative to Income in Many States for Those Earning Just Over the Subsidy Threshold

2019 HealthCare.gov premiums as a percentage of income for 40-year-olds earning \$49,000



Data: 2019 Marketplace QHP landscape data for 2019. Available at [healthcare.gov](https://www.healthcare.gov).

Can Congressional Health Reform Bills Decrease Uninsurance and Underinsurance and Lower Cost Growth?

The U.S. health insurance system comprises both private (employer and individual market and marketplace plans) and public (Medicare and Medicaid) coverage sources (Exhibit 20). Both coverage sources are paid for by a mix of private and tax-payer financed public dollars.

EXHIBIT 20

U.S. Health Insurance System Is Currently Both Private and Public

Source	People (millions)	Financing	Insurer type	Regulation
Employer	158	Federal, Employers, Individuals	Private	Federal and state
Individual market and marketplaces	27	Federal, Individuals, Private Insurers	Private	Federal and state
Medicaid	44	Federal, State, Individuals	Public and Private	Federal
Medicare	62	Federal, Individuals	Public and Private	Federal
Uninsured	28	Federal, State, Individuals	—	—



Source: Analysis of the 2018 U.S. Current Population Survey by Ougni Chakraborty and Sherry Glied of New York University for the Commonwealth Fund.

Most Americans — 158 million — get their insurance through employers, who either provide coverage through private insurers or self-insure. Employers and employees share the cost through premiums and cost-sharing. But the federal government significantly subsidizes employer coverage by excluding employer premium contributions from employees’ taxable income. In 2018 this subsidy amounted to \$280 billion, the largest single tax expenditure.²⁸

About 27 million people are covered through regulated private plans sold in the individual market, including the Affordable Care Act’s marketplaces. This coverage is financed by premiums and cost-sharing paid by enrollees. The federal government subsidizes these costs for individuals with incomes under \$48,560.

Forty-four million people are insured by Medicaid or the Children’s Health Insurance Program. These public programs are financed by federal and state governments, and small individual premium payments and cost-sharing in some states. In most states, these benefits are provided through private insurers.

Medicare covers 62 million people over age 65 and people with disabilities. The coverage is financed by the federal government along with individual premiums and significant cost-sharing. About 20 million people get their Medicare benefits through private Medicare

²⁸ Tax Policy Center, [Key Elements of the U.S. Tax System: Tax Policy Center Briefing Book](#) (Urban Institute and Brookings Institution, 2016).

Advantage plans. Most beneficiaries either buy supplemental private insurance or qualify for additional coverage through Medicaid to help lower out-of-pocket costs and add long-term care benefits.²⁹

The “Medicare for All” Continuum

The recent set of proposals from House and Senate Democrats seek to address the current problems in the health care system — millions of people uninsured or underinsured, and high health care costs — by expanding the public portion of our health care system.³⁰ These bills fall along a continuum that ranges from adding public plan features to private insurance to Medicare-for-All proposals.³¹ The bills may be broadly grouped into three categories:

- **Adding public plan features to private insurance**
 - HR 1884, Protecting Pre-Existing Conditions & Making Health Care More Affordable Act of 2019 (Rep. Pallone)
 - S 2582, Consumer Health Insurance Protection Act of 2018 (Sen. Warren)
- **A choice of public plans alongside private plans**
 - S 981, Medicare-X Choice Act of 2019 (Sens. Bennet, Kaine); HR 2000 (Rep. Delgado)
 - S 2708, Choose Medicare Act (Sen. Merkley); HR 6117 (Rep. Richmond)
 - HR 1346, Medicare Buy-In and Health Care Stabilization Act of 2019 (Rep. Higgins)
 - S 470, Medicare at 50 Act (Sen. Stabenow)
 - S 489 State Public Option Act (Sen. Schatz); HR 1277 (Rep. Lujan)
- **Making public plans the primary source of coverage in the U.S.**
 - HR 7339, Medicare for America Act of 2018 (Rep. DeLauro)
 - S 1129, Medicare for All Act of 2019 (Sen. Sanders)
 - HR 1384, Medicare for All Act of 2019 (Rep. Jayapal)
 - HR 676, Expanded and Improved Medicare for All Act (Rep. Ellison)

²⁹ Gretchen Jacobson, Anthony Damico, and Tricia Neuman, [A Dozen Facts about Medicare Advantage](#) (Henry J. Kaiser Family Foundation, Nov. 2018).

