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**Status of U.S. Health Insurance Coverage and Policy Levers to Expand Coverage and Lower Consumer Costs**

Sara R. Collins, Ph.D.  
Vice President, Health Care Coverage and Access  
The Commonwealth Fund  
One East 75th Street  
New York, NY 10021  
[src@cmwf.org](mailto:src@cmwf.org)

Invited Testimony

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# **Status of U.S. Health Insurance and Policy Levers to Expand Coverage and Lower Consumer Costs**

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## **EXECUTIVE SUMMARY**

Thank you, Chairwoman Maloney, Ranking Member Comer, and Members of the Committee, for this invitation to testify today on pathways to universal coverage in the United States. My comments will focus on the national gains in health insurance coverage since the passage of the Affordable Care Act (ACA), the effects of the pandemic and COVID-19 relief efforts on coverage, and potential policy levers to cover the remaining uninsured and lower consumer costs.

### **ACA Reduced the Number of Uninsured Americans and Lowered Financial Barriers to Care**

The ACA brought sweeping change to the U.S. health system, expanding comprehensive, affordable health insurance to millions of lower-and middle-income Americans and making it possible for anyone with health problems to buy health insurance by banning insurers from denying people coverage or charging them more because of preexisting conditions.

The number of uninsured people in the United States has fallen by nearly half since the ACA was signed into law, dropping from a historical peak of 48.6 million people in 2010 to a low of about 28 million in 2016. There was a slight uptick in the number of uninsured after that through 2020.

A large body of research on the effects of the ACA show conclusively that the law lowered financial barriers to care and improved people's ability to afford health insurance and get needed health care.

## **ACA and COVID-19 Federal Relief Efforts Prevented Widespread Coverage Losses During the Pandemic**

Despite expectations that the COVID-19 pandemic would leave millions more people uninsured, the latest federal data indicate that the uninsured rate in the under-65 population actually declined. This improvement in coverage is tied to four factors:

- employer coverage losses were low in part because the hardest hit economic sectors had rates of employer coverage that were low relative to other sectors;
- the ACA's coverage expansions provided safety-net coverage for people who lost their insurance
- federal COVID-19 relief bills provided substantially enhanced subsidies for marketplace coverage and increased federal matching funds for state Medicaid programs as long as states that accepted the funds kept people continuously enrolled in Medicaid
- special-enrollment periods and a significant increase in outreach and advertising efforts by the Biden–Harris administration and some state governments to get people covered.

These policy changes led to record enrollment of 15 million in the marketplaces by January 2022 and nearly 84 million in Medicaid and the Children's Health Insurance Program in 2021.

### **Risks to Coverage and Affordability Improvements**

There are four risk factors that will limit ongoing improvements in the uninsured rate and ability of Americans to afford health insurance and health care:

- the end of public health emergency (PHE) and the American Rescue Plan Act's (ARPA) enhanced subsidies could trigger extensive enrollment losses in Medicaid and the marketplaces by 2023
- 12 states have yet to expand eligibility for Medicaid under the ACA
- millions are eligible for ACA coverage expansions but not enrolled
- growth in health care costs is outstripping growth in median income leaving millions of people underinsured and with growing premium burdens.

## **End of the PHE and the ARPA Marketplace Subsidy Enhancements Could Trigger Enrollment Losses**

Policy options to prevent millions of people from becoming uninsured as the COVID-19 relief provisions end, include:

- *Extend the ARPA marketplace tax credit enhancements*, as proposed in the Build Back Better Act (BBBA).
- *Requiring states to conduct Medicaid eligibility redeterminations gradually*. The BBBA limits monthly redeterminations to a fraction (1/12) of the total participants.
- *Longer term, Congress could make it easier for people to maintain Medicaid eligibility*. For example, through legislation that would give states a continuous eligibility option, as for children in Medicaid and the Children's Health Insurance Program (CHIP).

## **Twelve States Have Not Yet Expanded Medicaid**

To help the estimated 2.2 million uninsured people caught in the coverage gap in the 12 states that have not expanded Medicaid, the federal government could:

- *Provide a federal fallback option for Medicaid coverage* as proposed in the BBBA, with fully subsidized marketplace coverage for people eligible for Medicaid in states that have yet to expand them.

## **Millions of Uninsured People Are Eligible for Marketplace Coverage or Medicaid But Not Enrolled**

About three-quarters of the remaining uninsured are likely eligible for existing sources of private and public coverage but not enrolled. In addition to extending the ARPA subsidies and the Medicaid continuous eligibility policy, policy options to cover those eligible include:

- *Maintain aggressive, targeted, and consistent outreach and enrollment efforts to reach the remaining uninsured and keep people covered..*
- *Develop an autoenrollment mechanism to allow for seamless coverage in comprehensive health coverage.*

## **Health Care Costs Are Rising Faster than Median Income, Leaving Millions Underinsured and with Premium Burdens**

Policy options to reduce underinsurance and the growing premium and deductible burdens among people with commercial insurance include:

- *Address the high provider prices that are the primary driver of health spending in commercial insurance, and by extension, the primary driver of worker premium contributions and deductibles, for instance, through the introduction of a public insurance option to the marketplaces as proposed in several congressional bills.*
- *Allow more workers in expensive employer health plans to become eligible for subsidized marketplace plans. The BBBA lowers the employer premium affordability threshold from 9.8 percent of income to 8.5 percent of income.*
- *Fix the “family coverage glitch” so that the 5 million people who are eligible for expensive family employer plans may access subsidized marketplace plans.*
- *Rein in deductibles and out-of-pocket costs in marketplace plans. A bill introduced by Senator Jeanne Shaheen (D–N.H.) would raise the cost-protection of the marketplace benchmark plan and make more people eligible for cost-sharing subsidies.*
- *Ban non-ACA compliant policies like short term plans that leave consumers exposed to catastrophic medical costs and increase marketplace premiums.*
- *Impose stronger consumer protection rules for medical debt collection such as grace periods following illness or during appeals processes and ban egregious hospital practices such as suing patients, garnishing their wages, or placing liens on their homes.*

## **Two Comprehensive Paths to Universal Coverage: Building on the ACA and Single Payer**

What approach will finally get the nation to universal coverage? Can it be achieved by building on the ACA? Or will it take a single-payer approach?

The Urban Institute tackled this question in 2019, when health insurance expansion was being hotly debated during the presidential election. They modeled a set of reforms that built on the ACA, and two versions of a single-payer approach — a “lite” version, as well as an “enhanced” one that includes more generous benefits like long-term care coverage. The ACA approach included a set of reforms similar to the targeted policies discussed in this testimony, combined with autoenrollment and a public option that lowered provider prices close to

Medicare rates. Urban found that it was possible to reach near-universal or universal coverage with any of the three approaches.

The researchers also found that both the ACA approach and the “lite” single-payer approach reduced national health expenditures, even though nearly everyone is covered. This is because both approaches address the primary driver of commercial health care spending: prices paid to providers by commercial insurers and employers. The ACA approach achieves this through a public plan option offered through the marketplaces; the single-payer approach does it through a single public plan for everyone. The enhanced single-payer approach leads to an increase in national health spending because it insures everyone with more benefits, especially long-term care benefits.

What captured headlines during the election, however, was not the fact that universal coverage achieved through either approach could actually lower U.S. health care spending, but that the cost to the federal government mushroomed under a single-payer approach. But what commentators failed to point out was that the extra cost to the federal government was not because the approach was so much more expensive than our current system, but because nearly all the responsibility for financing would shift away from employers, households, and states to the federal government.

We need to have reasonable discussions as a country about how to share our health care spending responsibilities. But it is not just about *who* pays but also about *how much* we pay and *why*, and *what* we are getting for our spending. We spend far more of our GDP on health care than other high-income countries, but rank last on most measures of health system performance, including access to care. Research points to prices paid to providers in private insurance as the primary reason we spend so much more. By focusing only on *who* pays, the debate during the 2020 election missed an important opportunity to educate the public about the drivers of health care spending, and, in particular, why middle-income households feel increasingly squeezed by their health insurance and health care costs.

Looking forward, as we consider strategies to expand health insurance coverage and lower consumer costs and weigh the benefits of those strategies against federal costs, it is critical that the prices paid to providers in private insurance be part of the discussion.

Thank you.

## **Status of U.S. Health Insurance Coverage and the Potential of Recent Congressional Health Reform Bills to Expand Coverage and Lower Consumer Costs**

**Sara R. Collins, Ph.D.**  
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Thank you Chairwoman Maloney, Ranking Member Comer, and Members of the Committee, for this invitation to testify on pathways to universal coverage in the United States. My comments will focus on the national gains in health insurance coverage since the passage of the Affordable Care Act (ACA), the effects of the pandemic and COVID-19 relief efforts on coverage, and potential policy levers to cover the remaining uninsured and lower consumer costs.

### **ACA Reduced the Number of Uninsured Americans and Lowered Financial Barriers to Care**

The ACA brought sweeping change to the U.S. health system, expanding comprehensive, affordable coverage options to lower-and middle- income Americans through a newly regulated and subsidized individual market and expanded eligibility for Medicaid. The law's provisions also made it possible for people with health problems at all income levels to buy health insurance on their own by banning insurers from denying people coverage or charging them more because of preexisting conditions. The law's elimination of cost-sharing for a growing number of preventive services and immunizations, including COVID-19 vaccines, has benefited more than 150 million people with private insurance.<sup>1</sup>

The number of uninsured people in the United States has fallen by nearly half since the ACA was signed into law, dropping from a historical peak of 48.6 million people in 2010 to a low of about 28 million in 2016 (Exhibit 1).<sup>2</sup> There was a slight uptick in the number of uninsured after that through 2020.<sup>3</sup> Still, had the ACA not passed, the Congressional Budget

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<sup>1</sup> Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, [Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act](#), (HHS/ASPE, Jan. 2022)

<sup>2</sup> Robin A. Cohen, Emily P. Terlizzi, and Michael E. Martinez, [Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2018](#). (National Center for Health Statistics), May 2019

<sup>3</sup> Robin A. Cohen, Emily P. Terlizzi, Amy E. Cha, and Michael E. Martinez, [Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2020](#) (National Center for Health Statistics, August 2021).



