U.S. Health Insurance Policy: Recent History and Future Directions

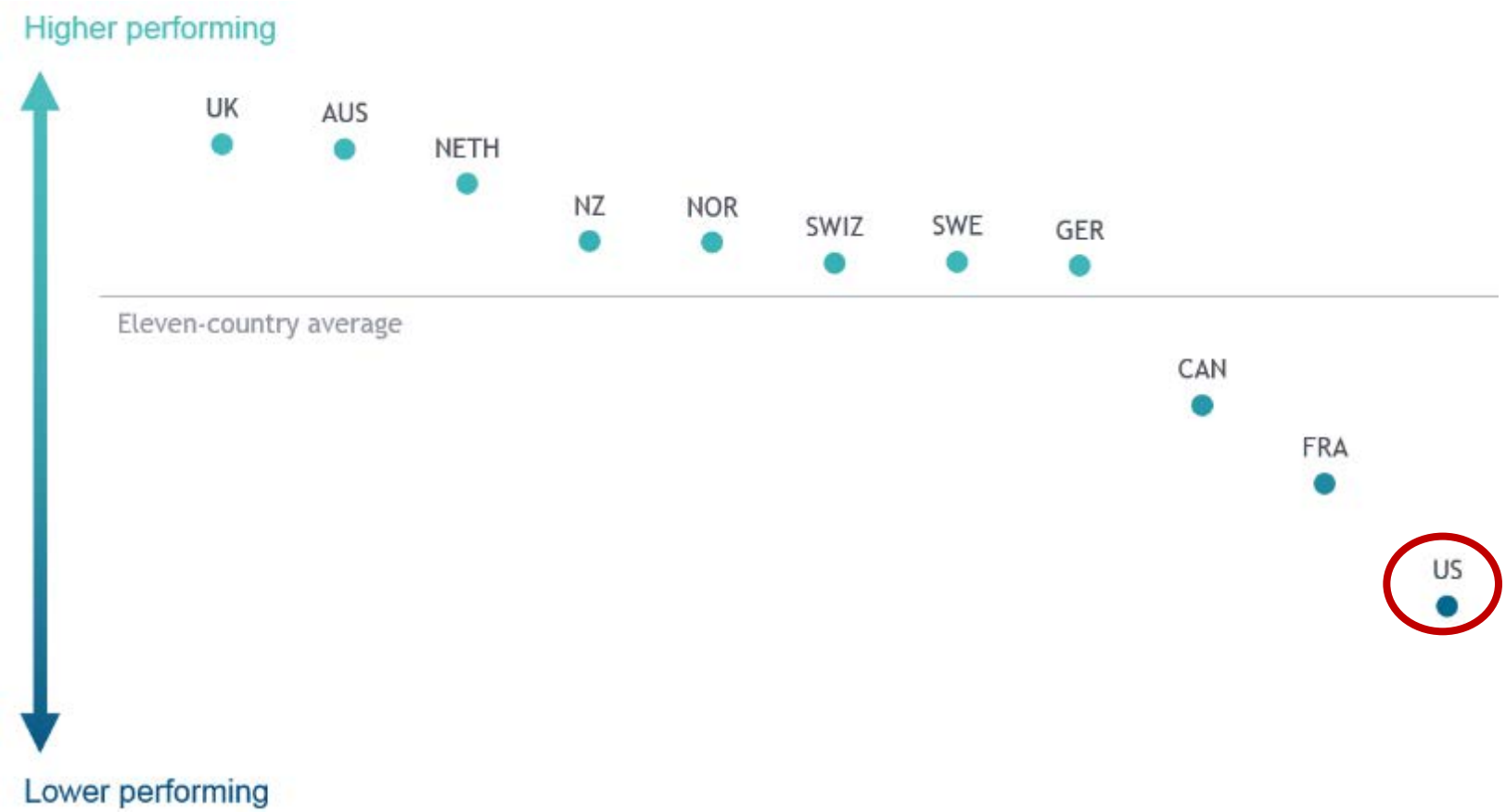
North Carolina Institute Of Medicine
Legislative Health Policy Fellows Program

Sara R. Collins, Ph.D.
Vice President, Health Care Coverage and Access
The Commonwealth Fund

Morrisville, NC
January 22, 2018

EXHIBIT 1

‘Mirror Mirror’
Rankings of Health System Performance



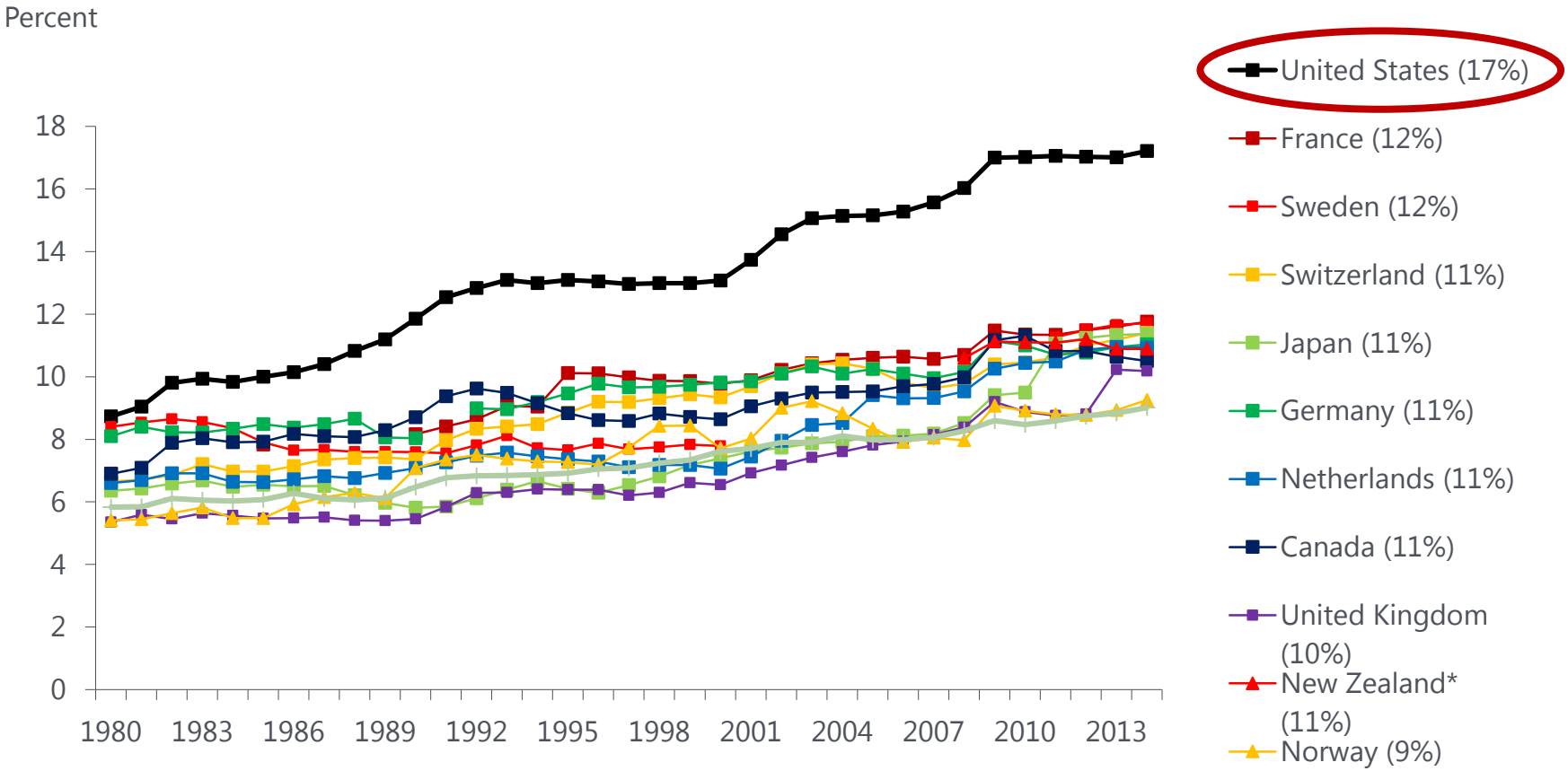
Source: The Commonwealth Fund, Mirror, Mirror On the Wall, 2017 Update

The Commonwealth Fund

EXHIBIT 2

U.S. Spends More than Other Countries

Health Care Spending as a Percentage of GDP 1980–2014



2013, ** 2012

GDP refers to gross domestic product.