³⁰ Sherry A. Glied and Jeanne M. Lambrew, “[How Democratic Candidates for the Presidency in 2020 Could Choose Among Public Plans](#),” *Health Affairs* 37, no. 12 (Dec. 2018): 2084–91.

³¹ Sara R. Collins and Roosa Tikkanen, “[The Many Varieties of Universal Coverage](#),” Commonwealth Fund, Apr. 24, 2019.

Summaries of these bills are available in an interactive tool on the Commonwealth Fund website.³² I next discuss the general provisions and implications of each category of approaches.

Adding public plan features to private insurance. The bills in this category include provisions to enhance the premium and cost-sharing subsidies for marketplace plans, fix the so-called family coverage glitch in employer plans, address the Medicaid coverage gap for low-income people in nonexpansion states, and increase the regulation of private plans by banning plans not compliant with the ACA or requiring private insurers who participate in Medicare and Medicaid to offer health plans in the ACA marketplaces.

Potential Effects: Directional

These bills as a group have the potential to make the following changes:

- Improve the affordability and cost-protection of individual market insurance
- Increase health plan choice in some individual markets
- Reduce the number of uninsured people
- Reduce the number of underinsured people.

Potential Effects: Estimates from the Literature

Researchers have estimated the effects of several provisions in these bills. I next review some notable examples.

Enhancing premium tax credits. Eliminating the income eligibility threshold for the premium tax credits (currently about \$48,560 for an individual and \$100,400 for family of four) would have the effect of capping the most anyone in the market would pay for premiums at 10 percent of income. This has a natural phase out — as people’s income rises, premiums take up a smaller and smaller share of their income, so fewer and fewer people are eligible for the tax credits.

Researchers Jodi Liu and Christine Eibner from the RAND Corporation estimated the coverage and federal budget effects of such a change.³³ They assumed current law: no individual mandate or federal reimbursement for cost-sharing reduction subsidies. They project that lifting the income threshold for the premium tax credits could insure 1.7 million more people and lower marketplace silver plan premiums by 2.7 percent at a net federal cost of \$10 billion in 2020 (Exhibit 21).

³² Sara R. Collins and Roosa Tikkanen, “[The Many Varieties of Universal Coverage](#),” Commonwealth Fund, Apr. 24, 2019.

³³ Jodi Liu and Christine Eibner, [Expanding Enrollment Without the Individual Mandate: Options to Bring More People into the Individual Market](#) (Commonwealth Fund, Aug. 2018).

EXHIBIT 21

Options to Increase Coverage and Affordability of Individual Market Plans

	Lifting the 400% FPL cap	Standard reinsurance	Generous reinsurance
Change in coverage	1.7 m	0.3 m	2 m
Change in individual market premiums*	-2.7%	-2.4%	-10.7%
Net deficit impact	\$9.9 b	-\$2.3 b	-\$8.8 b



* Change in silver premiums for a 40-year-old nonsmoker.

Source: Jodi Liu and Christine Eibner, *Expanding Enrollment Without the Individual Mandate: Options to Bring More People into the Individual Market* (Commonwealth Fund, Aug. 2018).

Liu and Eibner also modeled the effects of lifting the threshold combined with reducing the maximum premium contribution as a share of income to a range of 1.79 percent at 100 percent of poverty to 8.5 percent of income at 300 percent of poverty and above. Under this scenario, 2.4 million more people are estimated to gain coverage and silver plan premiums would drop by 3.1 percent, at an annual net deficit impact of \$18.8 billion.

In addition to increasing coverage, enhancing marketplace premium and cost-sharing subsidies would significantly increase the affordability of premiums and health care. The Urban Institute, for example, modeled the effect of lifting the premium tax credit threshold combined with reducing the maximum premium contribution as a share of income to a range of 0 percent at 100 percent of poverty to 8.5 percent of income at 400 percent of poverty and above. They pegged premium tax credits to the gold plan, rather than the silver plan. The modeling assumes the individual mandate is in place and the cost-sharing reductions are financed. Under these policy changes, average annual premiums for single-person policies are estimated to decline by \$356 for adults earning 138 percent of poverty, by \$721 for those earning 250 percent of poverty, by \$902 at 350 percent of poverty, and by \$9,434 for a 64-year old at 450 percent of poverty.

