Testimony

Health Insurance Coverage in America: Current and Future Role of Federal Programs

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Introduction

Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for the opportunity to discuss health insurance coverage in America and the role of federal programs. In this testimony, I hope to make three main points:

- The vast majority of Americans are covered by health insurance, with private insurance provided by employers being the leading source of coverage.
- During 2020, the onset of the pandemic slightly reduced private insurance, but public safety net programs offset the loss and left the fraction of Americans uninsured roughly unchanged.
- Despite this success, key public programs – Medicare and Medicaid – can benefit from reforms that raise the value of the care provided to their beneficiaries.

Let me discuss each of these in greater detail.

Sources of Health Care Coverage

Pre-COVID-19 Coverage

Released last month, the Census Bureau's report, "Health Insurance Coverage in the United States: 2020," describes the state of health insurance coverage from 2020, based on data collected in the Current Population Survey Annual Social and Economic Supplement (CPS ASEC). The survey was conducted from February to April 2021 and asked participants about health insurance held at any time throughout 2020. Given the wording of the question, people are considered uninsured in 2020 only if they had no coverage at any time during the year, and they are instead counted in the coverage group for insurance they held at the beginning of the year, and potentially in more than one group if they transitioned. Ultimately, those who lost coverage in 2020 due to the COVID-19 pandemic are not included in the uninsured rate for 2020. Therefore, the 2020 report provides the most recent look at health insurance coverage in the United States just prior to the effects of the pandemic.[1]

According to the report, 66.5 percent of people in the United States had private coverage in 2020, 34.8 percent had public coverage, and 8.6 percent of people in the United States, or 28.0 million, did not have health

insurance at any point during the year. Employer-sponsored insurance (ESI) remained the most common sub-type of health insurance, with 54.4 percent of the population covered for some or all of the calendar year, followed by Medicare (18.4 percent), Medicaid (17.8 percent), direct-purchase coverage (10.5 percent), TRICARE (2.8 percent), and coverage through Veterans Affairs (VA) or Civilian Health and Medical Program of the Department of Veterans Affairs (0.9 percent).

The report also details health insurance coverage across various demographic groups, displaying disparities in coverage that existed prior to the pandemic. In 2020, Hispanics, inclusive of all races, had the highest uninsured rate (18.3 percent), followed by Blacks (10.4 percent), Asians (5.9 percent), and non-Hispanic Whites (5.4 percent). Blacks had the highest rate of public coverage at 41.4 percent, while non-Hispanic Whites had the highest rate of private coverage (73.9 percent).

Adults aged 65 and older and children under age 19 were more likely to have coverage than those aged 19 to 64, given their age-eligible status for federal programs. Only 1.0 percent of those aged 65 or older and 5.6 percent of those under age 19 were uninsured for all of 2020, compared to 11.9 percent of those aged 19 to 64.

Poverty and employment also contributed to disparities in health care coverage in 2020. Those living in poverty, with an income below 100 percent of the Federal Poverty Level (FPL), were most likely to be uninsured for the entire calendar year at 17.2 percent, while those with incomes above 400 percent of the FPL were the least likely to be uninsured (3.4 percent). Additionally, among adults aged 19 to 64 years, 12.9 percent of those who did not work at least one week in the year were uninsured for the entire calendar year, compared to 8.4 percent of full-time, year-round workers. Many adults receive health insurance through their employer, and in 2020, 87 percent of full-time, year-round workers were covered by private insurance.

COVID-19 Impacts on Coverage

Since the second quarter of 2020, the COVID-19 pandemic has affected the United States economy and the health insurance market. Over half of the United States population received health insurance through their employer prior to the pandemic, leaving room for significant impacts on health coverage following the loss of 22.2 million jobs between March and April 2020. Last year, several studies attempted to predict pandemic-related losses in coverage, estimating between 3.5 to 5.7 million would become uninsured due to loss of ESI.[2], [3] Given the ongoing nature of the pandemic and the lack of significant real-time data, there is still no finite gauge on the effects of the pandemic on insurance coverage, yet more recent preliminary estimates suggest that the effects have not been nearly as detrimental as initially feared.

Last month, researchers at Duke University and Indiana University-Purdue University Indianapolis released a report that found nearly 2.7 million people in the United States lost their health insurance in the spring and summer months (April 23–July 21, 2020), based on data from the Census Bureau's 2020 Household Pulse Survey.[4] This change represented a decline of 1.36 percentage points over the 12-week period. By the fall and winter months (August 19–December 21, 2020), they found enrollment in other coverage types rose enough to offset the loss in ESI, resulting in an insignificant change in the uninsured rate in the fall and winter months of 2020.

