

United States Healthcare Reform: A Comprehensive Review of
the Issues and an Argument for the Public Option

by

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The United States' healthcare system is riddled with inefficiencies like unsustainable cost growth, poor coverage rates and poor health outcomes despite being one of the most expensive systems in the world. Because of this, healthcare reform is at the center of current political discourse and is one of the most important issues affecting American voters. This paper will review healthcare issues affecting the United States such as unregulated private insurance costs, changing enrollment patterns in public programs and low coverage rates for low-income populations, among others, and analyze how future healthcare reform policies can efficiently address these issues. Additionally, this paper will analyze the successes and shortcomings of healthcare reform policies previously introduced such as Medicare, Medicaid and the Patient Protection and Affordable Care Act. Finally, this paper concludes that introducing a publicly available, cost-controlled and nationally run healthcare option called the public option into the healthcare system can best address reform goals like containing costs, improving coverage rates and advancing positive health outcomes.

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Key Terms

Accountable care organization (ACO): ACOs are networks of medical practitioners, hospitals and other healthcare providers who coordinate patient care and services to improve efficiency and health outcomes.

Co-insurance: Co-insurance is the percentage of costs of a health service that the insured pays for after their deductible is reached.

Co-payment (co-pay): The co-pay is a set monetary amount that the insured must pay when accessing medical services in addition to what the insurance covers.

Death spiral: A death spiral refers to the financial impact that occurs when the portion of unhealthy or higher risk individuals in an insurance risk pool far exceeds the healthy or lower risk population. The costs of higher risk enrollees are typically offset by total premium payments from other individuals on the plan, but in this scenario, the insurer may have to raise the premium prices for everyone in the risk pool to cover the unhealthy individuals' costs. This leads to healthy individuals leaving the insurance plan because they may not be able to afford the higher premiums or may believe they are not accessing services enough to pay higher prices, which in turn leads to even higher premium prices for the remaining individuals due to an even higher-risk pool. Eventually, no one will be able to afford the extremely high premium prices and the insurer will most likely leave the insurance market.

Deductible: A deductible is the specified amount of money that the insured must pay out of their own pocket before the insurer will pay for medical claims in a twelve-month period.

Insurance premium: An insurance premium is the amount of money an individual or business pays for an insurance policy typically every month. The insurance company estimates their premiums based on their projection of claims and administrative services required. An individual must pay their premium to retain their coverage even if they do not utilize health services.

Out-of-pocket maximum payment: The out-of-pocket maximum payment is a health insurance plan design feature that limits the amount an insured party will pay out of their own pocket during a plan year. Once the maximum is reached, the insurer will pay the full cost of services for the remainder of a plan year.

Pre-existing conditions: Pre-existing conditions are medical conditions that began before an individual's medical benefits begin.

Private insurance: Private insurance plans are plans provided by and marketed by the private sector rather than the government. These could be group plans provided by employers to their employees or individual plans offered by insurance companies directly to consumers.

Provider: A provider is a medical practitioner or hospital providing medical services to patients.

Risk pool: A health insurance risk pool is the group of individuals insured on a certain plan wherein their collective monthly premium payments "pool" together to offset costs of medical care for those who become sick on the plan. A low-risk pool refers to a risk pool where individuals are moderately healthy and therefore do not frequently utilize costly health services, which results in everyone in the risk pool having lower premiums. A high-risk pool refers to a risk pool where individuals are

moderately unhealthy and therefore are frequently utilizing costly health services, which results in everyone in the risk pool having higher premiums.

Universal healthcare: A country has universal healthcare when every citizen has a guaranteed right to healthcare coverage. The World Health Organization (2019) defines universal healthcare coverage as coverage that is accessible to everyone regardless of the ability to pay, that has quality that is good enough to improve the health of those receiving services and that does not impose significant financial burden on those receiving services.

Chapter One: The United States Needs Healthcare Reform

1.1 Overview of the Issues

The United States of America is one of the wealthiest nations in the world and has the most expensive healthcare system by far among developed countries (Organisation for Economic Co-operation and Development, 2019a). According to the Center for Medicare and Medicaid Services (2017), the U.S. spends 17.9% of its total gross domestic product (GDP) or \$10,739 per person, on health spending. This is more than double what the median spending on health as a share of GDP among OECD countries was in the same year. While most people know of the U.S. healthcare system's exorbitant costs, many believe that U.S. citizens are paying a higher price for superior care.

However, the reality of the situation indicates that citizens are paying more to get an inferior quality of care. Research from the Institute for Health Metrics and Evaluation's Global Burden of Disease Study found that the United States has a 6% increase in disease burden from the average of that of comparable countries in size and economic level (2018). Americans also have documented higher rates of infant mortality, low birth weight, injuries and homicides, sexually transmitted infections, drug-related deaths, obesity, heart disease, chronic lung disease, diabetes, and disability than people in other industrialized countries while also having a lower life expectancy overall (Bradley & Taylor, 2013). There is something deeply wrong with this picture: why is the U.S. spending so much on premiums and a supposedly sophisticated healthcare system to get a lower quality of life in the end?

This paper will first examine the current structure of the U.S. healthcare system and examine healthcare issues it is currently facing like unsustainable spending, high prevalence of poor health outcomes and low coverage rates. Next, this paper will review three healthcare reform policies: Medicare, Medicaid and The Patient Protection and Affordable Care Act and analyze the political climate and healthcare discourse leading up to the implementation of these programs. Lastly, this paper will present the most efficient healthcare reform policy for the U.S. going forward: the public option. The public option expands the current healthcare system by adding an additional coverage option for Americans that allows any citizen, no matter their income or age, to enroll in a public plan. The public option is the ideal next step in U.S. healthcare reform because it will significantly increase coverage rates, decrease healthcare spending and improve on positive health outcomes for Americans.

1.2 Background on the U.S. Healthcare System's Structure

The United States healthcare system currently operates with a combination of private and public insurers working as third-party payers for citizens' health insurance coverage. For those on private insurance, which they can self-purchase or receive through their employer, citizens pay a monthly premium to their insurance provider so that the insurer will pay for medical claims on their behalf. For employer-sponsored insurance, employers either self-fund or purchase fully-insured plans for their employees through a third party who is generally responsible for negotiating provider reimbursement rates and processing claims. This coverage may include not only insurance for current employees and their families, but also can include retired employees. For those who choose to self-purchase insurance not through an employer

or association, they obtain health coverage that is commonly referred to as individual or non-group coverage. This type of health insurance is privately sold and managed by a third-party insurance provider. Non-group coverage is an important insurance option for those who are self-employed, unemployed or cannot access public insurance due to not meeting certain income and/or age requirements. The health insurance marketplaces, introduced through the Affordable Care Act and originally called “exchanges”, sought to expand non-group coverage options. For both employer-sponsored private insurance and individual private insurance, provider payment rates and medical service prices are not regulated by the government and prices are determined via market competition and risk-assessment. Insurers determine enrollee premiums based on expectations of how healthy a certain risk pool is. In 2018, 55% of the U.S. population was enrolled in a private insurance plan either through their employer or through an individual insurer. Of this group, 49% was covered through their employer and 6% was covered on an individual plan (Kaiser Family Foundation, 2020a).

For public insurance programs like Medicare, Medicaid, Children’s Health Insurance Program (CHIP), and the Veterans Health Administration, medical claims are sent to a third-party who pays for the claims on their behalf similarly to private insurance. However, for public programs, the U.S. government is the third-party insurer and can regulate provider reimbursement rates for medical services. The two most prevalent public insurance programs are Medicaid and Medicare, which are administered by the U.S. Centers for Medicare & Medicaid Services (CMS).

Medicare is a healthcare plan where people over the age of 65, those with permanent disabilities under the age of 65 and people of all ages with end-stage renal

disease qualify for coverage. Most Medicare recipients pay into the program with premiums, co-pays, and deductibles. Some do not pay into the program because Medicare has four “parts” (A, B, C and D) and not all parts have the same cost-sharing mechanisms. An individual only enrolled in Part A has a deductible but no premium, so if they do not access healthcare services then the program is free for them. In this program, the government regulates prices for provider services to control costs.

Medicaid is a healthcare plan for low-income individuals where one’s income level determines if they qualify for coverage. The plan abides by federal regulations but is state administered and each state may structure its Medicaid program differently. Enrollees may pay a premium or enrollment fee, depending on the state. 47 states (including the District of Columbia) do not impose any fees on Medicaid enrollees; however, four states do have some cost-sharing mechanisms imposed on enrollees (Brooks, Roygardner & Artiga, 2020). Medicaid is funded jointly by both the federal government and state governments. States regulate and set prices for their Medicaid programs.

The Children’s Health Insurance Program (CHIP) is an affordable coverage option for children in families who do not meet the income-eligibility requirements for their state’s Medicaid program. Depending on the state, CHIP may cover pregnant women as well. Every state offers CHIP, and the program is closely linked to state Medicaid programs.

The Veterans Health Administration is another public coverage program for veterans. Potential enrollees fill out an assessment while applying for coverage so the administration can determine if they will qualify for free healthcare. This is determined

by income level, disability rating, and military service history (U.S. Department of Veterans Affairs, 2020). Some veterans may also have access to coverage for their families through this program, depending on the veteran's specific circumstances.

In 2018, 37% of the population was enrolled in one of these public programs, with the majority of people enrolled in a Medicare or Medicaid plan (Kaiser Family Foundation, 2020a).

1.3 Cost Reform – Public, Pharmaceutical, and Private Markets

Because of the unsustainable spending growth found in the U.S. healthcare system as it currently exists, healthcare reform that addresses individual and long-term system-wide cost savings is essential for the economy to move forward into the next decade. The Center for Medicare and Medicaid Services found that the U.S.' spending on healthcare has drastically increased over the past five decades: from around 5% of GDP in 1961 to about 18% of GDP in 2017 and projected to rise to at least 20% of GDP over the next decade (2017). To combat this projected spending growth, experts believe that significant healthcare reforms must be made that address changes in the future healthcare ecosystem, such as the population enrolling in Medicare at higher than usual rates due to aging, rising bloat in administrative costs and continued growth in health service and drug prices due to lack of price regulation in the private insurance and pharmaceutical drug markets (Budrys, 2011).

