Testimony Before the Ways and Means Committee of the House of Representatives
Hearing on "Pathways to Universal Health Coverage"
Submitted by Chiquita Brooks-LaSure, Managing Director at Manatt Health Strategies, LLC

Chairman Neal, Ranking Member Brady, and esteemed members of the Ways & Means Committee, I appreciate the opportunity to provide testimony on "Pathways to Universal Health Coverage." I am Chiquita Brooks-LaSure, a managing director with Manatt Health, a professional services firm that integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system.

Across the country, state and federal policymakers, healthcare stakeholders, and consumer advocates are seeking to expand affordable coverage with the overarching goals of lowering the uninsured rate and addressing the high premiums and cost-sharing that prevent people from enrolling in insurance or using the healthcare services they need. These policymakers are exploring the role government-sponsored coverage programs can play in achieving universal coverage, while using state and federal government purchasing power to reduce the cost of healthcare borne by individuals, businesses, and taxpayers.

Healthcare Affordability and Access in America

- As of early 2018, 28.3 million people were uninsured, including 12.5% of non-elderly residents.[1]
- Today, 14 states have not expanded Medicaid[2]—leaving 2.5 million Americans in the "coverage gap," with incomes too high to receive Medicaid benefits but too low to qualify for tax credits and subsidies on the Marketplace. Residents of Texas and Florida alone account for nearly half of all Americans in the coverage gap.[3]
- In 2018, the average annual premiums for those with employer-based insurance was nearly $7,000 a year for individuals and over $19,000 a year for families. Employees' share of these costs were $1,186 for individuals and $5,547 for families, highlighting the high cost of care for stakeholders throughout the system.[4]
- This year, the average monthly premium for a 40-year-old purchasing the second-lowest-cost silver level, or "benchmark," plan on the Marketplace is $495 and combined medical and prescription drug deductibles are $4,375, on average. Despite being substantially offset by federal tax credits for those eligible to receive them, it remains high for individuals who cannot access tax credits.[5,6]
- Uninsured women are three times more likely to die during childbirth than women with insurance coverage; and African American women are nearly four times more likely to die during childbirth than are white women, regardless of insurance status.[7,8]

Government-sponsored coverage proposals have reemerged as a policy option due, at least in part, due to interest in further strengthening the individual insurance market, where insurer participation and costs fluctuate regularly, and the popularity of public health insurance

[1] CDC National Center for Health Statistics. Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2018. August 2018.
[2] Voter-approved expansion is underway in Idaho and Nebraska; in Utah, coverage is subject to an enrollment cap.
[3] Kaiser Family Foundation. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. March 2019.

programs like Medicaid, the Children's Health Insurance Program (CHIP), and Medicare. Recent polling shows that individuals with government-sponsored or –assisted plans are more satisfied with the current healthcare system than individuals receiving insurance from other sources.[4] Medicare remains highly popular: three-quarters of beneficiaries believe the program works well and offers strong financial protection.[5] Further, state Medicaid expansions, along with the efforts to repeal and replace the Affordable Care Act (ACA), have increased awareness of and support for Medicaid in communities around the country, and 74% of people of all political affiliations (across expansion and non-expansion states) hold favorable views of Medicaid.[6] Recent public polls suggest that the majority of Americans favor some form of additional public coverage—ranging from 56% in favor of single-payer programs and 77% in favor of Medicare buy-in for older Americans.[7]

Today, I will focus my remarks on a subset of proposals that would expand on current government programs and offer additional coverage options. These proposals do not endeavor to replace our existing healthcare system, but rather to provide a new, affordable insurance option by leveraging the existing insurance and delivery structure. Unlike single-payer proposals, these proposals also envision that commercial insurance markets and other facets of the existing healthcare system remain in place. Like all proposals to improve our healthcare system, each proposal has advantages and elements that could present challenges; therefore, input from healthcare stakeholders will be critical as Congress crafts policies to continue to build a better, more accessible healthcare system for all Americans.