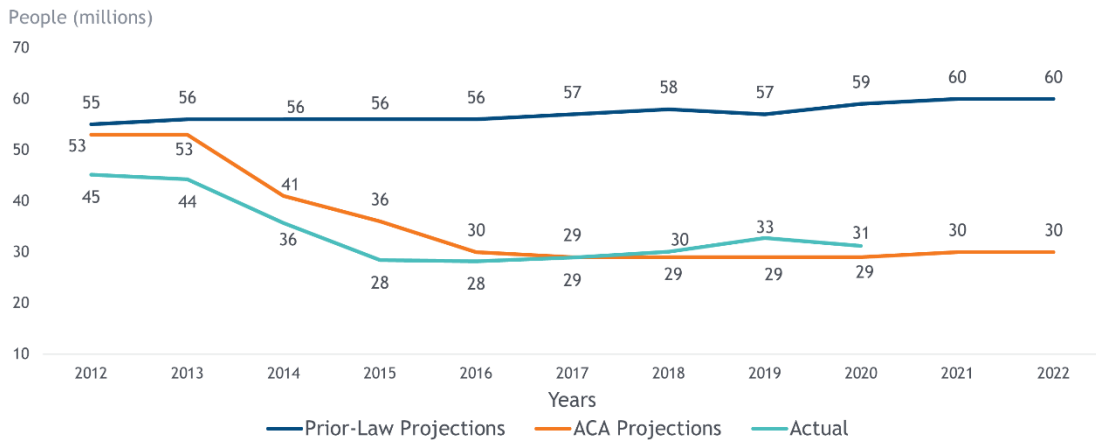
Office forecasts from 2012 projected that 60 million people would have been uninsured by 2022.

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EXHIBIT 1

## The ACA reduced the number of uninsured by half, compared to projections had the law not passed

Projected insurance coverage and the actual number of uninsured nonelderly people, 2012–2022



Notes: Shown are the CBO's projections of health insurance coverage for the nonelderly population (in millions) prior to the ACA and after the implementation of the law, as well as the actual number of uninsured nonelderly persons over time from the National Center for Health Statistics. The dependent coverage provision went into effect in September 2010. The major coverage expansions went into effect in January 2014, including the Medicaid expansion, marketplaces and subsidies, and the individual mandate penalty.



Source: Congressional Budget Office. [Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision](#), July 2012.  
National Center for Health Statistics. [Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2018](#). May 2019; [Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2020](#). August 2021.

A large body of research on the effects of the ACA show conclusively that the law lowered financial barriers to care and improved people's ability to afford health insurance and get needed health care.<sup>5</sup> Research has also suggested that the law's coverage expansions have

<sup>4</sup> Congressional Budget Office, [Estimates for the Insurance Coverage Provisions of the ACA](#), 2012.

<sup>5</sup> Sherry A. Glied, Sara R. Collins, and Saunders Lin, "[Did the ACA Lower Americans' Financial Barriers to Health Care?](#)" *Health Affairs* 39, no. 3, March 2020; Benjamin D. Sommers et al., "[Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults](#)," *Health Affairs* 36, no. 6 (June 2017); Olena Mazurenko et al., "[The Effects Of Medicaid Expansion Under The ACA: A Systematic Review](#)," *Health Affairs* 37, no. 6 (June 2018); Munira. Z. Gunja, Sara R. Collins, and Harman K. Bhupal, [Is the Affordable Care Act Helping Consumers Get Health Care?](#) (Commonwealth Fund, Dec. 2017); Sara R. Collins et al., [Americans' Experiences with the ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction](#), (Commonwealth Fund, May 2016); Sara R. Collins, Petra W. Rasmussen, and Michelle M. Doty, [Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period](#), (Commonwealth Fund, July 2014).

been associated with improvements in health status, chronic disease, maternal and neonatal health, and mortality and that these improvements will grow over time.<sup>6</sup>

### **ACA and COVID-19 Federal Relief Efforts Prevented Widespread Coverage Losses During the Pandemic**

Contrary to expectations that the economic fallout from the COVID-19 pandemic would upend insurance coverage, leaving millions more uninsured, the latest federal data indicate that the uninsured rate in the under-65 population dropped from a pandemic peak of 12.3 percent in the fourth quarter of 2020 to 10.7 percent in the third quarter of 2021 (Exhibit 2). These improvements in coverage are tied to four factors:

- the hardest hit economic sectors had rates of employer-based coverage that were low relative to other sectors<sup>7</sup>
- the ACA’s coverage expansions provided a safety-net coverage option for people who lost their insurance
- federal COVID-19 relief bills provided substantially enhanced subsidies for marketplace coverage and increased federal matching funds for state Medicaid programs as long as states that accepted the funds kept people continuously enrolled in Medicaid
- special-enrollment periods and a significant increase in outreach and advertising efforts by the Biden–Harris administration and some state governments to get people covered.

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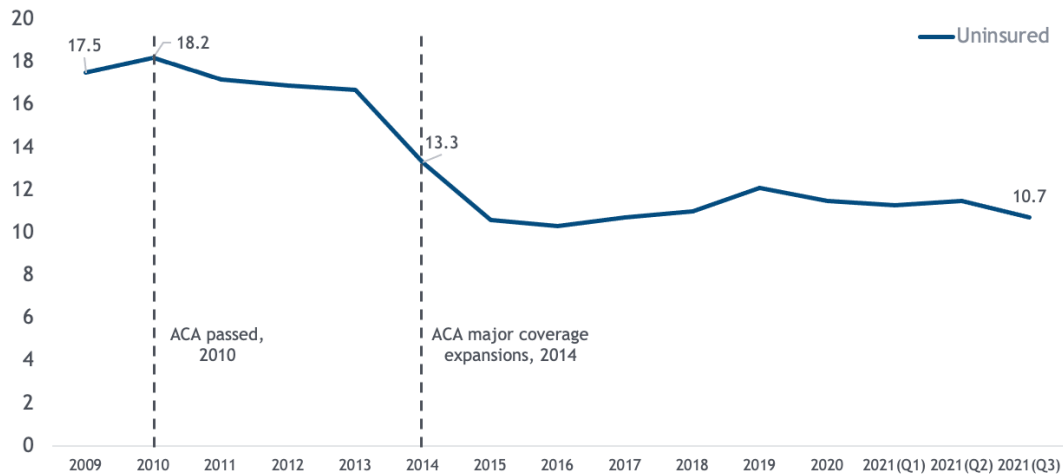
<sup>6</sup> Aparna Soni, Laura R. Wherry and Kosani I. Simon, “[How Have ACA Insurance Expansions Affected Health Outcomes? Findings from the Literature](#),” *Health Affairs* 39, no. 3 (March 2020); Benjamin D. Sommers, Atul A. Gawande, Katherine Baicker, “[Health Insurance Coverage and Health – What the Recent Evidence Tells Us](#),” *New England Journal of Medicine* 377, no. 6 (Aug. 2017): 586-593.

<sup>7</sup> Paul Fronstin and Stephen A. Woodbury, [How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?](#), (Commonwealth Fund, Oct. 2020); Sara R. Collins, Gabriella N. Aboulaflia, and Munira Z. Gunja, [As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.? Findings from the Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021](#), (Commonwealth Fund, July 2021).

## EXHIBIT 2

# The uninsured rate fell over the course of the pandemic

Percent of individuals under 65 years of age without health insurance, 2009-2021



Source: Cohen RA, [Long-term trends in health insurance: Estimates from the National Health Interview Survey, United States, 2009-2018 \(Table 1\)](#), National Center for Health Statistics. July 2019.  
National Center for Health Statistics, [Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2020](#), August 2021; [Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, July 2020-September 2021](#), January 2022.



The combined effects of the American Rescue Plan Act’s (ARPA) enhanced marketplace subsidies, a special-open enrollment period that lasted through mid-August 2021, and investment in outreach and advertising led to a record nearly 15 million people enrolled in marketplace plans by January 2022.<sup>8</sup> The Families First Coronavirus Response Act’s (FFCRA) state requirements to keep people enrolled in Medicaid through the end of the public health emergency (PHE) in exchange for enhanced matching funds led to a record increase in Medicaid enrollment of 13 million from February 2020 through July 2021 pushing up total enrollment in Medicaid and the Children’s Health Insurance Program (CHIP) to 83.6 million .<sup>9</sup>

<sup>8</sup> Katie Keith, “[Marketplace Enrollment Reaches New Record Of 14.5 Million](#),” *Health Affairs Blog*, Jan. 31, 2022.

<sup>9</sup> Manatt Health, “[Medicaid Enrollment Trends During the COVID-19 Pandemic](#),” March 2022.

## **Risks to Coverage and Affordability Improvements**

There are four risk factors that stand in the way of achieving ongoing improvements in the uninsured rate and the ability of Americans to afford health insurance and health care:

- the end of PHE and the ARPA enhanced subsidies could trigger extensive enrollment losses in Medicaid and the marketplaces by 2023
- 12 states have yet to expand eligibility for Medicaid under the ACA
- millions of people are eligible for ACA coverage expansions but are not enrolled
- growth in health care costs is outstripping growth in median income, leaving millions of people underinsured and with growing premium burdens.