Public Insurance

A key factor in the impending growth in healthcare spending is the high rate of the baby boomer generation aging out of private insurance plans and transitioning to

Medicare. When Medicare was created in 1965, a much smaller portion of the population was 65 or older and could qualify for the program. According to data from the 2010 U.S. census, about 9% of the population was over 65 in 1960 opposed to about 13% over the age of 65 in 2010 (U.S. Census Bureau, 2018). The first baby boomer qualified for Medicare just nine years ago (Doherty, 2018) and the generation is expected to flood Medicare enrollment rapidly over the next several years. It is also important to note that life expectancy has risen by about 10 years since the creation of Medicare in the sixties (MacroTrends, 2020). People are living much longer therefore qualifying for Medicare for much longer and incurring higher costs to the system in their older age. According to data from the Kaiser Family Foundation, Medicare's oldest enrollees who are 85 years of age or older are on average three times more expensive than Medicare's youngest enrollees at 65 years of age (Doherty, 2018). This age group incurs higher costs to the system due to not only their increased health risk, but also from the costly medical technologies needed to treat more complicated ailments. There may need to be significant cost-saving policy efforts for the entire healthcare ecosystem to accommodate this shift in enrollment patterns. Currently administrative costs are already very high and they are projected to rise even more as more people enroll in government-run plans like Medicare due to more claims and need for additional oversight of those claims. This trend indicates that the healthcare system needs to not only cut costs where it is possible to do so but also to create more streamlined and easier to administer coverage options for those who need them.

Private Insurance

Given that over half of people in the U.S. have private health insurance, a healthcare reform package that increases the government's ability to regulate provider reimbursement rates for the private health insurance market is necessary to combat rising healthcare costs. This is largely because of the projected rise in overall healthcare costs of 5.5% per year expected over the next decade. Experts project that healthcare spending will grow faster than the economy and rise from 3.5 trillion dollars to six trillion dollars per year by 2027 (Peter G. Peterson Foundation, 2019). The government may need to intervene in these cost increases and regulate the rates that the private market receives from providers, perhaps looking to the success of price-regulated government plans like Medicare, whose payment rates have "demonstrated acceptability" among providers (Blumberg and Holohan, 2016) when considering options to combat these rising prices.

Better regulation of provider reimbursement rates in the private market is also crucial to contain costs because of the lack of consistency between current provider reimbursement rates and quality of care received. This lack of consistency is largely due to the fee-for-service pricing model in the U.S. healthcare system. The fee-for-service model charges a patient a fee for every service they consume. It incentivizes providers to perform more testing, x-rays, and other services because they receive compensation for each additional service provided. Motaze et al. argue that in a fee-for-service model, "consumers may tend to demand increased healthcare services and providers may induce inappropriate use of healthcare services" (2015). A fee-for-service model increases costs to the system by encouraging patients to have as many tests and services

as their provider deems relevant to their health issue, even if they are unnecessary. This increases waste in the healthcare system. Unnecessary services are being provided because of perverse financial incentives, which can decrease quality health outcomes for the patient due to the health risks inherent in unnecessary services. Research has found that higher-cost providers are associated with higher mortality rates in patients, indicating there is no relationship between higher access of services and improvement in positive health outcomes (Olsen, Saunders & Yong, 2011). Olsen et al.'s research indicates that a financial incentive to provide additional services can increase the prevalence of poor health outcomes.

Some private insurance providers use an accountable care organization (ACO) model with a value-based care structure to combat this lack of consistency. ACOs are also referred to as managed care plans. Many ACOs use a cost-saving and quality-improving mechanism called "capitation with quality". Capitation with quality is defined as "a fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year, with payment adjustments based on measured performance and patient risk" (Delbanco, 2014). Some of these models compensate providers monthly for keeping patients in their care healthy, with their pay remaining unchanged despite the number of services provided. Other models compensate providers with a yearly salary to incentivize them to keep their patients healthy in the most cost-efficient way. Not only have capitation with quality models led to documented reductions in costs (Mongan, Ferris & Lee, 2008) but they have also led to fewer unneeded hospitalizations, tests and procedures (Delbanco, 2014). Additionally, healthcare delivery systems like Kaiser Permanente has seen

improvements with health outcomes like reduced tobacco usage, reduced heart attacks and reduced readmissions due to their capitation with quality model (Delbanco, 2014). The model can be an efficient tool to improve health outcomes while reducing costs.

These models also increase the negotiation power of the insurance provider with the health provider when determining prices. Managed care plans often dictate a certain network of providers that are “approved” on the insurance plan. These health providers are incentivized to negotiate affordable reimbursement rates with the insurance plan so that they can remain an in-network provider for that plan. Since the providers in one’s network will be covered under one’s insurance, consumers have a financial incentive to see these providers over others who are out-of-network. This network model can also lessen administrative costs associated with communicating patient information across different medical systems as the model facilitates more stream-lined provider communication regarding a patient. One healthcare delivery system, Partners HealthCare, has seen an estimated ten million dollars in savings and 51% reduction in hospital readmissions from using an integrated ACO model (Cosgrove et al., 2015). These ACO models may be interesting to consider for the U.S.’s cost reform options.

However, the consumer could see this in-network model as a downside to joining an ACO because they are restricted to their network for care options. If the consumer wanted to see a provider outside of their network, they may incur high out-of-pocket costs or require a complex referral process from their plan. In a study conducted in 1998 about Americans enrolled in an ACO, it was found that 60% of individuals thought their plan made it more difficult to access an appropriate medical specialist when they need one (Blendon et al., 1998). Despite their downsides, ACOs are an

interesting model to consider for healthcare reform due to their success in bringing down costs while simultaneously improving the quality of care that patients receive.

Pharmaceuticals

Although the government has some control in regulating payment rates and medical service prices for the private and public insurance markets, there is no current regulation of pharmaceutical prices in the U.S. which results in extremely high and unchecked drug prices. In the first month of 2020, 619 brand name drugs increased in price by an average of 5.2% and 20 generic drugs increased in price by an average of 29.4% (Marsh, 2020). When there is not a governmental role in setting prices for drugs that often require many resources to develop and market, companies have continually shown that they will charge high prices for consumers to get these drugs in order to cover their research and development costs.

However, research conducted by Dr. David Belk, a private medical practitioner and healthcare cost researcher, into the financial reports from 2011-2018 of the 13 largest pharmaceutical companies in the world, which includes eight U.S. companies, found that on average these companies spent about 60% more of their profits on drug marketing than they did on drug research and development. In just 2018, all 13 pharma companies generated \$244 billion in U.S.-based revenues (Belk, 2020). These numbers indicate that pharmaceutical companies are not charging high drug prices just to cover research and development costs but rather to fund activities like marketing and driving company profits up. Americans citizens who need these drugs to treat their illnesses and live healthy lives bear the brunt of these prices and unsustainable patterns in drug price growth. The spending growth needs to be curtailed not only to help Americans who

currently face extremely high out-of-pocket expenses due to high deductibles and exorbitant drug price tags for the medications they need but also to enable system-wide cost reductions to occur. In European Union member countries, where pharmaceutical prices are highly regulated, the evidence suggests that these regulations lead to lower prices for both generic and non-generic drugs (Puig-Junoy, 2010). Policymakers may consider increasing regulations on American pharmaceutical companies to decrease consumer and system-wide costs.

1.4 Coverage Rate Reform

Another appealing feature of potential reform options will be the ability to curtail rising prices in the long run, which can be achieved with higher coverage rates, or having more people enrolled in health insurance plans. In 2018, about 9.4% of the population, or thirty-four million people, was not enrolled in a health insurance plan (Centers for Disease Control and Prevention, 2020). Most uninsured people do not seek coverage because they cannot afford it, but some uninsured people face other barriers like citizenship or ineligibility for government assistance (Kirzinger, Hamel, DiJulio, Muñana & Brodie, 2017). Because most uninsured people do not seek coverage due to the high cost of healthcare but still may face health risks in their lives, many people will only seek coverage when they need to access services. This trend is troublesome because if only high-risk people are enrolling in insurance plans the premiums paid by those in the risk pool will not be enough to cover their higher healthcare costs. A well-functioning risk pool needs healthy people who regularly pay their premiums but do not consume many, if any, healthcare services. Without them, premiums in the risk pool will continue to increase at an accelerated rate to cover the

increasing cost of care of the unhealthy risk pool, which will eventually lead to a death spiral as healthy people drop the insurance because they cannot afford the higher premiums. Encouraging young people who are more likely to be uninsured to enroll in health coverage will help stabilize premiums (U.S. Census Bureau, 2019). Young people are generally healthier than older populations who have more health risk related to aging as well as higher rates of obesity (Hales, Carroll, Fryar & Ogden, 2017). Young people will pay regular premiums and will consume healthcare less than other less healthy age groups in the risk pool.

There are two additional options that could keep premium rates low with healthy participation in risk pools in addition to encouraging younger and healthier adult population enrollment. The first is requiring everyone to have health insurance. This could be achieved through some form of individual mandate. The Affordable Care Act initially passed a mandate like this with a tax penalty for not securing coverage, but it was unpopular with consumers and was eventually repealed by legislators in 2018. Evidence suggests that larger tax penalty would be more successful in increasing coverage rates because people would be more incentivized to choose enrollment over paying the tax penalty (Eibner & Nowak, 2018). Knowing that higher coverage rates lead to lower premiums, better access to preventative care and lower medical debt rates, a policy feature like an enrollment mandate may be worth revisiting.

Another option to keep premium rates low is excluding potentially high-risk enrollees from insurance plans. This was the method utilized by insurance companies to keep premiums affordable prior to the Affordable Care Act. This process, a component of medical underwriting, ensures a healthier risk pool with lower costs by either

denying plan enrollment to those with pre-existing conditions or denying coverage for only the condition that was pre-existing before the enrollee entered the plan. For example, if someone had a chronic illness that required a high degree of care and attempted to enroll in health insurance, the insurance company would find it fiscally responsible for them and their plan enrollees to deny the potential enrollee coverage as their high costs would raise premiums and may result in healthy enrollees leaving the plan, further exacerbating costs and leading to a death spiral. This process, often referred to as pre-existing condition limitations, was made illegal by the Affordable Care Act because of its discriminatory nature and effect on coverage rates. Legislators must consider legal and politically feasible options that increase coverage rates, paying mind to past legislative actions and strong public opposition of pre-existing condition limitations.

