

STATEMENT OF

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BEFORE THE SUBCOMMITTEE ON HEALTH
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PROPOSALS TO ACHIEVE UNIVERSAL HEALTH CARE COVERAGE

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Introduction

Madame Chair, Ranking Member Burgess, and Members of the Subcommittee:

I am Sara Rosenbaum, Harold and Jane Hirsh Professor of Health Law and Policy at the Milken Institute School of Public Health, George Washington University. Thank you for inviting me to offer testimony at today's important hearing on proposals to achieve universal health coverage.

Progress and Challenges

Over the past half century, Congress has been on a journey to address the question of how to make affordable, high quality health insurance a reality for all Americans. By the mid-1960s, the limits of a voluntary employer-sponsored system -- which by then had risen to dominance through favorable tax treatment and collective bargaining -- were evident. The shortcomings were particularly obvious for the elderly, the poor, and those with disabilities. The ensuing five decades have witnessed a range of tested strategies. Policymakers have taken a single payer approach in the case of Medicare. They have also pursued incremental reforms for targeted populations. These incremental strategies are represented by Medicaid (which straddles the worlds of public insurance and public health and whose flexibility has enabled federal and state policymakers to fashion solutions to major population health challenges) and its companion Children's Health Insurance Program (CHIP). This approach is also reflected in tax policies aimed at addressing the problem of affordability for lower and moderate-income people. All of these reforms have a common goal -- to strengthen the accessibility, affordability, and effectiveness of insurance health insurance for all Americans.

The journey remains far from over. Millions of Americans remain uninsured. Millions more are under-insured because premiums and cost sharing are too high, and coverage is too limited for people with serious and chronic health conditions that require ongoing care. All of this is taking place against a backdrop of the U.S. health system, whose costs are the highest among wealthy nations. Even preventive care and primary care, as well as standard treatments for conditions that can be well managed at low cost, are financially out of reach without reliable, steady health insurance.

Because of what we have been able to accomplish in the decade since passage of the Affordable Care Act, it is especially important to keep moving forward. What you seek to address through this hearing is your options for doing so, both incremental and sweeping.

What the Affordable Care Act Has Accomplished

As we approach the tenth anniversary of the Affordable Care Act, it is worth taking stock of what has been accomplished using a multi-payer, incremental approach. The major elements of this approach have been creation of a pathway to affordable private insurance, extension of Medicaid to low income adults left out of the traditional program, and crucial market reforms aimed at promoting coverage access and quality.

The ACA's multi-pronged approach has produced lasting, measurable achievements. In 2013, immediately before the ACA's major provisions took effect, 44 million people (16.8 percent of the

nonelderly population) lacked any insurance; by 2016 that figure had dropped to 26.7 million (10.0 percent).¹ Millions have gained coverage. Measurable progress has occurred across all income levels, but especially among low-income people, where the risk of being without insurance historically has been the greatest. Advances have been most significant in those states that elected to expand Medicaid, and they have been at visible across all racial and ethnic groups and all ages.²

Coverage has become more comprehensive. Most privately insured families are now guaranteed coverage for their children's ongoing preventive health needs, and all family members qualify for recommended immunizations at no cost. The proportion of women reporting out-of-pocket spending for oral contraceptives has declined from 23.3 percent to 2.7 percent.³ Those whose coverage is governed by the rules that apply to qualified health plans sold in the individual and small group markets are assured of coverage for mental health and addiction-related services, and parents of children with serious developmental disabilities who are insured through plans meeting these standards have a guarantee of access to habilitative care.

Extensive research has documented the ACA's impact not only on coverage but also on access to care itself. Experts attribute the ACA expansions to a 21 percent and 25 percent decline in the probability of not receiving medical care. The probability of having a usual source of care (a key test of a well-functioning health care system) has grown by between 47.1 and 86.5 percent.⁴ The Medicaid expansions have received particular attention, with scores of studies showing measurable impact on health care access, health outcome measures themselves, greater economic stability within community health systems (especially in poorer communities), and increased employability.⁵ Some 54 million

¹ Rachel Garfield et al., *The Uninsured and the ACA: A Primer* (Kaiser Family Foundation, 2019) (Figure 2) <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>

² Id. Figure 3

³ Laurie Sobel et al., *New Regulations Broadening Employer Exemptions to Contraceptive Coverage: Impact on Women* (Kaiser Family Foundation, 2018), <https://www.kff.org/health-reform/issue-brief/new-regulations-broadening-employer-exemptions-to-contraceptive-coverage-impact-on-women/>