Source: OECD Health Data 2016. Note: Australia, Germany, Japan, Netherlands and Switzerland data is for current spending only, and excludes spending on capital formation of health care providers.

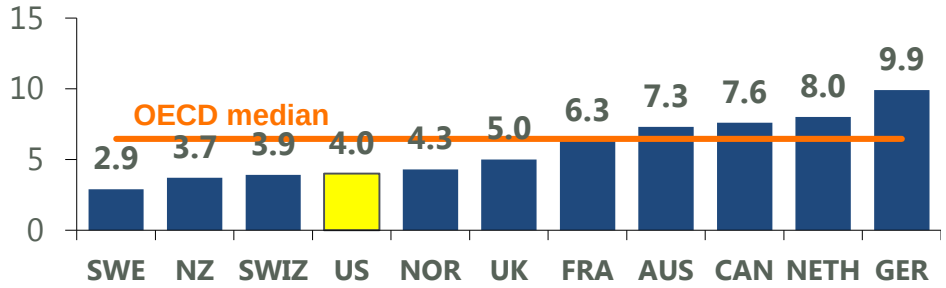
The Commonwealth Fund

EXHIBIT 3

U.S. Patients Often Get Less Care

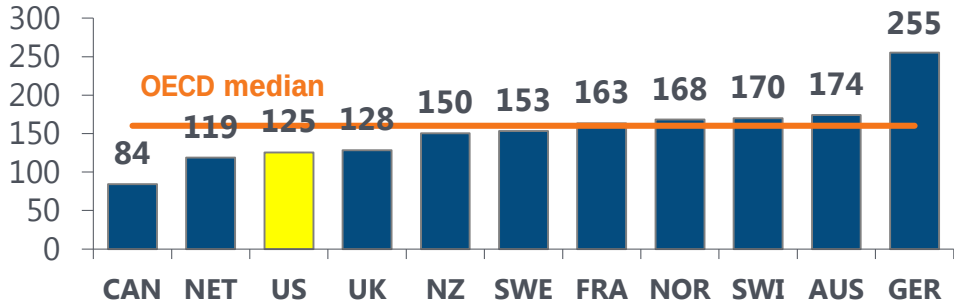
Doctor visits

Per capita



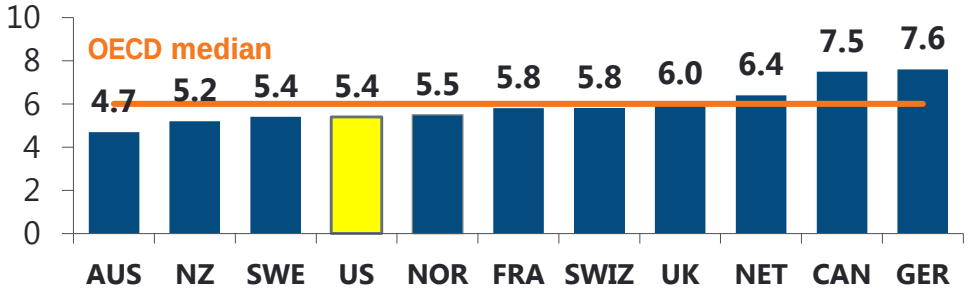
Hospital discharges

Per 1,000



Hospital average length of stay

Days, acute care



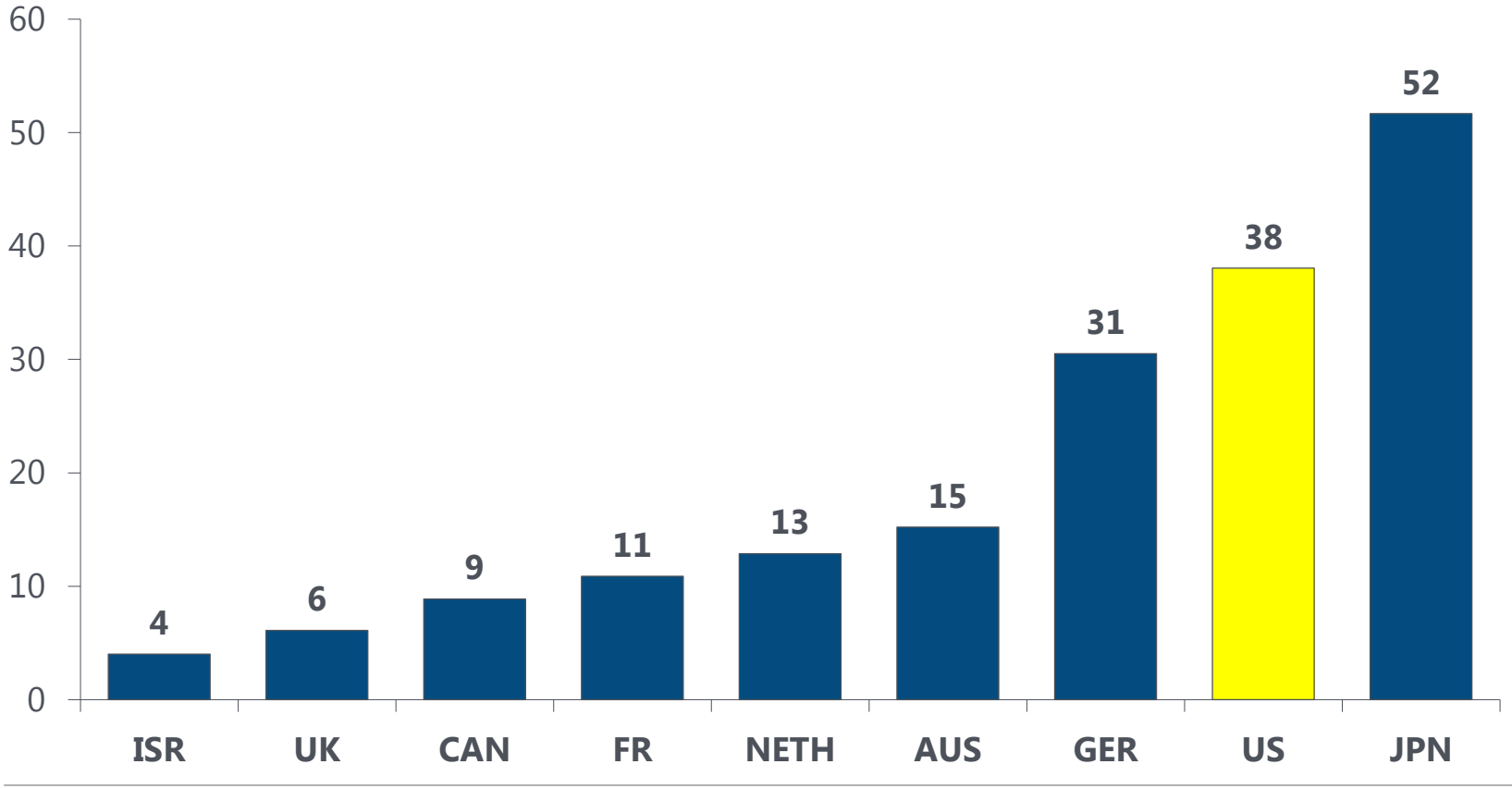
Source: OECD Health Data 2016 and 2017.
Data years: 2015, 2014, 2013, 2012, 2010, 2009.