I discuss each of these in turn and suggest policy options that might mitigate them.

### **The End of the PHE and the ARPA Marketplace Subsidy Enhancements**

The end of the PHE will trigger the end of the enhanced federal matching funds for state Medicaid programs and the continuous enrollment requirement for states. The Biden–Harris administration released guidance to states in March, giving them 14 months to complete their coverage redeterminations for people currently enrolled in Medicaid.<sup>10</sup> It is widely anticipated that some states will take the full amount of time and proceed carefully, aiding people who lose Medicaid to find alternative coverage. Other states will be more eager to reduce their caseloads and proceed quickly, raising the risk of disenrolling people actually still eligible and providing limited assistance to help those no longer eligible find other coverage. The Urban Institute estimates that nearly 15 million people could disenroll from the program.<sup>11</sup> This will likely lead to a temporary or permanent uptick in the uninsured rate nationally.

The ARPA marketplace premium tax credit enhancements will end this year, reverting marketplace subsidies to their pre-pandemic lower levels for the 2023 marketplace open-enrollment period. Commonwealth Fund surveys have consistently found that the main reason people give for either not enrolling in a marketplace plan or dropping marketplace coverage is

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<sup>10</sup>Centers for Medicare and Medicaid Services, “[Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children’s Health Insurance Program \(CHIP\), and Basic Health Program \(BHP\) Upon Conclusion of the COVID-19 Public Health Emergency](#),” State Health Official letter, March 3, 2022.

<sup>11</sup> Matthew Buettgens and Andrew Green, [What will Happen to the Unprecedented High Medicaid Enrollment After the Public Health Emergency?](#), (Urban Institute, Sept. 2021).

expensive premiums.<sup>12</sup> It is possible that marketplace enrollment levels could drop to pre-pandemic levels in 2023, sending the uninsured rate higher.

Policy options:

- *Extend the ARPA marketplace tax credit enhancements*, as proposed in the Build Back Better Act (BBBA).<sup>13</sup>
- *Require states to conduct Medicaid eligibility redeterminations gradually*. The BBBA, for example, limited monthly redeterminations to a fraction (1/12) of the total participants.<sup>14</sup>
- *Longer term, make it easier for people to maintain Medicaid eligibility*. The average length of enrollment in Medicaid is less than 10 months, reflecting frequent eligibility redeterminations, periodic checking by some states, and insufficient time provided to enrollees to provide appropriate documents.<sup>15</sup> Federal policymakers could apply lessons learned during the PHE to keep people enrolled longer and reduce the administratively costly enrollment “churn” off and on Medicaid. For example, Congress could pass legislation that would give states a continuous eligibility option, like for children in Medicaid and the Children’s Health Insurance Program (CHIP), which would allow redetermination of eligibility once a year, regardless of changes in eligibility. States that have taken this option have lower uninsured rates and churn rates among children.

### **Twelve States Have Not Yet Expanded Medicaid**

Eight years after it became possible, 12 states, mostly in the southeast, including the heavily populated states of Florida and Texas, have yet to expand eligibility for Medicaid under the ACA.<sup>16</sup> In these states, nearly 6 million people with incomes under 100 percent of the federal

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<sup>12</sup> Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, [U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability— Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020](#) (Commonwealth Fund, Aug. 2020).

<sup>13</sup> Timothy S. Jost, “[How the Build Back Better Bill Would Improve Affordable Care Act Coverage](#),” *To the Point* (blog), Commonwealth Fund, Jan. 19, 2022.

<sup>14</sup> Leighton Ku and Erin Brantley, “[What Are the Economic and Employment Consequences of Phasing Down Medicaid Enrollment After the Public Health Emergency Ends?](#),” *To the Point* (blog), Commonwealth Fund, Mar. 14, 2022.

<sup>15</sup> Sarah Sugar et al., [Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic](#), (HHS/ASPE, April 2021).

<sup>16</sup> Alabama, Florida, Georgia, Mississippi, Nebraska, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, Wyoming.

poverty level are uninsured.<sup>17</sup> Among those, 2.2 million fall into the “coverage gap”, that is, eligible for neither their states’ Medicaid program nor marketplace subsidies.<sup>18</sup> Those in this coverage gap are disproportionately Black and Latinx.<sup>19</sup>

Policy options:

- *Federal fallback option for Medicaid coverage.* The BBBA proposes to fill the coverage gap with federal, fully subsidized marketplace coverage for people eligible for Medicaid in states that have yet to expand the program.<sup>20</sup> There would be very little cost-sharing (99% actuarial value) starting in 2023 and the coverage would also cover nonemergency medical transportation and family-planning services. The Urban Institute estimates that a fallback option would reduce the number of uninsured people by 4.1 million, the same as if all 12 states were to expand.<sup>21</sup>

### **Millions of Uninsured People Are Eligible for Marketplace Coverage or Medicaid but Not Enrolled**

An analysis by the Assistant Secretary of Planning and Evaluation (ASPE) of pre-pandemic federal data found that the vast majority of uninsured people under age 65 were eligible for existing sources of coverage. About half of the remaining uninsured had incomes that made them eligible for the ARPA-enhanced ACA marketplace subsidies or were eligible for employer coverage, and 22 percent were eligible for Medicaid or CHIP in their state. People who were not eligible for subsidized coverage, those with incomes under poverty in Medicaid nonexpansion states and undocumented immigrants, accounted for just under one-quarter of uninsured people (Exhibit 3).

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<sup>17</sup> John Holahan et al., [Filling the Gap in States That Have Not Expanded Medicaid Eligibility](#) (Commonwealth Fund, June 2021, updated Oct. 5, 2021).

<sup>18</sup> Jacquelyn Rudich et al., [Estimates of Uninsured Adults Newly Eligible for Medicaid If Remaining 12 Non-Expansion States Expand Medicaid: 2022 Update](#), February 15, 2022.

<sup>19</sup> Jesse C. Baumgartner, Sara R. Collins, and David C. Radley, [Racial and Ethnic Inequities in Health Care Coverage and Access, 2013-2019](#) (Commonwealth Fund, June 2021).

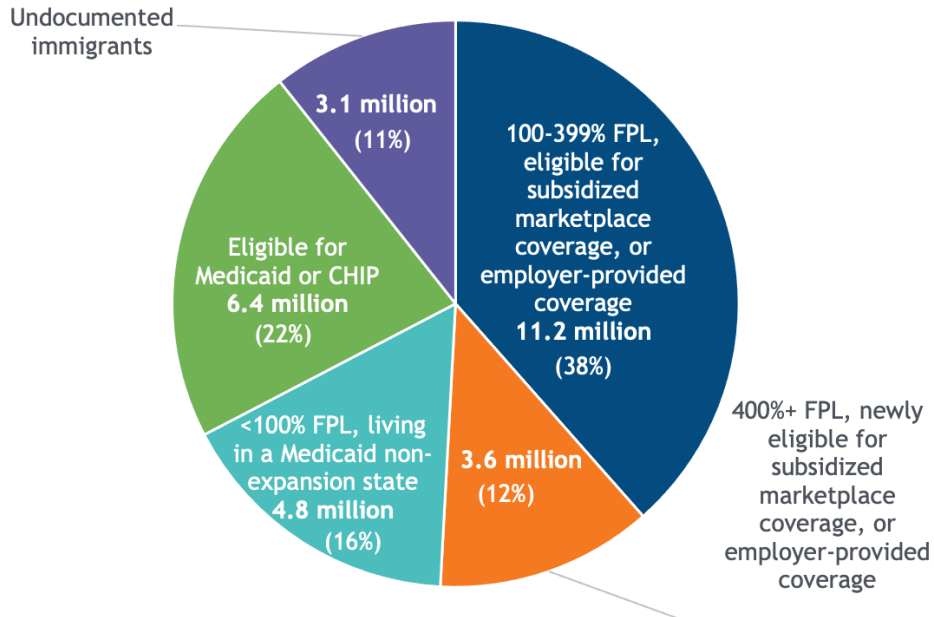
<sup>20</sup> Sara Rosenbaum, [“Expanding Health Coverage to the Poorest Residents of States That Have Not Expanded Medicaid,”](#) *To the Point* (blog), Commonwealth Fund, Feb. 1, 2022; Timothy S. Jost, [“How the Build Back Better Bill Would Improve Affordable Care Act Coverage,”](#) *To the Point* (blog), Commonwealth Fund, Jan. 19, 2022.

<sup>21</sup> John Holahan et al., [Filling the Gap in States That Have Not Expanded Medicaid Eligibility](#) (Commonwealth Fund, June 2021, updated Oct. 5, 2021).

EXHIBIT 3

## Who are the remaining uninsured?

29.2 million uninsured, under age 65, 2019



Source: Sara R. Collins and Gabriella N. Abouafia, “[Will the American Rescue Plan Reduce the Number of Uninsured Americans?](#),” *To the Point* (blog), Commonwealth Fund, Mar. 22, 2021.

