



FEATURE

Setting the stage for Medicare for All and the health coverage debate

Proposals, key policy questions, and stakeholder perspectives.

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THE DELOITTE CENTER FOR HEALTH SOLUTIONS, THE DELOITTE CENTER FOR REGULATORY STRATEGIES, AND
THE DELOITTE CENTER FOR GOVERNMENT INSIGHTS

Health coverage has taken center stage during the campaigns for the next presidential election. We explore four coverage expansion proposals and what they mean for industry stakeholders.

HEALTH COVERAGE AND financing are top debate issues in this election cycle. Presidential candidates, health policy experts, and think tanks are discussing a range of proposals. It is too early to say what proposals, or which candidates, will move to center stage. That said, there is reasonable likelihood that new health coverage policies will continue to be part of the ongoing campaigns and discussions in Washington. Health care stakeholders can benefit from getting to know more about the various proposals to prepare their future strategies.

This policy brief offers a high-level overview of the main proposals, reviews some of the key policy questions, and discusses possible stakeholder implications.

Health coverage today

Why is health coverage an issue? While the Affordable Care Act (ACA) reduced the number of uninsured in the United States, 11 percent (30 million people) were still uninsured in 2019 (figure 1). That said, the uninsured make up a relatively small share of the total population. Many more people, even if they have coverage, are worried about the costs they might face. A recent Gallup poll found that 45 percent of Americans are concerned a major health event could lead to personal bankruptcy, including a third of those earning more than US\$180,000 a year.¹

People with employer-sponsored coverage, in Medicare, and in the ACA exchanges, all might face out-of-pocket expenses in the form of premiums, deductibles, copayments, and coinsurance.

Employers, many of which pay a portion of premiums, have raised concerns about the cost of health care. Premiums and deductibles in the employer market increased significantly between 2009 and 2019—54 percent and 162 percent, respectively. Employees personally contribute about a third of premiums (US\$6,015 for family coverage in 2019) and employers contribute the rest (US\$14,561).² By contrast, wages have increased only modestly above the rate of inflation during that same 10-year period (figure 2).

Democratic presidential candidates are offering proposals aimed at expanding coverage and reducing consumers' out-of-pocket health care costs. Some proposals would create new coverage options, while others would fundamentally change how the US health care system is designed and financed by expanding the role of government and reducing the role of private insurers.

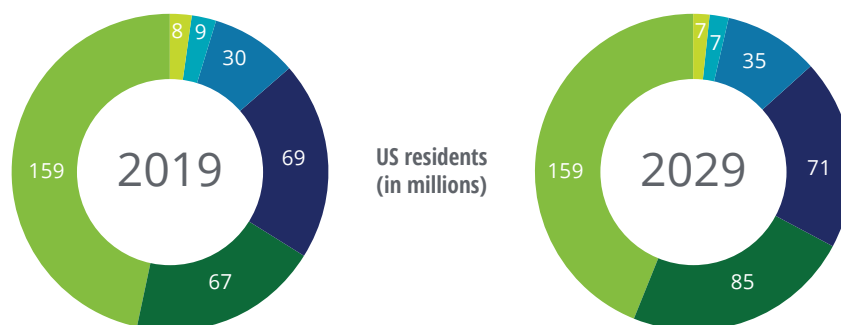
Few of the proposals include strategies to tackle ongoing cost issues in the system, such as reduction of waste, overutilization of services, and improper payments, or address social determinants of health or other public health issues. *The focus of this discussion is primarily on insurance coverage and affordability.*



FIGURE 1

Sources of health coverage for individuals, 2019 and 2029 projections

■ ACA exchanges
 ■ Nongroup and other coverage
 ■ Uninsured
 ■ Medicaid and CHIP
■ Medicare (Part A + MA)
■ Employer-sponsored coverage