Based on the same data from the 2020 Household Pulse Survey, the Urban Institute estimated that 3.3 million adults lost ESI and 1.9 million became uninsured from April 23—July 21, 2020. In their estimates, the overall uninsured rate increased by 1 percentage point in this time period but increased 3.8 percentage points among Hispanic adults and increased 1.6 percentage points among adults with a high school degree or less.

Additionally, public coverage rose by 1.1 percentage points during this 3-month period.[5]

A December 2020 report from the Kaiser Family Foundation (KFF) reached similar numbers using employment rates and enrollment in the fully insured group market to extrapolate a rough estimate for the entire ESI market, concluding that approximately 2 to 3 million people lost ESI between March and September 2020.[6] They also note, however, that losses in ESI were largely offset by gains in Medicaid and Marketplace enrollment.

A study from the Heritage Foundation, based on data from the National Association of Insurance Commissioners, found a 7 percent increase in Medicaid and Children's Health Insurance Program (CHIP) enrollment in the first three quarters of 2020, reflective of government measures to address pandemic-related loss of coverage, such as the temporary increase in federal funding for state Medicaid programs and the maintenance of eligibility provisions in the Families First Coronavirus Response Act.[7] More recently, in June 2021, CMS championed record increases in Medicaid and CHIP enrollment, citing a 13.9 percent increase between February 2020 and January 2021.[8] It appears that countercyclical social safety net programs are meeting demand without expansion or increased federal funding, though they should not become a primary source of health coverage for Americans.

While the pandemic may have led to a shift in the distribution of coverage across subtypes, overall coverage rates remained steady for several reasons. Those that lost employment were likely never enrolled in ESI; lower-wage workers are less likely to be covered by an employer plan, and pandemic-related job losses were most pronounced in industries with lower coverage rates.[9] People who did lose ESI as a result of job loss qualified for a special enrollment period for Marketplace coverage, and low-income individuals or families may have become eligible for Medicaid or CHIP. Additionally, many employers continued to temporarily offer ESI or premium support to furloughed or laid-off employees, which further mitigated the pandemic's effects on overall coverage.[10]

If preliminary estimates are true and the uninsured rate has indeed remained steady, there are still around 28 million people without health insurance. Yet according to KFF, 57 percent of the typical non-elderly uninsured population are eligible for, but do not enroll in, free or subsidized coverage. Based on 2019 data, around 40 percent of the typical non-elderly, uninsured population are eligible for free insurance through either Medicaid (24 percent) or a Marketplace Bronze plan with a $0 premium (16 percent). In addition, 17 percent are likely eligible for subsidized coverage through Marketplaces.[11] Using 2017 data, KFF estimated in another study that roughly 15 percent of the typical non-elderly uninsured population is ineligible for subsidies due to undocumented immigrant status, 14 percent declined an offer of ESI, and 7 percent had incomes above 400 percent of the FPL, making them ineligible for subsidies.[12] Ultimately, it is not clear that expanding federal programs would necessarily cover these populations. In January 2021, 2.2 million individuals fell in the coverage gap as a result of states electing not to expand their Medicaid programs under the Affordable Care Act.[13]

Much is still unknown about the future of COVID-19 and its lingering effects on health coverage. Looking ahead, policymakers should explore why people forgo viable coverage options, identify those that are truly without coverage options, and focus on the subset of individuals living in non-expansion states.

Drivers of Health Care Costs

According to the 2019 National Health Expenditure Account from the Centers for Medicare and Medicaid Services (CMS), individuals, health insurers, and federal and state governments spent a combined $3.8 trillion

on health expenditures in 2019, accounting for 17.7 percent of the national gross domestic product (GDP).[14] From 2010–2018, national health expenditures have grown an average of 4.5 percent each year compared to the previous year, but spending remained around 17 percent of national GDP.[15]

In 2019, roughly 73 percent of total health expenditures, or approximately $2.77 trillion, was spent on health insurance: private health insurance spending accounted for 31 percent of total health expenditures, Medicare accounted for 21 percent, Medicaid accounted for 16 percent, and other health care services (including VA, Department of Defense, and CHIP) made up 4 percent.[16] Based on this data, spending per beneficiary in 2019 was highest for Medicare ($13,276), followed by Medicaid ($8,485) and private health insurance ($5,927). The remaining 27 percent of total health expenditures was split between out-of-pocket (OOP) costs (11 percent), other third-party payers and programs (9 percent), investments (5 percent) and government public health activities (3 percent).[17]

A number of factors can drive health care costs—including, but not limited to provider consolidation, rising prices of health services, a growing, aging, or sicker population—yet pouring more money into the issue will not necessarily improve coverage, especially in the case of Medicare. According to the Medicare Trustees report released on August 31 of this year, the Medicare Trust Fund, which covers hospital services through Medicare Part A, will be depleted in 2026. In 2020, Medicare spending resulted in a $495.5 billion deficit, which accounted for 16 percent of the federal debt. Despite the fact that it would require a nearly 33 percent increase in Medicare payroll taxes to cover the Part A cash shortfalls in 2020, progressives continue to push costly agendas to expand the program.

