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While Considering Medicare For All: Policies For Making Health Care In The United States Better

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JUNE 6, 2019 **DOI:** 10.1377/hblog20190530.216896

While it is fascinating to think about "Medicare for All" (and one of us strongly favors it), it is unlikely that the United States will move quickly to fully publicly financed health insurance when Congress next considers health policy after the 2020 presidential election. Despite its theoretical advantages, passage of Medicare for All would require a

massive political battle to make feasible the shift from private to public funding, to develop enough public trust to expand an entitlement program for all Americans, and to mitigate the disruption (for many) of substituting public insurance for familiar, existing health insurance policies. That will take time. Fortunately, even while the Medicare for All saga rolls out, much can be done in the meantime that is politically plausible to augment and improve the Affordable Care Act (ACA) and make health care work better for all Americans.

The House of Representatives has begun passing legislation to bolster the ACA, but these proposals are unlikely to pass the Republican-controlled Senate. There is a great need for a set of bipartisan proposals that can move us forward now. In that spirit, we offer our thoughts about a package of reforms that we believe would be both achievable and impactful.

The most pressing problems are three: affordability of insurance, access to care, and pervasive defects in the quality of care. These challenges are becoming increasingly intertwined.

Improving Affordability

While US health care can and should be made more affordable by attacking waste, innovating in delivery system design, and improving productivity, these mechanisms are unlikely to achieve affordability quickly. Therefore, we recommend the following portfolio of policies:

- *Lower the cost of health insurance for more Americans.* The ACA created two major forms of financial assistance: premium subsidies and cost-sharing subsidies. Sliding-scale premium subsidies reduce the monthly cost of insurance substantially when they phase in for people with incomes at 133 percent of the federal poverty level but very little when they phase out at 400 percent of poverty. Regrettably, many people whose incomes exceed 400 percent of poverty have difficulty affording premiums. Four hundred percent is $100,400 for a family of four in 2019, while average silver-level insurance plans cost $15,855 or 16 percent of income. Premium subsidies must be extended further up the income spectrum such that no American spends more than 10 percent of income on insurance premiums. For higher-income Americans buying their own insurance, we would offer a fixed tax credit equal to 20 percent of the premium, mimicking the value of the tax exclusion enjoyed by people with employer-sponsored insurance. In addition, cost-sharing subsidies, currently available to those with incomes up to 250 percent of poverty, should be extended to more Americans, as average deductibles have risen to $3,000, and total out-of-

pocket costs are capped at $7,900 (in addition to premiums) for individuals with 2019 ACA Marketplace plans. We are alarmed by the bluntness of high deductibles, co-insurance, and copayments, since these approaches, alleged to give patients "skin in the game," are regressive and disproportionately penalize people with chronic diseases. We recommend eliminating all cost sharing for people with incomes below 250 percent of poverty, and, for people with incomes from 251 percent to 1,000 percent of poverty, we would offer sliding-scale subsidies similar to the current program. We would make these subsidies mandatory expenditures, instead of annual appropriations, so that the Executive Branch cannot use the funding of these benefits as a political weapon.

- *Reduce insurance premium growth rates by limiting hospital prices.* The biggest drivers of premium increases are hospital price increases. Hospital prices have risen much faster than physician prices: a whopping 42 percent from 2007 to 2014. Hospitals have exploited market consolidation to raise prices by employing multitudes of specialist doctors, making them "must haves" in insurance networks. In theory, consolidation should generate administrative cost synergy and quality benefits, but the facts have not borne out that promise. We believe that no hospital should be able to charge prices that are more than Medicare prices plus 20 percent, which is far less than many charge today. This is enough revenue to offset Medicaid underpayments and should provide appropriate pressure on hospitals to become more productive. We would index hospital prices to the Consumer Price Index rather than to medical inflation, so hospitals are not perversely rewarded for lower levels of productivity improvement than the rest of the economy. Finally, we would require all hospitals with greater than 40 percent market share in a given area to contract with all health plans so that they cannot limit choice and competition.
- *Make medications more affordable.* Medications are extremely expensive in the US compared with other nations. The Trump administration claims to have launched many policies to lower drug prices, but they have had little impact. We recommend extending the ban on rebates to all insurance markets, not just Medicare. We also recommend reducing the period of market exclusivity for biologic drugs from 13 years to 7 years to enable generic competition sooner, since biologic drugs are both the most expensive drugs and accounted for 70 percent of spending growth from 2010 to 2015. We also recommend adopting the Trump administration's proposed international market basket pricing approach to set the upper limit for drug prices.