Since the ASPE analysis, the ARPA provisions for marketplace subsidies and continuous enrollment in Medicaid have boosted enrollment in both programs, with particularly large gains in Medicaid. In addition, the Biden–Harris administration made a number of changes to make enrollment easier: a pandemic special-enrollment period through August 2021, a dramatic increase in funding for navigators who assist prospective enrollees searching for marketplace plans, an extensive advertising and outreach campaign to raise awareness of coverage options, an extension of the annual open-enrollment period by one month, and allowing people with incomes under 150 percent of poverty the ability to enroll in any month in most states.<sup>22</sup>

But even with the record enrollment in marketplace plans, millions of uninsured people are still likely eligible for subsidized coverage but not enrolled. Moreover, if the ARPA subsidy

<sup>22</sup> Katie Keith, “[New Special Enrollment Period for Low-Income People Could Boost Coverage](#),” *To the Point* (blog), Commonwealth Fund, Sept. 7, 2021; Sara R. Collins, “[During the ACA’s Open Enrollment Period, Consumers Will Get Lower Premiums, More Time, and More Help](#),” *To the Point* (blog), Commonwealth Fund, Nov. 1, 2021.



enhancements and continuous eligibility in Medicaid end, coverage gains stemming from those policies could reverse.

In addition to extending the ARPA subsidies and the Medicaid continuous eligibility policy options discussed above, policy options to cover those eligible include:

- *Maintain aggressive, targeted outreach and enrollment efforts to reach the remaining uninsured.* The 2021 effort by the Biden–Harris administration followed four years of the prior administration significantly reducing funding for outreach and enrollment. Getting people covered in subsidized coverage programs to avoid coverage erosion ideally would transcend the party in power. Tracking low enrollment by demographic group, like the California marketplace does, could help in targeting outreach efforts more effectively.
- *Allowing people to auto-enroll in comprehensive health coverage.* Linda Blumberg and colleagues at the Urban Institute developed and modeled a comprehensive autoenrollment option combined with many of the reforms discussed here, along with a public insurance option and allowing people in employer plans to enroll in marketplace coverage.<sup>23</sup> This autoenrollment approach, in combination with the other reforms, has the potential to move the nation to near universal coverage (Exhibit 4). The researchers also modeled a less comprehensive autoenrollment mechanism, also in combination with the same reforms, for people eligible for the Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF). While not achieving near universal coverage, the less comprehensive approach would reduce the number of uninsured by an additional 3.6 million people.

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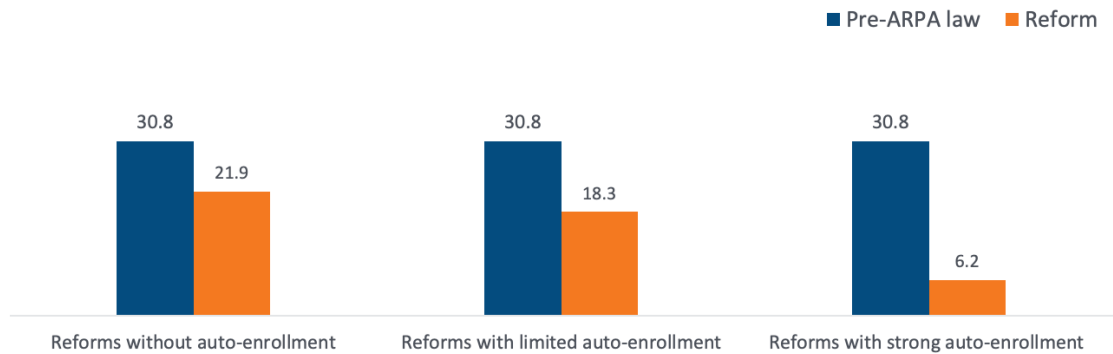
<sup>23</sup> The approach would treat all legal residents as insured 12 months a year regardless of whether they actively enrolled in a health plan. Income related premiums would be collected through the tax system. See Linda J. Blumberg, John Holahan, Jason Levitis, [\*How Auto-enrollment Can Achieve Near-Universal Coverage: Policy and Implementation Issues\*](#), (Commonwealth Fund, June 2021).



#### EXHIBIT 4

# Automatic enrollment would reduce the number of uninsured Americans

Number of uninsured people (millions), 2022



Data: Health Insurance Policy Simulation Model, Urban Institute, 2021.

Notes: ARPA = the American Rescue Plan Act. To produce estimates akin to steady-state effects, we do not include temporary reforms to health insurance premium subsidies enacted as part of the American Rescue Plan Act. Limited autoenrollment would apply to a narrow segment of the population: low-income people who are eligible for comprehensive \$0 premium coverage and who can be identified through their participation in other public assistance programs. Strong auto-enrollment assumes elimination of the 100 percent of poverty threshold for marketplace subsidy eligibility thereby covering everyone in the Medicaid gap.



Source: Linda J. Blumberg, John Holahan, and Jason Levitis, [How Auto-Enrollment Can Achieve Near-Universal Coverage: Policy and Implementation Issues](#) (June 2021).

## Health Care Costs are Rising Faster than Median Income Leaving Millions

### Underinsured and with Growing Premium Burdens

More than a decade after the passage of the ACA, employer coverage remains the backbone of the U.S. health insurance system, insuring more than 160 million workers and their families. This coverage also proved to be resilient during the severe pandemic-related recession of 2020. The main issue affecting employer coverage is costs, the growth of those costs, and most importantly, what families are contributing to those costs in terms of premium contributions and deductibles.

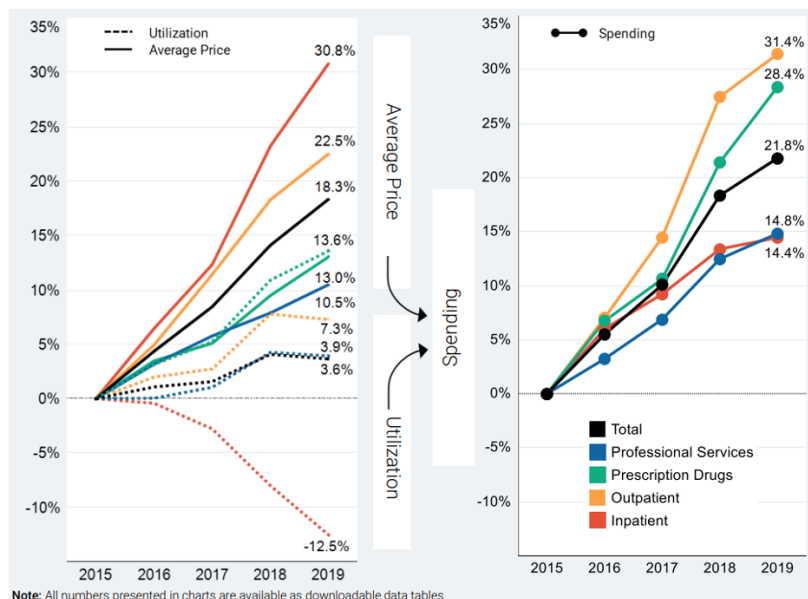
It is important to remember that overall health care spending growth — spending on hospital care and prescription drug costs, for example — drive the costs of employer health insurance and workers' contributions. Utilization has driven spending growth, but not nearly as much as prices have. Data from the Health Care Cost Institute show that spending per person in employer plans grew by nearly 22 percent between 2015 and 2019, outpacing both inflation and

economic growth (Exhibit 5).<sup>24</sup> Prices commanded by health care providers were the primary driver, accounting for nearly two-thirds of overall spending growth. This means that the prices insurers and employers pay for inpatient care, outpatient care, prescription drugs, and physician services drive what workers and their families pay for employer coverage and deductibles. These prices also play a role in the wage concessions workers make to have health benefits through their jobs.<sup>25</sup>

**EXHIBIT 5**

**Prices accounted for nearly two-thirds of per person spending growth in employer plans, 2015-2019**

Cumulative Change in per person spending, utilization, average Price, 2015-2019



Notes & Source: Utilization and average prices account for changes in the type or intensity of services used, with the exception of prescription drugs. Prescription drug spending is the amount paid on the pharmacy claim, which reflects discounts from the wholesale price, but not manufacturer rebates. Healthcare Cost Institute, 2019 Health Care Cost and Utilization Report, released October 2021. Available here: [https://healthcostinstitute.org/images/pdfs/HCCI\\_2019\\_Health\\_Care\\_Cost\\_and\\_Utilization\\_Report.pdf](https://healthcostinstitute.org/images/pdfs/HCCI_2019_Health_Care_Cost_and_Utilization_Report.pdf)

Over the last decade, in most years and parts of the country, workers’ premium contributions and deductibles have risen more quickly than their family incomes, meaning that these costs are taking up a growing share of household budgets. Commonwealth Fund analysis of the most recent federal data show that premium contributions and deductibles for people enrolled in employer plans amounted to an average of 11.6 percent of U.S. median income in 2020, up

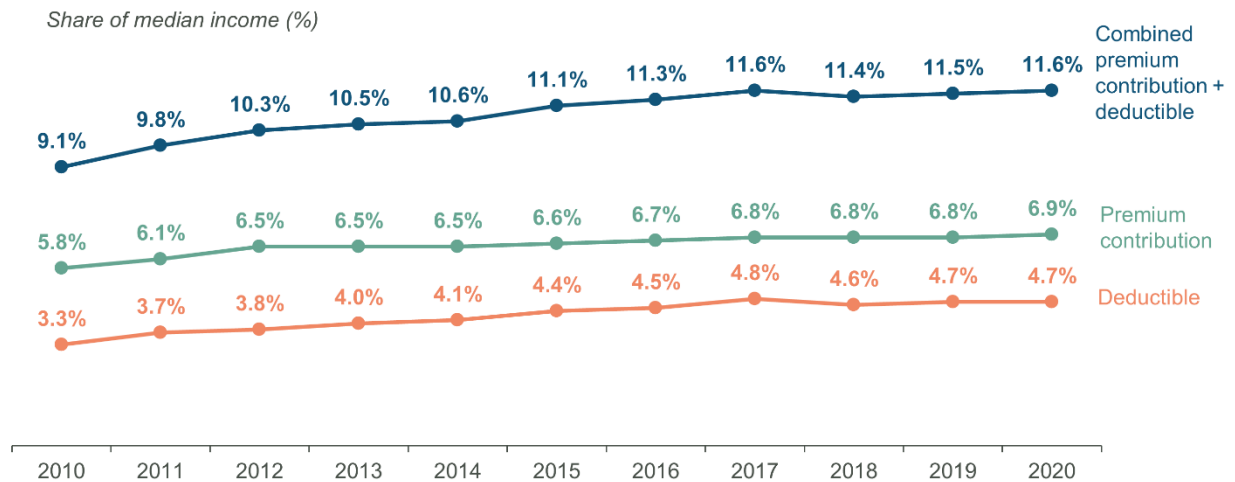
<sup>24</sup> Health Care Cost Institute, [2019 Health Care Cost and Utilization Report](#) (HCCI, Oct. 2021).