Building on the popularity of public programs, there are a range of "buy-in" and "public option" proposals under discussion at both the federal and state levels. These proposals vary in their design, and the terminology used to describe them is evolving and often differs across stakeholders—making it difficult to distinguish among proposed plans and concepts. What these proposals have in common is the idea of leveraging, in some way, the administrative savings and bargaining power of federal and state public health insurance programs to create more affordable coverage options for consumers. These proposals could be offered through public-private partnerships—similar to Medicare Advantage or Medicaid managed care plans—or through direct arrangements between the government and healthcare providers, similar to traditional fee-for-service Medicare. To date, proposals have mainly focused on affordable coverage in the individual market or ACA Marketplace, but could be made available more narrowly or broadly.

Despite potential variation in design, government-sponsored coverage proposals that maintain parts of the existing insurance system fall on a spectrum of policy ideas. I'll first focus on

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[4] Riffkin, R. Americans With Government Health Plans Most Satisfied. Gallup. November 2015.
[5] Norton, M., DiJulio, B., Brodie, M. Medicare and Medicaid at 50. Kaiser Family Foundation. July 2015.
[6] Kaiser Family Foundation. Data Note: 10 Charts About Public Opinion on Medicaid. June 2017.
[7] Kaiser Family Foundation. Public Option on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage. April 2019.

options that would be implemented federally, which have the benefit of reaching the widest number of Americans and reducing access barriers and coverage variation across all states. I'll then discuss state options that have the benefit of being tailored to particular state dynamics and needs.[8]

Federally-Administered Public Options

Under federal public option proposals, the government would offer a new coverage plan on the federal- and/or state-based Marketplace(s) in the individual market to improve competition and ensure that a stable option is available across all Marketplaces. The government-backed plan would use existing public infrastructure and could be administered either directly by a government agency, such as the Centers for Medicare & Medicaid Services (CMS), or in partnership with a contracted insurer, similar to Medicare Advantage. Some proposals envision requiring providers who participate in the current Medicare program to also participate in the public option to ensure network adequacy, some proposals assume Medicare rates, and others allow for a rate negotiated by the Department of Health and Human Services (HHS) Secretary.

Examples of a federally-administered public option proposal include The CHOICE Act introduced by Representative Schakowsky and the Medicare-X Choice Act introduced by Representative Higgins.

Targeted Medicare Buy-Ins

Under "a Medicare buy-in," the federal government would allow consumers who are currently ineligible for Medicare to purchase Medicare coverage. While targeted Medicare buy-ins could be designed to attract different population groups, proposals to date have been age-based. For example, some proposals allow people ages 50 to 64 to voluntarily enroll in Medicare coverage by paying a premium contribution. Such a program would expand Medicare eligibility, incorporating buy-in enrollees into the existing Medicare infrastructure. Buy-in enrollees would receive Medicare benefits, pay Medicare cost-sharing, and have access to Medicare providers. A Medicare buy-in for Americans over 50 years old is an opportunity to increase coverage options for a population in immediate need of assistance, with limited disruption to existing commercial markets and government programs. Most proposals, such as the Medicare Buy-In and Health Care Stabilization Act of 2019, introduced by Representative Higgins, keep the payments for this population separate from the Medicare Trust Fund, aimed at preventing any adverse impact on the current Medicare program.

Medicare for America

The "Medicare for America Proposal"—introduced by Representatives DeLauro and Schakowsky—would expand Medicare to enroll all people covered by Medicaid and the ACA

[8] For more information about federal and state proposals, see Manatt-Arnold Ventures issue brief, The Landscape of Federal and State Healthcare Buy-In Models.

Marketplace today and improve the Medicare program by adding additional benefits and cost-sharing protections. It would maintain premium contributions and some parts of the current insurance system, creating a Medicare Advantage-type option, while preserving the employer-sponsored insurance market and allowing people to keep their employer-based coverage if they choose. This hybrid model features more consolidation of public healthcare programs than do some of the other models discussed in my testimony and could meet the policy objectives of universal coverage and using federal purchasing power to influence system-wide reform and healthcare cost containment.