The Commonwealth Fund

EXHIBIT 4

… Although, Sometimes Get More Care

Magnetic Resonance Imaging (MRI) machines per 1,000,000 population



Source: OECD Health Data 2016

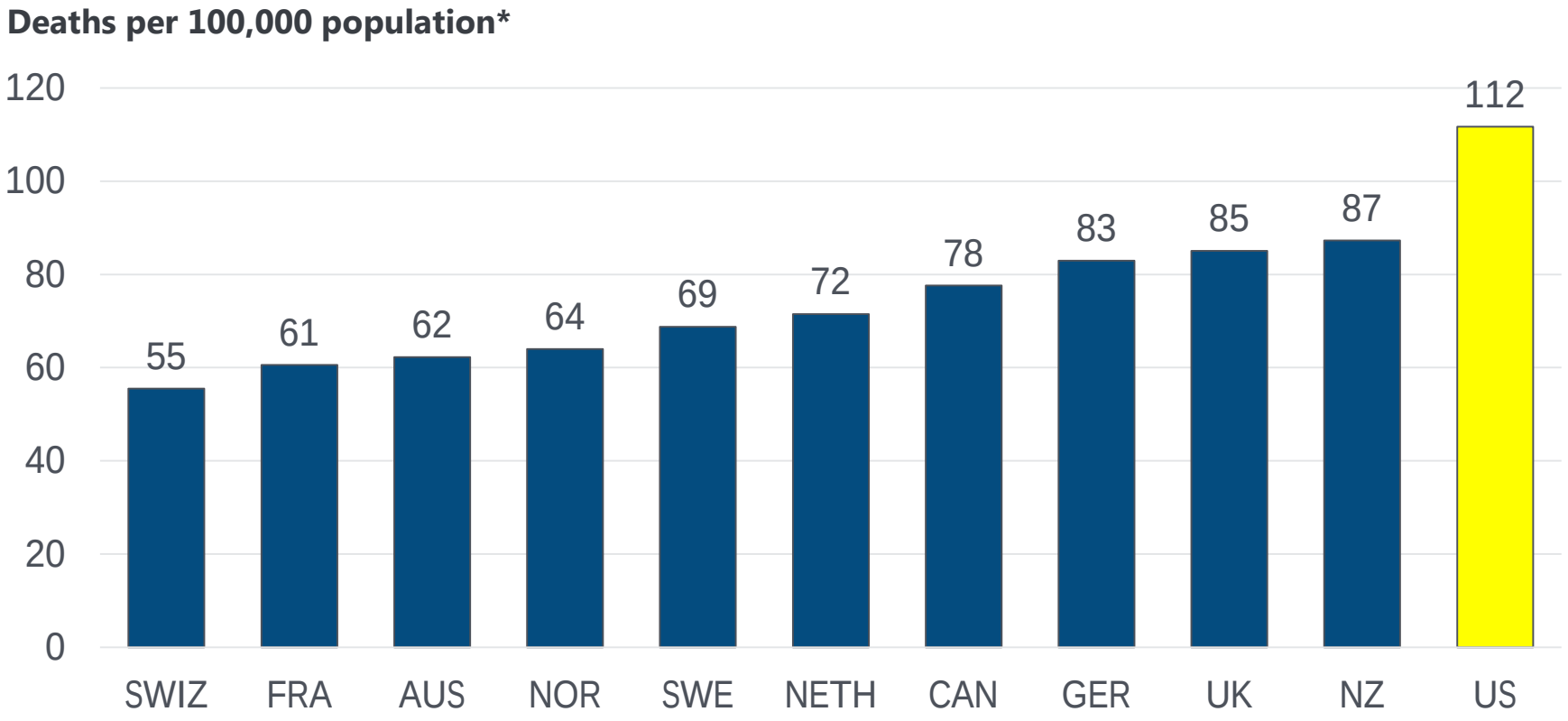
Canada MRI machine data from 2013, Germany MRI exam data from 2012, Japan and Netherlands exam data from unpublished Commonwealth Fund grant.

The Commonwealth Fund

EXHIBIT 5

US Adults Often Have Poorer Outcomes

Avoidable Deaths: Mortality Amenable to Health Care, 2014

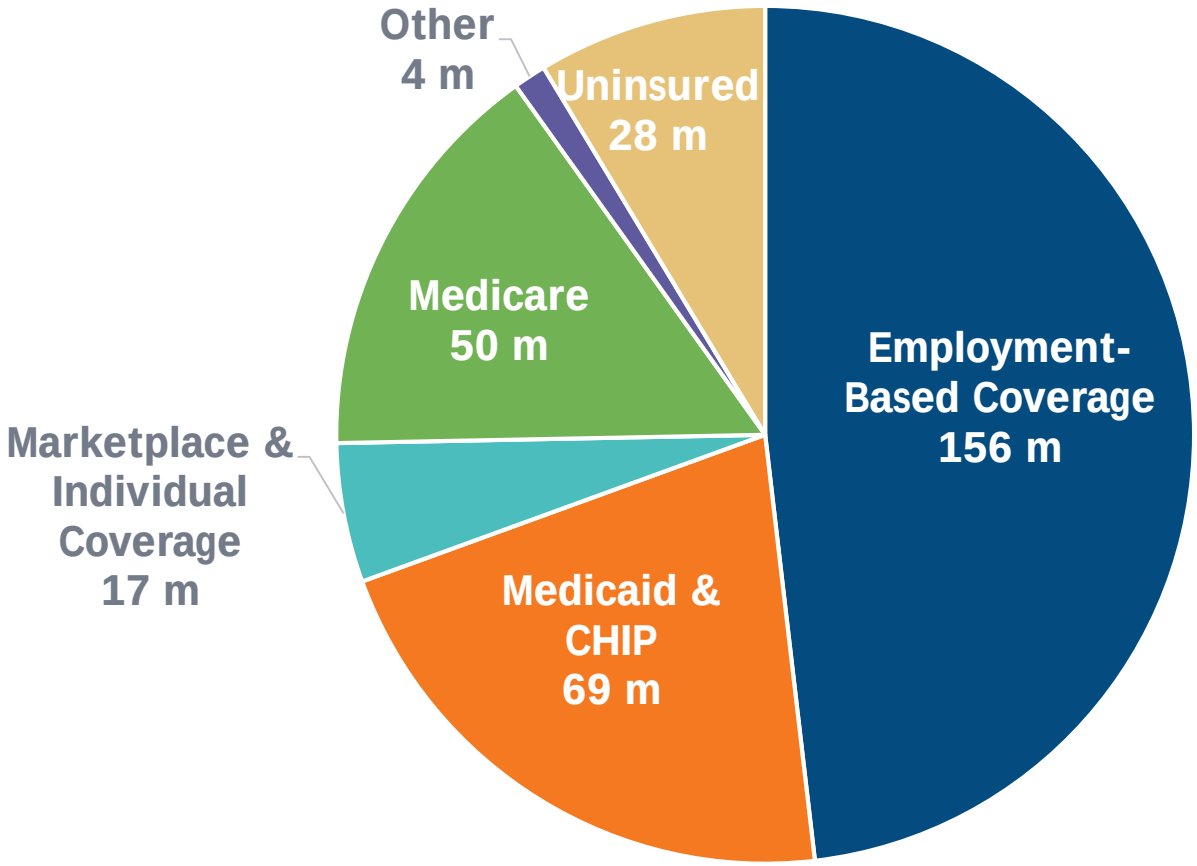


The Commonwealth Fund

Marina Karanikolos, European Observatory on Health Systems and Policies (2017). Trends in amenable mortality for selected countries, 2014. Data from 2014 in all countries except Canada (2011), France (2013), Netherlands (2013), NZ (2012), Switzerland (2013), UK (2013). WHO Mortality files (number of deaths by age group) and populations (except Human Mortality Database for Canada, UK and the USA). List of amenable causes: Nolte & McKee 2004 (Australia, Canada, NZ, Nor, US) Calculations by European Observatory on Health Systems and Policies (2016), Amenable mortality causes based on Nolte & McKee, 2004. Mortality and population data from WHO mortality files, released September 2016 (population data for Canada and the USA from Human Mortality Database). Age-specific rates standardised to European Standard Population 2013.