In addition to low coverage rates increasing premiums for those enrolled in plans, low coverage rates also mean people are not accessing important preventative care services, like well-visits, check-ups and cancer screenings, which are crucial for not only improving people's health outcomes but also for bringing down future healthcare costs. Without preventative care, many chronic illnesses and conditions will go untreated until a point of urgency is reached, when the individual will access much more costly care through an emergency room visit. This is particularly burdensome for people living below the federal poverty level. The Robert Wood Johnson Foundation found in 2015 that "60.1% of uninsured legal residents had family incomes at or below 200 percent of the federal poverty level, compared with 14.8 percent of those with incomes at or above 400 percent of the federal poverty level" (America's Health

Rankings, 2020). Most people are uninsured because they cannot afford to purchase coverage and cannot access public insurance programs due to eligibility requirements. These unexpected emergency room visits or urgent medical care will often lead to significant medical debt for these populations. According to Yabroff, Zhao, Han, and Zheng (2019), 137.1 million Americans experienced hardship in paying their medical bills in 2018. The study found this hardship especially burdensome for uninsured populations who were paying off medical debt. In fact, medical bills are the most common unpaid bills sent to collection agencies, according to the U.S. Consumer Financial Protection Bureau (Himmelstein, Lawless, Thorne, Foohey & Woolhandler, 2019). Increasing the insured rate would undoubtedly decrease unpaid medical bill prevalence.

1.5 Quality Reform

Because the United States' has poor health outcomes compared to other developed nations, a healthcare reform policy that could increase the quality of care received within the system must be considered. As previously mentioned, a policy that encourages more Americans to enroll in affordable health plans would effectively improve health outcomes due to increased access to preventative care. A study from the American Journal of Health Economics examined mortality rates in three states that expanded Medicaid and found that mortality rates in each state decreased by 6% after coverage was expanded, "(...) with the most robust reductions for health-care amenable causes" (Sommers, 2017). This indicates that preventative care is crucial for improving people's health. The study also found that there was "one life saved annually for every

239 to 316 adults gaining insurance” (2017). If more people have health coverage and access to preventative services, this will lead to improved population health.

Another aspect of potential healthcare reform policy that would improve health quality is a higher degree of competition in the insurance market. Currently, private insurers compete with one another but do not compete with government, price-regulated plans like Medicare or Medicaid. This is because these public programs are age, income and/or disability exclusive, so the private market is not competing with them for enrollees – public program enrollees will stay enrolled in their respective programs despite private market price innovations. Kaplan and Rodgers (2009) argue that a policy that puts government-run plans in competition with private insurance would reduce prices of all plans, which may increase the quality of each plan on the marketplace as providers try to provide the best and most comprehensive plans possible in this new, more competitive market.

Additional innovations like capitation with quality and expanded telehealth availability should be considered in improving the quality of the healthcare system. Previously discussed in the private insurance cost reform section, using a capitation with quality mechanism to pay providers according to the quality of their care rather than according to the cost of their service can improve the amount of positive health outcomes seen in the healthcare system as well as improve provider accountability. Providing financial incentives to improve a provider’s quality of care will put the burden on providers to improve their own quality (James & Poulsen, 2016), rather than on the government with costly top-down approaches that may be administratively burdensome. Expanded telehealth usage would also improve the quality of the

healthcare system because using remote services accessed through a mobile phone or computer in rural areas can fill important gaps in access to preventative care. According to the CDC, people living in rural communities in the U.S. are more likely than people living in urban communities to prematurely die of the five leading causes of death (2019). Out of these causes, heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke, the majority could be prevented with adequate prevention and disease management programs from medical professionals. The CDC promotes telehealth usage to address these inequities because using remote services providers can monitor their patient's chronic disease management and provide counseling, improving the likelihood of positive health outcomes, without the patient bearing the burden of having to travel long distances to see the provider in person. Additionally, the COVID-19 pandemic has further demonstrated telehealth services to be a key element of effective healthcare delivery. Congress' COVID-19 Telehealth Program has so far provided 200 million dollars in funding to participating providers (Federal Communications Commission, 2020).

1.6 Choosing the Best Option for Reform

The U.S. healthcare system needs reform because of rising costs, poor health outcomes and a high uninsured rate. While there are many different reform options and policy considerations debated today, in determining the ideal package for the United States in the coming decade, one must first look to what can be learned from the most rigorous healthcare policy legislation created in U.S. history: the Social Security Amendments of 1965 which created Medicare and Medicaid. What was the healthcare climate at this time that enabled such a robust public program to pass? Did the act

foresee challenges that face the program today? In looking at this policy's history, policymakers can more aptly design an effective reform policy today.

Chapter Two: The Creation of Medicare and Medicaid

In 1965, the Social Security Amendments were passed by the U.S. government. These amendments to the Social Security Act that was passed in 1935 sought to increase healthcare coverage for low-income and aging adults through the creation of Medicare and Medicaid. Two amendments to the 1935 act were made: Title XVIII, which created Medicare Part A and B, and Title XIX, which created Medicaid.

2.1 Medicare

Firstly, this legislation passed two national health insurance programs for those over sixty-five: Medicare Part A and B. The first is a hospital insurance plan that sought to protect the elderly from high in-patient and out-patient hospital care costs. This plan was designed to have no premiums for enrollees as well as affordable deductibles and co-insurance mechanisms for when an individual does need access to care. It was to be financed through an income tax. The second is a voluntary and supplemental medical insurance plan that could cover payments for “physicians’ services, home health services, and numerous other medical and health services rendered in and out of medical institutions” (Social Security Administration, n.d.). The medical insurance program was established to have a premium for enrollees unlike the hospital insurance program and the premium was initially set at six dollars per month with the federal government paying for three dollars of the premium for every enrollee. Medicare is currently paid for by two trust funds: The Hospital Insurance (HI) Trust Fund and the Supplemental Medical Insurance (SMI) Trust Fund. These are funded by federal income taxes, enrollee premium payments and interest earned on the trust funds. In 1972, the

Nixon Administration expanded Medicare beyond those over the age of 65 to include those who are permanently disabled under the age of 65 as well as those who have end stage renal disease. These eligibility groups are the same as of today.

Often referred to as “Original Medicare”, Parts A and B were the only parts of Medicare created in the original legislation. Other parts were later created to respond to modern healthcare demands regarding both supplemental coverage and prescription drug coverage. In 2003, Medicare Part C was created through the Medicare Prescription Drug Improvement and Modernization Act. The act created Medicare Advantage plans which are optional, supplemental and Medicare-approved coverage options provided by private insurers. Medicare Advantage enrollees receive their Medicare Part A and B benefits through Medicare Advantage in addition to often receiving prescription drug, or Part D, benefits through their plan. Medicare Advantage plans often have lower out-of-pocket costs, streamlined medical and prescription drug coverage and additional benefits like vision, fitness club memberships, dental and hearing care (Centers for Medicare and Medicaid Services, n.d.-a). In 2019, about one-third of Medicare enrollees were enrolled in a Medicare Advantage plan and paid an average premium of 26 dollars per month (Jacobson, Freed, Damico & Neuman, 2019). For this 22 million person large group, supplemental coverage provided by the private sector is an essential and affordable part of their healthcare plan.

In 2006, Medicare Part D was implemented in response to calls for affordable prescription drug coverage. The Medicare Prescription Drug Improvement and Modernization Act of 2003 also created Part D in addition to Part C, but it was not implemented until 2006. Part D is supplemental coverage to Original Medicare,

provided by the private insurance market, that covers prescription drugs. Before this legislation Medicare recipients could not use their insurance to cover prescription drugs purchased from pharmacies, which are essential and at times costly healthcare hubs for many. Those on Medicare who need prescription drug coverage either enroll in a Part D “stand-alone prescription drug plan [or] PDP” or enroll in a Medicare Advantage plan that covers prescriptions (Kaiser Family Foundation, 2020b). About 75% of Medicare enrollees elect to also receive prescription drug coverage through either of these two methods (2020b). Medicare prescription drug plans impose a monthly premium on enrollees that they must pay in addition to Part B premiums. Because the demands of supplemental coverage and prescription drug coverage are difficult to provide solely with the public sector, Medicare’s partnership with the private sector is an effective alliance that helps to control costs, improve plan choice and address changing modern demands. This is demonstrated in the consistently high enrollment for Parts C and D since being enacted.

2.2 Medicaid

The Social Security Amendments also passed the legislation that created Medicaid, aiming to provide healthcare coverage for low-income families and individuals who were already receiving other public assistance. Medicaid is designed to be administered as a joint federal-state program, administered largely at the state level, with federal matching funds provided by the government as well as some administrative support. The federal government set certain parameters for how states could run their Medicaid programs while giving them the flexibility to administer it in individualized ways. Medicaid is an entitlement program, meaning if someone qualifies for the

program based on eligibility requirements then they are entitled to a certain set of benefits. States are also entitled to federal funds to run their respective Medicaid programs. Eligibility was originally to be determined by the states using “flexible income tests” and liberally asserted that states could not deny coverage to people based on presumptions of high medical bills (Cohen & Ball, 1965). States were also given the choice to extend coverage to those in need who did not already receive public assistance (U.S. Department of Health and Human Services, 2005). The legislation also stated that states were to set reasonable prices for deductibles and cost-sharing that were in line with the enrollee’s income level (Cohen & Ball, 1965). Additionally, for both Medicaid and Medicare, the legislation protected American citizens from low-quality coverage options by creating minimum benefit requirements for new plans that required coverage of services from inpatient hospital care to nursing home services in order to receive federal funds.

Since the introduction of Medicaid in 1965, the federal government has changed which population groups states are required to cover. Mandatory coverage is now expanded to groups including qualified pregnant women and children, people receiving Supplemental Security Income (SSI) benefits, people who are disabled and more low-income families and individuals. The Affordable Care Act of 2010 gave states the option to expand coverage to groups who previously made too much income to qualify for Medicaid but were uninsured because of inability to afford other healthcare coverage. States were required to extend coverage to children whose family incomes met up to 133% of the federal poverty level and were given the option to also provide Medicaid to adults with incomes at or below 133% of the federal poverty level (Centers

for Medicare and Medicaid Services, n.d.-b). 37 states chose to participate in the expansion option (Rudowitz, Garfield, & Hinton 2019) providing critical coverage for people straddling the line between low-and middle-income status.

