Cornell University

Alternative Reform Policies

PUBPOL 2350

November 30, 2023

The State of

THE AMERICAN DREAM

Thursday, Nov. 30 | 4:30 – 6:00 PM

Physical Sciences Building 401

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Cornell Brooks Public Policy

BROOKS SCHOOL JOHN W. NIXON '53
DISTINGUISHED POLICY FELLOWS PROGRAM

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Thursday, November 30
6 - 7:30 PM
Location: MVR 1153

LIVE Narcan Education+Training!

In partnership with:

ADC Alcohol & Drug Council of Tompkins County, Inc.

SIGN UP!

Final on Friday, December 8th at 9am

- Barton Hall
- Covers info from October 31st lecture until what we cover today
- Office hours next week:
  - Tuesday, December 5: 9:00 – 10:30 am
  - Wednesday, December 6 9:00 – 10:00 am
  - Thursday, December 7 2:30 – 4:00 pm

Please Complete Your Course Evaluation

- Available soon

- I read the course evaluations carefully and often make changes to the course as a result.

- Please fill it out. Don’t be a part of the silent majority.

Today's Agenda

1. **Possible reforms:** discuss possibilities ranging from somewhat likely, to relatively unrealistic reform policies
2. **Single-Payer:** Discuss how a single-payer policy (or a public option) would affect access, quality, and costs
3. **Universal basic insurance with optional supplemental plans**

Two Paradigms for Categorizing Health Care Reform

- Does the reform focus on the financing of health care *(i.e., how much we spend on medical care, who makes that decision, and who is able to receive medical care);* **OR** the organization and delivery of medical care *(i.e., how providers deliver care to patients)*?
- Consumer autonomy and competition: does the reform rely heavily on for-profit companies competing with one another in markets, with consumers/patients choosing the company offering the highest value product? **OR** does the reform feature government decisions made on our behalf?

Ideological Differences on Health Policy

Ideology	Values	Cost Containment	Redistribution
Left	• Trust in government as regulator • Distrust of profit motive • Distrust of consumers' ability to make choices	• Fee and price controls IPAB (hospitals, MDs) • Government negotiation with pharmaceutical companies • Comparative/cost-effectiveness	• Expand existing public programs • Expand eligibility for Medicare (age 55+) • Expand eligibility for Medicaid (by income and age) • Maintain employer-paid system • Single-payer program (by combining above programs)
Right	• Trust in market competition • Belief in necessity of financial incentives • Values consumer sovereignty and choices	• Markets and competition • FEHB for Medicare • Individual choice (HSAs) • Eliminate state mandates	• Income-related refundable tax credits • Medicare a fixed contribution program (premium support) • Income-related public programs • Cap amount of health insurance premiums that are tax exempt

FEHB: federal employees health benefits; HSA: health savings account; IPAB: independent payment advisory board

Source: Feldstein and Melnick, 2022.

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The ACA Has a Little Bit of Everything

- Major focus on financing reform by changing how insurance is paid for 40 million people
- New provider reimbursement programs (e.g., ACOs, bundled payment, pay-for-performance) hope to trigger a reorganization of the delivery of medical care to focus on high-value care
- Relies on markets and competition on the ACA exchanges
- Relies on government decisions for Medicaid expansion and the administration of the larger Medicaid program

Possible Reforms to Complement/Replace the ACA

Relatively Realistic

- **Strengthen the ACA** (Biden made some progress in 2021)
- **Public Option**: either added to current system or as a component of a single-payer system
- **Prescription Drug Prices**: allow Medicare to negotiate directly with biotech and pharmaceutical firms (this happened in summer 2022)

Longshots

- **Medicare-for-All** single payer
- **Baicker et al.** proposal: universal basic coverage plus optional supplemental coverage

Key Issues When Analyzing Any Proposed Reform

1) **Spending:** focus first on how much the policy will change total national spending on medical care, not changes in taxes. Total spending is what matters first; separately, we can debate who pays, and how much.
2) **Distribution of the cost**: who will pay more/less of the total cost than today? This affects equity and a policy's political prospects.
3) **Access**: any plan that covers more people will increase spending.
4) **Choice:** will people be able to choose health plans that are truly different? Tradeoff: policies allowing more choice will be less effective at reducing total spending and will perpetuate inequities. But allowing choice improves political feasibility.
5) **Provider payments**: how much less will MDs/hospitals and other provider receive vs. today, and how will they react to lower payments (e.g., queues, "brain drain")?
6) Will the government really have the **resolve** to drive down provider payments? This is hard and will make enemies (and politicians don't like having enemies).
7) **Innovation**: how will this be affected, and will it affect health (much)?