At the start of the pandemic in spring 2020, social distancing measures and attempts to mitigate the spread of the virus led to cancellations of elective procedures and outpatient appointments. Despite subsequent increases in health spending as demand grew for laboratory services and hospitals resumed procedures at the end of the year, overall health spending fell slightly in 2020, according to analysis from the Peterson-KFF Health System Tracker.[18] Total health spending in December 2020 was 1.5 percentage points lower than total health spending from December 2019. Yet GDP fell by 3.5 percent in 2020, meaning that total health spending likely represented a greater share of overall national spending for the year. The sustained decrease in the utilization of preventative services and chronic disease screenings may have long-term impacts on health outcomes and health costs.[19]

Room for Improvement

While over half of the United States population receives health insurance through their employer, a significant portion of the population relies—for better or worse—on federal and state programs for health care coverage. For these individuals, the future of health care coverage should focus on enhancing existing federal programs to balance costs and provide high value care.

Medicare Advantage

Medicare Advantage (MA) allows beneficiaries to enroll in plans managed by private insurers, as opposed to partaking in the traditional fee-for-service (FFS) Medicare program. MA's popularity continues to grow, because it provides beneficiaries with expanded choices of plans and coverage options at affordable prices.[20] In fact, MA has leveraged the power of competition to control costs: Average premiums for MA plans have continuously decreased since 2015, with average premiums at $21 a month this year.[21] Additionally, MA beneficiaries spend 40 percent less on OOP costs than FFS beneficiaries and nearly two-thirds of MA seniors

are in $0 premium plans.[22] These savings are significant, especially when considering that more than half of all MA enrollees live on an annual income of less than $24,500.[23]

The average MA enrollee chooses from 33 plans offered by 8 different issuers in their geographic area,[24] and there is even some evidence that MA enrollment leads to better health outcomes: MA enrollees have 33 percent fewer emergency department visits and 23 percent fewer hospital visits than those in FFS Medicare.[25] MA beneficiaries also experienced lower COVID-19 hospitalization and mortality rates than FFS beneficiaries, perhaps in part due to coordinated care services for seniors that included vaccination support, meal delivery, and at-home testing.[26]

Enrollment in MA continues to grow, with 42 percent of current Medicare beneficiaries enrolled in MA as of March of this year and 51 percent of Medicare beneficiaries expected to be enrolled in MA by 2030.[27] MA beneficiaries are proportionally more diverse, lower income, and more complex than those in FFS: racial minorities make up a larger share of the MA population (33 percent) than they do of the FFS population (16 percent).[28]MA costs $7 billion more a year than traditional Medicare, largely because of the supplemental benefits MA plans offer, such as dental, hearing, and vision.[29] Yet, in the grand scheme of a $776 billion entitlement program, $7 billion amounts to less than 1 percent of total spending.[30]

Rather than pursuing costly agendas to expand supplemental benefits or lower the Medicare eligibility age, advocates for enhancing health care coverage for the elderly should focus on bolstering MA.

Medicare Part D Reform

Medicare Part D provides Medicare beneficiaries with access to subsidized prescription drug coverage, and in 2021, 48 million seniors, or 77 percent of all Medicare beneficiaries, enrolled in Part D benefits.[31] While the program has been largely successful, it represents approximately a third of all drug spending in the United States, and its current structure, along with pricing incentives in the broader pharmaceutical market, creates perverse incentives for insurers and drug manufacturers to benefit from high-cost drugs.

Growing pharmaceutical expenditures in the past several years, driven by a significant increase in both the number of beneficiaries reaching catastrophic coverage and the costs that each of them incur, have led to a resounding push to reform Part D to realign incentives. Spreading the risk for high-cost beneficiaries to insurers and drug manufacturers, while capping the liability of beneficiaries, could induce behavioral changes that lead to lower costs for all parties.