State-Based Proposals

In addition to these federal proposals, states are also considering a range of options to increase access to and the affordability of health insurance. While some proposals are state-specific, the federal government may also have a role to play in state innovation by offering states increased flexibility and funding for coverage expansion programs.[9]

State markets vary greatly depending on state dynamics. Variations in uninsured rates (and the income distribution of the remaining uninsured), Medicaid coverage, and Marketplace participation all influence the specific policy issues states need to solve and how they are designing their solutions to achieve universal coverage.

States are in various phases of studying or planning coverage programs using these emerging models:

- **State Medicaid or SEHP Buy-In.** Under a buy-in model, the state leverages an existing state program such as Medicaid or the state employee health plan (SEHP). Similar to a Medicare buy-in, a state makes one of these programs—either Medicaid or the SEHP—available for purchase by consumers who are not otherwise eligible for them. The state could choose to make eligibility open to a broad or targeted population.

State-Based Coverage Programs Will Depend on State-Specific Goals

Goals could include:

- Reducing the uninsured rate by expanding access to subsidized or lower-cost coverage—for middle-class families with income above Marketplace subsidy levels (above 400% of the federal poverty level) or for individuals who find coverage unaffordable and/or who are ineligible for subsidies due to immigration status
- Increasing the affordability of coverage and care for both the uninsured and those currently enrolled in coverage
- Strengthening the Marketplace by improving participation and the market risk pool by adding healthy individuals to the market
- Leveraging state purchasing power across programs
- Injecting greater competition into insurance markets
- Simplifying coverage, particularly for families with members enrolled in different coverage programs (e.g., parents in Marketplace and children in CHIP coverage) and individuals who "churn" into and out of varying coverage programs (e.g., Medicaid)
- Promoting healthcare initiatives that improve health outcomes and result in long-term savings (initiatives states can implement in the Medicaid and state employee plans)

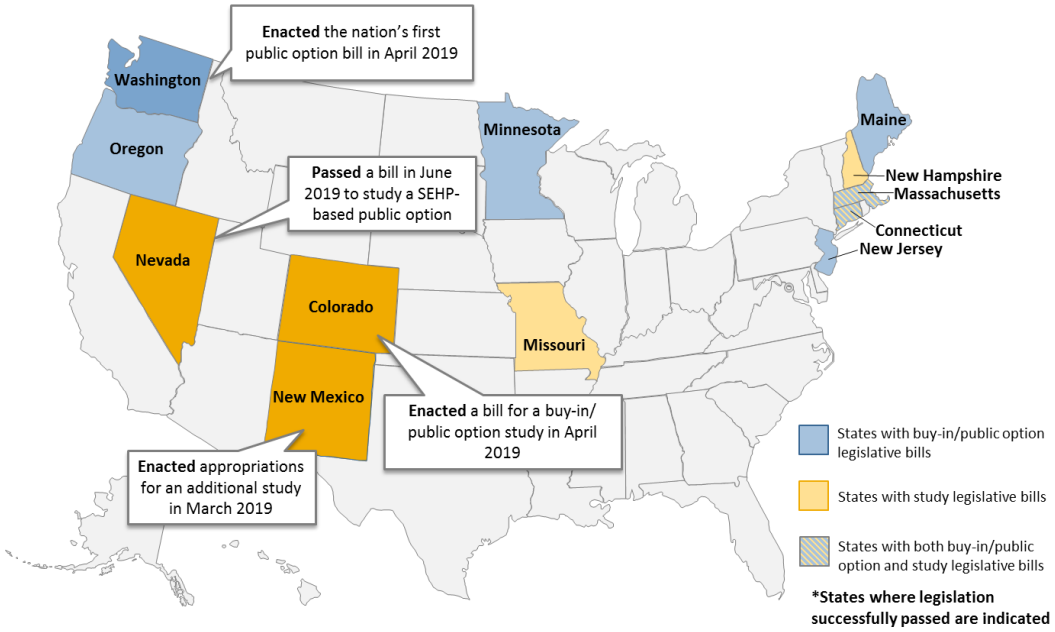
[9] For more information about state-specific consideration, see the Manatt-Robert Wood Johnson/State Health and Value Strategies program issue brief, State Medicaid Buy-Ins: Key Questions to Consider.

