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Building on the ACA to Achieve Universal Coverage

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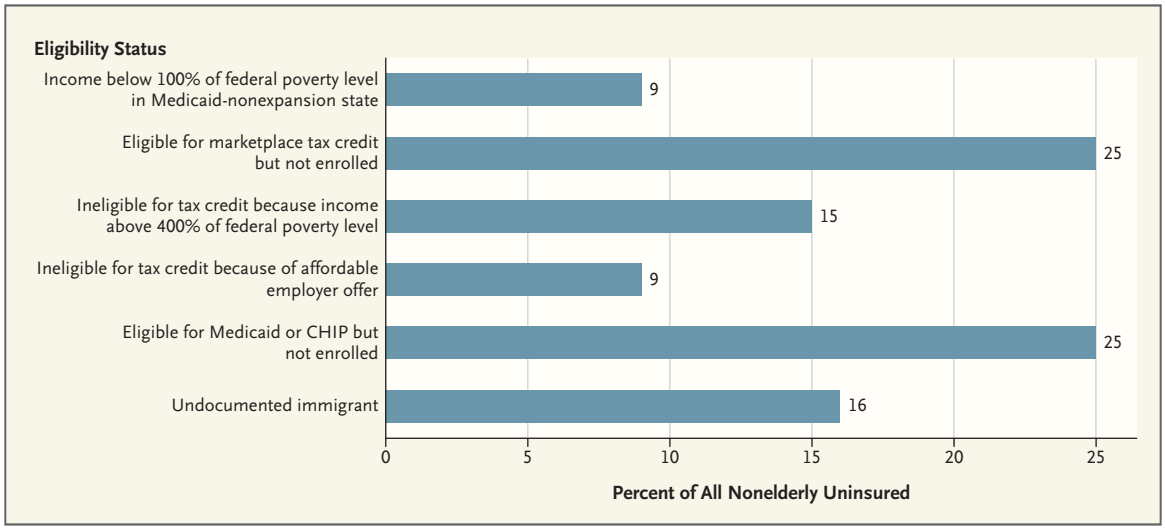
For decades leading up to enactment of the Affordable Care Act (ACA), the United States failed to reduce the percentage of Americans who lacked health insurance coverage. Since the ACA's passage, the percentage of U.S. residents without coverage has fallen by almost half, from 16% to approximately 9%. Yet more needs to be done if we are to achieve universal coverage.

The bar graph, which draws on estimates by researchers at the Urban Institute, shows which groups remained uninsured in 2017.[1] In our view, these estimates make clear that achieving universal coverage within the framework created by the ACA requires four basic steps: implementing the ACA's Medicaid expansion in all states, increasing and expanding financial assistance to people who purchase coverage through the health insurance marketplace to make coverage more attractive, ensuring that people actually enroll in the affordable coverage for which they are eligible, and addressing coverage for undocumented immigrants.

Policymakers can tackle each of these steps and thereby finish the job of ensuring universal coverage by building on the ACA. The framework presented here has many elements in common with proposals put forward by others, including teams at the Urban Institute and the Center for American Progress.[2,3] The similarities among these proposals reflect the fact that each seeks to fill the same gaps in the U.S. health insurance system.

For people who are concerned about the fiscal cost, political feasibility, or disruption associated with a single-payer approach to providing universal coverage, this framework may be viewed as an alternative. Or it can be seen as a stepping stone to such a system. Although we see these four steps as an integrated whole, policymakers could expand coverage by enacting only some of these proposals, and states could implement some without federal action.