2.3 The Healthcare Climate Leading Up to 1965

A public assistance program that could increase healthcare coverage rates and bring down individual healthcare cost burdens was long anticipated for many Americans in the 20th century. While 77% of Americans had healthcare coverage through their employer on the private healthcare market in 1965 (Enthoven & Fuchs, 2006) there remained great coverage gaps for low-income and aging Americans. Consequently, such robust public assistance programs like Medicare and Medicaid were able to be signed into law in 1965 because of high public demand. However, there is a long history of previous attempts in creating public assistance programs to address gaps in affordability and rising costs of healthcare. In fact, according to Cohen and Ball (1965), “health benefits as part of the social security system [had] been introduced in every Congress since 1952”. Although none were as successful as Medicare and Medicaid, these failed public assistance programs are worth discussing when considering future healthcare reform.

Low-income individuals over the age of 65 had access to cash assistance through the Old Age Assistance program created by the original Social Security Act of 1935. This program operated through federal matching grants given to states to run their own program. States, however, were not required to implement the Old Age Assistance program (Social Security Administration, n.d.). Amendments to the Social Security Act in 1950 stipulated that these federal matching funds could be used for the direct

payment of hospitals and medical providers in states, creating a bigger focus on health insurance for the public assistance program. Ten years later, Congress approved the first official medical insurance program for aging adults through the Kerr-Mills Act, which approved federal funding to states to cover medical costs for low-income aging individuals. The program distributed the federal matching funds based on the per-capita income levels of each state, with no caps. This system was easy to administer and favorable to both low- and high-income states. Eligibility standards were left to the states to decide for their individual programs. The Kerr-Mills Act was a unique program because it sought to provide coverage for aging adults who did not qualify for Old Age Assistance but who could also not afford the costs of medical care, filling an important and previously unaddressed coverage gap.

However, the Kerr-Mills Act was not as successful as its legislators had hoped. Only forty states utilized the matching funds and created programs, and only 2% of the country's aging population secured coverage through it in 1965 (Moore & Smith, 2005). The program's lack of success could be attributed to legislators not foreseeing how much funds were actually necessary to run the state programs, stigma surrounding receiving benefits due to the connection between one's income level and eligibility status and lack of national unity in state implementation (United States Senate, 1963). Despite the Kerr-Mill Act's inadequacies, the program provided a template for how Medicaid would be structured and led the way for a more robust old-age medical assistance program.

Following the Kerr-Mills Act, Americans had a greater demand for more affordable coverage options that addressed the growing aging population as well as the

rising costs of healthcare services. The high demand, particularly for Medicare, was also caused by the high population of people becoming eligible for Social Security benefits at this time. According to Stevens (1996), “[In] 1964, 83 percent of the population 65 years of age or over were eligible for Social Security benefits; and there were almost three times as many aged Social Security beneficiaries as there were 10 years earlier”. Meanwhile, in 1965 less than one half of the population over the age of 65 had some form of health insurance (Social Security Administration, n.d.). With this new population group becoming accustomed to entitlement-style benefit programs, along with high uninsured rates among aging populations, a program like Medicare was long over-due for many American seniors.

2.4 The Future of Medicare

After Medicare was implemented in 1965, hospital admission rates rose approximately 6% for the first few years after its passage and then returned to a slow and steady growth as the program aged (Gornick et al., 1996). This higher rate of healthcare access seems to have increased the health of those enrolled, most likely due to higher well-exams and preventative care services utilized. According to Gornick et al., “From 1965, when Medicare was enacted, to 1994, life expectancy at age 65 increased nearly 3 full years. Those who reached age 75 in 1994 could expect to live, on average, 11 additional years” (1996). Although passing a bill that helped increase the country’s life expectancy is a grand feat, the 89th U.S. Congress may not have anticipated what that would change about their bill’s future solvency.

As mentioned before in the previous chapter, when Congress passed Medicare into law in 1965, the average life expectancy was about 10 years shorter than it is today

(U.S. Census Bureau, 2018). People often lived to 65 when the bill was passed but did not typically live far into their seventies. With the average person now often living well into their seventies (U.S. Census Bureau, 2018), and sometimes even much longer than that, Medicare became much more expensive than the original legislators anticipated. There are multiple reasons for this enrollment shift. Firstly, 11% of the population was Medicare-eligible in 1980 versus 17% in 2020 (U.S. Census Bureau, 2018). People live to the age of 65 more often in the 21st century, which means more people are simply reaching the age when they are entitled to start their benefits. Secondly, because life expectancy has also greatly risen since the bill's passing, there are not only more people on Medicare, but people are also entitled to its benefits for much longer than anyone predicted the aged population would be. Thirdly, as previously mentioned, older enrollees also mean higher costs, with Medicare's oldest enrollees costing three times as much as its youngest enrollees (Doherty, 2018). This is further exacerbated by the constant innovation of medical technology in the 21st century which not only increases life expectancy even more but also often adds costly bloat to the system with high technological health intervention price tags (Leavitt, 2008). In addition to these reasons why Medicare is becoming more expensive, healthcare service and good prices are also continuously rising (Peter G. Peterson Foundation, 2019). Overall, Medicare's per-capita spending is expected to grow by 5% annually from 2020 to 2028 while the HI trust fund is expected to fully be depleted by 2026 (Cubanski, Neuman & Freed, 2019). Even if the healthcare system's structure does not change to include new reforms in coming years, congress will need to consider alternative funding options to keep Medicare alive as its funding depletes.

2.5 The Future of Medicaid

Although only 37 states have expanded Medicaid to all individuals or families with incomes at or below 133% of the federal poverty level, more states including Oklahoma, Missouri, Kansas and North Carolina are considering the expansion in upcoming legislative sessions (Kaiser Family Foundation, 2020c). This is important because the research demonstrates that in Medicaid expansion states the increased coverage rates are helping states and individuals save money on healthcare costs (Sommers, 2017). In the previously mentioned American Journal of Health Economics study that looked at mortality rates in three states that expanded Medicaid, it was found that “one life [is] saved annually for every 239 to 316 adults gaining insurance” and the cost per life saved ranges from \$327,000 to \$867,000 (Sommers, 2017). Increased coverage rates save money firstly because they make for better access to preventative and long-term cost-saving care and secondly because they diminish the likelihood of providers and hospitals seeing cases of uncompensated care. Research from Guth, Garfield and Rudowitz found that “(...) that Medicaid expansion has improved access to care, utilization of services, the affordability of care, and financial security among the low-income population” (2020) in implemented states. Knowing this, more states may consider Medicaid expansions in coming years to address cost containment and quality improvement concerns.

A more recent development that could affect the future of Medicaid is legislation that allows states to require individuals to work to receive Medicaid benefits. In February of 2020, seven states approved a work requirement in their state’s Medicaid program and 10 more have pending legislation to do so (Kaiser Family Foundation,

2020d). In addition to employment, activities that count toward the work requirement may include volunteering, job-training classes and job searching depending on the state. Hours per month required and exempt populations also vary from state to state. For states that passed a work requirement, this legislation does not bar most current Medicaid enrollees from receiving their benefits because the majority (63%) work either full- or part-time but enroll in Medicaid insurance either because they work in low-wage jobs with low employer-sponsored insurance rates or because they are eligible for such an affordable option (Garfield, 2019). However, some Medicaid enrollees living in states that passed a work requirement cannot work due to barriers like chronic illness, disability, having a caretaking role at home and/or attending school. For these individuals who may be also living in a state that did not expand Medicaid to adults with incomes at or below 133% of the federal poverty level, they face a reasonably high probability of being uninsured because they have no access to public or private health insurance.

2.6 Lessons learned from Medicare and Medicaid for Future Healthcare Reform

There are several important takeaways from the history of Medicare and Medicaid implementation that should be considered for future healthcare reform. Firstly, one can learn from the shortcomings of the Ker-Mills Act that Congress may have more success in raising coverage rates for low-income populations if they consider how the potential coverage gaps in state-administered programs affect a program like Medicaid's overall success. The federal government may need to take national action to secure coverage for low-income populations or consider ways to better promote state Medicaid expansion if the U.S. wants to see a large nation-wide coverage increase.

Secondly, one can learn from the healthcare climate at the time of Medicare and Medicaid's passing that low coverage rates stemming from few public coverage options for those who needed them as well as changing enrollment patterns, particularly for aging populations, paved the way for such robust reform packages to pass. In today's healthcare climate, where the U.S. is again seeing low coverage rates for lower-income populations as well as rapidly changing health coverage enrollment patterns for aging populations, it may be an optimal time for policymakers to introduce a healthcare reform package that addresses these critical issues. Raising the coverage rate particularly for lower-income populations was a main priority in the introduction of the Affordable Care Act. Next, this paper will look more closely at this more recent healthcare reform package and consider what one can learn from its successes and shortcomings.

Chapter 3: The Creation of the Affordable Care Act

Although Medicare and Medicaid addressed many important healthcare issues, many issues in healthcare remained prior to 2010, like low coverage rates, particularly among low-income groups, and still-rising healthcare costs. In 2010, the Obama Administration passed a comprehensive reform package called the Patient Protection and Affordable Care Act (ACA).

3.1 The Patient Protection and Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act, or ACA, was signed into law on March 23rd, 2010. The ACA expanded access to health insurance, implemented important regulations to protect consumers, and sought to improve the health and wellness of American citizens and decrease system-wide healthcare costs (King, 2011). The main goal was to improve access to health insurance for the millions of individuals living uninsured prior to the ACA and therefore improve the national coverage rate.

The ACA created multiple policies targeting this main goal. Firstly, it mandated that employers offer their employees working at least 30 hours per week health coverage or pay a fine, with exceptions for small businesses who would receive tax credits to help fund insurance for their employees. Secondly, it mandated that states create online and state-based insurance marketplaces or exchanges where individuals and small business owners could purchase private insurance policies. Plans were offered in four tiers: bronze, silver, gold and platinum with platinum plans having the most expensive premiums and lowest cost-sharing thresholds and bronze plans having the least expensive premiums but highest cost-sharing thresholds. Individuals who deem

themselves as lower risk may choose the bronze or silver plans because they intend to utilize less healthcare. Individuals who deem themselves as higher risk may choose the gold or platinum plans because they intend to utilize more healthcare. The tiers intended to increase consumer choice and industry transparency. Premiums were also to be subsidized by the federal government with premium tax credits offered to households depending on income level. The ACA mandated that these insurance plans both provided by employers or bought on the individual market must cover the following minimum essential benefits: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health, prescription drugs, rehabilitative services, laboratory services, preventative and wellness services and pediatric services (Legal Information Institute at Cornell Law School, n.d.). These policies intended to reduce the number of uninsured in the U.S. by increasing access to affordable and quality insurance plans.