The Urban Institute researchers also modeled the combined effect on cost-sharing from pegging tax credits to the gold plan and enhancing and extending the cost-reduction subsidies to people up to 300 percent of poverty. The improved cost-protection from enrolling in gold plans

combined with enhanced cost-sharing decreases single-policy deductibles by \$1,650 for adults earning 250 percent of poverty and above.

Reinsurance. Reinsurance has a proven track record in lowering marketplace premiums. The ACA's temporary reinsurance program resulted in premiums that were up to 14 percent lower than they would be otherwise. All seven states that have implemented reinsurance programs through the ACA's 1332 waiver program have experienced drops in premiums, some of them substantial.³⁴

Liu and Eibner estimated the effects of reinstating the ACA's reinsurance program, which was wholly financed through insurer fees. They estimate that depending on the generosity of the program (ACA year one vs. ACA year three), reinsurance could increase insurance coverage from 300,000 to 2 million people, lower silver plan marketplace premiums by 2.4 percent to 10.7 percent, and result in net deficit savings of \$2.3 billion to \$8.8 billion annually (Exhibit 21).

Family coverage glitch fix. Urban Institute researchers estimated the effect of fixing the family coverage glitch by pegging unaffordable coverage in employer plans to family policies rather than single policies.³⁵ In 2016, the researchers estimated that more than 6 million people were affected by the glitch and were ineligible for marketplace subsidies because of it. They estimated that fixing the glitch would lower family spending on premiums from 12 percent of income on average to 6.3 percent, at a cost to the federal government of \$3.7 billion to \$6.5 billion in 2016. The fix was not estimated to significantly expand insurance coverage.

Comprehensive package of policy options. The Urban Institute also recently modeled a set of policy changes that build on one another, beginning with the reinstatement of the ACA's individual mandate and funding for the cost-sharing reduction subsidies.³⁶ The additional options include enhanced premium and cost-sharing subsidies (discussed above), expanded eligibility for Medicaid in all states, a \$10 billion federal investment in a reinsurance program, and capping what providers are paid in the individual market somewhat above Medicare rates. The combined effect of these policies is a drop in the number of uninsured by 12.2 million, or 7.3 percent of the under-65 population, at a total federal cost of \$119 billion in 2020.

Giving people a choice of public plans alongside private plans. In addition to enhancing ACA subsidies and providing reinsurance, the bills in this category also give consumers (employers and people in the ACA marketplaces) a choice of a public plan, based on either Medicare or

³⁴ Justin Giovanelli, [What Is Your State Doing to Affect Access to Adequate Health Insurance?](#) Commonwealth Fund, last updated April 2, 2019; Rachel Schwab, Emily Curran, and Sabrina Corlette, [Assessing the Effectiveness of State-Based Reinsurance: Case Studies of Three States' Efforts to Bolster Their Individual Markets](#) (Robert Wood Johnson Foundation, Nov. 2018).

³⁵ Matthew Buettgens, Lisa Dubay, and Genevieve M. Kenney, "[Marketplace Subsidies: Changing The 'Family Glitch' Reduces Family Health Spending But Increases Government Costs](#)," *Health Affairs* 35, no. 7 (July 2016): 1167–75.

³⁶ Linda J. Blumberg et al., [A Path to Incremental Health Care Reform: Improving Affordability, Expanding Coverage, and Containing Costs](#) (Urban Institute, Dec. 2018).

Medicaid. The bills also use the leverage of the federal government's buying power in setting premiums for the public plan, establishing provider payment rates, and negotiating prescription drug prices. Some bills also improve benefits for people currently enrolled in Medicare.

Potential Effects: Directional

These bills have the potential to:

- Improve the affordability and cost-protection of individual market insurance employer plans, and Medicare
- Increase health plan choice in the individual market and in employer plans
- Lower rate of growth in the cost of health care and prescription drugs
- Reduce the number of uninsured people
- Reduce the number of underinsured people.

Potential Effects: Estimates from the Literature

Lowering health care cost growth. A major goal of introducing a public plan option into the marketplaces is to lower marketplace premiums through increased competition with a lower-priced plan. The HHS secretary would set premiums. Presumably these premiums would be lower than private plans as the secretary could pay participating providers closer to Medicare reimbursement rates and would have fewer administrative costs to cover. Lower premiums in all plans would also reflect the new power accorded the secretary in negotiating prescription drug prices. The potential effects of these cost-control mechanisms are reviewed in the next section.