<sup>25</sup> David Scheinker, Arnold Milstein, Kevin Schulman, “[The Dysfunctional Health Benefits Market and Implications for U.S. Employers and Employees](#),” *JAMA* 327, no. 4 (Jan. 2022): 323-324.

from 9.1 percent a decade earlier (Exhibit 6).<sup>26</sup> In 37 states, average premium contributions and deductibles amounted to 10 percent or more of median income in 2020, up from 10 states in 2010 (Exhibit 7). These costs ranged from a low of 7.7 percent in Washington to a high of 19 percent in Mississippi.

EXHIBIT 6

## Worker premium contributions and deductibles in employer plans added up to more than 11 percent of U.S. median income in 2020



Note: Combined estimates of single and family premium contributions and deductibles are weighted for the distribution of single-person and family households in the state.

Data: Premium contributions and deductibles — Medical Expenditure Panel Survey—Insurance Component (MEPS-IC), 2010–2020; Median household income and household distribution type — analysis of Current Population Survey (CPS), 2010–2021, by Mikaela Springsteen and Sherry Glied of New York University for the Commonwealth Fund.

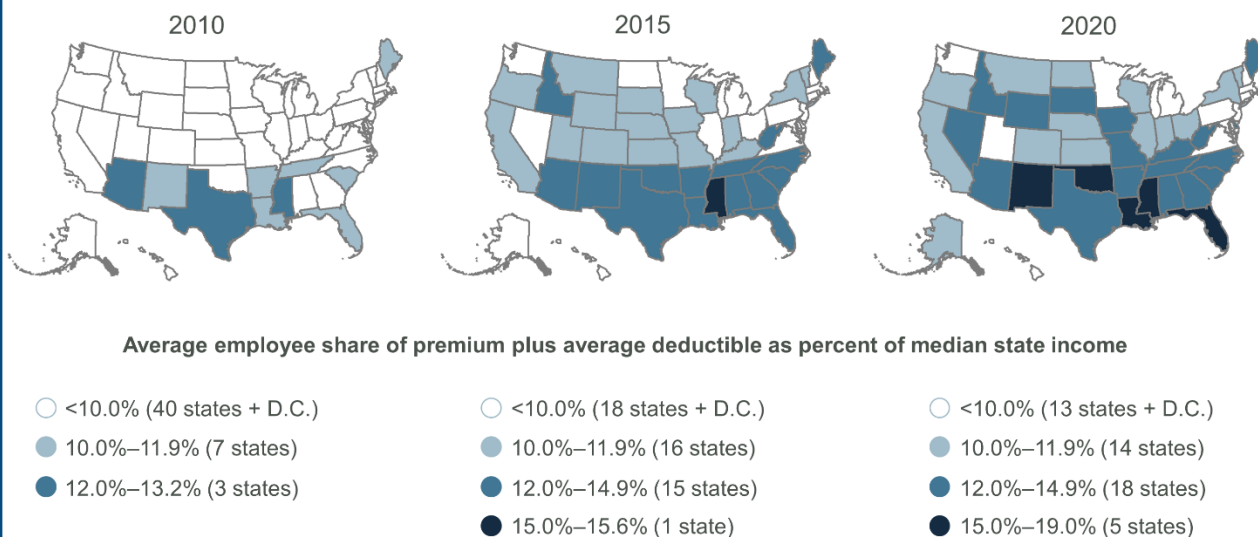


Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2020* (Commonwealth Fund, Jan. 2022). <https://doi.org/10.26099/m5dt-5f70>

<sup>26</sup> Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, [\*State Trends in Employer Premiums and Deductibles, 2010–2020\*](#) (Commonwealth Fund, Jan. 2022).

**EXHIBIT 7**

**In growing number of states, worker insurance premium contributions and deductibles in employer plans make up 10 percent or more of median income**



Note: Combined estimates of single and family premium contributions and deductibles are weighted for the distribution of single-person and family households in the state.  
 Data: Premium contributions and deductibles — Medical Expenditure Panel Survey—Insurance Component (MEPS-IC), 2010–2020; Median household income and household distribution type — analysis of Current Population Survey (CPS), 2010–2021, by Mikaela Springsteen and Sherry Glied of New York University for the Commonwealth Fund.



Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2020* (Commonwealth Fund, Jan. 2022). <https://doi.org/10.26099/m5dt-5f70>

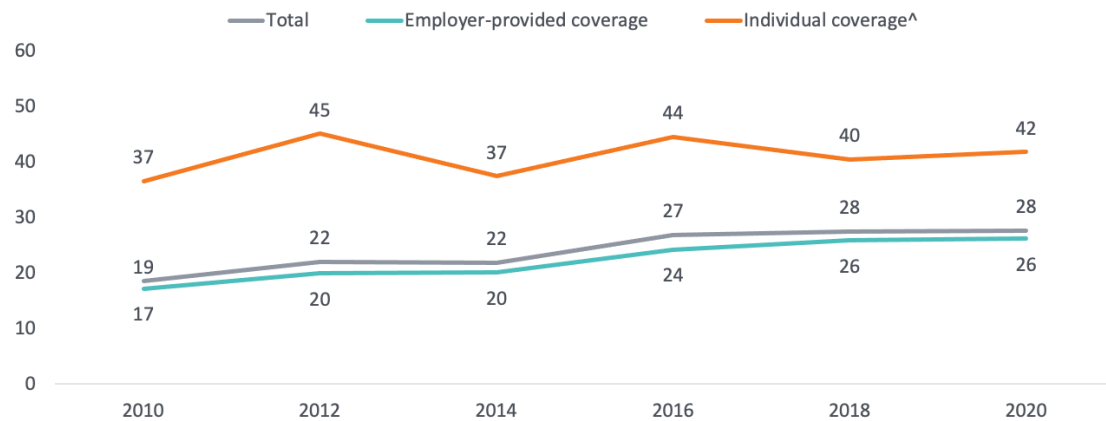
Years of research has shown that cost-sharing and deductibles are critical factors in people’s ability to access health care. High out-of-pocket costs and deductibles can lead to delayed or avoided care and to medical debt when people do get care. The Commonwealth Fund has created a measure of underinsurance, which calculates a person’s out-of-pocket spending and deductibles, excluding premiums, relative to income. We define people as underinsured if they have been insured all year and their out-of-pocket costs are 10 percent or more of their income; 5 percent or more, with an income under 200 percent of poverty; or if their deductible amounted to 5 percent or more of income.

In 2020, 28 percent of people with private insurance were underinsured by this measure, up from 19 percent a decade earlier (Exhibit 8).<sup>27</sup> The biggest growth in the share of people who are underinsured over the last decade has occurred in employer plans. In 2020, average deductibles in employer plans amounted to 5 percent or more of median income, our threshold measure of underinsurance, in 22 states (Exhibit 9). Underinsured rates continue to be highest in the individual market, despite ACA reforms. The ACA’s cost-sharing subsidies significantly lower cost-sharing and deductibles, but they are limited to the lowest-income enrollees.

**EXHIBIT 8**

## One-quarter of adults in employer plans are underinsured; individual market continues to be challenging

Percent of adults ages 19–64 insured all year who were underinsured



Data: Commonwealth Fund Biennial Health Insurance Surveys (2010, 2012, 2014, 2016, 2018, 2020).

Notes: “Underinsured” refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. Respondents may have had another type of coverage at some point during the year but had coverage for the entire previous 12 months. <sup>^</sup> For 2014–2020, individual coverage includes adults who got coverage in the individual market and the marketplaces.

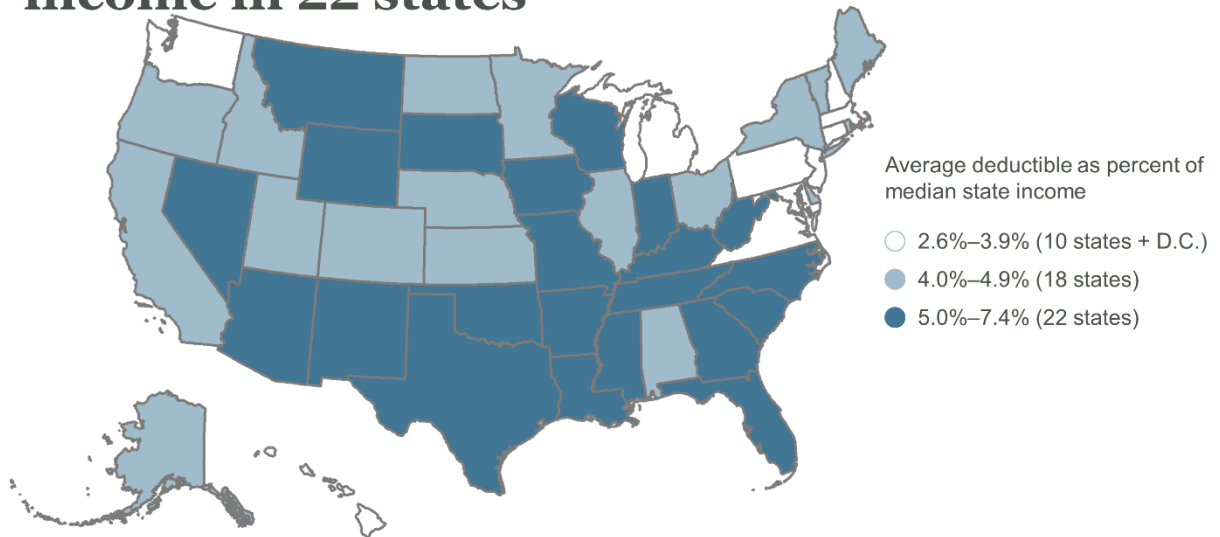


Source: Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, [U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020](#) (Commonwealth Fund, Aug. 2020).