EXHIBIT 6

The U.S. Health Insurance System is Highly Fragmented



324 million people, 2017

The Commonwealth Fund

Sources:

Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027. Congressional Budget Office, September 2017.

Current Population Survey data.

EXHIBIT 7

Federal and state revenues are a major source of financing across all coverage types

	Source of Financing
Medicaid	Federal and state general revenues
Medicare	Federal payroll taxes and enrollee premiums
Employer-Sponsored Insurance	Federal employer and employee tax exclusion; employer and employee premium contributions
Individual and Marketplace	Various federal taxes and general revenues, enrollee premiums, employer and individual mandate penalties, insurer fees

EXHIBIT 8

Benefits vary by coverage source

	Benefits
Medicaid	Comprehensive
Medicare	Comprehensive, no long-term care
Employer-Sponsored Insurance	Comprehensive on average, but no national standard
Individual/ Marketplace & Small Group	Comprehensive, federal floor set by ACA

EXHIBIT 9

Cost-sharing varies by coverage source

	Cost-Sharing
Medicaid	Minimal with monthly or quarterly cap 5 % of income
Medicare	High; supplemental public and private insurance
Employer-Sponsored Insurance	Variable, but has increased significantly over time
Individual/ Marketplace & Small Group	High; lower for lower income ACA marketplace enrollees

EXHIBIT 10

Major U.S. Policy Changes That Increased Insurance Coverage

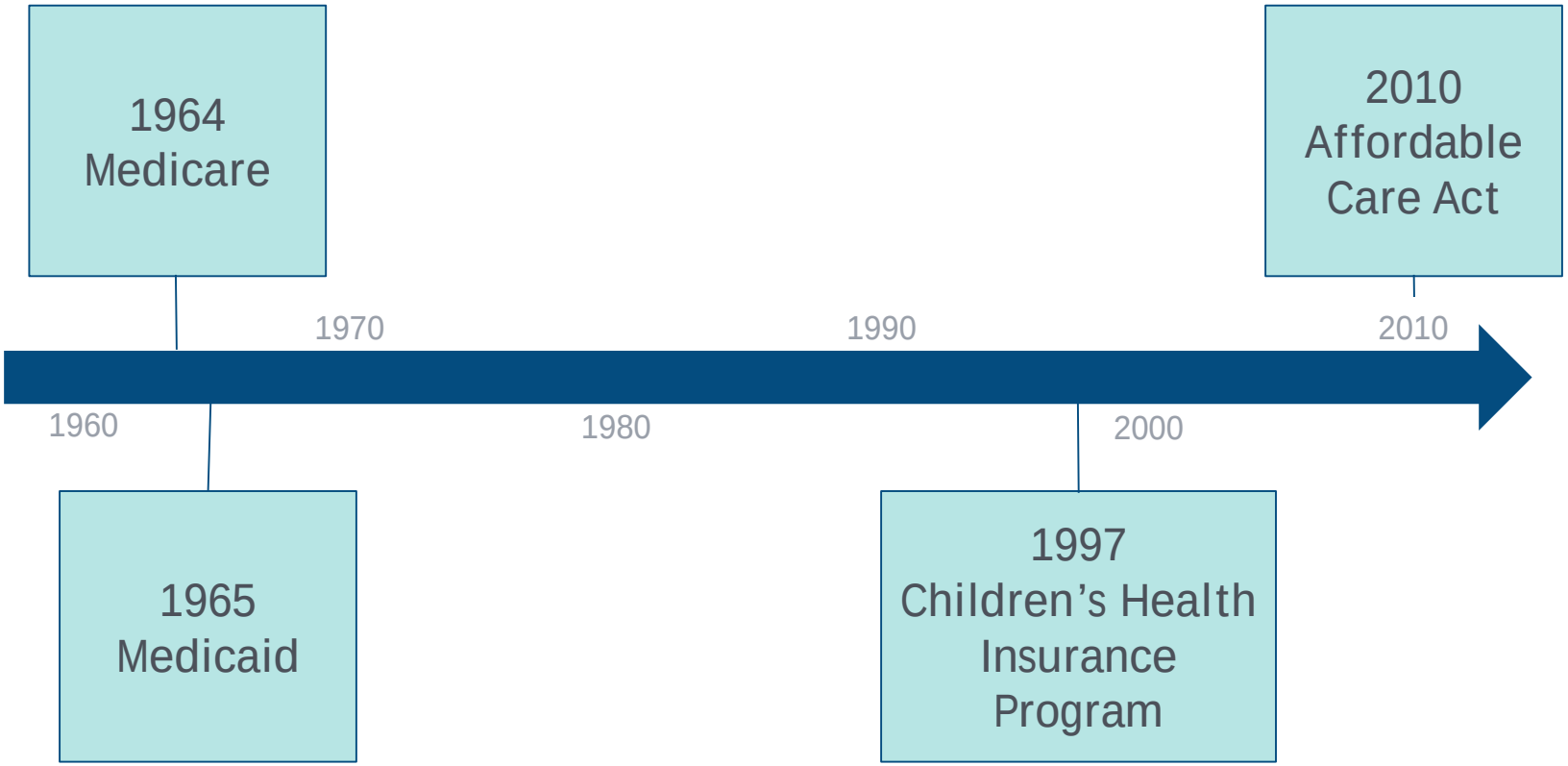
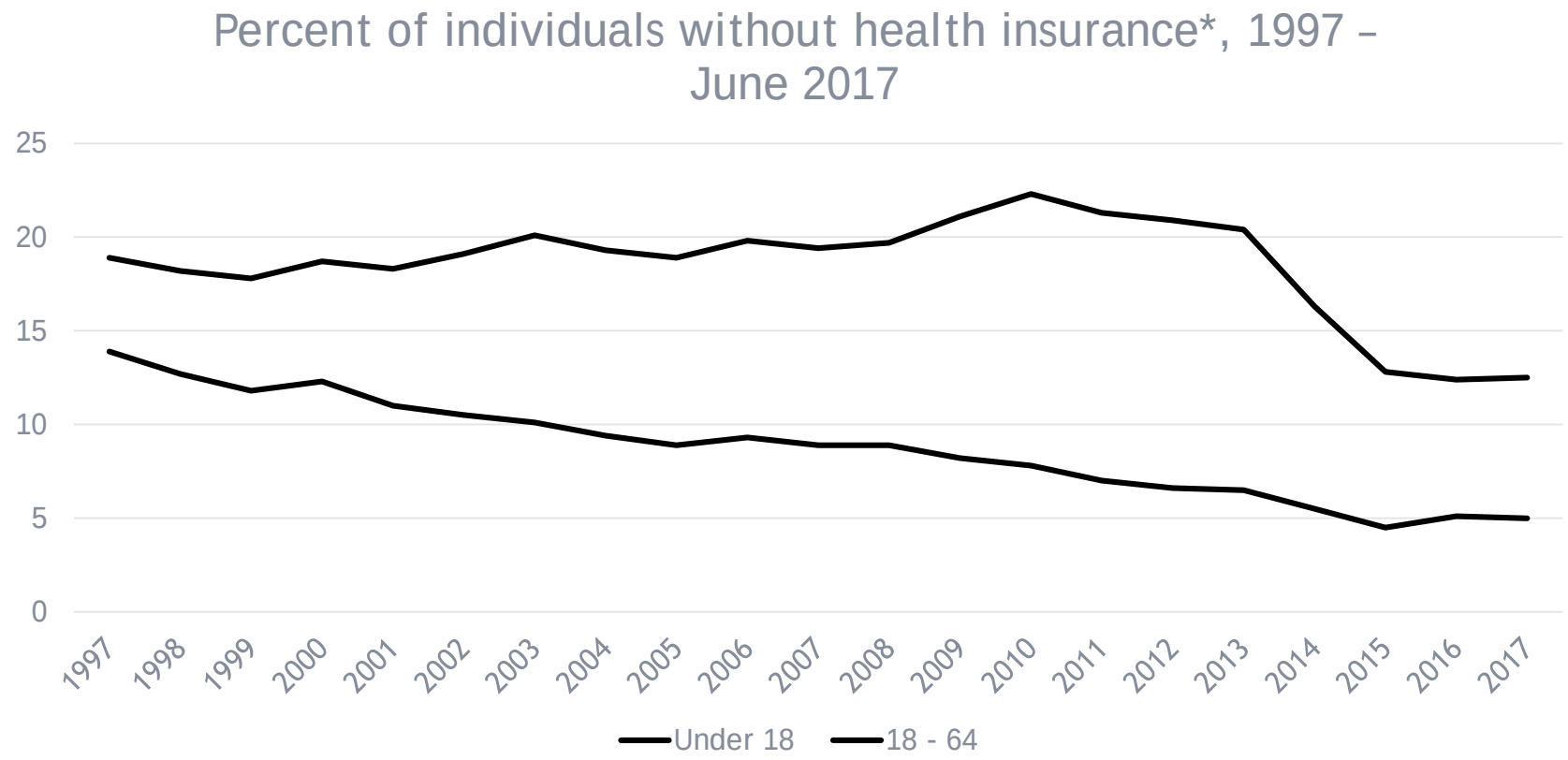