Improving Access

To improve access to affordable insurance, we must improve the risk pool of people buying coverage and make Medicaid more universal. Specifically, we would recommend the following:

- *Create larger, lower-cost, healthier risk pools to reduce premiums.* The laws of mathematics for insurance premiums are simple and inescapable. Larger and healthier risk pools reduce the average insurance premiums in the ACA's community-rated and guaranteed-issue Marketplaces. To expand risk pools, we would reimpose the individual mandate, which was essentially eliminated in the legislation that created Trump's tax cut. Since we propose making subsidies more generous, we would also make the penalty for not buying insurance larger. We would rescind Trump's executive order that allows people to buy short-term plans for up to three years, since those plans selectively draw healthy people from the risk pool. We would also cancel the Trump-issued rules that allow short-term plans and association health plans to not cover essential health benefits in a bid to make them cheaper. This practice leaves unsuspecting and vulnerable patients underinsured and further undermines the risk pool. In addition, the aforementioned subsidy enhancements will also expand and improve the risk pool. Because lowering the price of insurance enables more people to afford insurance, it makes the risk pool larger and more stable, which creates a virtuous cycle of lower premiums and lower subsidy payments for each policy.

- *Expand the use of reinsurance.* The expanded use of reinsurance is an effective approach for lowering premiums. Reinsurance lowers premiums by reimbursing plans for medical expenses for the most expensive patients, so that these expenses do not have to be offset by increases in premiums for healthier patients. The impact of reinsurance can be dramatic and very cost effective, as was demonstrated in Alaska. During the first three years of the ACA, Marketplace plans used reinsurance to subsidize high-cost cases, leading to premium that were 10 percent to 15 percent lower than they would have been without reinsurance.

- *Improve Medicaid access.* Medicaid provides comprehensive insurance for 74 million Americans. Unfortunately, in some states, coverage is dropping as a result of work requirements and other barriers to enrollment and reenrollment. While helping Americans gain job skills and employment opportunities is laudable, we think that denying patients access to health care if they cannot search for or find employment actually works against employability. Similarly, we would eliminate Medicaid cost sharing since even small amounts of cost sharing can reduce use of necessary services. We also would eliminate waiting times for enrolling in Medicaid coverage after losing commercial insurance. Finally, we would encourage the 14 states that

have not expanded Medicaid to accept federal funds to expand their programs. We urge the administration to welcome waiver applications from these states, as long as they do not include work requirements, cost sharing, or other policies that undercut the core mission of Medicaid.

Improving Health Care Quality

Much of the excess cost of US health care comes from pervasive and serious defects in the quality of care. In 2001, the Institute of Medicine categorized six such defects, and they are still abundant: problems in patient safety, unscientific variations in care leading to ineffective treatment, lack of patient-centeredness, unwarranted delays due to poor system designs, excessive prices due to lack of transparency and open competition, and fraud. Most, if not all, of these defects waste resources, lead to worse outcomes for patients, and erode value.

Some of the provisions in the ACA were designed to switch market forces from "volume" (getting paid more for doing more) to "value" (getting paid more when patient outcomes are better). Accountable care organizations and bundled payments were two such innovations. Both appear to have had mild, but directionally desirable, impacts on both quality and cost, but we have much more to learn from these prototypes. We recommend continuing, serious evaluation of these models. We also recommend that the secretary of the Department of Health and Human Services draw directly on the unusual ACA provision that allows him to extend successful models by regulation to the Medicare and Medicaid programs as a whole, without requiring new statutes.

The ACA also created the Center for Medicare and Medicaid Innovation to sponsor tests of new payment models and delivery system designs, such as home- and community-based alternatives to hospitalization, telemedicine, integration of behavioral health into the care mainstream, and many more. We thoroughly endorse the continuation and expansion of such federally sponsored care delivery demonstrations, along with support to spread lessons learned widely and quickly. That agenda should include renewed efforts to improve patient safety through innovations in training, equipment, and job roles. Federal goals for improving patient safety should become more ambitious and must be supported consistently.

Finally, as knowledge has grown about the power of "social determinants of health" (such as housing, food availability, exercise patterns, precursors of substance abuse, early childhood trauma, and more), stakeholders have become more interested in spending health care dollars to mitigate these factors and prevent such harms—essentially moving "upstream" to the causes of ill health, not just the consequences. Early signals from both

public and private payers suggest increasing appetite for experiments and pilots addressing social determinants, and we strongly favor action and funding in that direction.

A Few More Themes

While affordability, access, and quality improvement are the top priorities, we think it would also make the US health system better if we addressed medical malpractice and surprise bills.

