BlueCross BlueShield Association

Statement for the Record to:

ENERGY AND COMMERCE SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

Hearing: Proposals to Achieve Universal Health Coverage

Submitted by:

Blue Cross Blue Shield Association

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The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to comment on critical issues impacting health care access and cost and share our views regarding the best approach to achieve universal health care coverage.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies that collectively provide health care coverage for one in three Americans. For 90 years, BCBS companies have offered quality health care coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

BCBSA strongly believes everyone should have access to health care, no matter who you are or where you live, and we commend the House Energy and Commerce Health Subcommittee for holding today's hearing to examine "Proposals to Achieve Universal Health Care Coverage."

We agree the health care system has to work better and provide more affordable insurance and care options. As we seek meaningful solutions, it is important to recognize that while our health care system is not perfect, we have made great progress in expanding access to coverage, and most people like the coverage they have today, so we should not start over from scratch. When it comes to improving health care, we should take the best from the public and private sectors and build on what we have to make it better and ensure everyone has insurance.

We are committed to working with policymakers and partners throughout the health care system to make sure everyone has access to affordable, quality coverage and care that best meets their needs. That is why, earlier this year, BCBSA released a series of recommended steps, that taken together, will reduce premiums in the individual market by an average of 33 percent and provide 4.2 million more people with access to affordable health insurance at a fraction of the cost of many proposals being debated today. When coupled with changes to improve access to Medicaid, enroll those eligible for existing programs and address rising costs, these proposals offer the fastest and most pragmatic path toward achieving universal coverage.

BCBSA's specific recommendations are outlined below.

Step 1: Closing Current Gaps in Coverage

Today, 90 percent of Americans are covered. Moving forward, we must close the gap that leaves the remaining 10 percent uninsured, without disrupting coverage and care for those who already have health insurance.

Most of the uninsured today already are eligible for coverage with financial assistance available to help them afford it. Of the estimated 27.4 million uninsured in the U.S., more than half are estimated to be eligible for Medicaid (6.8 million) or tax credit assistance to help purchase coverage in the individual market (8.2 million).[1] Many more are eligible for employer coverage. Only a small percentage of the uninsured are ineligible for financial assistance due to higher

[1]Garfield R, Orgera K, "The Uninsured and the ACA: A Primer," Kaiser Family Foundation. January 2019. http://files.kff.org/attachment/The-Uninsured-and-the-ACA-A-Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-amidst-Changes-to-the-Affordable-Care-Act.

incomes or citizenship status. However, too many people simply do not know they are eligible. A recent Commonwealth Fund survey found that 40 percent of uninsured, working-age adults were not aware of their state's marketplace or HealthCare.gov.[2]

To get more people covered, we must educate them on why obtaining and maintaining insurance is important and provide information on how to do it. BCBSA urges Congress to restore federal funding for outreach to those who are eligible for coverage to 2014 levels and encourages states to reinvigorate their enrollment efforts.

In fact, a recent Commonwealth Fund report found that the U.S. could achieve near-universal coverage and even decrease national health spending by building on our current public-private insurance system. The report analyzes how eight health care reforms – ranging from modest changes to the current system to single-payer – could affect insurance coverage, national health care costs and spending by government, consumers and employers.[3]

The report found that reaching true universal coverage requires an auto-enrollment mechanism for those not voluntarily enrolling in insurance. This finding underscores the need for Congress to take steps to make it easier for states to identify their eligible uninsured populations and support simplified pathways to enrollment.

For example, Maryland's Easy Enrollment program leverages the tax filing process to identify the state's uninsured, and with taxpayers' consent, the state automatically enrolls those eligible for Medicaid into coverage and facilitates enrollment for those eligible for coverage on the exchange marketplace, often at no premium cost. More than a third of the uninsured have incomes below 200 percent of the federal poverty level (FPL), and over half of rating areas across the U.S. offered premium-free Bronze coverage to individuals with incomes below 200 percent of poverty in 2018.[4,5] With Congress' support, states could make significant and rapid progress towards lowering their uninsured rates by facilitating enrollment into subsidized coverage.