To ensure the coverage rate improved, which would consequently lower healthcare premiums and make plans more affordable as discussed in Section 1.4, the ACA also required individuals to obtain health insurance or pay a tax penalty, known as the “individual mandate”. It was put into law in 2014. Exemptions were available for many situations including inability to access an affordable plan in one’s area, religious belief and financial hardship. The tax penalty was to be the greater of either a flat fee based on the number of uninsured individuals in their household or a certain percentage of their income. The flat fee and income percentage fluctuated by year after the ACA’s passing. In 2015, the flat fee was \$325 or 2% of income per household, with the income percentage amount capped at the national average cost of a bronze insurance plan

(Norris, 2019). Norris claims that because wealthier households with uninsured individuals would be more likely to be subject to the income percentage penalty since it would be greater than the flat fee, in 2015 the average penalty ended up being around \$470 with the maximum penalty \$2484 for an individual (2019). Data from the Internal Revenue Service indicates that about 6.7 million tax filers, or 4.5% of all tax filers, paid the tax penalty for not obtaining health insurance in 2015 (Lai & Parlapiano, 2017). Other policies that targeted the goal of directly increasing the coverage rate included mandating young adults ability to be covered on their parents' insurance plans until the age of 26 as well as expanding state Medicaid coverage to individuals with incomes up to 133% of the federal poverty level. To enforce the latter policy and encourage the states to implement the expansion, the federal government was to withhold all federal Medicaid funding from states who did not implement it.

The ACA also implemented policies that protected consumers from low quality healthcare plans and unfair insurance practices. Firstly, the ACA implemented the minimum essential list of benefits that were previously mentioned in this chapter in order to ensure healthcare plans offered met certain quality standards. In addition to requiring plans to cover this list of benefits, they also mandated insurance plans to set a cap on people's out-of-pocket spending as well as not limit lifetime coverage amounts. Secondly, the ACA prohibited the practice of pre-existing conditions limitations, or denying coverage to people with pre-existing health conditions. This policy is particularly important because it made it illegal for insurers to discriminate based on someone's health status by charging higher rates or denying coverage to people who had a health condition that started before obtaining insurance. This policy also ensured

that women could not be charged higher prices than men for the same plan (U.S. Department of Health & Human Services, 2017). Other policies intending to protect consumers were prohibiting insurers from cancelling coverage except in cases of fraud, establishing state-based reviews of unreasonable premium increases and prohibiting insurers from setting annual monetary caps on coverage.

The ACA also sought to improve the health and wellness of American citizens, primarily through creating the Prevention and Public Health Fund. The fund invests in public health programs that use evidence-based strategies to improve the health of Americans while also intending to curb private and public healthcare costs (Centers for Disease Control and Prevention, 2018a). The fund also supports localized community-based solutions through providing public health block grants to all 50 states, eight U.S. territories, two American Indian tribes and Washington D.C., so states and entities can adequately address their own unique public health issues (Centers for Disease Control and Prevention, 2018b). In addition to the Prevention and Public Health Fund, the ACA also created the National Prevention, Health Promotion and Public Health Council to streamline federal prevention goals like ending childhood obesity, curbing tobacco use and encouraging physical activity. Other initiatives that the ACA created to improve the health of Americans include requiring large restaurant chains to display nutrition information to consumers, increasing the federal burden of Medicaid payments for preventative care and requiring insurance plans to cover certain preventative services like immunizations and common chronic disease screenings with no cost-sharing for consumers.

3.2 Healthcare Climate Leading up to the ACA

Leading up to the creation of the ACA, millions of people did not have access to quality health insurance. According to a survey conducted by the Centers for Disease Control and Prevention (CDC) in 2010, 16% of people (or 48.6 million individuals) of all ages surveyed did not have health insurance (Cohen, Ward & Schiller, 2015). In the same survey, the CDC also found that 33.9% of people age 19 to 25 did not have insurance, illuminating the fact that many young people lacked access to health insurance or did not prioritize getting insured before the ACA's expansion of coverage and individual mandate policies. However, the low coverage rates before the ACA were especially burdensome for adults living at or below the federal poverty level in 2010. According to the survey, "42.2 percent of poor and 43.0 percent of near poor adults aged 18–64 years lacked coverage at the time of interview" (Cohen, Ward & Schiller, 2015), showing why the ACA's Medicaid expansion was popular with and in demand by many individuals and families.

Low coverage rates prior to the ACA were also exacerbated by the Great Recession of 2008's effects on employment. Many were laid off from their jobs and therefore lost their health insurance while many others who were able to keep their jobs were subject to employee benefit cuts that resulted in them losing their insurance as well. Despite the Consolidated Omnibus Budget Reconciliation Act (COBRA) requiring employers to offer terminated employees the option to extend their employer-based private insurance coverage for 18 months after their termination, the percentage of people with employer-based health insurance fell about three percent from 2008 to 2009 (DeNavas-Walt, Proctor & Smith, 2010). Terminated employees may not have been in

the financial position to accept this coverage because it stipulates that enrollees must pay the full price of their premium without the employer's contribution. After the recession hit, the U.S. saw a decrease in the national coverage rate for the first time since 1987 according to a U.S. Census Bureau report on Income, Poverty and Health Insurance Coverage in 2009. The data show that "the number of people with health insurance decreased to 253.6 million in 2009 from 255.1 million in 2008" (DeNavas-Walt, Proctor & Smith, 2010). Reflecting the healthcare climate during this recession, a 2009 New York Times poll indicated that 85% of respondents "said that the health care system required fundamental reform" (Budrys, 2011). Because many faced unemployment, Budrys claims that there was national sentiment from frustrated Americans that their health insurance should not have been linked to their jobs as they faced lost coverage resulting in unpaid hospital bills bringing them medical bankruptcy (2011).

Leading up to the Affordable Care Act, the healthcare system was also burdened with exceedingly high costs. According to historical healthcare spending data from the Centers for Medicare and Medicaid, from 2000 to 2010 healthcare costs rose between four and 10 percent (2019). As a percentage of gross domestic product, healthcare spending was hovering around 18% in 2009 while it consistently stayed around 14% through the nineties (DeNavas-Walt, Proctor & Smith, 2010). This spending growth paved the way for comprehensive healthcare reform to be prominently discussed by all presidential candidates in the 2008 election, with former President Barack Obama winning the presidential bid with his promise to curb these rising healthcare costs primarily through improving the national coverage rate.

3.3 Post-Implementation Changes to the ACA

Despite the Affordable Care Act's successes, it has faced much resistance over the past 10 years by some politicians, businesses and individuals who worked to repeal several components of the bill through lawmaking and legal action. The most impactful revision to the ACA was the repealing of the individual mandate, done in the Tax Cuts and Jobs Act of 2017 (TCJA). The TCJA changed the individual mandate's penalty amount to zero, effectively changing the nature of the penalty from a tax to a command. This change set the stage in 2018 for U.S. District Court Judge Reed O'Connor to declare the individual mandate without the tax penalty unconstitutional in *Texas v. Azar* (Stewart, 2018). Effective in 2019, people were no longer legally obligated to purchase health insurance. Projections from the Congressional Budget Office (CBO) estimate that by 2027 the individual mandate repeal will have increased the number of uninsured Americans by 13 million as well as increase average premiums by about 10% in the non-group market (2017).

Another aspect of the ACA that was changed post-implementation was the penalty to states for not expanding their Medicaid programs. In 2012, the U.S. Supreme Court in *National Federation of Independent Business v. Sebelius* deemed the penalty unconstitutional because of its coercive nature toward the states. The court came to this determination using precedent from a 1937 Supreme Court case that said federal grants to states could be unconstitutionally coercive depending on the specific conditions of the grant (Rosenbaum & Westmoreland, 2012). Because of this court decision, Medicaid expansion is now completely voluntary and today only 37 states, including Washington D.C., have expanded their Medicaid programs.

In addition to the individual mandate and penalty for not expanding Medicaid repeals, the ACA’s “Cadillac Tax”, or tax on high-cost employer-based health plans was also repealed in recent years. The “Cadillac Tax” was going to be a tax amounting to 40% of the value of health benefits exceeding specific high thresholds for individuals and families on employer-sponsored health plans, originally set to begin in 2018 (Tax Policy Center, n.d.). Because of immense bipartisan support for its repeal, it was delayed until 2020 and then delayed until 2022 before its eventual repeal in an expansive spending bill signed by President Trump in 2019. This spending bill also repealed other taxes created by the ACA that intended to fund its widespread coverage expansions, like the Health Insurance Tax levied on insurers and the Medical Device tax levied on domestic sales of medical devices like pacemakers. According to Health Affairs contributor Katie Keith, “Collectively, repeal of the three taxes would result in the loss of \$373.3 billion in projected revenue over 10 years” (2019), with the largest projected revenue loss of \$197 billion stemming from the Cadillac Tax’s repeal.

3.4 Lessons learned from the ACA for Future Healthcare Reform

Although the ACA did not achieve all its intended outcomes due to many post-implementation changes, the landmark policy has had many victories in the healthcare reform policy discussion. The ACA built on what worked in the previous system while altering unsuccessful aspects of it. It preserved successful programs like Medicaid and Medicare while expanding and regulating the private market to increase transparency, decrease costs and improve coverage rates. Estimates from the office of the Assistant Secretary for Planning and Evaluation in 2016 indicate that the bill increased the amount of people with health coverage by at least 20 million (2016). Because most

states opted to expand their Medicaid programs and many lower-income individuals can use the ACA's premium tax credits to obtain affordable insurance, the ACA was indeed successful in improving coverage rates. However, in 2018, 23% of low-income adults aged 19-64 with incomes under 200% of the federal poverty level did not have health coverage (Kaiser Family Foundation, 2019a). In the same year, 24% percent of low-income adults aged 19-64 with incomes under 100% of the federal poverty level also did not have health coverage (Kaiser Family Foundation, 2019b). For individuals in these income groups who live in a state that did not expand Medicaid such as Texas, in 2018, the uninsured rate was 43% and 47% for these income groups respectively. These numbers indicate there is still a large coverage gap for low-income adults who live in non-expansion states. These individuals, often adults without children, simultaneously make too little to qualify for marketplace premium tax credits while also making too much to qualify for their state's Medicaid program. This group is made up of more than two million individuals (Garfield, Orgera & Damico, 2020).