Making public plans the primary source of coverage in the U.S. Bills in this category are single-payer or Medicare-for-All bills in which all residents are eligible for a public plan that resembles the current Medicare program. The bills limit or end premiums and cost-sharing and end most current forms of insurance coverage including most private coverage, with the exception of HR 7337, which retains employer coverage as an option. Benefits are comprehensive and include services not currently covered by Medicare such as dental, vision, and long-term care. The approach harnesses substantial federal leverage in setting premiums and lowering provider and prescription drug prices.

Each bill includes provisions aimed at improving coverage during the transition period, some of which appear in bills in other categories. These include providing a public plan option through the marketplaces, addressing the Medicaid coverage gap, and improving benefits for the current Medicare program.

Potential Effects: Directional

The bills have the potential to:

- Improve the affordability, benefit coverage, and cost protection of insurance for most of the U.S. population
- Increase health plan choice for people in employer plans (for those bills that retain employer coverage)
- Lower the rate of cost growth in hospital and physician services, prescription drugs, and health plan and provider administration
- Lower the uninsured rate to near zero
- Lower the underinsured rate to near zero.

Potential Effects: Estimates from the Literature

The single-payer bills can achieve universal coverage and eliminate underinsurance, depending on whether undocumented immigrants are included. The approach also has the potential to significantly slow the rate of growth in health care costs, including those for hospital and physician services, prescription drugs, and health plan and provider administration. But there is uncertainty about the degree of savings that might be achieved. I briefly review current estimates of the effect of a single-payer approach on national health spending in five areas: provider payment, prescription drugs, administration, and overall spending. I review estimates by researchers from RAND, the Mercatus Institute, the Urban Institute, Emory University, and the University of Massachusetts, Amherst.

Provider payment. There is growing evidence that prices paid to providers — especially hospitals — rather than use of health care services, are the primary driver of health care cost and premium growth.³⁷ For example, the Health Care Cost Institute (HCCI) recently found that found that between 2013 and 2017, prices of inpatient services in private plans climbed by 16 percent while utilization fell by 5 percent (Exhibit 22).³⁸ HCCI found similar patterns in outpatient and professional services and prescription drugs. There is also considerable evidence that prices explain the wide health care spending gap between the United States and other wealthy countries (Exhibits 23 and 24).³⁹ Other research has found that this greater spending in the U.S. does not result in better health outcomes compared to other countries.⁴⁰

³⁷ Zack Cooper et al., “[Variation in Health Spending Growth for the Privately Insured from 2007 to 2014](#),” *Health Affairs* 38, no. 2 (Feb. 2019): 230–36; Zack Cooper et al., “[Hospital Prices Grew Substantially Faster than Physician Prices for Hospital-Based Care in 2007-14](#),” *Health Affairs* 38, no. 2 (Feb. 2019): 184–89; and Andrea M. Sisko et al., “[National Health Expenditure Projections, 2018–27: Economic and Demographic Trends Drive Spending and Enrollment Growth](#),” *Health Affairs* 38, no. 3 (Feb. 2019): 1–11.

³⁸ Health Care Cost Institute, *2017 Health Care Cost and Utilization Report* (HCCI, Feb. 2019).

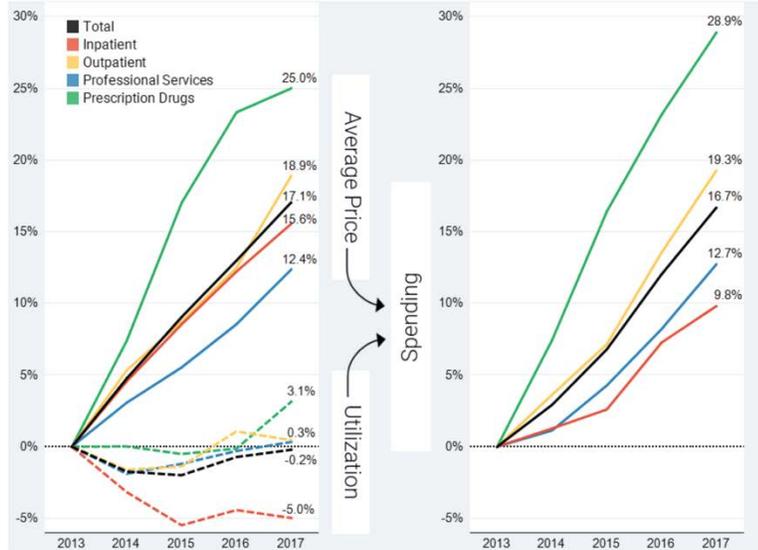
³⁹ Gerard. F. Anderson, Peter S. Hussey, and Varduhi Petrosyan, “[It’s Still the Prices Stupid: Why the U.S. Spends so Much On Health Care, and A Tribute to Uwe Reinhardt](#),” *Health Affairs* 38, no. 1 (Jan. 2019): 87–95.