<sup>27</sup> Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, [U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020](#) (Commonwealth Fund, Aug. 2020).

EXHIBIT 9

## Average deductibles in employer plans amounted to 5 percent or more of median income in 22 states



Note: Single and family deductibles are weighted for the distribution of single-person and family households in the state.

Data: Deductibles — Medical Expenditure Panel Survey—Insurance Component (MEPS-IC), 2020; Median household income and household distribution type — analysis of Current Population Survey (CPS), 2020–2021, by Mikaela Springsteen and Sherry Glied of New York University for the Commonwealth Fund.



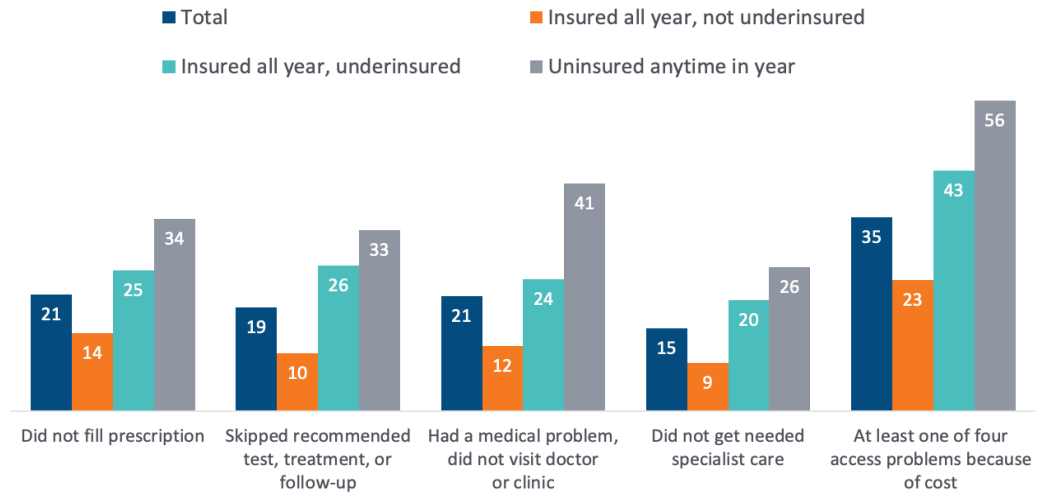
Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2020* (Commonwealth Fund, Jan. 2022). <https://doi.org/10.26099/m5dt-5f70>

The survey has found that people who are underinsured report rates of avoiding or delaying care because of costs at twice the rate of those not underinsured (Exhibit 10). Underinsured adults report problems with medical bills or say they are paying off medical debt at rates nearly as high as those who are uninsured (Exhibit 11).

EXHIBIT 10

## Uninsured or underinsured adults often avoid or delay getting needed health care and medications

Percent of adults ages 19–64 who had any of four access problems in past year because of cost

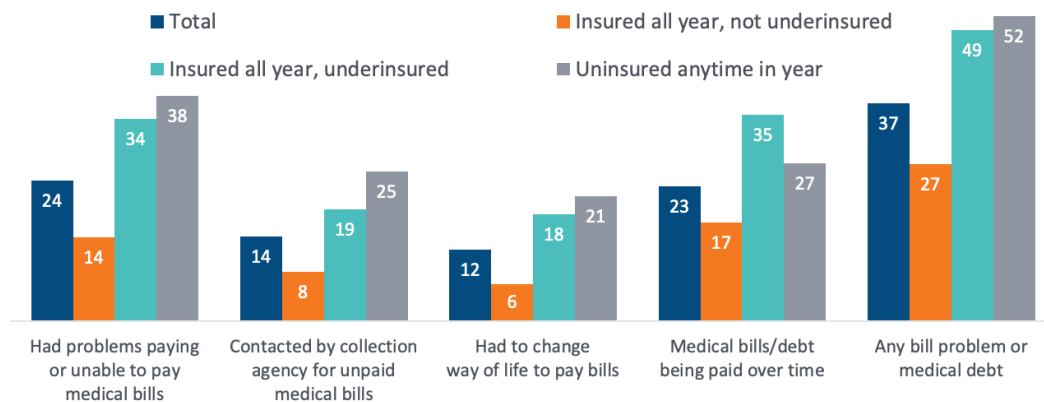


Source: Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulaflia, *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020* (Commonwealth Fund, Aug. 2020).

EXHIBIT 11

## People with inadequate insurance coverage have more problems paying medical bills

Percent of adults ages 19–64 who had any of the following medical bill/debt problems in the past year



Notes: “Underinsured” refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. “Uninsured anytime in the past year” refers to adults who were either uninsured at the time of the survey or spent some time uninsured in the past year. Data: Commonwealth Fund Biennial Health Insurance Survey (2020).



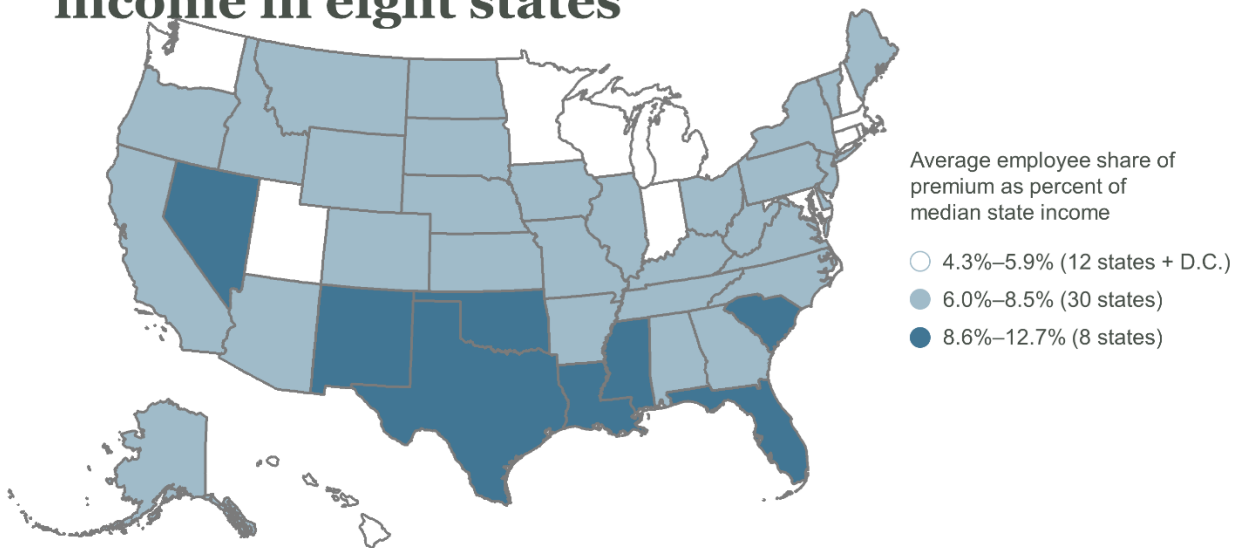
Source: Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulaflia, *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020* (Commonwealth Fund, Aug. 2020).

## Policy Options

- *Allow more workers in expensive employer health plans to become eligible for subsidized marketplace plans.* Under current law, enrollees in employer coverage whose premiums exceed 9.8 percent of income are eligible for subsidized marketplace plans. The BBBA lowers that threshold to 8.5 percent of income. Premium contributions across single and family plans averaged more than 8.5 percent of median income in eight states in 2020 (Exhibit 12).

### EXHIBIT 12

## Premium contributions in employer plans were more than 8.5 percent of median income in eight states



Note: Single and family premium contributions are weighted for the distribution of single-person and family households in the state.

Data: Premium contributions — Medical Expenditure Panel Survey—Insurance Component (MEPS-IC), 2020; Median household income and household distribution type — analysis of Current Population Survey (CPS), 2020–2021, by Mikaela Springsteen and Sherry Glied of New York University for the Commonwealth Fund.



Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2020* (Commonwealth Fund, Jan. 2022). <https://doi.org/10.26099/m5dt-5f70>

- *Fix the “family coverage glitch.”* Under the ACA, families are ineligible for marketplace premiums if a family member’s employer offers single coverage that is deemed affordable (i.e., premiums are less than 9.83 percent of family income; the BBBA would



lower this to 8.5 percent).<sup>28</sup> But 5 million people eligible for family employer plans with premium contributions above that threshold are ineligible for marketplace subsidies.<sup>29</sup> An administrative fix could save families that switched to marketplace plans an average of \$400 a person annually.