⁴ Sherry Glied et al., *Effect of the Affordable Care Act on Health Care Access* (Commonwealth Fund, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/may/effect-affordable-care-act-health-care-access>

⁵ Larisa Antonisse et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* (Kaiser Family Foundation, 2019), <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/>

people (27 percent of the nonelderly population) have benefitted from the law's pre-existing condition protections; in a pre-ACA world, their conditions would have triggered a denial of coverage.⁶

Other ACA investments have yielded notable results. The law's Medicare reforms have improved preventive services coverage and have reduced beneficiaries' financial exposure for out-of-pocket prescription drug costs. Its dependent coverage provisions have enabled 2.3 million young adults to gain insurance. The law's investment in community health centers has enabled health centers to double their sites in medically underserved urban and rural communities while increasing the number of patients served by over 50 percent.⁷ Coupled with the Medicaid expansion, the health center investment has given community health centers the financial investment they need to expand their care to include opioid addiction treatment and prevention, expanded oral health care, expanded services for patients with serious and chronic health conditions, and other types of care.⁸

Stalled Progress

Today, however, progress has stalled. Indeed, the nation shows signs of slipping backward. As a result of the United States Supreme Court's 2012 decision in *National Federation of Independent Businesses v Sebelius*, the Medicaid expansion effectively became optional. As a result, 2.5 million people fall into a coverage gap – ineligible for Medicaid but too poor for tax subsidies, whose lower income threshold in non-expansion states sits at 100 percent of the federal poverty level.⁹ Beyond the problems created for the poorest people by the Court's decision are aspects of the ACA that need to evolve; the need to improve complex legislation over time is an inevitable part of the lawmaking process. Chief among these are premium and cost-sharing structures that are insufficiently protective, benefits that need to be strengthened, and strategies to inject greater competition into the market for private insurance as a strategy for helping to hold down costs.

⁶ Potential Impact of Texas v. U.S. Decision on Key Provisions of the Affordable Care Act (Kaiser Family Foundation, November 2019), <https://www.kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act/>

⁷ Sara Rosenbaum et al., Community Health Centers: Growing Importance in a Changing Health Care System (Kaiser Family Foundation, 2018), <https://www.kff.org/medicaid/issue-brief/community-health-centers-growing-importance-in-a-changing-health-care-system/>

⁸ Corinne Lewis et al., The Role of Medicaid Expansion in Care Delivery at Community Health Centers (Commonwealth Fund, 2019), <https://www.commonwealthfund.org/publications/issue-briefs/2019/apr/role-medicare-expansion-care-delivery-FQHCs>

⁹ The Uninsured: A Primer, op. cit.

Beyond these follow-on challenges is a need to reverse this administration's systematic efforts to undermine the law. The two most prominent aspects of this effort are its multi-strategy campaign against Medicaid (not just the expansion but traditional populations as well, as evidenced by its embrace of a block grant), as well as its aggressive pursuit of policies that carry serious implications for a stable and affordable risk pool for comprehensive coverage. Since the President assumed office, over 1 million people have dropped individual coverage because of high cost. Experimentation on the poorest people through Medicaid work rules – approved by the Administration without considering its impact on the experimental subjects -- cost over 18,000 people their coverage in one state before the courts stepped in. Leading research in the field concluded that 95 percent of those losing Medicaid coverage in Arkansas – the first experimental state to go live – remained eligible for coverage or exempt from the experiment but lost their benefits in a welter of confusion.¹⁰

Finally, of course, the ACA did not address the fundamental and underlying cost of health care. These costs have grown so steeply that insurance is now riddled with cost-sharing and coverage limits, and even standard care is out of reach, especially for those who depend on prescription drugs to manage treatable health conditions.

No payer can cope with this problem alone, one driven principally by the price of medical care along with intensity of services. By themselves, these two factors accounted for over 50 percent of the spending increase between 1996 and 2013. Population growth and aging together were minority contributors (slightly less than 35 percent), changes in disease prevalence or incidence contributed only modestly (about 2.4 percent) and changes in utilization did not contribute at all over this time period.¹¹ Even drugs like insulin that previously cost literally pennies per day are now completely unaffordable.