⁴⁰ Eric C. Schneider et al., *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care* (Commonwealth Fund, July 2017).

EXHIBIT 22

Prices, Not Utilization, Are Driving Spending Growth in Private Insurance

Cumulative change in spending per person, utilization, and average price since 2013



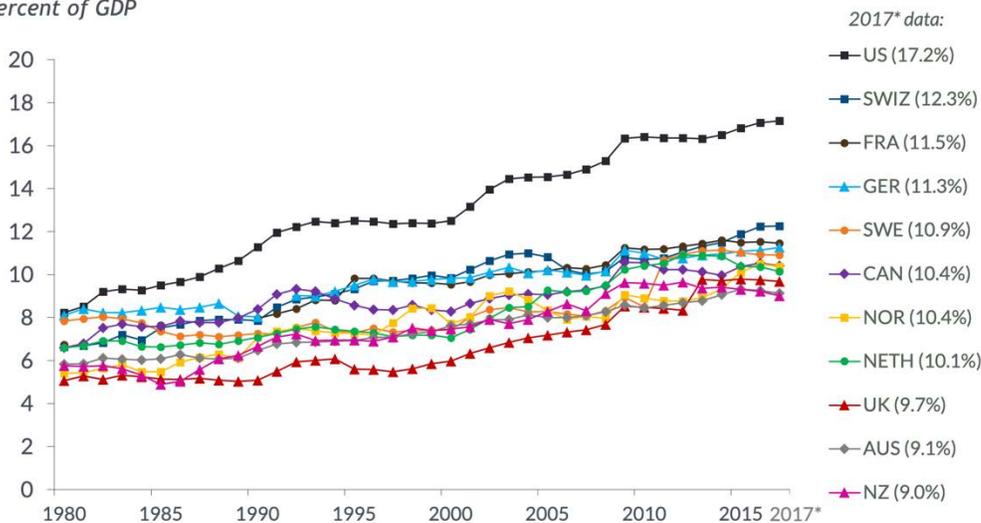
Note: Utilization and average prices account for changes in the type or intensity of services used, with the exception of prescription drugs. Prescription drug spending is the amount paid on the pharmacy claim, which reflects discounts from the wholesale price, but not manufacturer rebates.
 Source: Health Care Cost Institute, *2017 Health Care Cost and Utilization Report* (HCCI, Feb. 2019).

EXHIBIT 23

Health Care Spending as a Percent of GDP, 1980–2017

Adjusted for Differences in Cost of Living

Percent of GDP

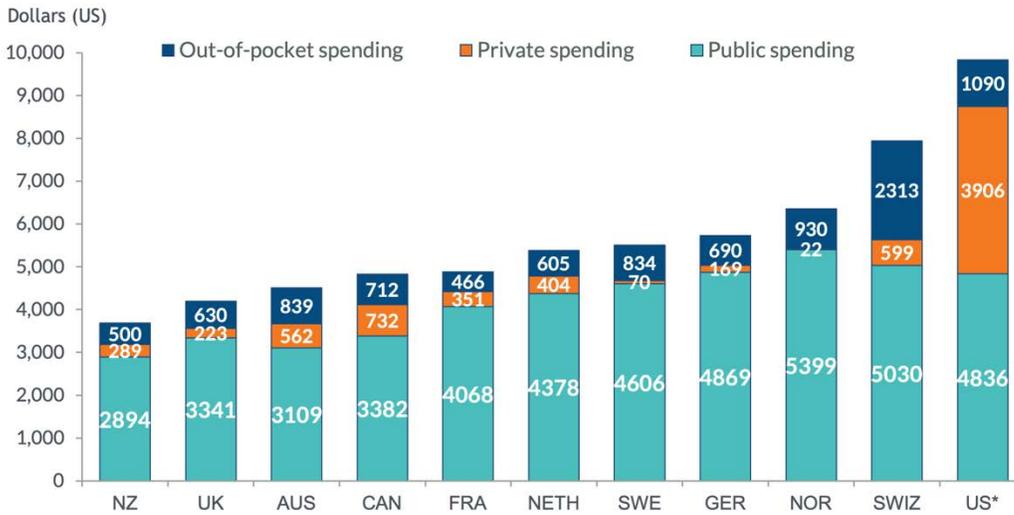


Notes: Current expenditures on health per capita, adjusted for current US\$ purchasing power parities (PPPs). Based on System of Health Accounts methodology, with some differences between country methodologies (Data for Australia uses narrower definition for long-term care spending than other countries). *2017 data are provisional or estimated.
 Source: OECD Health Data 2018.