It could finance the program through consumer premium contributions, general fund contributions, federal pass-through funding obtained through a federal waiver, or some combination of these sources.

- **State Public Option.** Several states are considering versions of a public option, such as creating a state-sponsored option that is structured like a qualified health plan and offered by a private insurer in the state's Marketplace. These proposals may be structured to leverage Medicare rates and to operate like other plans on the Marketplace.

During the 2019 session, multiple states introduced legislation for state coverage programs. Most recently, the Nevada legislature voted to study the feasibility of establishing a public health insurance program by allowing Nevadans to buy into the state Public Employees' Benefits Program, joining New Mexico and Colorado as the third state this year to enact a bill to study potential models in their states. In April, Washington became the first state to enact a state public option plan, which is expected to be available for enrollment in 2021. As they have in the past, state experiences can inform future national health reform action.

A Dozen States Considered State Coverage Programs During the 2019 Legislative Session



States interested in implementing coverage proposals like these are considering a range of key design elements, for example, inclusion on the federal- or state-based Marketplace, the offering agency, how provider rates will be determined and defining target populations. Under current rules, these models, particularly a Medicaid buy-in, may also require collaboration with the federal government through Section 1332 waivers for access to tax credits and benefit design flexibility. States will need to carefully study these design considerations and the

likelihood of an approved waiver when choosing a model that meets their specific coverage goals.

Congress can further catalyze these reforms by offering support to state-based proposals. For example, Representative Lujan has introduced the State Public Option Act, which, among other policies, would extend tax credits to state programs without seeking a waiver and allows for federal Medicaid match dollars for some program expenses. During the last Congress, several Senators introduced The Basic Health Program Expansion Act to allow states to expand income eligibility for Basic Health, another program created by the ACA.

Conclusion

There are many pathways to universal health coverage. Federally-based options have some clear advantages give the role of the federal government in subsidizing coverage under Medicare and the ACA, in combination with the fact that many of the savings produced by reforms would accrue to the federal government. State-based approaches also have advantages, since states can move forward without federal legislation and can tailor solutions to state-specific dynamics. But many states have limited resources and capacity to take on the responsibilities envisioned in these proposals, and, at least in the short term, a state-based approach is likely to increase the already widening variations in coverage access across states. Federal legislative to support state-based innovations—with additional authority, funding, or the ability to intersect with existing federal programs—may be a pragmatic way to move forward government health reforms in the short term and could serve as an example for future collaborative national reform. All of these policies have merits and considerations that policymakers must weigh, and engagement with healthcare stakeholders will be critical to successfully achieving coverage and access goals.

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Chiquita Brooks-LaSure is a Managing Director with Manatt Health. At Manatt Health, Chiquita provides policy analysis and strategic advice on federal and state health policy to states, foundations, and other healthcare stakeholders.

Prior to joining Manatt, Chiquita played a key role implementing the Affordable Care Act during the Obama Administration; first as Director of Coverage Policy in the Office of Health Reform at the Department of Health & Human Services and later as Deputy Director for Policy at the Center for Consumer Information and Insurance Oversight within the Centers for Medicare & Medicaid Services.

Chiquita served as professional staff for the Ways and Means Committee in the U.S. House of Representatives from 2007 to 2010, where she was involved in the passage of major health care legislation, including Medicare Improvements for Patients and Providers Act of 2008 and the Affordable Care Act.

She began her health policy career as a program examiner for the Office of Management and Budget, coordinating Medicaid policy development and staff for the health financing branch.

Chiquita received her undergraduate degree from Princeton University and a master's degree in public policy from Georgetown University.

She serves as a board member of FAIR Health and of the Children's Law Center.

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