Surging spending has placed immense strains on public programs and has eroded the level of protection against covered health risks offered by private insurance, including employer plans. Research shows that between 2014 and 2018, the percentage of people reported being underinsured (out-of-pocket health care costs, excluding premiums, that exceed 10 percent of household income) increased from 23 percent to 29 percent. Growth in underinsurance was biggest for those insured through job-based plans – from 20 percent in 2014 to 28 percent in 2018.¹² In 1992 my own employer, George Washington University, offered its employees a workplace health plan that allowed us a wide choice of insurers and provided actuarial value of better than 90 percent. Today GW offers a single plan for workers and their

¹⁰ Benjamin D. Sommers et al., Medicaid Work Requirements – Results from the First Year in Arkansas *New Eng. J. Med* (2019) 381:1073-1082

¹¹ Joseph L. Dielman et al., Factors Associated with Increases in US Health Care Spending, 1996-2013. *JAMA* 2017; 318(17): 1668-1678

¹² Sara R. Collins et al., Health Insurance Coverage Eight Years after the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured (Commonwealth Fund, 2019), https://www.commonwealthfund.org/sites/default/files/2019-02/EMBARGOED_Collins_hlt_ins_coverage_8_years_after_ACA_2018_biennial_survey_sb_v4.pdf

families, whose actuarial value is slightly more than 80 percent value – a better-than ten-percentage point drop in value, with significantly elevated cost sharing.

Furthermore, the percentage of nonelderly insured Americans has declined from its 2016 high. In 2017, 7.9 percent of the total population was uninsured; in 2018, this figure rose to 8.5 percent – 27.5 million people, including children.¹³ In addition to rising costs, other factors contributing to this trend and identified by experts have been federal policies that weakened the individual insurance market and that are associated with the departure of over a million people from the individual market. An additional major cause of this drop was a 1.6 million-person decline in Medicaid coverage. A strong economy and better access to employer coverage might explain some of this decline. However, at the same time, this is occurring at a time that the administration has effectively weaponized Medicaid's important Program Integrity safeguards in order to target expansion states and warn non-expansion states of what they can expect should they decide to adopt the expansion.

Continuing Challenges

Even as we make progress, we thus find ourselves in 2019 confronting the same basic set of challenges that led to the enactment of Medicare and Medicaid in 1965, the creation of CHIP, and ultimately the Affordable Care Act in 2010. The first challenge is the absence of a coverage guarantee for all Americans regardless of place of residence, family social or economic circumstances, or other factors unrelated to the need for coverage. Among the more than 27 million uninsured Americans in 2018, three quarters lived in families with one or more full-time workers, and nearly half had incomes below twice poverty. The greatest risk of being completely uninsured is borne by Americans who are members of racial and ethnic minority groups. Moreover, certain states reflect an especially high risk of being uninsured; in 18 states, the uninsured rate continues to exceed 10 percent. Nearly half the uninsured report cost as the single greatest barrier even though more than half are eligible for a subsidy through Medicaid or Marketplace coverage.¹⁴ What to do in states that have not adopted the Medicaid expansion and whose decision has stranded the poorest people in the country represents an especially urgent aspect of the problem.

Should the ACA be overturned as unconstitutional, the number of people without a meaningful coverage pathway will skyrocket. This outcome, which the administration is actively advocating for in the courts, would mean coverage losses for nearly 13 million Medicaid beneficiaries and over 9 million Marketplace enrollees (5.5 million of whom receive marketplace subsidies). Tens of millions would lose the ACA's access and market protections; ending the vital protection against denial of coverage based on preexisting condition would end, affecting an estimated 54 million people who depend on this reform. Several million young adults would stand to lose dependent coverage. Community health

¹³ Edward Berchick et al., Health Insurance Coverage in the United States: 2018 (United States Census Bureau, Current Population Reports, P60-267(RV))

¹⁴ The Uninsured and the ACA: A Primer (op. cit.)

centers would face a loss of 70 percent of their grant funding and widespread care reductions would follow.¹⁵

Beyond the absence of any coverage is the problem of coverage “churn”, which produces constant breaks in coverage. This problem disproportionately affects lower income families who are likely to experience more frequent income fluctuations owing to the nature of work and changes in life circumstances that can disrupt insurance enrollment in a nation whose main source of benefits comes from fulltime workplace employment at jobs with good wages. People who experience coverage churn are also likely to experience disruptions in medical care and access to needed drug prescriptions, increased reliance on emergency departments, and worse self-reported quality of care and health.¹⁶

A third problem is inadequate coverage, reflected in the high proportion of under-insured Americans. However, being under-insured entails more than high cost sharing for covered services; it can also involve the extensive coverage exclusions and limitations – increasingly a tool of insurers along with cost-sharing and narrow networks in order to hold down premium costs. These restrictions and exclusions disproportionately affect children and adults with serious and chronic physical, mental, and developmental disabilities. In modern private insurance products, coverage exclusions are pervasive, especially the use of medical necessity criteria that restrict coverage to patients who can “improve” in insurer parlance, with exclusions applicable to patients who need treatment to maintain functioning or avert functional deterioration. A variation on this problem is prescription drug tiering that places essential drugs out of financial reach, even if ostensibly covered.