EXHIBIT 11

Uninsured Rates Have Fallen In Response to Policy Changes



The Commonwealth Fund

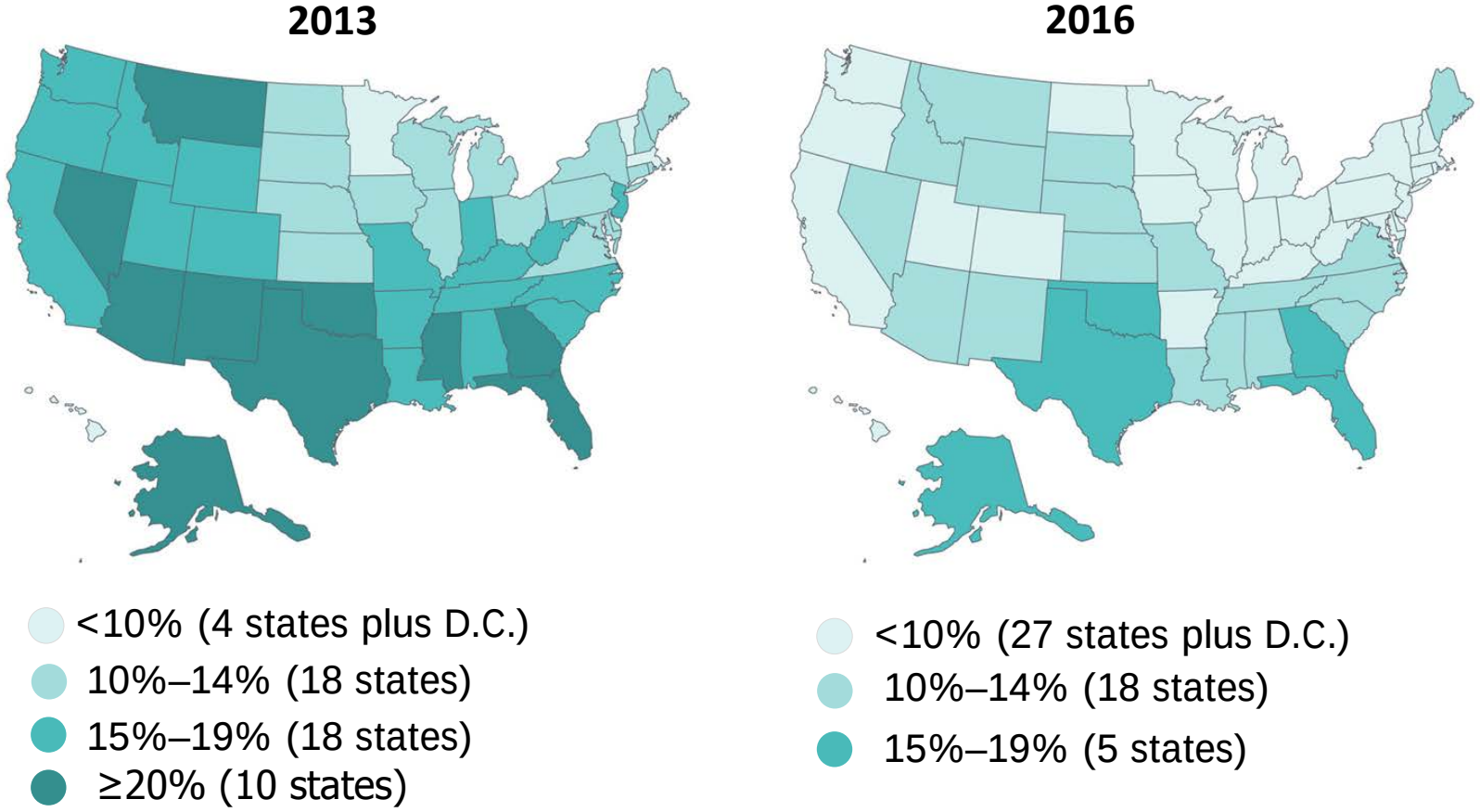
Notes: * At the time of interview. 2017 data is for January – June 2017.

Source: *Early Release of Selected Estimates Based on Data From the January–June 2017 National Health Interview Survey*. National Center for Health Statistics, December 2017.