- *Reform medical malpractice policy.* A reformed medical malpractice system will reduce emotional distress for doctors, eliminate the excuse that medical malpractice necessitates wasteful extra tests and treatments, and encourage doctors to adopt new risk-based payment models and more parsimonious approaches to care. One approach to medical malpractice reform is to provide clinicians a safe harbor for adhering to clinical guidelines and evidence-based care. Another idea is to expand the highly successful experiments on rapid disclosure, apology, and commitments to improvement that have been pioneered in the Veterans Health Administration and at the University of Michigan Hospitals—so called “policies of extreme honesty.”

- *Protect Americans from surprise bills.* To protect Americans from surprise bills when they choose in-network providers, we would require all doctors who provide care at in-network hospitals or outpatient facilities to bill patients at average in-network prices. In May 2019, legislators in both the House and Senate have introduced bipartisan bills to address this issue. For drugs, we would prohibit formularies from moving drugs to higher cost-sharing tiers during a plan year as well. These formulary changes lead to needless switching of medications for no clinical benefit, more side effects, and lower adherence.

Concluding Thoughts

This portfolio represents a set of policies that could be supported at least somewhat on a bipartisan basis and that we believe are likely to be effective and, in the short term, more politically viable than Medicare for All. If enacted, this portfolio will make the ACA work better and enable all Americans to benefit from more affordable health insurance and better access to care. And, for those who favor Medicare for All, these policies represent steps in the right direction.

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Name

Margaret Steele • 11 days ago

Thank you for this extremely reasonable set of ideas. I hope there might be some bipartisan agreement on some of these suggestions, but I admit I'm not optimistic.

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John R. Griffith • 7 days ago

Kocher and Berwick are overlooking yet one more problem: the capability of the delivery organizations we call "hospitals." They now commonly support ambulatory as well as acute inpatient care. The evidence suggests that many are ill-prepared to implement excellence, care that is safe, effective, patient-centered, timely, efficient, and equitable. Widespread caregiver "burnout" is also important; excellence requires caregiver commitment. The recent New York Times article on the University of North Carolina Medical Center (5/30/19, p. 1) is a dramatic example. Not only was care inadequate, basic practices for assessing and improving care were lacking. The fact that someone made secret recordings is telling in itself. The next round of provider payment contracts must stimulate a "ground-up" transformation improving care quality, patient satisfaction, and worker satisfaction.

"Best practice" is clearly understood and well-documented among those organizations that seek it. Unfortunately, it is not easy to achieve. The path is clear. It is built around two concepts, "Empower" and "Improve." "Empower" changes the organization's culture, requiring senior leadership to seek comments of all kinds from first line workers and respond constructively to them. "Improve" upgrades the management technology, providing balanced scorecards of performance measures to every permanent work team, identifying OFIs (opportunities for improvement), redesigning work processes, and carefully training workers to use them. Neither "Empower" or "Improve" is simple. They require a minimum of three years to implement in a typical community organization, even with trained, dedicated leadership.

The next payment system should:

1. Reward multi-dimensional excellence supported by auditable measures.
2. Provide incentives to install performance measures, learn servant leadership, and establish a

system identifying and pursuing OFIs.
3. Reward documented worker satisfaction measured by turnover and auditable survey.
Excellence can be learned; dozens of organizations have made and documented the "journey." Organizations like the American Hospital Association and the American College of Healthcare Executives can teach it. The essential first step is incorporating rewards into the next round of payment contracts.

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Michael Seibold • 11 days ago

While capping commercial insurance rates at 120% of Medicare sounds like a good idea, it would be disastrous to hospitals if implemented without a long phase in. Why? Well as the recent Rand 2.0 data shows, the variation in hospital payment rates for commercial insurers varies widely with a low of 125% (central Michigan) to over 300% in Indiana.

Data indicates that health systems with high commercial payments are both exceedingly profitable as well as having high costs. For example, Indiana hospitals have operating margins that are 5 times the US average.

This is solvable but will take some careful analysis and thought as to how one transitions from these very high payment rates to something more reasonable with an explicit and calculated rate reduction process.

And, by the way, you can just imagine how strong the hospitals, particularly the larger urban hospitals will scream and yell about this.

Why not start at capping all ACA plans at 110% of Medicare? Has anyone looked at the issue of what ACA health plans are paying as a % of Medicare?

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"While Considering Medicare For All: Policies For Making Health Care In The United States Better, " Health Affairs Blog, June 6, 2019.
DOI: 10.1377/hblog20190530.216896

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