Another step to lowering uninsured rates among low-income individuals would be to incentivize states that have not previously expanded Medicaid to expand eligibility (up to 138 percent FPL). States considering options to curb the uninsured rate among low-income Americans should be provided with the same incentives offered to early adopters. To accomplish this, Congress should provide incentives to states to expand Medicaid by offering an enhanced federal match (100 percent) for the initial three years of expansion, phasing down annually for five years to 90 percent federal match, in perpetuity.

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[2] Collins S, Gunja M, Doty, M., "Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage?," September, 2017. https://www.commonwealthfund.org/publications/issue-briefs/2017/sep/following-aca-repeal-and-replace-effort-where-does-us-stand.

[3] Bloomberg L, Holahan C, et. al., "Comparing Health Insurance Reform Options: From "Building on the ACA" to Single Payer," October, 2019. https://www.commonwealthfund.org/publications/issue-briefs/2019/oct/comparing-health-insurance-reform-options-building-on-aca-to-single-payer.

[4] Kaiser Family Foundation. "Uninsured Rates for the Nonelderly by Federal Poverty Level (FPL)." https://www.kff.org/uninsured/state-indicator/rate-by-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[5] BCBS analysis of public Marketplace data.

Step 2: Making Coverage and Care More Affordable

In order to achieve universal coverage, it also is imperative to address the persistently high cost of coverage and care. Premiums and out-of-pocket costs remain too high, putting health insurance out of reach for many.

Many consumers purchasing coverage in the individual market pay substantially more in premium and out-of-pocket costs than those in the employer market, even after subsidies are considered. For example, someone age 45 with an income at 300 percent FPL would be required to pay about 10 percent of their income on premiums and another 5 percent on out-of-pocket costs – even with the assistance available under current law today.

In the exchange market, BCBSA urges Congress to adjust the current tax credit structure to ensure no one purchasing coverage in the individual market pays more than 12 percent of their income for health insurance – a level that would bring more people into coverage while being mindful of the cost to taxpayers. In addition, lawmakers should enhance tax credits for younger people to make coverage more affordable and boost enrollment among younger, healthier adults to help balance the cost of caring for those who are ill. We also support expanding cost-sharing protections to reduce out-of-pocket costs for lower-income people who are having trouble affording the care they need.

BCBS data show 5 percent of people who buy coverage in the individual market represent almost 60 percent of medical claims' costs. To protect those with serious conditions and lower premiums for everyone, Congress should establish a sustained federal funding mechanism to support the cost of caring for those with significant medical needs. Analysis from the actuarial firm Oliver Wyman concludes that such a mechanism alone would reduce average premiums in the individual market by 27 percent and increase enrollment by 1.2 million.

Step 3: Addressing the High Cost of Chronic Disease

For at least the last decade, the national health policy debate has centered on expanding access to coverage, with a limited focus on the underlying reasons that health care costs so much for consumers and taxpayers alike. As we work to expand coverage to all, we urgently need to address causes like the prevalence of chronic illness and the escalating cost of prescription drugs, which make health care more costly in the United States than anywhere else.

Treating people with chronic disease such as diabetes, heart disease and behavioral health conditions like depression accounts for 90 percent of U.S. health care spending,[6] which totaled $3.5 trillion in 2017. Nearly 150 million Americans – six in 10 – are living with at least one chronic condition, and about 100 million people have more than one chronic illness.[7] Almost a

[6] Buttorff C, Ruder T, Bauman M., "Multiple Chronic Conditions in the United States." RAND. 2017. https://www.rand.org/content/dam/rand/pubs/tools/TL200/TL221/RAND_TL221.pdf.
[7] Ibid.

third of Americans live with three or more chronic conditions, and spending on their care accounts for more than half of all U.S. health spending.[8]

BCBSA commissioned Professor Ken Thorpe of Emory University to examine trends in spending on chronic disease among privately insured adults, with a focus on common chronic conditions. His research shows that, even as the number of people with chronic conditions has been climbing, growth in the per capita cost of treating each patient has slowed. This is largely because patents on brand-name drugs treating many chronic diseases have expired, and lower-cost generics are now widely used to treat these conditions.

Yet, overall spending to treat chronic disease continues to climb because of increased prevalence of these conditions. BCBSA recommends that policymakers take action to combat chronic illness and manage these diseases more effectively.