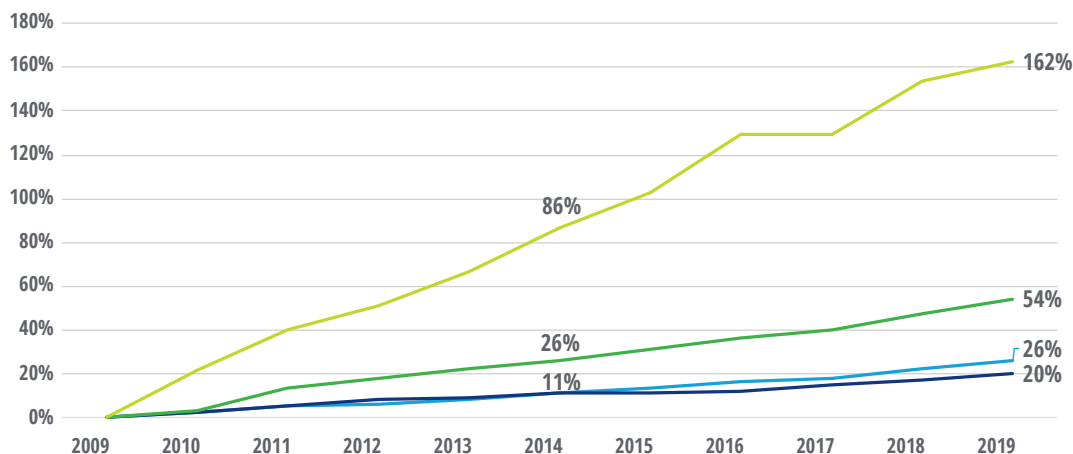
	Employer-sponsored coverage	Medicare (Part A + MA)	Medicaid and CHIP	Uninsured	Nongroup and other coverage	ACA exchanges
2019	159	67	69	30	9	8
2029	159	85	71	35	7	7

Sources: Congressional Budget Office (CBO), *Federal subsidies for health insurance coverage for people under age 65: 2019 to 2029*, May 2, 2019; CBO, “Medicare—CBO’s May 2019 baseline,” May 2, 2019.

FIGURE 2

Premiums and deductibles rose faster than workers’ wages over the past decade

— Workers' earnings
 — Overall inflation
 — Family premiums
 — Deductibles



Sources: KFF Employer Health Benefits Survey, 2018-2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2009-2019; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2009-2019 (April to April).

What are the proposals and their basic tenets?

This brief focuses on how four proposals would change (1) who is covered, (2) what benefits are covered, (3) how health care coverage is funded and regulated, (4) how prescription drugs are paid for, and (5) how much consumers will pay (figure 3). We will describe some of the high-level concepts behind these proposals rather than delving into specific candidates’ ideas as the details continue to evolve.

WHO IS COVERED?

- **Medicare for All:** Expands coverage to every US resident by January 1 of the fourth year after passage.³
- **Medicare for all who want it:** Replaces nongroup coverage, Medicare, Medicaid, and

the Children’s Health Insurance Program (CHIP) with a new form of coverage for all US residents beginning in 2023. Individuals who have qualifying employer-based coverage could opt out of the program.⁴

- **Medicare for more (Medicare Buy-In):** Expands eligibility for Medicare to individuals aged between 50 and 64.⁵
- **Public option:** Proposals vary from allowing individuals who shop on the individual market to purchase a Public Option plan to also allowing those with employer coverage to purchase through the Public Option.⁶

WHAT BENEFITS ARE COVERED?

- **Medicare for All:** ACA’s essential health benefits, long-term services and supports (LTSS), dental, audiology, and vision services.