In addition to people in this coverage gap, people in modest-income groups are also still being burdened by a lack of affordable coverage options. According to an Urban Institute report on ACA marketplace enrollees' financial burden relative to income level, individuals with incomes below 200% of the FPL are on average spending 4.4% of their income on insurance premiums while individuals with incomes between 300% and 400% of the FPL are on average spending 9.6% of their income on premiums (Blumberg, Holahan & Buettgens, 2015). Blumberg et al. argues this results in groups who are eligible for premium tax credits remaining uninsured because costs

are still too high. Despite the ACA's sizable coverage rate gains, many Americans still lack affordable health coverage options.

Current healthcare reform legislation should build off the ACA's achievements while considering how to avoid repeating its shortcomings. While the current healthcare climate indicates that it is an optimal time for comprehensive insurance reform, to be successful it must address the prominent coverage gaps the U.S. is seeing and the unaffordability of plans on the marketplace for modest-income populations. Next, this paper will introduce a healthcare reform policy that could not only address these specific issues but also increase coverage access to all, greatly improve the health of Americans and decrease rising healthcare costs through market forces: the public option.

Chapter 4: The Public Option

4.1 Overview of the Public Option

To address the issues the U.S. healthcare system is facing, fundamental reform is needed. This chapter analyzes why implementing a public option into the healthcare system, that all citizens can buy into, addresses the cost, quality and coverage rate reform necessities raised so far in this paper. This healthcare plan is called the public option because it expands the current system by adding an additional coverage option for Americans rather than replacing current options like private insurance or Medicare/Medicaid. The public option would exist in tandem with the current system, enabling people to stay on their plans while also allowing people without coverage, no matter their income or age, to enroll in a public plan. The public option would be offered through the health insurance marketplaces to directly compete with private insurance offerings and additionally mirror the marketplace's actuarial value tiers of bronze, silver, gold and platinum to give consumers choice in how they want to engage in cost-sharing. See the following table (Table 1) to better understand how the public option compares to other public programs in the current system.

	<i>Public Option</i>	<i>Medicare</i>	<i>Medicaid</i>
<i>Enrollment Criteria</i>	Any U.S. citizen ineligible for Medicare/Medicaid	People aged 65 plus or younger people that are permanently disabled	Low-income families, children, pregnant women and some low-income adults depending on state
<i>Automatic Enrollments</i>	People who file for unemployment, low-income people in non-Medicaid expansion states	People enrolled in Social Security benefits upon turning sixty-five, permanently disabled people receiving disability benefits for two years	Eligible children in states with express lane eligibility option
<i>Cost-Sharing</i>	All enrollees pay premiums and participate in cost-sharing, premium tax credits for lower-income enrollees	Some enrollees pay premiums and all participate in cost-sharing	Some enrollees have limited premiums, some have cost-sharing depending on state and income level
<i>Provider Participation</i>	Required if provider opts to cover Medicare enrollees	Optional	Optional
<i>Provider Reimbursement Rates</i>	Regulated by the federal government	Regulated by the federal government	Regulated by federal and state governments
<i>Funding Mechanism</i>	Enrollee premiums and cost-sharing	Federal payroll taxes, trust fund investments, enrollee premiums and cost-sharing	Federal and state taxes, enrollee premiums and cost-sharing
<i>Coverage</i>	Essential health benefits	Essential health benefits	Essential health benefits

Table 1: Public insurance programs compared to the public option

While one U.S. state, Washington, has passed a public option that will take effect in 2021, a public option at the national level in the U.S has never been implemented. A national public option was initially passed as part of the ACA in 2009 however it did not make it into the final reform package in 2010. Failure of the ACA's proposed public option was in large part due to conservative opposition deeming the plan as a "government take-over" of healthcare (Halpin & Harbage, 2010), so preserving consumer choice in any future proposal is paramount to its success. Because there is no set structure for what other features a national public option would utilize in practice, this paper advocates for three essential features of a public option: provider reimbursement rates and provider networks tied to Medicare, a self-sustained financing model with the availability of premium tax credits and availability of the plan to all with automatic enrollments for select groups.

4.2 Plan Feature – Tied to Medicare Rates and Provider Networks

The most important feature that a successful public option would have is close ties with Medicare. Although the public option would be a separate program from Medicare, allowing people under the age of 65 to enroll (unlike Medicare), the public option would use Medicare payment rates for providers. With a public option using Medicare payment rates, Blumberg and Holahan (2016) argue that a public option would be fairly easy to implement because of the already established rate schedules that it could replicate as well as because of providers' "demonstrated acceptability of the Medicare rates". Additionally, administering the public option in a way that appears seamless to providers by replicating a system they already use will increase provider satisfaction and lessen administrative costs that come with transitioning to a new system

(Kaplan & Rodgers, 2009). The low administrative costs associated with the public option could enable more health care dollars to go directly to medical care (Halpin & Harbage, 2010).

Additionally, tying the public option to Medicare reimbursement rates will increase competition in the healthcare market and therefore reduce overall costs in the system. The private insurance market will have to financially compete with government regulated public option rates as well as for insurance enrollees in general as the public option would be an alternative for people dissatisfied with the private market. To be a competitive player in this new market, private insurance providers would need to adjust enrollee costs to be competitive with the government-run plan, therefore reducing prices of all plans (Kaplan & Rodgers, 2009) and then hopefully increasing the quality of each plan on the marketplace as providers try to provide the best plans possible in this new, more competitive market.

The public option would also tie provider participation to Medicare, therefore mandating providers who take Medicare patients also take public option patients. While providers are not required to take Medicare patients in the current system, data from the Kaiser Family Foundation found that 93% of primary care providers accepted Medicare in 2015 (Boccuti, Fields, Casillas & Hamel) most likely because of its wide patient network. Requiring providers who choose to take Medicare enrollees to additionally take public option enrollees would enable public option enrollees to have access to a wide provider network. If the government did not enforce this requirement, public option enrollees would be potentially subject to narrow provider networks and the government would have lessened ability to set cost-saving reimbursement rates

(Neuman, Pollitz, Tolbert, Rudowitz & Koma 2019). Additionally, if potential enrollees would be subject to narrow provider networks and higher rates, consumers may be less likely to enroll in the public option. With less people in the public option's risk pool, adverse selection will likely occur leading to a death spiral and potential collapse of the plan. Mandating provider participation be tied to Medicare is crucial for the public option's future solvency.

4.3 Plan Feature – Use of Premium Tax Credits and Self-Sustained Financing

Model

The next most important feature of a successful public option is subsidization of premiums for low- and modest-income individuals by the federal government. The public option would utilize the premium tax credit program used on the national health insurance marketplace, stipulating that anyone with an income amounting of one to four times the federal poverty level has access to cost-saving tax credits when purchasing insurance. Premium tax credits are calculated by setting caps, determined by income level, on how much an individual can spend on monthly premiums and setting the amount of credit to the difference between the cap and the cost of an “benchmark” or average plan. In the national marketplace for private insurance, the benchmark plan used to set caps is the second-lowest cost silver plan available to the individual (Kaiser Family Foundation, 2020e). These premium tax credits operate on a sliding scale; people with lower incomes receive larger credits, people with higher incomes receive smaller credits. To accommodate different needs, all individuals choose from either receiving their tax credit through direct lowering of their monthly premiums or receiving their total yearly tax credit when filing a tax return.

Because the public option will use government-regulated Medicare payment rates, marketplace subsidies may be lower for public option premiums compared to private insurance premiums (Neuman, Pollitz, Tolbert, Rudowitz & Koma, 2019). The cost-savings coming from government price regulation could also raise the benchmark plan from a silver level plan to a gold level plan where enrollees have higher premiums but lower cost-sharing mechanisms like deductibles and out-of-pocket maximums. This policy feature would address growing concerns over consumer medical debt, affecting 137.1 million Americans in 2018 (Yabroff, Zhao, Han, and Zheng, 2019).

Because of the cost-savings associated with government price regulation, premium tax credits for enrollees could be fully financed by public option premiums, creating a self-sustained financing model for the program (Berenson, Holahan & Zuckerman, 2009). This self-sustained financing model is made possible because the public option will impose premiums on all enrollees, providing tax credits to individuals unable to afford their premiums, unlike Medicare where some enrollees pay no premium. With this financing model, the public option will not push healthcare debt onto future generations but rather enable enrollees to “pay as they go” with their healthcare coverage. The concept of “pay as you go” coverage is especially relevant as we are face Medicare’s HI trust fund fully depleting by 2026 (Cubanski, Neuman & Freed, 2019). This model also helps enrollees see the true cost of their care which could potentially decrease waste in the system and improve high quality health outcomes over time as attitudes toward healthcare usage change. While additional funds will likely be needed to fully finance the introduction of the public option, these start-up funds could be factored into plan rates until they are paid back over time.

The success of this self-sustained model would only be feasible if the public option has a large and relatively stable risk pool. Similarly to how a large risk pool stabilizes risk by enrolling many low-risk individuals with low utilization of services to offset the risk of high-risk individuals with high utilization of services, a large risk pool also stabilizes premium costs by enrolling many individuals with low premium costs (i.e. individuals either ineligible for premium tax credits or those receiving lower amounts of premium tax credits) to offset the costs of individuals receiving higher amounts of premium tax credits. Because of this need for a large risk pool, it is important that the public option is available to all citizens with automatic enrollment for select groups.

4.4 Plan Feature –Available to All, Automatic Enrollments for Some

The last most important aspect of a successful public option’s design is availability to all interested citizens who do not qualify for other public programs. Medicare and Medicaid enrollees would keep their coverage as is while anyone else either without insurance or dissatisfied with their insurance would be eligible to enroll in the public option. This includes people who are offered coverage from their employer, no matter how large their company is. Opening the public option to this large spectrum of individuals makes for a more stabilized risk pool.

While the failed public option proposal in the ACA limited enrollment to only those who have not been offered employer-sponsored insurance or employees of small-sized companies, limiting access to the public option curtails its potential to be a driving force for competition and cost-savings in the market. Because the public option intends to lower consumer and system healthcare costs primarily through increased competition

to the private insurance market, allowing broad access to enrollment is crucial. Additionally, broad access will help avoid potential death spiraling in the public option risk pool. While broad access to the plan may drive some private insurers out of the market, the remaining insurers would be the most efficient in negotiating with providers and managing utilization (Berenson, Holahan & Zuckerman, 2009). Faced with competition from the public option, these remaining insurers would have greater incentive to use the cost-saving and quality-enhancing tools discussed in Section 1.5 such as capitation with quality and telehealth services. On the provider side, providers may be more willing to negotiate prices with private insurers to avoid large amounts of their patients switching to the public option.