EXHIBIT 12

Uninsured Rates Fell in All States After The ACA Major Coverage Expansions

Percent of Population Under Age 65 Uninsured, 2013–2016



The Commonwealth Fund

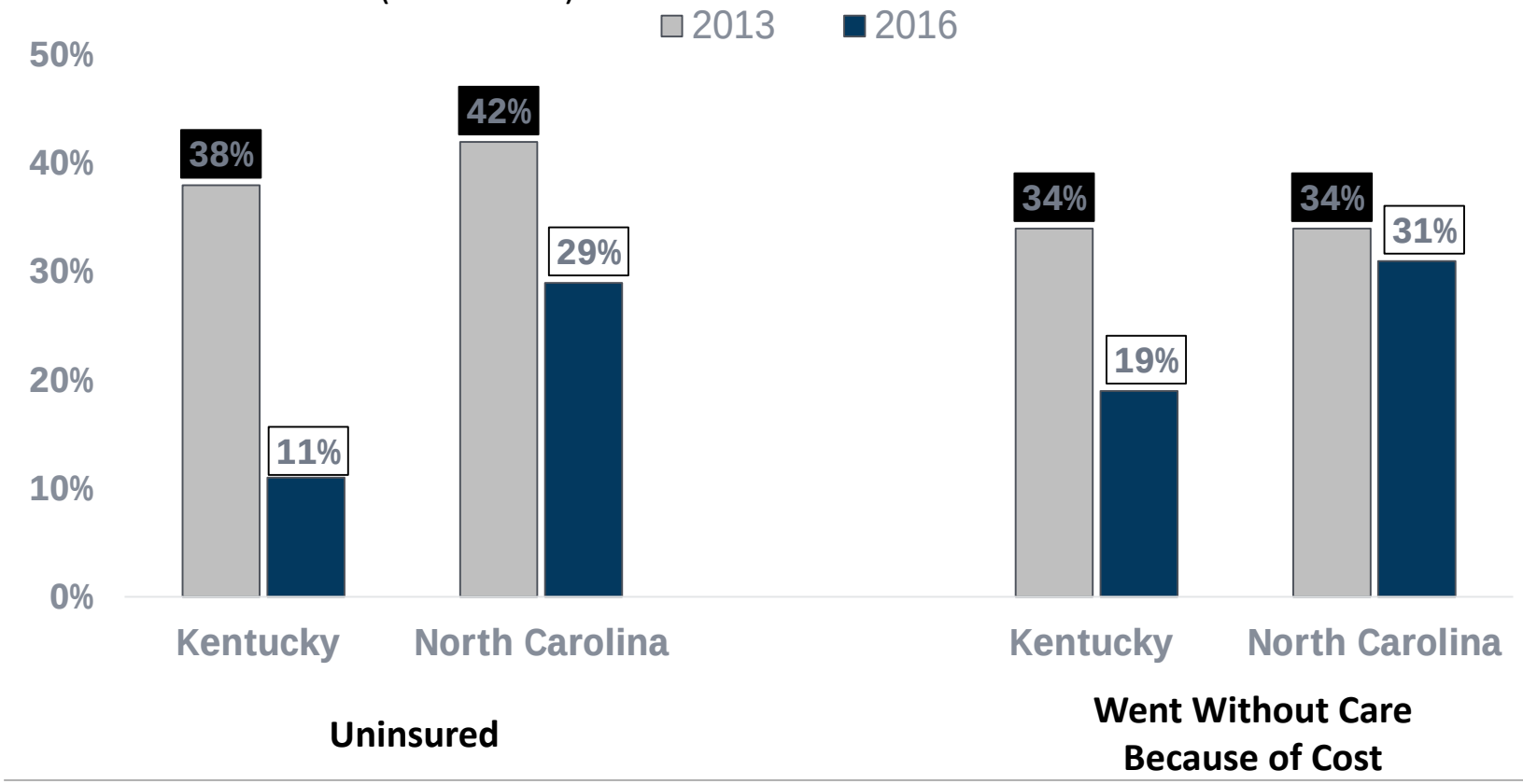
Notes: "D.C." stands for District of Columbia.

Data source: U.S. Census Bureau, 2013 and 2016 1-Year American Community Surveys, Public Use Micro Sample (ACS PUMS).

EXHIBIT 13

North Carolina Improved on Key Access Measures, but Gains Were Smaller Compared to Kentucky

Percent of low-income (<200% FPL) adults*



Note: FPL refers to Federal Poverty Level. *Ages 19-64 for uninsured rate, age 18 or older for going without care because of cost and without a usual source of care.

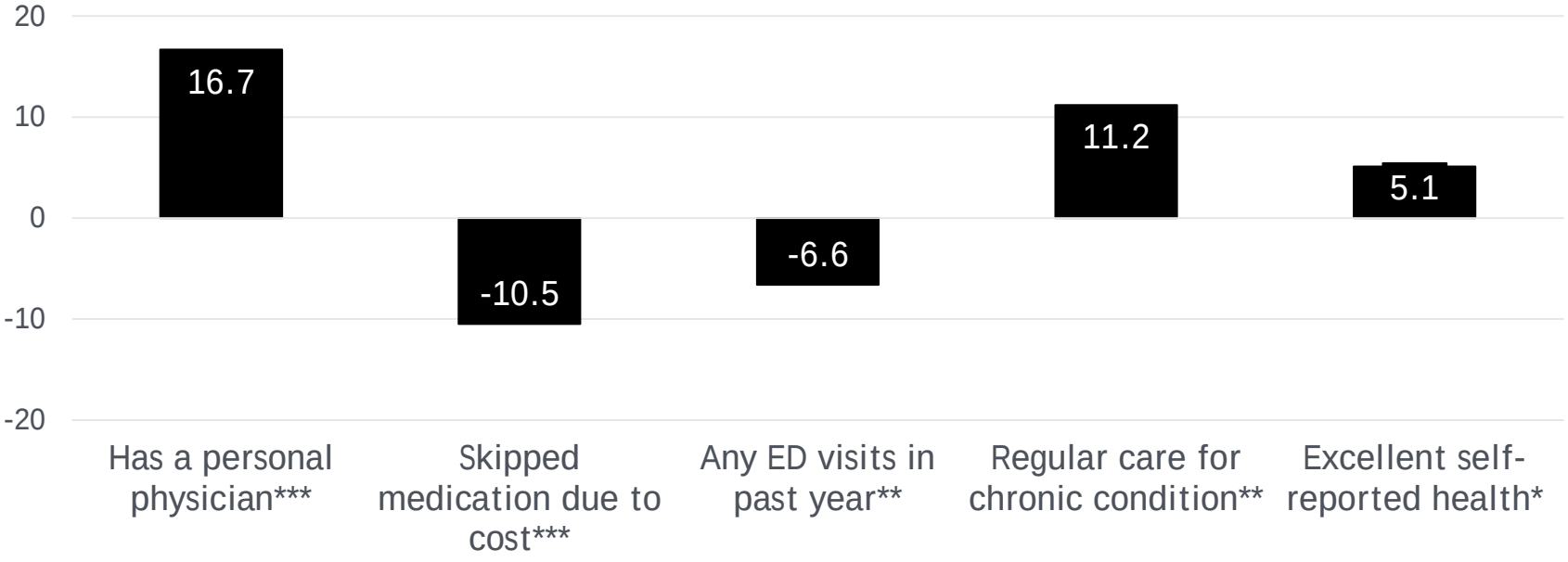
Source: S. L. Hayes, S. R. Collins, D. C. Radley, and D. McCarthy, What's at Stake: States' Progress on Health Coverage and Access to Care, 2013–2016, The Commonwealth Fund, December 2017.

The Commonwealth Fund

EXHIBIT 14

Low-Income Adults in Arkansas and Kentucky Experienced Marked Improvements in Health Care Access and Affordability Following Medicaid Expansion Compared to Adults in Texas, Which Did Not Expand Medicaid, 2016

Percentage point change since baseline (2013) compared to non-expansion states (Texas)



The Commonwealth Fund

p < .10. ** p < .05. *** p < .01.

Adapted from B. D. Sommers, B. Maylone, R. J. Blendon 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.

EXHIBIT 15

Major Federal Insurance Policy Developments, 2017-18: Implications for State Individual and Small Group Markets

- Trump Administration's decision to end cost-sharing reduction (CSR) payments.
- Open enrollment 2018: Cuts in advertising and navigator funding; shortened by 45 days.
- Repeal of the individual mandate penalties in tax bill.
- New DOL proposed rule to increase access to association health plans.
- Expected proposed rule to extend short term insurance policies to 12 months.
- New regulations for 2019 marketplace plans allow states greater flexibility to determine what health plans cover.

➢ Points to fragmentation of insurance markets with considerable challenges for states.