FIGURE 3
Summary of major provisions

	Medicare for All	Medicare for All who want it	Medicare for more (Medicare Buy-In)	Public option
Who is covered?	Every US resident; carves out Veterans Affairs and Indian Health Services for the first 10 years	Replaces individual market, Medicare, Medicaid, and CHIP; qualifying employer coverage could be exempted	Expands Medicare to people aged 50 to 64	At the very least, available to anyone who shops on the individual market
What benefits are covered?	Essential health benefits plus LTSS, dental, audiology, and vision services		Benefits covered under Medicare Parts A, B, and D	Essential health benefits
How would payments for prescription drugs be set?	Gives the secretary power to negotiate drug prices		Gives the secretary power to negotiate drug prices paid by Medicare Advantage and Part D plan sponsors	Gives the secretary power to negotiate drug prices
What is the proposed financing mechanism?	Higher taxes on employers and high-income households, elimination of tax preference for employer-paid premiums	Premiums paid for by enrollees and through a tax on employers that do not provide qualifying coverage	Establishes a Medicare Buy-In Trust Fund that would be funded by premiums paid by eligible individuals	Premiums that enrollees pay into the program
What do consumers pay?	No premiums, no out of pocket costs	Premiums are paid based off of individuals’ income related to the federal poverty level	Premiums would be set to cover 100 percent of the benefits and administrative costs to administer the program; cost-sharing would be the same as what current Medicare beneficiaries are responsible for	Enrollees would be responsible for paying premiums and cost sharing under the public option plans; the plan would expand premium tax credits

Source: Deloitte analysis.

Bans health plans and employers from offering coverage that duplicates any of the benefits under the program.⁷

- **Medicare for all who want it:** ACA's essential health benefits, LTSS, dental, audiology, and vision services.⁸
- **Medicare for more:** Same benefits as provided under Medicare Parts A, B, and D.⁹
- **Public option:** ACA's essential health benefits.¹⁰

HOW WOULD PAYMENTS FOR PRESCRIPTION DRUGS BE SET?

- **Medicare for All:** Gives the secretary power to negotiate drug prices and directs the secretary to create a prescription drug formulary that encourages the use of generic drugs.¹¹ Note that one variant of this proposal would adopt a pricing scheme that ties drug prices to those in other countries, similar to the International Pricing Index proposal from the Trump Administration.
- **Medicare for all who want it:** Gives the secretary power to negotiate drug prices. Bans the use of prior authorization and step therapy in any type of public or private health insurance coverage.¹²
- **Medicare for more:** Gives the secretary power to negotiate drug prices paid by Medicare Advantage and Part D plan sponsors. Does not make any changes to the rules around formularies.¹³
- **Public option:** Gives the secretary power to negotiate drug prices in Medicare, limits price increases for certain drugs in Medicare and the Public Option, and allows consumers to purchase drugs from other countries.¹⁴

WHAT IS THE PROPOSED FINANCING MECHANISM?

- **Medicare for All:** One proposal would aim to fund the program entirely through taxes. Options include higher employer payroll taxes and increased taxes on corporations and high-income households.¹⁵
- **Medicare for all who want it:** Premiums paid by enrollees and a payroll tax on employers that do not provide qualifying coverage. Increases taxes on high-income households and raises the Medicare payroll tax.¹⁶
- **Medicare for more:** Establishes a new Medicare Buy-In Trust Fund that would be funded by premiums paid by eligible individuals.¹⁷
- **Public option:** Premiums that enrollees pay into the program.¹⁸

WHAT WOULD CONSUMERS PAY?

- **Medicare for All:** No premiums or out-of-pocket costs except for prescription drugs and biologics, which would be prohibited from exceeding US\$200 per year (the amount would be indexed to inflation).¹⁹
- **Medicare for all who want it:** Individuals who earn less than 200 percent of the federal poverty level (FPL) would not pay premiums. Individuals who earn between 200 and 600 percent of the FPL would pay premiums based on a sliding scale. Individuals who earn more than 600 percent of the FPL would pay no more than 8 percent of their adjusted gross monthly income toward their premiums.²⁰
- **Medicare for more:** Premiums would be set to cover 100 percent of the benefits and administrative costs to run the program.

Cost-sharing would be the same as under current Medicare.²¹

- **Public option:** Enrollees would be responsible for paying premiums and cost-sharing. One plan would expand the premium tax credits to cover more generous plans than under the ACA, putting less financial responsibility on the enrollee.²²

A key question is how the government-run program envisioned in Medicare for All would be able to take on the job of paying claims, given health plans do this now through contracts with the Medicare program. (See sidebar, “What role do health plans play in Medicare today?”)

Where is the current administration focused?

The Trump Administration’s health policy actions and proposals have focused on three main goals: expanding access to lower-premium coverage,

increasing price transparency, and promoting delivery system reform.