High health costs, of course, loom over the challenge of coverage. The cost of care is such a foundational issue that it simply must be tackled if the nation is to move decisively toward coverage universality.

The final issue is one that the ACA grappled with to a certain degree and that over time has commanded increasing attention. This is the problem of health inequity, which strikes not only individuals but entire communities. This set of challenges has many dimensions: community impoverishment and elevated health risks that in turn contribute to deep health care shortages, especially for primary care and basic medical management of treatable conditions. We have only to look at U.S. maternal and infant mortality rates – two of the most sensitive measures of population health – to see a manifestation of these problems. The opioid epidemic is yet another manifestation of the combined effect of widespread poverty and the adverse social conditions that accompany it, combined with an acute shortage of health

¹⁵ Kaiser Family Foundation, Community Health Centers Prepare for Funding Uncertainty (September 2019), <https://www.kff.org/medicaid/issue-brief/community-health-centers-prepare-for-funding-uncertainty/>

¹⁶ Benjamin D. Sommers et al., Insurance Churning Rates For Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many

care. These problems are now so bad that we are actually witnessing rising mortality among nonelderly adults and declining life expectancy. In rural communities, the health care system is literally collapsing.

Certainly moving to universal coverage would help stabilize health care systems and provide badly needed resources for hospitals, physicians and clinics, all of which face overwhelming survival odds stacked against them in communities with badly elevated rates of uninsured people. But direct economic investment is also necessary to support the modernization of regional health systems weakened by years of neglect. National health reform needs to include approaches that complement insurance expansions, such as direct investments in health care infrastructure necessary to modernizing rural hospitals, creation of new primary care access points, and continuation of past, highly successful investments in community health centers, teaching health centers, and the National Health Service Corps. New care models must be designed to take advantage of major strides in communication technology that enable good quality care even in remote areas. Also essential are regional-level public health investments that assist communities, working with public health agencies and health care and social service providers, in tackling community-wide health problems whose solution lies in better coordination across health care, public health, education, job development, and social service systems.

The Proposals Before this Subcommittee

This hearing represents an important effort by this Subcommittee to begin serious consideration of its options. The bills under consideration today differ from one another in important ways. All, in my view, represent steps forward. The central legislative and political question lawmakers face is how broadly to aim.

Should Congress take a sweeping approach that essentially replaces the multi-payer system with one that operates under strong, uniform standards of federal design and program administration as is the case with Medicare? If so, should the shift happen in the relative near term (within a few years) or only over a lengthier phase-in period? Alternatively, should lawmakers pursue a more incremental approach designed to address the important but discrete and specific challenges that tend to arise a multi-payer system but at the same time, doing so in a more coordinated fashion? What tools should be introduced that can hold down costs in multi-payer markets? Moreover, should one of those tools include competition by a public insurer?

Medicaid poses separate questions in my view. A key one is whether Medicaid should be preserved because of its programmatic uniqueness and flexibility. If Congress proceeds with a public option, what flexibilities should states have to merge Medicaid into a larger public program, and if so, for what populations and for what services? Must Medicaid be retained to carry out public health functions that traditional insurance – public or private – simply cannot be expected to play, such as coverage whenever care is needed, retroactive eligibility, and the ability to flexibly expand to meet new needs? Moreover, should Congress assure that all poor Americans have a guaranteed pathway to coverage regardless of the Medicaid expansion choice their state of residence might make?

Finally, is investment in stabilizing and strengthening the health care system in medically underserved communities to be viewed as integral to any reform effort? Furthermore, should health care itself be

viewed as part of a larger health and social welfare enterprise, in which health care systems work with other community programs and providers, not just as clinicians, but as public health and social actors?

These are the enormous issues that this Subcommittee – and Congress as a whole – will need to confront in the coming years.

I welcome questions.