Reforms should include placing a true cap on beneficiary OOP expenditures, eliminating the coverage gap phase entirely and instead requiring drug manufacturers to pay rebates during the catastrophic phase, reducing the federal government's reinsurance rate, and increasing plans' liability in the catastrophic phase. Under a Part D redesign such as the one proposed by the American Action Forum in 2018, assuming a maximum OOP (MOOP) cap of $2,500, would collectively save beneficiaries $7.4 billion over 10 years (from 2020-2029). Each beneficiary would see an increase in their premiums of only $61 over the entire 10-year window, or an average monthly increase of $0.51. Across all beneficiaries, the reduced cost-sharing expenses would more than offset the increase in premiums paid.

In this same proposal, the federal government would be expected to save $23.4 billion over 10 years if a $2,500 MOOP were implemented in 2020 and a 5 percent reduction in brand drug spending occurred. While total premium subsidies would increase $637.4 billion, reinsurance expenditures would decline by $473.2 billion, and

low-income subsidy cost-sharing subsidies would decline by $187.6 billion.

If the maximum OOP cap is increased, however, expected overall beneficiary savings would decrease while federal government savings would increase. With a $4,000 maximum OOP cap, the federal government would save $31 billion over the 10-year period, and beneficiaries would save $400 million over 10 years. In this scenario, premium increases would offset nearly all of the expected reductions in cost-sharing.

Insurers will want to find ways to counter beneficiaries' loss of incentive to use lower-cost alternatives; such tools already at plans' disposal include requiring pre-authorization or step therapy for coverage of higher-cost drugs. Beneficiaries may resist if the tools impose too much of a barrier to accessing their preferred drug. If policymakers take seriously the effort to reduce expenditures and use of low-value health care products, however, they will have to make tradeoffs. Alternatively, current rules could be loosened to provide plans more options to control costs in ways that are less punitive or burdensome to beneficiaries. This approach could include greater formulary flexibility such as loosening the protected classes requirements and allowing more narrow coverage options in certain therapeutic classes, as recommended by MedPAC.[32]

That being said, restructuring the benefit design of Medicare Part D in a way that realigns incentives away from high-cost, high-rebate drugs may be the best option to reduce overall program costs as well as drug prices in other parts of the market.

Managed Medicaid

Medicaid managed care programs can assist states in reducing Medicaid costs and better utilizing health services to improve outcomes for Medicaid beneficiaries. While traditional FFS Medicaid encourages greater use of services and use of more expensive services as it reimburses providers for each service performed without any quality controls or value assessments of services, Managed Care Organizations (MCOs) are required to meet certain quality standards as part of their contract with the state and are paid a fixed amount for each enrollee, thus eliminating the incentive to provide unnecessary services. As of this year, 40 states and the District of Columbia use MCOs.

MCOs establish a network of providers and connect patients with a primary care provider, disincentivize overutilization of services or use of high cost services, and incentivize and encourage wellness and preventive services. These and other cost management strategies to discourage resource use, limit subspecialists and/or require approvals for referrals work very well for generally healthy populations with preventive and episodic health needs. Chronic complex populations, particularly children, have many specialized needs that must be closely integrated and delivered in a coordinated fashion, often on a daily basis, to be effective.

While all individuals can benefit from managed care programs, individuals with above-average health care needs will benefit the most from the stricter regulations regarding quality of care and beneficiary protections. Future efforts to improve MCOs should focus on enrolling higher-cost populations. The aged and disabled are the costliest Medicaid beneficiaries, therefore their lack of enrollment in managed care programs (and thus their continued enrollment in FFS Medicaid) has resulted in much of the potential benefit offered by such programs to go unrealized. Aged and disabled beneficiaries account for 60 percent of all Medicaid expenditures despite being only a quarter of the Medicaid population.[33] As such, despite 69 percent of Medicaid beneficiaries being enrolled in MCOs in 2018, only 46.2 percent of total Medicaid spending was spent on MCOs in 2019.[34]

Adults and children with chronic or complex medical conditions have expenditures far above the average for

those without such conditions, yet many of these individuals with complex needs are not receiving the most appropriate or beneficial care, and they—and the Medicaid budget—are worse off because of it. A more integrated and coordinated approach through managed Medicaid would expand coverage for the most vulnerable populations while controlling costs and improving outcomes for all.

Conclusion

Collectively, Americans are getting older, living longer, and becoming increasingly burdened with chronic diseases.[35] Looking to the future, the federal government should focus on maximizing spending power and improving the value of existing programs to ensure sustainable and high-quality health care.

Thank you. I look forward to answering your questions.

Notes

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