EXHIBIT 24

Health Care Spending per Capita by Source of Funding, 2017

Adjusted for Differences in Cost of Living



Data from 2017 or most recent year: 2016 for FRA, SWIZ, UK and the US, and 2015 for AUS. Current expenditures on health, adjusted for US\$ purchasing power parities (PPPs). Numbers may not sum to total health care spending per capita due to excluding capital formation of health care providers, and some uncategorized health care spending. * For the US, spending in the 'Compulsory private insurance schemes' (HF122) category has been reclassified into the 'Voluntary health insurance schemes' (HF21) category, given that the individual mandate will end starting in 2019. Source: OECD Health Data 2018.

Recent research also indicates that per capita costs in U.S. private insurance are rising faster than those in public insurance programs and that prices are a likely culprit. Between 2007 and 2014, Cooper and colleagues found that private health spending per enrollee increased more rapidly and showed much more variability than in Medicare. Medicare sets prices for providers while prices in commercial plans are usually the result of negotiation between providers and insurers, or employers. Anderson and colleagues note that the difference between prices paid by public and private insurers ballooned from 10 percent in 2000 to 50 percent in 2017.⁴¹ The authors argue that to slow the rate of growth in U.S. health care costs, we must pay increased attention to private insurer payments to providers.

The congressional Medicare-for-All bills, as well as those that give consumers a choice of enrolling in a Medicare-like public plan, do that. They propose setting provider prices at Medicare rates or somewhere between private and public rates. HR 1384 also proposes setting regional budgets for hospitals. This option has not been modeled as part of the research reviewed here. Paying providers in employer and other private insurance plans at or near Medicare rates could also be done without a public plan or single-payer system.⁴²

⁴¹ Gerard F. Anderson, Peter S. Hussey, and Varduhi Petrosyan, “[It’s Still the Prices Stupid: Why the U.S. Spends so Much On Health Care, and A Tribute to Uwe Reinhardt](#),” *Health Affairs* 38, no. 1 (Jan. 2019): 87–95.

⁴² Sherry A. Glied and Jeanne M. Lambrew, “[How Democratic Candidates for the Presidency in 2020 Could Choose Among Public Plans](#),” *Health Affairs* 37, no. 12 (Dec. 2018): 2084–91.

Jodi Liu and Christine Eibner of RAND recently estimated the effect of a Medicare-for-All approach on national health spending.⁴³ They note that commercial insurers pay, on average, 167 percent of Medicare rates for hospital services and 125 percent of Medicare physician prices. Meanwhile, Medicaid pays about the same as Medicare for hospital prices and 72 percent of Medicare physician prices. They assume that a Medicare-for-All plan would pay hospitals about 124 percent of current Medicare rates and pay physicians 107 percent of Medicare rates, resulting in an overall blended rate of 109 percent.

In its analysis, the Urban Institute assumed providers would be paid at Medicare rates, with an upward adjustment for hospitals, for an overall blended rate of 107 percent of Medicare rates.⁴⁴ Kenneth Thorpe of Emory University makes a similar assumption for an overall blended rate of 105 percent of Medicare rates.⁴⁵ In these scenarios, payments would rise for services now covered by public plans and fall for those covered by private plans.

Charles Blahous from the Mercatus Center at George Mason University also estimated the cost implications of a Medicare-for-All proposal and assumed provider prices would be set at Medicare rates.⁴⁶ At those rates, he estimates savings in 2022 of \$384 billion, or \$5.3 trillion over 10 years. Robert Pollin and colleagues' analysis of a Medicare-for-All proposal also assumes prices would be set at Medicare rates leading to a reduction in U.S. health care expenditures of 2.8 percent.⁴⁷

None of these estimates include HR 1334's proposal to establish regional global budgets for institutional providers and separate budgets for capital projects. Such a provision could have very different implications for the cost of hospital and nursing home care than does setting payment rates at or near Medicare rates.