1. Strengthen the ACA

- Re-instate the individual mandate/fine for not having health insurance.
- Cover 100% of Medicaid expansion costs for all states.
- American Rescue Plan (2021): made the ACA exchange subsidies more generous so consumers pay less; 5 million people gained coverage since 2020.
- Reinstate ACA cost control provisions that were repealed by Congress in 2018 and 2019: Independent Payment Advisory Board (IPAB) and Cadillac tax
- Commonwealth Fund estimates:
  - 11 million additional people would become insured (leaving 20 million uninsured).
  - Medical spending would rise by 1%. Small increase due to reinstating the ACA cost control provisions.

Source: Commonwealth Fund, October 2019; ASPE, August 2022.

2. Inflation Reduction Act (2022) Will Reduce Drug Spending by About $30 Billion Per Year

- For the first time, the U.S. federal government can negotiate the prices of prescription drugs for about 100 drugs per year by 2030.
- Estimated to save taxpayers $30 billion per year.
- Pharmaceutical firms will be penalized if they raise their drug prices much faster than inflation.
- Beginning in 2024, the elderly cannot pay more than $2,000 per year out-of-pocket on prescription drugs.
- Medicare patients will not pay more than $35 per month out-of-pocket for insulin drugs.
- Pharmaceutical firms are arguing that lower prices will reduce R&D spending, which will result in fewer approved drugs in the future, especially for follow-on indications.

Source: Hwang et al., *JAMA*, August 19, 2022.

3. Medicare-for-All (single-payer with no choice)

- Eliminate all private health insurance, including employer-provided health insurance.
- All residents, or all legally-residing U.S. residents, receive the identical Medicare plan. Similar to Canada.
- Elizabeth Warren estimated no change in medical spending over the next 10 years: reduced provider payments and administrative costs fund insurance expansion (including to undocumented immigrants).
- Taxes rise, particularly for high-income population. Premiums are gone.
- Commonwealth Fund: 5% cut in spending if coverage extended to legally-residing residents; 18% increase if extended to all residents.
- Challenge: we value autonomy and choice; are reluctant to give the government too much control; and would oppose queues for care that might occur if providers lose generous private insurance reimbursement.
- Allowing people to buy supplemental or replacement private insurance might be more politically feasible, but compromises equity.

Source: Commonwealth Fund, October 2019.

4. Public Option Added to the Current System

- Provide Medicare as an option to everybody (or certain groups, such as lower-income or 55+); allow private insurance to remain as an option.

- Biden's plan (along with strengthening the ACA). Transition plan to Medicare-for-All for Bernie Sanders and Elizabeth Warren.

- Medicare would be a popular choice due to low premiums, which are low b/c Medicare has low provider reimbursement.

- Commonwealth Fund estimates:
  - Would extend health insurance to 13 million people.
  - No change in national spending in spite of expanded coverage due to lower provider payments.

Source: Commonwealth Fund, October 2019.

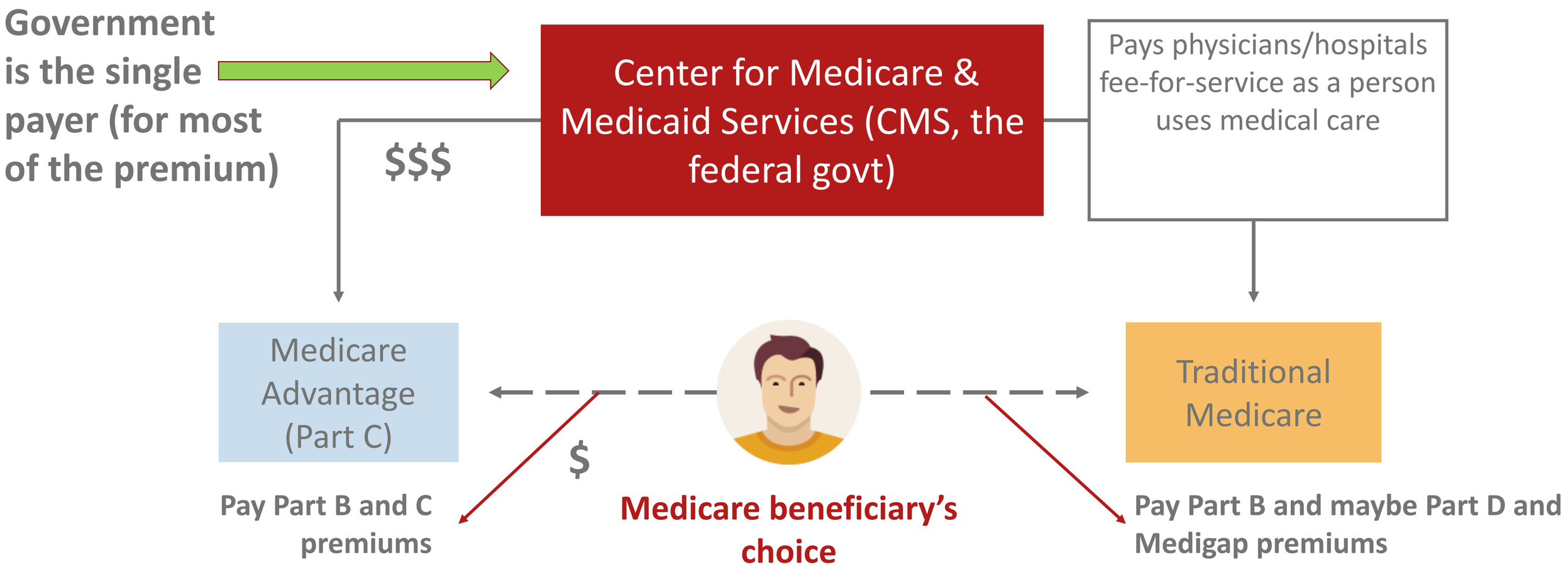
A Single-Payer System Could Still Allow Consumers to Choose From Competing Health Plans – Public and Private