The administration’s regulations, guidance, and waivers aim to expand access to health coverage with lower premiums for individuals who purchase coverage in the nongroup market, increase price transparency, continue to move the traditional Medicare program to new payment models, and (with support from Congress) give more flexibility to Medicare Advantage plans’ benefit design.

ADDRESSING HEALTH CARE PREMIUMS

- **Approving state reinsurance waivers:** A dozen states have been granted waiver approval through Section 1332 of the ACA to receive federal pass-through funding to partially finance the state’s reinsurance program for health plans that sell coverage through the ACA’s insurance exchanges.²³
- **Expanding health reimbursement arrangements:** Beginning with the 2020

WHAT ROLE DO HEALTH PLANS PLAY IN MEDICARE TODAY?

As of 2018, the Medicare program covered nearly 60 million people—more than one-sixth of the US population—and is growing due to the aging population. Most enrollees (85 percent or 51 million) became eligible for Medicare when they reached age 65; the rest qualified either because of disability or because they have end-stage renal disease. About 36 percent of Medicare beneficiaries purchase private Medicare Advantage plans, which provide Part A and Part B health services and supplemental benefits; the rest are in traditional fee-for-service Medicare.²⁴

While Medicare is a public, government-financed health care program, privately owned health plans, hospitals, physician groups, and pharmacy benefit managers (PBMs) administer most of the benefits and services covered by the program. Even in the traditional Medicare program, the US Centers for Medicare & Medicaid Services (CMS) contracts with private health plans to help pay claims to private hospitals, physicians, and other providers. Moreover, all Medicare beneficiaries who choose drug coverage receive those benefits from private health plans (some are Medicare Advantage plans and others are run by PBM companies).

Many individuals in the traditional Medicare program also buy supplemental coverage from private health plans or—if their incomes are low enough—may qualify for supplemental coverage from state Medicaid programs, many of which contract with private plans.

coverage year, employers can create an individual coverage health reimbursement arrangement (ICHRA) that employees can use to purchase coverage on the individual market. According to the administration, the rule could help small- and mid-sized employers make health insurance more affordable for employees who do not qualify for premium tax credits under the ACA.²⁵

- **Expansion of short-term, limited duration (STLD) health plans:** The administration expanded the availability of STLD health plans, which tend to have lower premiums due to less comprehensive benefits and fewer financial protections than required by the ACA. The Trump Administration issued a rule that allows STLD health plans to last for 12 months, but coverage can be extended up to an additional 36 months.²⁶

INCREASING PRICE TRANSPARENCY

In November 2019, CMS released two rules, one final and one proposed, calling for greater price transparency by hospitals and health insurers. The Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule requires hospitals to make public their standard charges—both gross charges and payment rates that health plans have negotiated with them—by January 2021. The Transparency in Coverage proposed rule would require health plans to publicly disclose both negotiated rates for in-network providers and allowed payment amounts for out-of-network providers. Plans would also be required to post cost-sharing information online and provide their members with an online tool that would allow them to see what their cost-sharing liability is for covered items and services. The intent of both rules is to give consumers a way to compare services based on cost and to drive competition between health care providers and health plans.²⁷

PROMOTING DELIVERY SYSTEM REFORM

The administration continues to use the Center for Medicare & Medicaid Innovation (CMMI) together with authority from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to test new models of payment and care delivery, with the goal of moving toward outcomes-based reimbursement.

ADDING MORE FLEXIBILITY TO MEDICARE ADVANTAGE

Following enactment of the Bipartisan Budget Act of 2018 and an executive order by the White House in 2019, the administration has implemented and proposed regulations to allow Medicare Advantage plans more flexibility to design their benefits to target enrollees who need social services and to encourage the use of virtual care.

Key flashpoints in the coverage debate

Some of the key questions under debate regarding the various coverage proposals include:

WOULD CONSUMERS BE ABLE TO KEEP THE COVERAGE THEY HAVE NOW?