While enrollment in the public option would be optional, some Americans would be automatically enrolled with the option to opt-out of coverage. Automatic enrollments would primarily target low-income adults living in states that did not expand Medicaid to offer them coverage. Individuals living in this coverage gap make up over two million people in 14 states (Garfield, Orgera & Damico, 2020). Because of the prominent cost-savings and increase in preventative care usage associated with expanding Medicaid to more low-income individuals (Sommers, 2017), these individuals should be automatically enrolled in the public option modeling automatic enrollment processes in Medicaid. To lower administrative hurdles associated with the automatic enrollment of such a large population group, the public option should emulate Medicaid's express lane eligibility option where uninsured individuals are automatically enrolled in coverage when interacting with certain services like Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and

Women, Infants, and Children (WIC) among others (Centers for Medicare and Medicaid Services, n.d.-c). To make the public option affordable for this group, fiscal subsidies in the form of premium tax credits would be available for individuals to use to mimic the affordability of coverage that low-income individuals living in Medicaid expansion states have. Individuals should be able to seamlessly opt out of the public option if they do not want it.

Additionally, those who file an unemployment claim will automatically be enrolled in the public option if they are no longer receiving coverage from their past employer and/or are not enrolled in Medicare or Medicaid. This design feature intends to be a social safety net for individuals experiencing joblessness who are statistically more likely to experience health issues and utilize physician care (Wilson & Walker, 1993), therefore needing adequate health coverage. Again, these individuals can opt out of the public option if they do not want it.

Because the public option will automatically enroll low-income individuals in non-expansion states and individuals experiencing joblessness in addition to being an option for millions of people, like those unable to afford private insurance, those unable to qualify for age- and income-restricted public programs and those dissatisfied with the costs of their private coverage, the public option will likely significantly increase national coverage rates. Increased coverage rates will significantly increase high quality health outcomes of Americans, as seen in the 2017 American Journal of Health Economics study that found higher coverage rates to be associated with decreased mortality in states (Sommers, 2017), as well as create a large and stabilized public

option risk pool that will allow for low-cost premiums and low-cost government subsidies of premiums.

4.5 Other Public Option Models

The State of Washington

As previously alluded to, the State of Washington has recently passed a public option of their own to be introduced in 2021. Washington's public option is not structured like the public option outlined in Table 1 but rather is a private-public partnership wherein the state authority will contract with private insurers to offer a public option in their state marketplace. Initially, the public option will be offered in at least one county but will be eventually expanded into every county in the state. Rather than create a completely state-run public option, Washington has chosen to collaborate with private insurers to introduce healthcare reform similar to a public option. To participate, private insurers face a detailed contracting process and must directly negotiate with the state. The program's design suggests that it is less a public option and more so a conglomerate of private plans that must adhere to great regulation. Plans approved to participate face higher standards of cost transparency than other plans on the marketplace, requirements aimed at reducing administrative waste, capped provider reimbursement rates and aggregate payment caps. The provider reimbursement rates cannot exceed 135% of Medicare rates and aggregate payment caps are set at 160% of Medicare prices for the same service (Capretta, 2019). These payment rates were 100% of Medicare rates in the original legislation but were increased due to heavy opposition from the health care industry. Additionally, provider participation in these plans is

voluntary. This is a great risk to the plan because enrollees may be subject to narrow provider networks which could decrease the likelihood of wide enrollment interest. The bill also stipulated that reimbursement rate and aggregate spending caps could be lifted if the insurer cannot form a robust provider network using the proposed rates (Wynne, 2019). This stipulation combined with voluntary provider participation may greatly thwart the Washington public option's affordability, provider network and overall enrollment. Washington State's public option is an important lesson in the power of the health care industry's opposition to cost-saving reforms like low reimbursement rates and greater regulation. Because the program is at the state level, the government has less leverage to impose these regulations. With a national public option tied to Medicare, a program providing millions of patients and their dollars to providers, the government is in a better position to implement these cost-saving reforms.

Germany

Currently, no other country has the exact healthcare system structure that the U.S. has either with or without a public option (The Commonwealth Fund, n.d.). However, other countries with multi-payer systems in at least part of their infrastructure use a model that has features like the public option outlined in this paper. Models like this, in countries of similar economies and size to us, can illuminate potential features the U.S. may or may not want to include in a government-regulated healthcare plan.

In Germany's multi-payer healthcare system consumers have choice over how they obtain coverage but are required to enroll in health coverage, achieving universal healthcare for the country. Citizens are required to obtain coverage through competitive nonprofit funds called "sickness funds" unless their income is above a certain threshold.

Individuals equally share contributions to their sickness funds with their employer at a government-regulated contribution rate based on the percentage of one's gross wages. Everyone in a fund pays a premium, but higher-income citizens pay more, and lower-income citizens pay less. These sickness funds are primarily financed through enrollee contributions but also through payroll taxes. Higher-income citizens also have the choice to purchase private insurance to either supplement their social insurance or replace it. Those who want a more rigorous set of services covered on their plan and lower premiums, usually higher-income young people, tend to choose private insurance in Germany (Blümel & Busse, n.d.). In 2017, about 70 million Germans were enrolled in a sickness fund out of Germany's 81.2-million-person total population ("German Healthcare Statistics", 2019). While Germany requires citizens to obtain coverage and sets robust cost-containment requirements, the system is made up of self-regulating private firms who directly control financing and care delivery. Germany's healthcare system proves that a decentralized healthcare system can achieve positive outcomes while still imposing cost-containing regulations. Over the past 140 years, life expectancy has been steadily increased in Germany and is now two years higher than the OECD average ("German Healthcare Statistics", 2019). For the U.S., where choice is highly valued, Germany can be a great example of how to give consumers choice while achieving universal coverage.

Japan

Like Germany, Japan also has a strong multi-payer system that requires citizens to obtain coverage while regulating prices. Japan achieved universal health coverage through their Statutory Health Insurance System (SHIS). Citizens are required to enroll

in a SHIS plan that is funded by taxes, enrollee premiums and additional user charges. Employed individuals help fund the system solely through payroll taxes whereas self-employed individuals pay a premium based on their income. Additionally, the government sets enrollee payment rates and enrollees typically pay for thirty percent of the costs of the services they access (Matsuda, n.d.). The Japanese government also sets provider reimbursement rates and provides support to insurers and providers through subsidies. To adjust for healthcare spending increases, the set fee schedule is reevaluated every two years (Ruggles, Xiong & Kyle, 2015). Private insurance also has a role in this system but it only provides people with supplemental coverage. Unlike in the U.S., Japan's private insurers are not allowed to advertise or make a profit. Japan's healthcare system has not only achieved universal coverage with this model but also has the highest life expectancy of all OECD countries while only spending about as much as the average OECD country on total healthcare costs (Organisation for Economic Co-operation and Development, 2017). Japan's model can illuminate the importance of a strong regulatory force in setting payment rates to contain costs and increase positive health outcomes.

4.6 The Optimal Time for the American Public Option is Now

While the public option proposed at the beginning of this chapter is not designed like Washington State's program or Japan and Germany's healthcare systems, it is the most effective solution to the unique problems the American healthcare system is facing in 2020. The best time for a publicly available, nationally run and cost-controlled healthcare option for Americans is now primarily because of current low coverage rates, particularly for low- and modest-income people. Additionally now is the optimal time

for a public option because of strong public opinion and high unemployment rates stemming from the COVID-19 pandemic.

Public Opinion

According to a 2019 New England Journal of Medicine article, over 75% of Americans believe they are paying too much for their healthcare relative to the quality they receive (Harvard T.H. Chan School of Public Health, 2019). Because so many are frustrated with the healthcare system's high prices and experience poor health outcomes, healthcare reform has taken a central role in the current political discourse. Democratic campaigns for the 2020 presidential election have largely focused on healthcare reform with 83% of Democratic voters deeming it their most important political priority (Kirzinger, Muñana & Brodie, 2019). While prominent presidential candidates Senator Bernie Sanders and Congresswoman Elizabeth Warren gained popularity through their promise to implement Medicare-for-All, a single-payer healthcare system proposal that enrolls all Americans with no cost-sharing, both have ended their campaigns in the 2020 presidential race. The sole candidate left in the race, former Vice President Joe Biden, calls to fix the healthcare system with a public option or "The Biden Plan to Protect & Build on the Affordable Care Act". Biden proposes increasing coverage rates, reducing consumer costs and preserving choice through his plan, which is similar to the plan outlined in this thesis. While numerous factors led to Biden's status as the Democratic frontrunner, his standing as the last Democratic candidate in a race dominated by healthcare issues shows that the public option is becoming a mainstream idea in the health reform policy debate. Furthermore, data from the Kaiser Family Foundation has found that overall support for a public option from

both conservative and liberal stakeholders has risen from 47% in 2009 (Kaiser Family Foundation, 2009) when one was first proposed to 65% of voters in 2019 (Kirzinger et al., 2019).

While favorable opinions toward a public option from conservative stakeholders are still somewhat low, with only 42% of Republicans in 2020 favoring a public option versus 85% of Democrats (Lopes, Hamel, Kearney & Brodie, 2020), additional data from the Kaiser Family Foundation in 2019 has found that the opinions of both stakeholders largely swayed when the polls used language like “greater competition” and “more choice” (Kirzinger et al., 2019). The study showed that if the respondents were asked if they would better support a public option if it drove down costs due to competition with the private market, support grew to 75% of all respondents. If asked if they would better support the public option if it would provide more choice in coverage options, support grew to 74% of all respondents. Support from across the political spectrum fell to 40% when told the public option would lead to heavy government involvement in the healthcare market. These studies indicate that Americans value choice in their healthcare but support the competition and cost-savings that a public option could introduce, with overall support rising about 20 percentage points since the last introduction of a public option in legislation 10 years ago. Keeping enrollment in the public option a choice rather than a mandate will significantly increase its popularity in public opinion as well as its likelihood to pass in Congress. Despite this, if people do not choose to enroll in the public option at high rates, people who do enroll will face more expensive enrollee costs than anticipated. If enrollee costs are too high, this will further discourage enrollment and potentially force the public option out of the market.

Policymakers must consider ways to simultaneously keep enrollment optional while also making it an appealing coverage choice in the healthcare market. Overall, a public option best serves current public interests for reform issues like building off the ACA, providing better competition in the market to bring down prices and preserving coverage choice.