Prescription drugs. Most of the recent congressional reform bills, including Medicare for All and those that add a choice of public plan, would allow HHS to negotiate drug prices. RAND assumes that this negotiation power would enable HHS to negotiate prices that are 10 percent lower than current levels. At that rate, RAND estimates savings of \$39.2 billion in 2019. Blahous projects prices would be 12 percent lower and estimates savings of \$61 billion in 2022,

⁴³ Jodi Liu and Christine Eibner, [National Health Spending Estimates Under Medicare for All](#) (RAND Corporation, Apr. 2019).

⁴⁴ John Holahan et al., [The Sanders Single-Payer Health Care Plan The Effect on National Health Expenditures and Federal and Private Spending](#) (Urban Institute, May 2016); and Josh Katz, Kevin Quealy, and Margot Sanger-Katz, ["Would 'Medicare for All' Save Billions or Cost Billions?"](#) *New York Times*, Apr. 10, 2019.

⁴⁵ Kenneth E. Thorpe, ["An Analysis of Senator Sanders' Single Payer Plan"](#) (Emory University, Jan. 2016, unpublished paper).

⁴⁶ Charles Blahous, ["The Costs of a National Single-Payer Healthcare System,"](#) Mercatus Working Paper, Mercatus Center at George Mason University, July 2018.

⁴⁷ Robert Pollin et al., [Economic Analysis of Medicare for All](#) (Political Economy Research Institute, University of Massachusetts Amherst, Nov. 2018).

or \$846 billion over 10 years. Thorpe estimated that negotiation could lower drug prices by 4 percent.⁴⁸ Pollin assumes a reduction of 40 percent.

The Urban Institute assumed that negotiation would leave drug prices about halfway between Medicare and Medicaid prices, after rebates. This translates into a 30 percent reduction for prices in commercial plans, an 18 percent reduction in Medicare prices, and a 29 percent increase in Medicaid prices, or about a 20 percent overall decline.⁴⁹

Administrative costs. Administrative costs for private health plans exceed similar costs in Medicare. RAND notes that administrative costs were 6.9 percent of personal health spending in Medicare in 2017, compared to 13.9 percent in commercial plans. RAND also estimates that administrative costs such as billing comprise 13 percent of physician expenditures, 8.5 percent of hospital costs, and 10 percent of other costs. RAND assumes that Medicare for All would lower health plan administrative costs to 5.3 percent of spending and provider administrative costs to 5.6 percent, for a combined savings of \$158.7 billion in 2019.

Blahous assumes health plan administrative costs would decline to 6 percent of spending for an overall savings of \$83 billion in 2022, or \$1.57 trillion over 10 years. The Urban Institute and Thorpe assume health plan administration of 6 percent and 4.7 percent of spending, respectively. Pollin assumes a larger decline to 3.5 percent of spending.

Demand for health care. Medicare for All would increase demand for health care because millions more people would have coverage and most people would face no cost-sharing. Benefits would also include more services than many people have, including those in Medicare. RAND assumes that demand for health care under Medicare for All would rise by 2.2 percent for people currently covered by Medicare, by 2.6 percent among those insured by private plans, and by 25 percent for those currently uninsured. In its estimates, RAND assumes that limits on provider capacity would leave 50 percent of the new demand either unmet or delayed. Blahous assumes demand would increase by 11 percent for those with private coverage, 16 percent for people with Medicare who do not have supplemental coverage, and 89 percent for those currently uninsured. Thorpe assumes demand by those currently insured would climb by about 7 percent and by 60 percent for those currently uninsured, for an overall increase of about 15 percent.⁵⁰ Pollin assumes overall demand would increase by about 12 percent.

Overall spending. Based on the above assumptions, RAND estimates that national health spending under Medicare for All would increase by 1.8 percent in 2019, rising from \$3.823 trillion under current law to \$3.891 trillion. However, RAND estimates that if new demand for health care is fully met, overall spending would increase by 9.8 percent to \$4.2 trillion. Using slightly older national expenditure data, Blahous estimates that Medicare for All would lead to a 2 percent decrease in U.S health care spending, falling from an estimated \$4.562

⁴⁸ Josh Katz, Kevin Quealy, and Margot Sanger-Katz, "[Would 'Medicare for All' Save Billions or Cost Billions?](#)" *New York Times*, Apr. 10, 2019.