Under many of the proposed plans, consumers could keep their coverage. The Public Option plan, for example, would add a new coverage option, as would a Medicare Buy-In. However, under Medicare for All, every US citizen (except for a few groups) would move to the new plan; coverage through other programs such as employer-based coverage and Medicaid would end.

WOULD PRIVATE INSURERS BE COMPLETELY REMOVED FROM THE SYSTEM?

None of the proposals entirely eliminate commercial health insurance companies. But,

Medicare for All would bar employers and health plans from offering coverage that duplicates any of the benefits available under the program.

Supporters of Medicare for All say that the need for private health plans would effectively be removed because the program would provide more comprehensive benefits than required under current law and regulation.

Plans like the Medicare Buy-In proposal could create *more* revenue for private Medicare Advantage plans by allowing more individuals (ages 50–64) to purchase coverage. It is not clear what the insurance risk pool for this new population might look like. The Public Option would exist to compete directly with health plans that sell coverage on the individual market today but would not remove them entirely from the system.

HOW MUCH WOULD THESE PROPOSALS COST THE FEDERAL GOVERNMENT, AND WOULD NEW TAXES BE NEEDED?

All of the proposals aim to reduce what most individuals pay for health care in premiums and out-of-pocket costs. Most proposals would increase the amount the government spends on health care. Financing provisions—most of which have not yet been fully specified—could increase how much individuals or employers pay to support the health care system through taxes or other financing mechanisms.

How much more the government would need to raise (or find savings in current federal spending) to pay for the proposals depends on:²⁸

- Who would be eligible and what benefits would be covered
- The role, if any, of private insurance and other public programs

- How broad the benefit packages are and how much cost-sharing is required
- The size of the subsidies and how many individuals receive them
- How provider payment rates and prescription drug prices are set
- How the system would be financed (i.e., whether states, local governments, employers, or other entities would be required to maintain their current level of funding)

Observers have noted that the more sweeping proposals could affect the economy through changes to tax policy that would finance the proposals. Other observers question whether the money employers pay today in benefits could turn into higher wages if employers no longer paid for health coverage. Another related question is how contributions that employers would make under some of the plans might impact employees' wages and the larger economy.

The Congressional Budget Office, the official scorekeeper on legislation for Congress, has not estimated costs for any of the proposals. However, two recent studies have come up with estimates for Medicare for All:

- The RAND Corporation projects that total health expenditures would have increased 2019 spending by 1.8 percent (to US\$3.89 trillion) under a Medicare for All plan that provides comprehensive coverage and long-term care benefits.²⁹
- The Commonwealth Fund and the Urban Institute compared eight possible health reform proposals, six that build on the ACA and two that look more like Medicare for All. The study finds that Medicare for All would increase federal spending by US\$2.8 trillion in 2020 and US\$34.0 trillion over 10 years.³⁰

HOW MIGHT MEDICARE FOR ALL AFFECT PAYMENTS FOR PROVIDER SERVICES AND PRESCRIPTION DRUGS?

Some proposals call for lowering payment rates to hospitals, physicians, drug companies, and other health care stakeholders. One key question is whether Congress would agree to enact legislation that would lower payment rates to the extent contemplated in the current policy proposals.

WHAT DOES THE PUBLIC THINK ABOUT THE VARIOUS PROPOSALS?

The public appears generally confused about these health care proposals. For example, nearly half of those surveyed (47 percent) believe Medicare for All and the Public Option are either very or somewhat similar.³¹

Opinions also change depending on which facts are presented.

- **November 2019 polling data:** When asked if they're in favor of or opposed to having a national health plan, roughly half of surveyed Americans said they're in favor—though this rate has fluctuated over time.³² Moreover, 47 percent said they're in favor of a Medicare for All plan if it required people to pay more taxes, while 54 percent said they're in favor of it if private insurance is eliminated but people are allowed to choose their providers.³³
- **July 2019 polling data:** Nearly two-thirds of the public (65 percent) favored a public option, but views shifted after hearing arguments for and against it. Seventy-five percent of respondents said they supported a Public Option if they heard it would help drive down costs. However, only 40 percent were in favor if they had heard it would lead to too much government involvement in health care.³⁴

Views also differ by political party (just as they continue to differ on the ACA). For example, most Democrats (77 percent) and the majority of Independents favor Medicare for All (53 percent). Most Democrats and Independents also favor a Public Option (87 percent and 72 percent, respectively). Meanwhile, most (69 percent) Republicans strongly oppose a national Medicare for All plan and nearly four in 10 (39 percent) strongly oppose a government-administered Public Option.³⁵

WHERE DO VARIOUS INDUSTRY GROUPS AND STAKEHOLDERS COME OUT ON THE DEBATE?