The first step — ensuring that all states expand Medicaid coverage to people with incomes below 138% of the federal poverty level, the standard set in the ACA — can be achieved with a combination of carrots and sticks.[4] The



Uninsured Nonelderly People in the United States by Program Eligibility Status, 2017.
CHIP denotes Children's Health Insurance Program. Data are from Blumberg et al.[1]

stick is a reduction in the base federal matching rate for Medicaid spending in states that continue to refuse to implement the Medicaid expansion. The carrot is an increase in the matching rate for states that expand Medicaid coverage. These changes need not be particularly large to be effective; for example, increasing expansion states' base federal matching rate by about 2 percentage points (or reducing nonexpansion states' base federal matching rate by the same amount) would make expansion effectively free for a typical state. The small size of these adjustments would insulate this approach from being judged unconstitutionally coercive. The Supreme Court struck down the approach taken in the ACA, which conditioned the entirety of each state's Medicaid funding on its willingness to expand coverage. Here, the vast majority of Medicaid funding would be unaffected. The small size of the adjustments would also limit unintended consequences for Medicaid beneficiaries if, contrary to our expectations, some states continued to resist expansion. States would also need to be barred from implementing Medicaid-eligibility restrictions such as work requirements, substantial premiums, and limits on retroactive coverage of services delivered before formal Medicaid enrollment.

The second step involves increasing and expanding eligibility for the subsidies available through the ACA's health insurance marketplaces to encourage more people to take up coverage. This step includes increased tax credits to offset insurance premiums, higher cost-sharing subsidies to offset out-of-pocket costs, and extension of subsidies to people with incomes exceeding 400% of the federal poverty level, the current income limit on eligibility for marketplace assistance. Extensions along these lines are essential for achieving universal coverage, given that people who were eligible for subsidies but did not buy coverage accounted for fully one quarter of the nonelderly uninsured population in 2017, and some people with incomes above the current income-eligibility threshold also face burdensome premiums.

Marketplace subsidies would also need to be extended to workers who are currently ineligible because they are offered coverage at work that is considered "affordable" under the ACA's standards but still imposes onerous premiums. This group accounted for roughly one tenth of the uninsured population in 2017. In addition to increasing coverage, this change would reduce premium and out-of-pocket costs for many currently insured low- and moderate-income workers who face burdensome costs.

Even after these two steps are undertaken, some people would remain uninsured. Some would be eligible for Medicaid or the Children's Health Insurance Program (CHIP) but would not enroll in these programs. Though technically uninsured, they are financially protected against the

costs of a serious illness because such coverage is generally retroactive. Even so, policymakers can streamline enrollment procedures to encourage more people to enroll before the onset of illness.

For higher-income people, however, a different approach is needed. Thus, the third step covers anyone who is not eligible for Medicaid or CHIP and who does not have other coverage. They would be automatically enrolled in a "backstop" insurance plan, which could be either public or private. Health care providers would submit claims to the backstop plan whenever people in this group used health care services. On each year's income tax return, people who lacked coverage other than the backstop plan for at least 1 month during the year would pay a premium for the backstop plan for each month they lacked other coverage, whether or not they actually used the backstop coverage. The premium would be reduced by the amount of any tax credit for which they were eligible. The expansion of marketplace subsidies described above would help make automatic enrollment in the backstop plan palatable by reducing these net premiums.

In combination, these steps would expand coverage to all legal U.S. residents. However, they would not reach the one sixth of the population who were undocumented immigrants and therefore ineligible for both Medicaid and marketplace subsidies. The final step to universal coverage would be to ensure this group access to insurance programs. This goal can be achieved by creating a path to citizenship or in other ways. Expanding insurance coverage is far from the only rationale for reforming immigration policy, but without some such reform, genuinely universal coverage is impossible.

An audio interview with Dr. Fiedler is available at NEJM.org

How much this approach would cost the federal government depends on parameters we have not fully specified — notably, the size of the marketplace-subsidy expansions. However, we anticipate that legislation in line with this framework would have federal costs broadly similar to those of the ACA's coverage expansions, as such legislation would drive the uninsured rate from about half its pre-ACA level to zero. These costs could be covered by measures similar to those that paid for the ACA, which included reforms to Medicare payments and revenue increases.