- *Ban non-ACA compliant policies, including short term plans.* Consumers often enroll in skimpy policies that require premiums but leave them exposed to catastrophic medical costs.<sup>30</sup> By drawing healthier people out of the individual market and marketplaces, they also have increased premiums for people remaining in the market.<sup>31</sup>
- *Rein in deductibles and out-of-pocket costs in marketplace plans* by enhancing cost-sharing reduction subsidies and changing the benchmark plan in the ACA marketplaces from silver to gold. A bill introduced by Senator Jeanne Shaheen (D–N.H.) would raise the cost-protection of the marketplace benchmark plan and make more people eligible for cost-sharing subsidies.<sup>32</sup> This could eliminate deductibles for some people and reduce it for others by as much as \$1,650 a year.<sup>33</sup>
- *Impose stronger consumer protection rules for medical debt collection* such as grace periods following illness or during appeals processes; banning egregious hospital practices such as suing patients, garnishing their wages, or placing liens on their homes; and placing bans or limits on medical debt interest rates.<sup>34</sup>
- *Address the high health care prices that are driving up employer premiums and deductibles* through federal and state policies. These include the introduction of a public insurance option to the marketplaces as proposed in a number of congressional bills.<sup>35</sup>

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<sup>28</sup> Katie Keith, "[Fixing the Family Glitch and Other Priorities: The Next Wave of Federal Administrative Action to Enhance the Affordable Care Act](#)," *To the Point* (blog), Commonwealth Fund, Jan. 11, 2022; Timothy S. Jost, "[Eliminating the Family Glitch](#)," *To the Point* (blog), Commonwealth Fund, May 18, 2021.

<sup>29</sup> Matthew Buettgens and Jessica Banthin, "[Changing the 'Family Glitch' Would Make Health Coverage More Affordable for Many Families](#)" (Urban Institute, May 2021)

<sup>30</sup> Emily Curran et al., "[In the Age of COVID-19, Short-Term Plans Fall Short for Consumers](#)," *To the Point* (blog), Commonwealth Fund, May 12, 2020.

<sup>31</sup> Mark A. Hall and Michael J. McCue, "[Short-Term Health Insurance and the ACA Market](#)," *To the Point* (blog), Commonwealth Fund, Mar. 16, 2022.

<sup>32</sup> [Improving Health Insurance Affordability Act of 2021](#), S. 499, 117th Cong. (2021).

<sup>33</sup> Linda J. Blumberg et al., [From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs](#) (Urban Institute, Oct. 2019).

<sup>34</sup> Chi Chi Wu, Jenifer Bosco, and April Kuehnhoff, [Model Medical Debt Protection Act](#) (National Consumer Law Center, (Sept. 2019); Christopher T. Robertson, Mark Rukavina, Erin C. Fuse Brown, "[New State Consumer Protections Against Medical Debt](#)," *JAMA* 327, no. 2 (Jan. 2020)

<sup>35</sup> [H.R. 5011](#) - Choose Medicare Act, [H.R. 1227](#) - Medicare-X Choice Act of 2021, [S. 386](#) - Medicare-X Choice Act of 2021, [H.R. 4974](#) - State Public Option Act, [S. 2639](#) - State Public Option Act, [H.R. 2010](#) - Public Option

Other bills have proposed Medicare buy-ins for older adults who are under 65 or lowering the Medicare eligibility age.<sup>36</sup> These could be mechanisms to lower provider payment rates or maintain rate increases closer to Medicare for segments of the population, but reduced rates could be accomplished without a public option. Additional proposals outlined in a recent Commonwealth Fund report include containing growth in prescription drug prices, implementing health care cost growth targets, promoting adoption of population-based provider payment, and strengthening health insurance rate review.<sup>37</sup> Directly reducing growth in workers' share of health insurance could ensure the benefits of reduced prices are shared with consumers. For example, the Department of Labor, which regulates self-insured plans, could place limits on growth in what employees in self-insured plans pay every year in premiums, deductibles, coinsurance.<sup>38</sup> The BBBA includes drug pricing reforms that extend to the commercial sector, including caps on price increases and insulin copayment caps. Senators Warnock, Shaheen, and Collins and Reps. McBath and Kildee also have proposed insulin copay caps.

## **Two Comprehensive Paths to Universal Coverage: Building on the ACA and Single Payer**

I have thus far discussed targeted policy options for addressing four distinct risks to coverage and affordability. But whether the goal of universal or near-universal coverage? What approach will finally place the U.S. on equal footing with other high-income countries, all of which have achieved universal coverage for their residents?<sup>39</sup> Can the nation get there by building on the ACA? Or will it take a single-payer approach?

In 2019, when health insurance expansion was being hotly debated in the run-up to the presidential election, Linda Blumberg and colleagues at the Urban Institute tackled this question.<sup>40</sup> They modeled a set of reforms that built on the ACA and two versions of a single-

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Deficit Reduction Act, [S.983](#) - CHOICE Act, [S.352](#) - Health Care Improvement Act of 2021, [H.R.3775](#) - State-Based Universal Health Care Act of 2021.

<sup>36</sup> [S.1279](#) - Medicare at 50 Act; [H.R.5165](#) - Improving Medicare Coverage Act; Bowen Garrett, [Rationalizing a Medicare Buy-In Policy for Adults Ages 50 to 64 That Builds on the ACA](#), February 2021.

<sup>37</sup> Ann Hwang, Amy M. Lishko, Tom Betlach, Michael H. Ballit, [State Strategies for Slowing Health Care Cost Growth in the Commercial Market](#), Commonwealth Fund, February 2022.

<sup>38</sup> Schneinker, [The Dysfunctional Health Benefits Market](#), 2022.

<sup>39</sup> Roosa Tikkanen, "[Variations on a Theme: A Look at Universal Health Coverage in Eight Countries](#)," *To the Point* (blog), Commonwealth Fund, Mar. 22, 2019.

<sup>40</sup> Linda J. Blumberg et al., [Comparing Health Insurance Reform Options: From "Building on the ACA" to Single Payer](#) (Commonwealth Fund and Urban Institute, Oct. 2019).

payer approach. They found that it was possible to reach near-universal or universal coverage with any of the three, but each carried distinctly different implications for federal financing. I discuss each in turn.

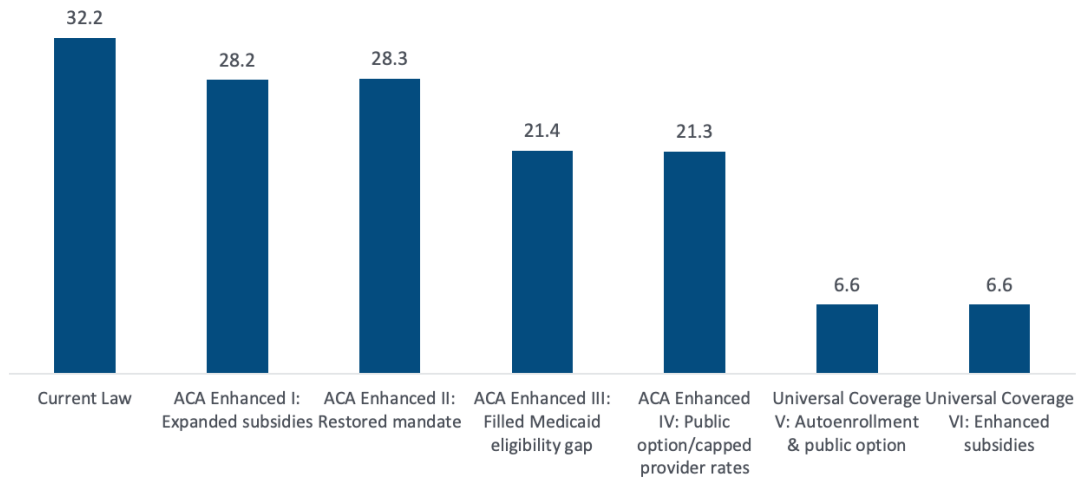
### **Reaching Universal Coverage by Building on the ACA**

The Urban Institute researchers modeled a set of reforms similar to those discussed in this testimony. They showed the incremental effects on the uninsured and federal revenue needs as each policy is implemented (Exhibit 13). Reform I enhances marketplace premium and cost sharing subsidies, slightly reducing the number of uninsured. Reform II reinstates the individual mandate and bans short-term policies. Reform III provides a federal fallback option to insure people in Medicaid nonexpansion states and adds a limited autoenrollment mechanism for lower-income people, further reducing the uninsured. Reform IV seeks to drive down provider prices and health spending with either a public option or by capping provider prices close to Medicare levels and allows people in employer plans to enroll in marketplace plans and become eligible for the ACA tax credits. Reform V adds a comprehensive autoenrollment mechanism. With this reform, everyone is covered except for 6.6 million undocumented immigrants. Reform VI is the same package of reforms but with more generous coverage.