- **Health care industry:** Many health care industry organizations and their associations say they oppose Medicare for All.³⁶ Data from the American Hospital Association shows that, for hospitals, commercial health plans pay significantly more than Medicare rates on average.³⁷ [Health care provider organizations](#) say that lowering their payments would significantly limit their ability to cover the cost of doing business. Drug company associations have raised concerns that lowering drug prices would dampen research, development, and innovation.³⁸ The Congressional Budget Office has said that it would expect fewer drugs to be developed if drug prices were limited to an index of payment rates in other countries.³⁹
- **Employers:** Many large employers and the US Chamber of Commerce oppose Medicare for All. However, a recent poll by the National Business Group on Health (which represents large employers) found that more than half are in favor of expanding Medicare to younger populations (50 to 64 years old).⁴⁰
- **Supporters:** Groups that have come out in favor of Medicare for All include National Nurses United, the nation's largest nurse's union, and Physicians for a National Health Program (PNHP).⁴¹

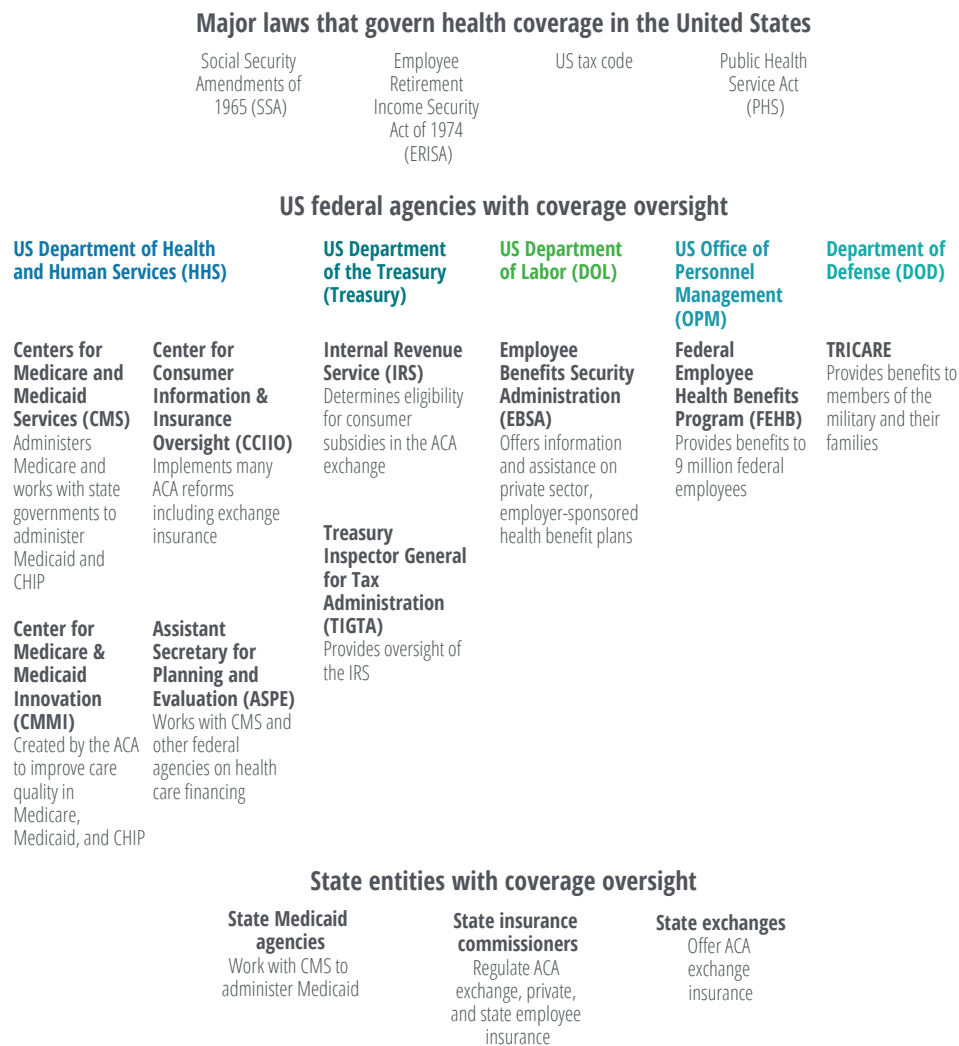
WHICH LAWS AND AGENCIES MIGHT BE AFFECTED—ELIMINATED, CHANGED, EXPANDED, OR CREATED?