In addition to expanding coverage, these proposals would reduce premiums and out-of-pocket costs for many people who already have coverage.

Policies aimed at reducing the unit prices of health care services, such as introducing a public plan that would pay the lower prices currently paid by public programs and that would compete with private plans, could also help to finance this agenda. Policies that successfully reduced health care prices would reduce the cost of providing marketplace subsidies and, if applied to the employer-sponsored insurance market, would also reduce the revenue lost to the tax exclusion for employer-sponsored coverage.

In addition to expanding coverage, the proposals discussed above — notably those to expand marketplace subsidies and reduce the unit prices of health care services — would reduce premiums and out-of-pocket costs for many people who already have coverage. These reforms could be combined with other reforms to improve coverage for people who are already insured. The additional reforms could include implementation of rules to eliminate surprise out-of-network bills, lowered caps on annual out-of-pocket spending, and expansion of the list of services that insurers must cover without cost sharing to cost-effective services that pose little risk of overuse, such as generic drugs that treat chronic conditions.[5]

Nearly 9 years after the ACA became law, proposals to expand insurance coverage are again a major topic of public debate. The approach described here provides a blueprint for achieving the widely shared goal of universal coverage at a manageable fiscal cost and with minimal disruption for the hundreds of millions of Americans who are already insured.

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A New Safe Harbor — Turning Drug Rebates into Discounts in Medicare Part D

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The Department of Health and Human Services (HHS) proposed a rule on January 31, 2019, that would fundamentally change the role of medication rebates in Medicare Part D — and with it, drug pricing in general.[1] The rule requires drug manufacturers to pass discounts directly to Medicare patients at the point of sale, rather than through the current opaque rebate system that doesn't directly lower drug prices and may actually raise them. So how might the rule affect Medicare Part D and its beneficiaries?

Rebates are partial refunds paid by drug manufacturers to buyers, which are typically insurance companies or pharmacy benefits managers (PBMs). If an insurer pays $100 for a patient's drug, it might get $20 back from the manufacturer as a rebate. If that insurer can offer the manufacturer a larger number of customers, the manufacturer will probably offer a larger rebate, lowering the drug's cost to the insurer. When a brand-name drug has competitors (e.g., insulin products Lantus and Levemir), insurers can use their formularies to favor one drug over the others, while negotiating higher rebates for that product. These negotiations are confidential, which allows purchasers with greater bargaining power to obtain lower prices. Insurers in Part D have historically used rebate savings to offset premium costs for their members, rather than lower costs for individual drugs at the pharmacy counter. Premiums are key to attracting beneficiaries to Part D plans.

Normally, rebates in Medicare (along with "bribes" and "kickbacks") would be prohibited by the Anti-Kickback Statute, which bans payments that induce provision of services paid for by the federal government. These anti-kickback rules were originally passed in 1972, soon after Medicare and Medicaid were established. Part D rebates, however, are specifically allowed by a "safe harbor" clause exempting them from the statute. These rebates have increased over time, from 11% of gross costs in 2010 to a projected 27% in 2020, with an estimated value of $43.4 billion.[2]

When it released the proposed rule, HHS outlined three major problems with the Part D rebate system.[3] First, rebates reward increasing list prices. Because rebates are based on a percentage of list prices, when those prices rise, rebates rise and plans benefit. Second, though rebates may lower premiums for all plan members, they lead to higher out-of-pocket costs for patients who need drugs with very high list prices, who cannot receive discounts directly.[4] Rebates, critics argue, lower premiums for the healthy at the expense of out-of-pocket costs for the sick. Third, the common use of rebates in Part D makes it less attractive for plans to switch to less expensive biosimilars or generic drugs.

In January 2019, HHS moved to eliminate safe-harbor protection for rebates in Medicare, essentially making them prohibited kickbacks. This reclassification would prevent manufacturers and insurers from using rebates to reduce overall drug spending and hold premiums steady, upending