EXHIBIT 13

# Reforms that build on the ACA have the potential to reach near-universal coverage

Number of uninsured nonelderly individuals (in millions), 2020



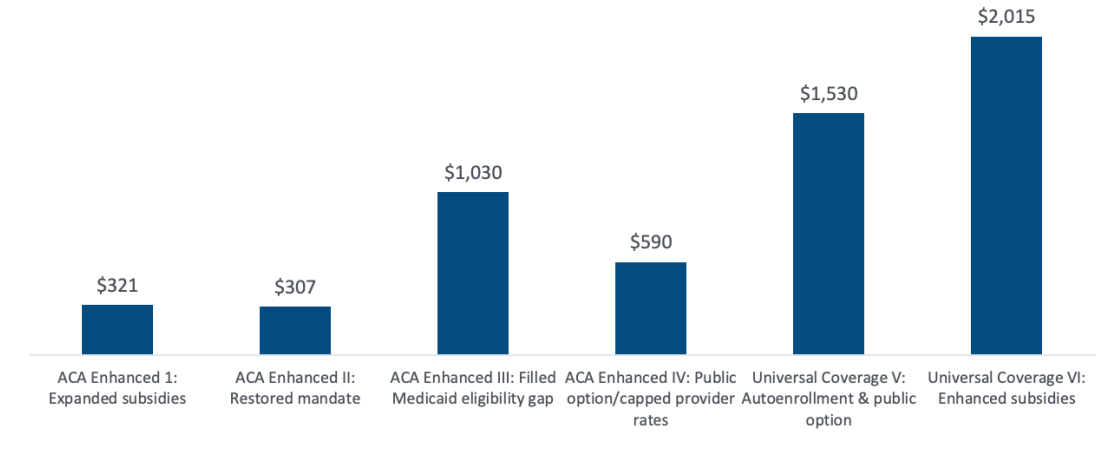
Source: Linda J. Blumberg et al., [Comparing Health Insurance Reform Options: From "Building on the ACA" to Single Payer](#) (Commonwealth Fund and Urban Institute, Oct. 2019).

The federal costs of these incremental reforms naturally increase as more people are covered (Exhibit 14). But capping provider rates closer to Medicare rates in reform IV, with or without a public plan option, lowers the overall federal costs of the prior set of reforms. This also means that reforms V and VI, which reach near-universal coverage, are less costly to the federal government than they would be with higher provider prices.

EXHIBIT 14

# Capping provider rates directly or via a public option has the potential to reduce the federal costs of reform

10-year estimates of additional federal revenues needed to finance each reform, 2020-2029 (billions of dollars)



Source: Linda J. Blumberg et al., [Comparing Health Insurance Reform Options: From “Building on the ACA” to Single Payer](#) (Commonwealth Fund and Urban Institute, Oct. 2019).



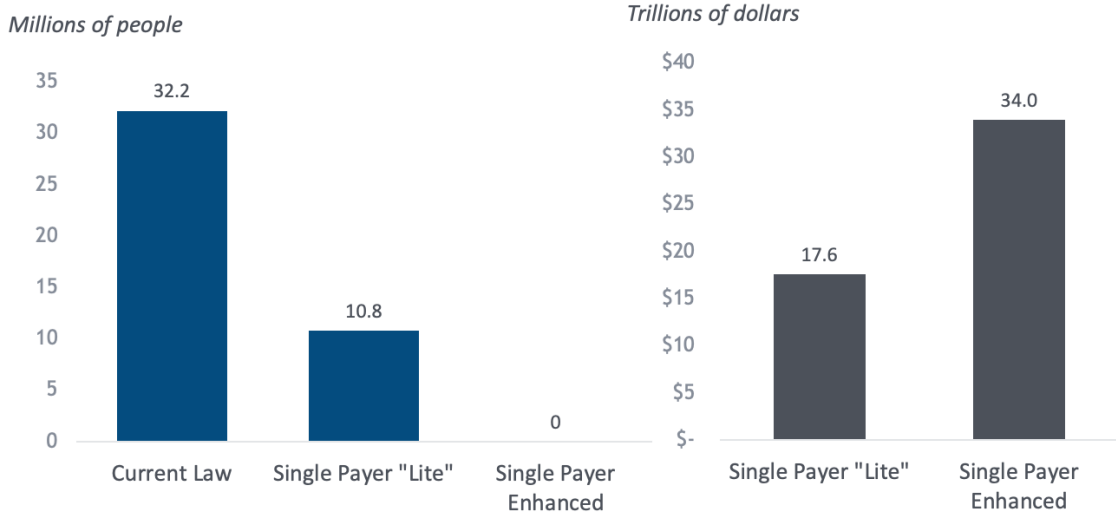
## Reaching Universal Coverage with a Single-Payer Approach

The Urban Institute then modeled two single-payer approaches. The first — single-payer “lite” — insures everyone through a single public plan, eliminates private insurance, eliminates premiums but includes some income-related cost-sharing, and does not cover undocumented immigrants. Because it eliminates private insurance, more undocumented immigrants are uninsured compared to the reforms that build on the ACA since there is no option for them to purchase on their own or get employer coverage (Exhibit 15). Providers are reimbursed close to Medicare rates, similar to the reforms that build on the ACA.

EXHIBIT 15

# Single-payer approaches can reach near-universal or universal coverage

Number of uninsured nonelderly individuals (2020) and additional federal revenues needed to finance each reform, 2020-2029



Notes: Single Payer "Lite": A single-payer plan that covers all people legally residing in the U.S. and includes all the ACA's "essential health benefits" and has no private insurance option. Single Payer Enhanced: This plan covers all U.S. residents, including undocumented immigrants, and features a broader set of benefits than Single Payer "Lite," including adult dental, vision, and hearing care as well as a home- and community-based long-term services and supports benefit. In addition, there are no cost-sharing requirements nor private insurance option.

Source: Linda J. Blumberg et al., *Comparing Health Insurance Reform Options: From "Building on the ACA" to Single Payer* (Commonwealth Fund and Urban Institute, Oct. 2019).

The single-payer enhanced approach includes more generous benefits, including adult dental, vision, and hearing services and coverage of home- and community-based long-term services and supports. It eliminates private insurance, premiums and cost-sharing, and covers all U.S. residents. No one is left uninsured.

## National Health Expenditures vs. Financing

There was considerable confusion during the 2020 presidential campaign about the cost of the various approaches. Public commentary frequently conflated the effects of the reforms on overall national health care expenditures with how they would be financed.<sup>41</sup>

<sup>41</sup> Linda J. Blumberg, John Holahan, Michael Simpson, "[Don't Confuse Changes in Federal Health Spending with National Health Spending](#)," Urban Institute Blog, October 16, 2019.

Two of the approaches modeled by the Urban Institute, building on the ACA and single-payer “lite,” both reduce national health expenditures (Exhibit 16). This is because they address the primary driver of commercial health care spending: prices paid to providers by commercial insurers and employers. The ACA approach achieves this through a public plan option offered through the marketplaces and the single-payer approach through a single public plan for everyone. Under the ACA approach, even though nearly everyone is covered, national health spending falls because providers are paid closer to Medicare rates through the public option. Under the single-payer “lite” approach, national health spending falls by an even larger amount because everyone is in a plan that pays providers near Medicare rates. The enhanced single-payer plan leads to an increase in national health spending, but that is because it insures everyone with more benefits, including long-term care benefits.

#### EXHIBIT 16

## Changes in national health spending under health reform approaches

Actual and estimated projected national health expenditures, billions in 2019 and 2020	Change in NHE (dollars)	Change in NHE (percent)	Total NHE, 2020
Current law	-	-	3,496.8
Universal coverage by building on the ACA w/public option	- 22.6	- 0.6%	3,474.2
Universal coverage via single payer “lite”	- 209.5	- 6.0%	3,287.2
Universal coverage via single payer “enhanced”	+ 719.7	+ 20.6%	4,216.5



Notes: Single Payer Enhanced: This plan covers all U.S. residents, including undocumented immigrants, and features a broad set of benefits including adult dental, vision, and hearing care as well as a home- and community-based long-term services and supports benefit. In addition, there are no cost-sharing requirements nor private insurance option.

Source: Linda J. Blumberg et al., [Comparing Health Insurance Reform Options: From “Building on the ACA” to Single Payer](#) (Commonwealth Fund and Urban Institute, Oct. 2019).

What captured headlines during the election, however, was not the fact that universal coverage achieved through either approach could actually lower U.S. health care spending, but

that the cost to the federal government mushroomed under a single-payer approach (Exhibit 17). The extra cost to the federal government occurred not because the single-payer approach was much more expensive than our current system, but because the responsibility for financing shifted away from employers, households, and states to the federal government.

**EXHIBIT 17**

## Enhanced single-payer approach would shift most household, employer and state spending to the federal budget

Actual and estimated projected national health expenditures, billions in 2019 and 2020

	Current Law	Single payer
Federal government	1,284.3	4,128.9
State	302.3	42.7
Employers	954.7	0
Households	931.4	44.9
In kind uncompensated care from providers	24.1	0
<b>Total</b>	<b>3,496.8</b>	<b>4,216.5</b>



Source: Linda J. Blumberg et al., *Comparing Health Insurance Reform Options: From "Building on the ACA" to Single Payer* (Commonwealth Fund and Urban Institute, Oct. 2019).

We need to have reasonable discussions as a country about how to share our health care spending responsibilities. But it is not just about *who* pays but also about *how much* we pay and *why*, and *what* we are getting for our spending. We spend far more of our G.D.P on health care than other high-income countries, but rank last on most measures of health system performance, including access to care.<sup>42</sup> Research points to prices paid to providers in private insurance as the

<sup>42</sup> Eric C. Schneider et al., *Mirror, Mirror 2021—Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021).



primary reason we spend so much more.<sup>43</sup> By focusing only on *who* pays, the debate during the 2020 election missed an important opportunity to educate the public about the drivers of health care spending, and, in particular, why middle-income households feel increasingly squeezed by their health insurance and health care.

Looking forward, as we consider strategies to expand health insurance coverage and lower consumer costs and weigh the benefits of those strategies against federal costs, it is critical that that the prices paid to providers in private insurance be a part of the discussion.

Thank you.

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<sup>43</sup> Gerard F. Anderson, Peter Hussey and Varduhi Petrosyan, “It’s Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt,” *Health Affairs*, 38:1, January 2019.