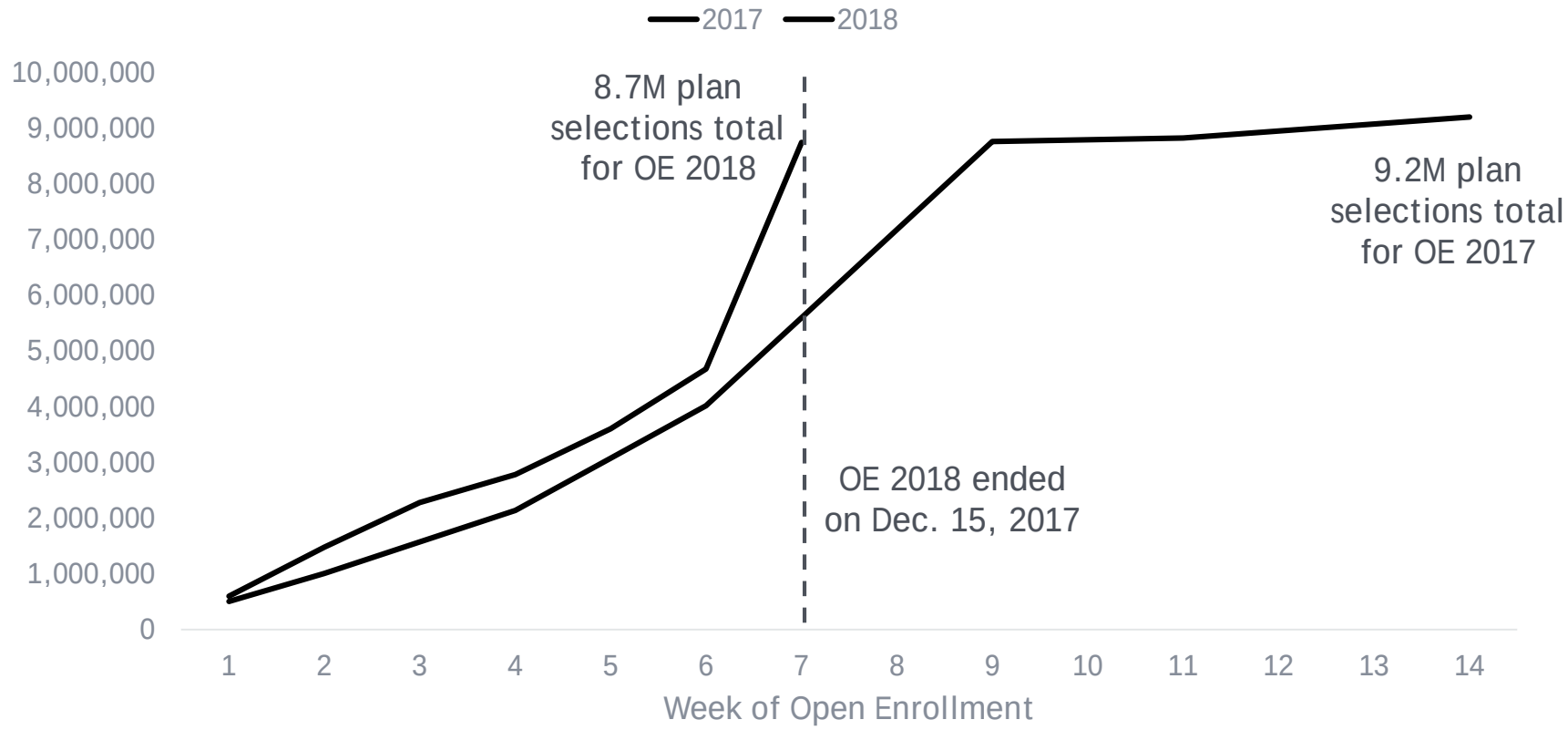
EXHIBIT 16

States Managed Loss of CSR Payments Effectively

- Premiums were 20 percent higher on average.
- 36 states followed CA and allowed insurers to load their premium increases on silver marketplace plans.
- This meant that federal premium tax credits increased: many subsidized consumers paid less than 2017, federal government paid more in tax credits than it would have on CSRs.
- Unsubsidized enrollees in some states faced higher premiums, but enrolling outside marketplaces may have saved people money.
- Alexander-Murray bill would restore the CSR payments for future years but fate is uncertain.

EXHIBIT 17

Final Healthcare.gov Open Enrollment 95% of 2017; Ten States Extended OE



The Commonwealth Fund

Data: Center for Medicare and Medicaid Services.
Note: The above data are for states using healthcare.gov and do not include state-based marketplaces.

EXHIBIT 18

Mandate Penalty Repeal: What States Can Do to Maintain Market Stability

- Insurers will respond by increasing premiums, some may not offer plans.
- Most enrollees will be protected from increases by tax credits, but potential for "bare" counties, and some will pay more.
- States have the legal authority to require residents to have health insurance and impose penalties on those who don't comply, but would have to act quickly to give insurers sufficient time to set rates for 2019.
- States can increase outreach efforts to consumers and insurers.
- States may continue to pursue reinsurance options through 1332 waivers.

EXHIBIT 19

Association Health Plan Proposed Rule Could Preempt States' Authority

- The rule would increase the availability and popularity of these plans.
- Three ways consumers and state insurance markets could be hurt:
  1. Plans have a history of fraud and insolvency that have left consumers and providers with unpaid medical claims.
  2. Plan enrollees could lose the ACA's consumer protections such as essential health benefits, and bans or limits on rating on gender, age, industry/occupation, and other factors.
  3. If healthier people leave the ACA's regulated individual and small group markets, people and businesses who rely on them could see higher premiums and less plan choice.

➢ Will states retain their authority to regulate these plans and what will be the extent of that authority? In particular, will states be prevented from protecting consumers against fraud and insolvent health plans?