The entry of newer, higher-priced drugs, combined with manufacturer strategies to extend patent protections for current brand drugs, could quickly reverse this trend. Without rebalancing the laws governing brand-name and generic drugs, patients will be deprived of lower cost generic drugs and biosimilars.

Congress can rein in prescription drug costs, in part, by taking action to bring more low-cost generic drugs to the marketplace faster, as envisioned under the CREATES Act. Lawmakers also should restrict the use of drug "discount" coupons when there is a lower-cost, equally effective medication available. Manufacturer coupons for brand drugs can help some patients, but they contribute to higher overall drug costs by eliminating incentives for patients to seek lower-cost alternatives, such as generics. One recent study estimated that national spending on drugs, on average, grew by $30 million to $120 million for each copayment coupon for a particular brand drug over a five-year period following the entry of generic competitor drugs.[9] Coupons also provide a way for manufacturers to charge the highest price possible for their products, maximizing the revenue from better-insured consumers while discounting the price to under-insured consumers.

In addition, Congress should ensure changing care delivery to emphasize prevention and better management of chronic illness is supported and speeded where possible. Private insurers are well-positioned to manage the delivery of care, but need the flexibility to continue to innovate in care management programs and insurance benefit designs that will encourage the most effective treatments. To that end, BCBSA urges policymakers to protect insurer flexibility to develop value-based insurance designs.

In recent years, insurers have devoted considerable effort to developing clinician networks that deliver high-quality health care. They have also developed insurance benefit designs that encourage members to obtain necessary care to effectively and efficiently treat chronic disease, and to avoid developing chronic diseases in the first place. Policymakers should be careful to

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[8] Ibid.

[9] Dafny L, Ody, C Schmitt, M. "Undermining Value-Based Purchasing — Lessons from the Pharmaceutical Industry." The New England Journal of Medicine. November 2016. https://www.nejm.org/doi/full/10.1056/NEJMp1607378.

not undermine this progress toward value-based care by moving the nation toward fee-for-service programs without similar incentives for consumers to manage their health.

Step 4: Avoiding Actions that Cause Additional Harm

At the same time, it is also critical to avoid undermining recent progress to build on existing coverage and close gaps for the uninsured. It is clear that most Americans do not support eliminating private health insurance in favor of a single-payer system. While some present a public option or Medicare buy-in as just another choice for consumers, these plans could also have detrimental impacts on access to and affordability for ACA plans and employer coverage.

Proposals to allow those aged 50-64 to buy into Medicare would cause ACA premiums to increase by up to 9 percent.[10] Individual market ACA premiums would increase because individuals aged 50-64 are helping to stabilize that market today. Collectively, they make up 40 percent of the enrollment and 60 percent of the premium revenue. Importantly, their premiums are allowed to be set at a level to adequately cover their claims. By contrast, individuals under age 50 are relatively less healthy and their claims are higher compared to premiums issuers can charge under standard age rating criteria.

If the 50-64 year-old population moves out of the individual market, the remaining market will be much smaller and more volatile. As actuarial experts at Milliman recently concluded, “A buy-in option has the potential to further fragment the ACA markets and introduce selection opportunities that may be challenging or impossible to predict or control.”[11] With enrollment declining and premium revenues shrinking, many issuers might decide it’s simply not worth it to stay.

Thus, proposals for a Medicare buy-in could help those aged 50-64, but lead to higher premiums and fewer choices in the individual market.

Conclusion

The foundation is there for us to build on what we have to make our current health care system better and ensure everyone has coverage at a more affordable price. Rather than introducing complexity and disruption into the system, we recommend that Congress build on recent progress in expanding access to coverage and make changes that encourage more affordability, competition and choice for consumers.

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[10] Eibner C, Vardavas R, et. al, “Opening Medicare to Americans Aged 50 to 64 Would Cut Their Insurance Costs, but Drive Up Insurance Prices for Younger People,” RAND. November, 2019. https://www.rand.org/news/press/2019/11/18.html.

[11] Kotecki L, Westrom, S, “Actuarial Implications of a Medicare Buy-in Option,” June, 2019. https://www.soa.org/globalassets/assets/files/e-business/pd/events/2019/health-meeting/pd-2019-06-health-session-038.pdf.