- "To have any chance of success in the U.S., single payer would have to be simple, require a minimum of bureaucracy, be based on decentralized organizations to deliver care, and provide opportunities for individuals to choose among competing health plans."
- People would "choose membership in a local health plan that takes responsibility for the individual's health and is reimbursed (by the government) on a risk-adjusted per capita payment" method.
- Public option could be offered alongside private plans.
- Similar to the Medicare Advantage, Part C structure (next slide), where the government pays most of the premium of the plan selected by an individual in Medicare. In a full single-payer system, the government would pay most of the premium for people of all ages. Employers would no longer be involved.

Source: Victor Fuchs, *JAMA*, December 18, 2017.

Reminder About Medicare Part C: Single Payer Can Accommodate Diverse Plans That Compete With Each Other

CMS pays most of Part C premium to a private health insurer. Insurer must cover same set of services as traditional Medicare. Usually has narrower provider network because it is a managed care plan.



Victor Fuchs' Spin: Single-Payer With Choice (continued)

- "This system could provide the plans with incentives for efficiency and effectiveness and leave them free to organize production as they deem best. Plans could compete with each other for members on the basis of service and quality of care."

Source: Victor Fuchs, *JAMA*, December 18, 2017.

5. Recent Proposal by 3 Professors: Universal Basic Coverage With Optional Supplemental Health Insurance Plans

- "In every nation, citizens have some access to health care, regardless of ability to pay, simply by being part of society. We call this the 'basic bundle'."
- Basic bundle would be granted to all at no premium, financed by progressive income taxes.
- **Design Question #1: What Should the Basic System Cover?**
- "Include care with health benefits that sufficiently exceed resource costs."
- Some services would be obviously included; a few would be obviously excluded.
- "But this leaves a host of care with high cost and more questionable benefits, and the debate about inclusion of such services in the basic bundle would likely be heated."

Source: Baicker, Chandra, and Shepard, 2023.

5. Universal Basic Coverage With Optional Supplemental Health Insurance Plans (continued)

- Would need to establish a mechanism/organization to determine which services to include in the basic bundle. Could be a medical board or a government agency (e.g., Center for Medicare and Medicaid Services)

- "Such a system…would also provide an incentive for innovators to develop new treatments with higher health benefit and/or lower cost."

- The services included in the basic bundle would evolve over time.

Source: Baicker, Chandra, and Shepard, 2023.

5. Universal Basic Coverage With Optional Supplemental Health Insurance Plans (continued)

Design Question #2: What Mechanisms Are Used to Control Spending? Who will decide how much cost sharing patients will face; how much providers will be paid; which providers will be included; and whether to approve specific treatments for specific patients?

1) A centralized public process, such as a medical board or a government agency. Simple with low administrative costs.

2) Capitated payments from government to providers, like with Part C Medicare Advantage plans. Payments would be adjusted for a person's health status.

Source: Baicker, Chandra, and Shepard, 2023.