Unemployment Rates and COVID-19

Additionally, the COVID-19 pandemic affecting not only millions of people's physical health but people's livelihoods has illuminated prominent flaws in the current healthcare system. The federal and state governments' stay-at-home advisories, aimed at flattening the curve of the virus in order to keep hospitals from becoming overburdened, have created an unfortunate situation for many Americans who have lost their jobs due to not being able to work from home. As of April 30, 2020, more than 30 million jobs have been lost due to the pandemic (Tappe, 2020), exceeding the 15 million jobs lost during the eighteen-month Great Recession (Rainey & Forgey, 2020) when former president Barack Obama came into office and was able to pass comprehensive health reform. Because of this extreme joblessness, economic forecasting predicts unemployment rates will soon exceed the record 25% seen during the Great Depression in the early 20th century. Because 49% of the population obtains health coverage through their employer (Kaiser Family Foundation, 2020a), long-term joblessness and sustained unemployment rates will drastically affect health coverage rates. While people can hold on to their health coverage upon losing their job because of the Consolidated Omnibus Budget Reconciliation Act (COBRA), some may not be able to afford this option because it stipulates that the consumer has to pay the full price of

their previous premium without the contribution of their employer. The current pandemic is highlighting a need to move away from a system where one's health coverage is tied to their employer.

Additionally, according to data from the Pew Research Center, 43% of all U.S. adults reported in late April that they or someone in their household has lost a job or experienced extreme pay cuts due to COVID-19 with the number rising to 52% when isolating low-income groups (Parker, Horowitz & Brown, 2020). This is particularly concerning when considering the correlation between low-income status and not having health coverage (America's Health Rankings, 2020). Healthcare reform that can address these coverage gaps will be in high demand as the aftermath of COVID-19 unfolds.

The public option can adequately address these issues because it will automatically enroll in coverage low-income individuals living in states that did not expand Medicaid as well as those who file for unemployment benefits. Additionally, political leaders may find it easier to pass comprehensive healthcare reform because of COVID-19's effects on joblessness and health. Former President Obama achieved healthcare reform very progressive for its time in a more economically stable period than the U.S. is in now. The unstable economic situation currently facing Americans will continue to elevate progressive healthcare reform as the top issue affecting voters. Furthermore, the lack of adequate COVID-19 testing (Rosenthal, 2020) taking place to combat the virus has illuminated how the U.S. does not prioritize preventative care. Implementing a public option moves the U.S. closer to universal healthcare where more people can access preventative care despite their income level.

Chapter 5: Potential Shortcomings of This Analysis and Conclusions

While the public option is the best healthcare reform option for the United States right now because of the current political and healthcare climates, it may face barriers in successfully being implemented. These barriers relate primarily to lobbying but also to public opinion both from liberal and conservative stakeholders. This chapter will discuss some potential shortcomings of the reform to consider.

5.1 Potential Shortcomings of the Public Option

Healthcare Industry Lobbying

The public option may face heavy opposition from healthcare industry lobbyists and interest groups representing physicians, hospitals, and private insurers. The public option stipulates that Medicare providers must accept public option patients, that provider reimbursement rates be set at Medicare levels and that private insurers will have to compete with a price-regulated plan. While these aspects are necessary for the public option to succeed, powerful stakeholders may influence the public option's final design. For example, in Washington State's public option, provider participation is voluntary because of heavy opposition from the healthcare industry. However, if tying provider participation to Medicare threatens the likelihood of the public option passing into law, policymakers may consider an opt-out option for provider participation. With this design, providers who accept Medicare would be automatically enrolled in the public option provider network but would be able to opt-out if they choose to do so. Behavioral economic studies suggest that individuals are more likely to participate in a

program if they are automatically enrolled even if opting out is a seamless process (Kaplan & Rodgers, 2009). To avoid a narrow provider network while also paying mind to criticisms about mandatory participation, policymakers may consider using an automatic enrollment/opt-out design feature for provider participation in the public option.

Washington's public option is also using a provider reimbursement rate at 135% of Medicare levels rather than utilizing exact Medicare rates. This feature is similarly a result of industry lobbying. Critics of the public option say that using Medicare rates will drive out all private insurers from the market as they struggle to compete. While increased competition in the market will likely encourage private insurers to improve on pricing, service and quality, some contend that private insurers will never be able to compete with price-regulated rates and they will leave the market (Pipes, 2019). As a result, compromising on rates above Medicare rates that still provide competition but also keep industry players in the market may need to be considered.

Critics of the public option may also argue that hospitals will make up for losses resulting from the public option's price-regulated rates by shifting costs to patients using private insurance. If this were true, private insurers would likely be driven out of the market over time. Despite some assertions that hospitals do this to counteract low Medicare reimbursement rates (Roy, 2019), a study conducted by health economist Austin Frakt analyzing hospital cost-shifting patterns from 1996-2011 and found that cost-shifting rarely occurs due to public payment changes, and when it does occur it is on miniscule levels (Frakt, 2011). The study found that when private payment rates rise, cost-shifting is only a small part of the explanation whereas "simultaneous changes in

market power will likely explain the rest” (2011). If a hospital is fully maximizing profits and exploiting its market power, the conditions under which cost-shifting can occur will not be present. Based on his data, Frakt predicts that if cost-shifting occurs at higher rates in the future, then the rate will be close to 20 cents for every dollar rather than the dollar-for-dollar rate that healthcare industry officials have claimed. Rather than shift costs to private enrollees, price-regulated payment rates may squeeze out administrative bloat in the hospital system making up for 20% of all healthcare costs (Hackbarth, 2012).

Public Opinion from Liberal Stakeholders

Critics of the public option may also contend that the plan does not achieve universal healthcare because it does not extend guaranteed coverage to every American. Most industrialized countries of similar size and economy to the U.S., like the United Kingdom, Canada and Japan, guarantee 100% of their citizens will have access to core health services (Organisation for Economic Co-operation and Development, 2019b). Despite the public option being the best option for American healthcare reform right now, many Americans support moving to a progressive Medicare-for-All system that would guarantee universal healthcare like many other industrialized countries in the world. However, American voters from both the right and left of the political aisle highly value choice and competition (Kirzinger, 2019). Additionally, estimates from the Committee on a Responsible Federal Budget suggest that a substantial increase in high-income tax rates would only cover about 40% of the cost of Medicare-for-All (2019). They suggest that additional Medicare-for-All funding would need to come from taxes on the middle class. Data from the Kaiser Family Foundation found that public support

for Medicare-for-All significantly falls when respondents learn it will increase their taxes (Kaiser Family Foundation, 2020f). While the public option does not guarantee universal healthcare guarantee, it will increase coverage for millions of Americans and serve as a stepping stone to greater reforms, like Medicare-for-All.

It is also important to note that in her presidential bid Congresswoman Elizabeth Warren proposed Medicare-for-All with a transition period where a public option-like Medicare buy-in would be implemented into the system. Other past presidential candidates in the 2020 race, like Senator Amy Klobuchar and entrepreneur Andrew Yang, advocated for the importance of universal healthcare but also promoted a public option as a stepping stone or transitional program to something like Medicare-for-All. If the public option achieves its intended goals and is popular with consumers, policymakers can consider automatically enrolling all citizens onto the plan. The public option puts the U.S. healthcare system on the right path toward greater coverage rates and lower prices.

Public Opinion from Conservative Stakeholders

Some critics of the public option also contend that it will raise taxes because it cannot fully self-sustain with enrollee premiums. The likelihood of a successful self-sustained funding model greatly increases if the public option has a large and relatively stable risk pool. To increase the likelihood of a stable risk pool, automatic enrollment for the previously mentioned groups as well as a wide provider network connected to Medicare need to be a part of the public option's final design. If these features are not included, additional taxes may be needed to fund the program. This will raise complications because many Americans do not support paying higher taxes to fund

healthcare programs (Kaiser Family Foundation, 2020f). Policymakers may need to innovate and consider alternative funding mechanisms if financing the public option with increased taxes faces significant opposition.

5.2 Conclusions

The United States healthcare system needs comprehensive reform. Among OECD countries, the U.S. spends the most on healthcare (Organisation for Economic Co-operation and Development, 2019a), has increased disease burden (Institute for Health Metrics and Evaluation, 2018) and is one of the only countries without universal coverage with over 30 million Americans uninsured in 2018 (Centers for Disease Control and Prevention, 2020). Low-income people are particularly burdened by the current healthcare system's flaws as they are living in states that did not expand Medicaid and are most likely to be uninsured (America's Health Rankings, 2020). Medical debt is also the most common reason people file for bankruptcy in this country (Himmelstein, Lawless, Thorne, Foohey & Woolhandler, 2019). People with modest incomes are also negatively affected by the current system's structure because they could make too much to qualify for public programs, but too little to afford private insurance. Additionally, people who secure healthcare through their employer may be particularly burdened by the current healthcare system's structure as the COVID-19 pandemic threatens peoples' livelihoods.

These issues illuminate the fact that the U.S. needs to add a publicly available, cost-controlled and nationally run healthcare option that builds on what the system has that works and resolves what it has that does not. The public option will have provider reimbursement rates and provider networks tied to Medicare, a self-sustained financing

model with the availability of premium tax credits and availability of the plan to all with automatic enrollments for select groups. Americans have long been demanding more competition and choice, lower prices and increased access to quality coverage in their healthcare system. The public option is the best way to meet these demands.

In addition to presidential candidate proposals for a public option, recently seven different public option bills have been introduced in Congress (Neuman, Pollitz, Tolbert, Rudowitz & Koma 2019). These bills all propose the introduction of a federal public option but vary in their specific design. The Keeping Health Insurance Affordable Act of 2019, introduced by Senator Ben Cardin, proposes limiting enrollment to marketplace-eligible individuals. The Medicare-X Choice Act of 2019, introduced by Senators Michael Bennet and Tim Kaine, proposes increasing provider reimbursement rates to 25% above Medicare level in rural areas. The Medicare for America Act of 2019, introduced by Congresswoman Rosa DeLauro, proposes eliminating premiums and cost-sharing for low-income enrollees in addition to eliminating Medicare, Medicaid and non-group insurance so the only coverage options are the public option and employer-based group coverage. These varying interpretations of the public option show how future policymakers can design their own version of the public option with a unique approach to solving current issues. At the core of the public option, it is healthcare reform that liberates consumers from the current system that confines them to low-quality coverage options. However policymakers decide to implement a public option, any variation of a publicly-run plan introduced into the market will set a precedent to empower the American citizen to be able to make the coverage choice best for them.

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