⁴⁹ Author communication, Apr. 24, 2019.

⁵⁰ Author communication, Apr. 25, 2019.

trillion in 2022 to \$4.469 trillion. Pollin estimates that health spending in 2017 would have fallen from \$3.24 trillion to \$2.93 trillion, or a 9.6 percent decline. Thorpe estimates an increase of about 12.6 percent in 2019.⁵¹ The Urban Institute projects the greatest increase in national health expenditures: 16.9 percent in 2017.

In the area of costs, what has captured the greatest attention in the emerging debate about Medicare for All, is the significant shift in the how national health spending would be financed. With the exception of HR 7339, which retains employer coverage as an option for employers and employees, all the bills in this category would shift most U.S. health care spending from households and employers and state and local governments to the federal budget.⁵² This shift raises important questions about financing sources, in particular the incidence of taxation, which is discussed in some of the analyses reviewed here.

What is notable about the range of national health expenditure estimates for the Medicare-for-All proposals is that the increase in expenditures is often less than the increase in demand for health care induced by providing comprehensive coverage to everyone. The range of estimates on spending is very wide. This is because the degree of potential savings and efficiencies depend on assumptions, particularly the ability of a single-payer plan to lower provider payments, prescription drug costs, and administrative costs. The mechanisms for achieving slower health care cost growth in these proposals could be considered, refined, and applied not only in single-payer approaches but in other health reform strategies. For example, as part of a set of incremental ACA reforms, the Urban Institute estimated that capping provider payments at a level just above Medicare rates in the individual market could lower federal spending on the ACA's premium tax credits by \$11.8 billion and household spending on premiums by \$1.7 billion in 2020.⁵³

Conclusion

Since the passage of the ACA in 2010, Congress has not passed subsequent legislation that would insure more people or improve the affordability or cost-protection of private plans. Many states have stepped up by promulgating regulations, passing legislation, and establishing programs like reinsurance to secure insurer participation, inform consumers of their coverage options, and lower consumer costs. But people living in states that did not embrace the coverage expansions (i.e., Medicaid expansion or choosing to operate a state-based marketplace) are lagging those who live in more actively engaged or resourced states. Moreover, some states that have taken actions like establishing reinsurance programs are struggling to finance them long term.

⁵¹ Author communication, Apr. 25, 2019.

⁵² HR 7339 requires employers to meet the new coverage requirements of the public program and gives them and their employees the option to elect the public plan.

⁵³ Linda J. Blumberg et al., [*A Path to Incremental Health Care Reform: Improving Affordability, Expanding Coverage, and Containing Costs*](#) (Urban Institute, Dec. 2018).

Improving coverage for all U.S. residents will require federal legislation. These recently introduced bills are an amalgam of provisions that individually or collectively have the potential to make significant improvements in coverage and increase the ability of people to get the health care they need. Expanding coverage, limiting out-of-pocket cost exposure, and lowering the overall rate of health care cost growth are achievable goals; these bills provide mechanisms to move forward on each.

Each policy approach presents trade-offs and financing decisions that will require more microsimulation modeling, analysis, and information gathering through hearings like these, as well as public vetting and discussion. The set of policy options discussed in this testimony should be viewed along a continuum. Some ideas, like enhancing the ACA's subsidies, won't completely solve the U.S.'s significant affordability problem, but move toward providing targeted relief to several million people.

Many of these ideas can be implemented without a major reorganization of the health care system. For example, paying providers in commercial insurance plans at prices closer to those in Medicare or allowing the Secretary of Health and Human Services to negotiate drug prices have the potential to slow health care cost growth and would not require an immediate shift to a single-payer system. The Medicare-for-All bills feature some of the proposed approaches in less sweeping bills, such as enhancing marketplace subsidies or transitional coverage improvements during a multiyear transition to a single-payer system. On the other hand, moving piecemeal also involves trade-offs. Based on the experience of the ACA, it appears possible or even likely that additional steps may take some time to achieve.⁵⁴

The committee is to be commended for taking on the issue of health reform. Hearings like these allow for fact-based consideration of policy options and their trade-offs. I look forward to your questions.

Thank you.

⁵⁴ Sherry A. Glied and Jeanne M. Lambrew, "[How Democratic Candidates for the Presidency in 2020 Could Choose Among Public Plans](#)," *Health Affairs* 37, no. 12 (Dec. 2018): 2084–91.