5. Universal Basic Coverage With Optional Supplemental Health Insurance Plans (continued)

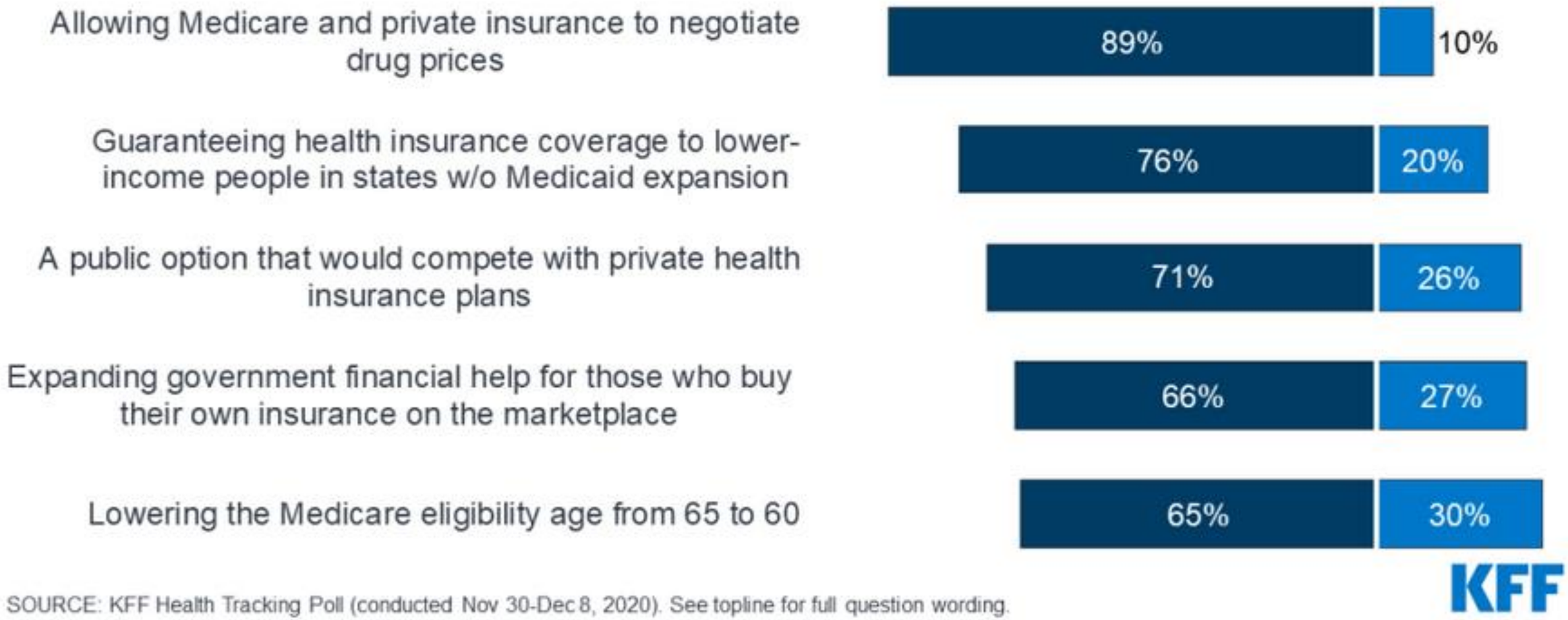
Design Question #3: What Supplementary Coverage Should Be Available?

- Many people, especially those with higher income, will be interested in purchasing a private health plan that supplements or replaces the basic bundle. Could be offered by employers.
- This option makes it easier to keep the basic bundle small and inexpensive, but makes the system less equitable.
- Allows the government to gain information on what should be included in the basic bundle.
- Supplemental plans could cover:
  - A patient's cost sharing (like Medigap)
  - Services not included in the basic bundle (e.g., Canada)
  - Providers not included in the basic bundle (e.g., U.K)
  - Shorter waiting times or amenities
  - Coverage that replaces the basic bundle

Strong Support for Biden's Proposed Health Policy Changes

Majorities Favor Key Health Care Proposals Put Forward By President-Elect Joe Biden

Do you **favor** or **oppose**…



SOURCE: KFF Health Tracking Poll (conducted Nov 30-Dec 8, 2020). See topline for full question wording.

KFF

Surprise, Surprise! Strong Divide Along Party Lines

Table 2: Support for President-Elect Biden's Proposed Health Care Policies				
Percent who say they **favor** each of the following **health care proposals**:	**Total**	**Party ID**		
		Democrats	**Independents**	**Republicans**
Allowing the federal government to negotiate with drug companies to get a lower price on medications that would apply to both Medicare and private insurance	89%	97%	87%	84%
Guaranteeing health insurance coverage to lower-income people whose states have not expanded their Medicaid program	76	95	74	54
Having a government-administered health plan, sometimes called a public option, that would compete with private health insurance plans and be available as an option to all Americans	71	92	71	45
Expanding government financial help for those who buy their own insurance on the marketplace	66	84	64	48
Lowering the age when people become eligible for Medicare from 65 to 60	65	79	61	51

Conclusions

- Reforming the U.S. health care system is difficult; we will be working on it (and you'll be voting on it) for decades.
- What I said at the end the 2009 version of my course: "comprehensive reform is likely to occur:
  - During a brave president's 2nd term, or
  - After a major health crisis"
- The ACA proved that I was wrong about the first bullet point; maybe I will be correct regarding the impact of Covid.
- The pace of health care reform is likely to accelerate in the future, occurring during most presidential terms.

- **Be an active participant!**