EXHIBIT 20

Short-Term Plans: What States Can Do to Protect Consumers & Maintain Stability

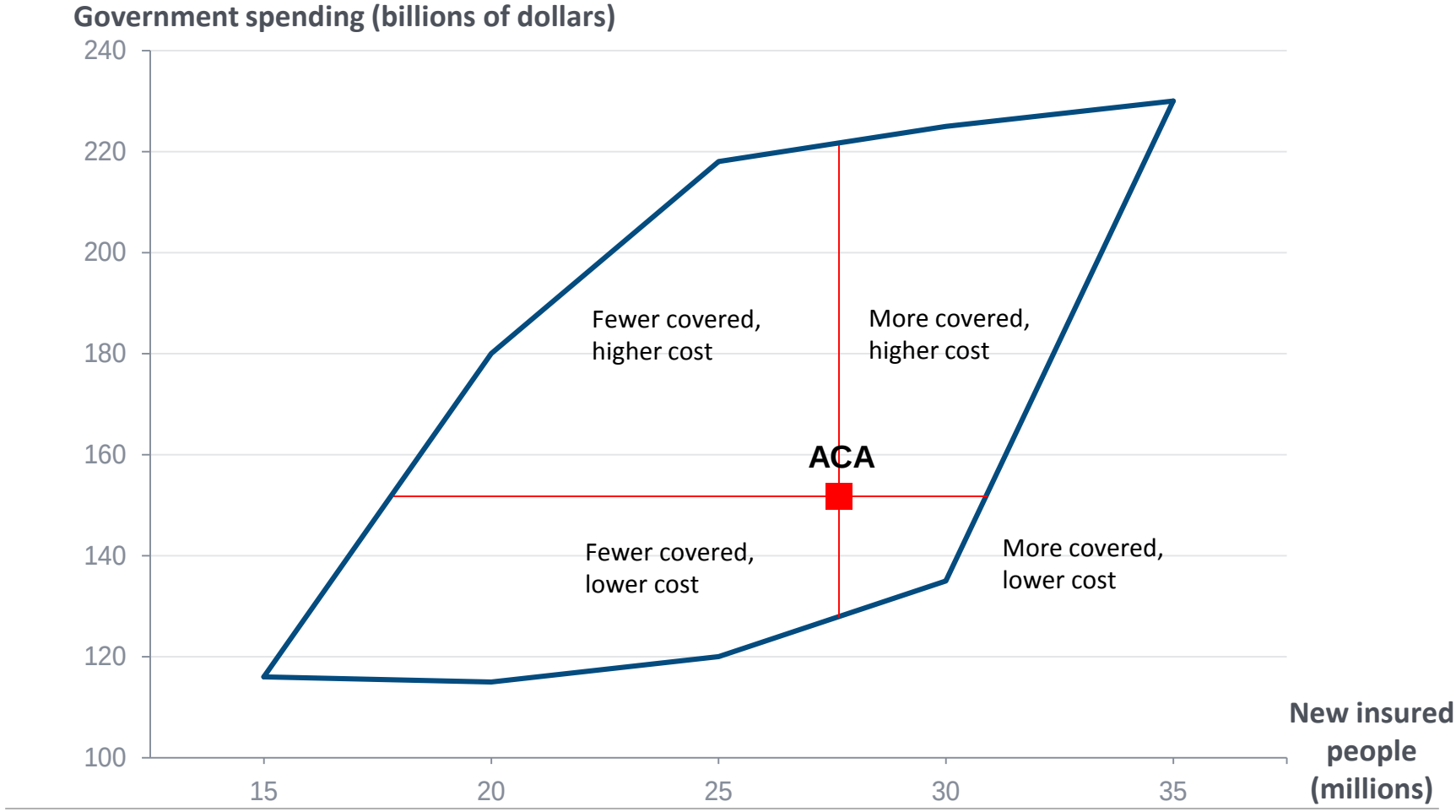
- Ban or limit short-term policies
  - Require compliance with individual market rules.
  - Limit duration.
  - Require nonrenewable short-term plans to discontinue on Dec. 31.
- Reduce risk of premium hikes on ACA compliant policies
  - Assess insurers that offer short-term plans and use $ for reinsurance.
  - Require minimum medical loss ratios.
- Increase consumer disclosures and regulatory oversight.

The Commonwealth Fund

Source: Sabrina Corlette, et al., "State Options to Protect Consumers and Stabilize the Market: Responding to President Trump's Executive Order on Short-Term Health Plans," Georgetown University Center on Health Insurance Reforms, December 2017.

EXHIBIT 21

The ACA Has Expanded Health Insurance Relatively Efficiently



The Commonwealth Fund

Source: E.A. McGlynn, A Cordova, J. Wasserman, and F. Girosi, "Could We Have Covered More People at Less Cost? Technically Yes: Politically Probably Not," Health Affairs 29, no. 6 (2010): 1142-1146, http://content.healthaffairs.org/content/29/6/1142.abstract

EXHIBIT 22

Options to Increase Affordability of and Enrollment in Individual Market Plans

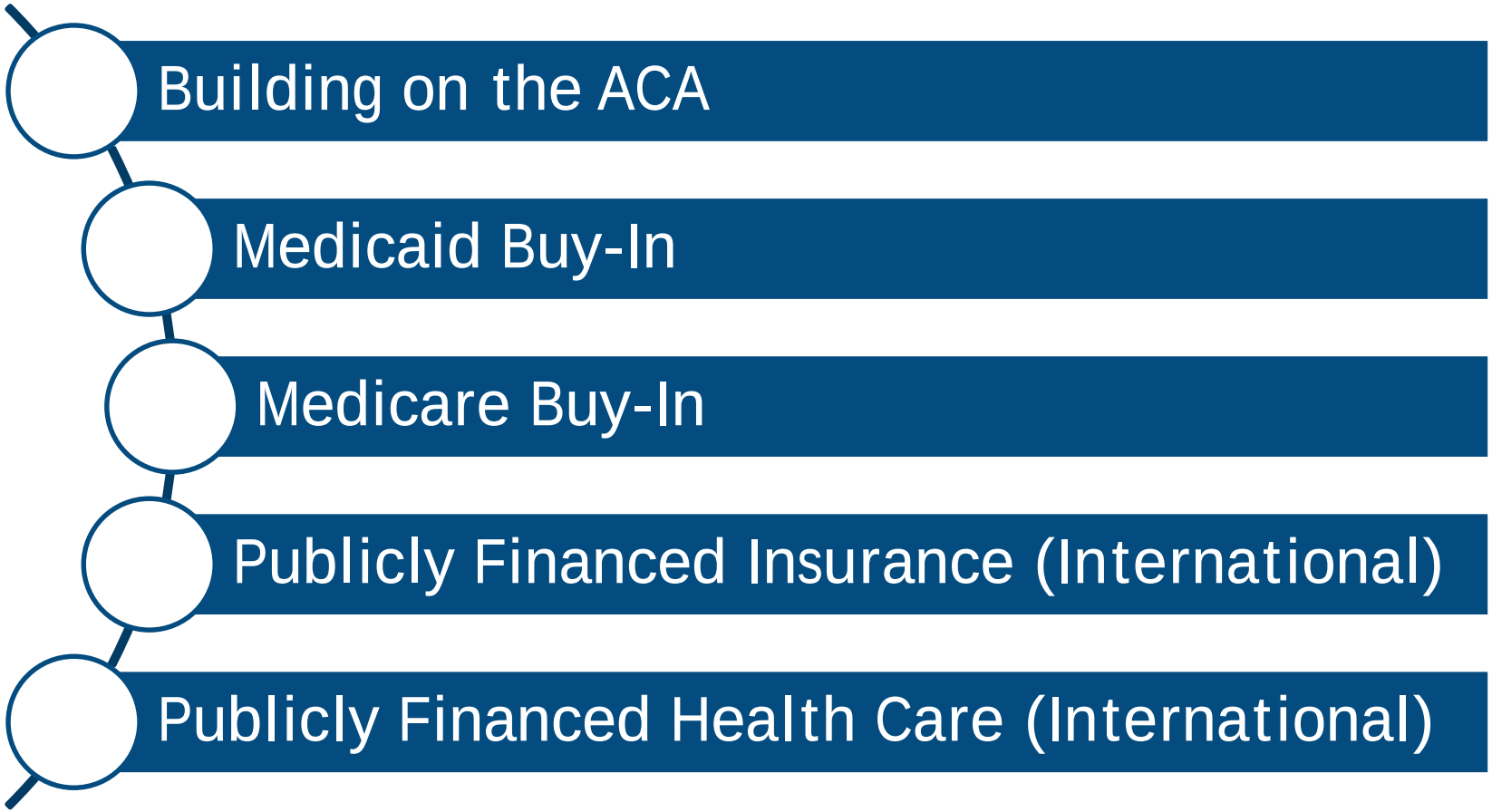
	Lifting the 400% FPL cap	Standard reinsurance	Generous reinsurance
Change in individual market enrollment	1.6 m	1.2 m	5.4 m
Change in premiums	-2.5%	-3.9%	-19.3%
Net deficit impact	$4.9 b	-$2.9 b	-$13.1 b

The Commonwealth Fund

Source: C. Eibner and J. Liu, Options to Expand Health Insurance Enrollment in the Individual Market, The Commonwealth Fund, October 2017.

EXHIBIT 23

Pathways to Universal Coverage



Acknowledgments

Munira Z. Gunja
Senior Researcher, Health Care Coverage & Access

Michelle M. Doty
Vice President, Survey Research & Evaluation

Herman K. Bhupal
Program Assistant, Health Care Coverage & Access

The Commonwealth Fund