All of the proposals have the potential to affect all the federal and state agencies that pay for or regulate health care coverage and insurance (figure 4). Most of the major laws that impact coverage would also need to be addressed. For example, the Social Security Amendments of 1965 amended the Social Security Act (SSA) and created the Medicare

and Medicaid programs. The Public Health Service (PHS) Act and the Employee Retirement Income Security Act (ERISA) impact individual and employer-sponsored coverage. The US tax code under the Internal Revenue Service (IRS) contains numerous provisions to encourage employer-sponsored coverage, impose penalties for not offering coverage, and raise revenue to pay for many programs. The ACA made significant revisions to each of these laws.

FIGURE 4

Today, many federal and state agencies and departments touch the US health coverage system



Source: Deloitte analysis.

Looking ahead: Expanding health coverage and the Future of Health

All of the proposals face challenges to becoming law, even if Democrats gain control of the White House, the US Senate, and the House of Representatives. The legislative history of the ACA illustrates that it can be challenging to forge consensus around health care, which requires a delicate balance of policy goals with budget and political constraints.

But even if some version of these proposals were to become law, it would likely not solve all the issues ailing America's health care system. Remaining challenges could include:

- **Improving health care delivery** so that patient care is coordinated and there is less waste in the system. Today there is bipartisan consensus around the need to evolve value-based payment models to provide the right incentives and deliver high-quality care at lower costs. The passage of MACRA showed broad support, receiving 92 votes in support and eight that opposed in the Senate that year.⁴²
- **Improving the health data and technology infrastructure** so that electronic health records and health information exchanges can share patient data swiftly and accurately to give patients access to their own health data, give health care providers a holistic view of their patients, and reward providers for delivering high-value and efficient health care, thus helping to further drive value-based care.
- **Spurring scientific and digital innovation** to detect, prevent, and treat disease and to give people a [longer and healthier lifespan](#).

- **Addressing social determinants of health**, which are significant contributors to health outcomes but are not always covered as benefits.

At Deloitte, we believe that by 2040 health care stakeholders will evolve to focus on health and well-being and much less on health care. This vision of the [Future of Health](#) anticipates a complete transformation of the delivery system. Innovation—spanning the use of data and platforms to drive insights and efficiencies, consumer engagement, and scientific discovery—is critical to that vision.

How should stakeholders prepare?

Health care is a major part of the political and public debate. Now that we are less than a year away from the 2020 elections, we should think through the implications of the Democratic candidates' proposals, the administration's policies and possible priorities in a second term, and how to prepare for various election outcome scenarios.

Expanding coverage, reducing health care costs, and improving outcomes for patients will likely remain at the forefront of the US policy agenda and will require agility for many health care stakeholders. The US health care system is a balance of public programs and private sponsorship. That balance will likely continue to be challenged and debated as federal funding, private contributions, and tax incentives exist for coverage, financing, and delivery of innovative health care approaches. Health care is dynamic by nature—diseases emerge, discoveries are made, and new paths to wellness are emulated. All of this should be considered for health care stakeholders to best meet their business priorities, respond to the constantly evolving health care environment, and pursue their commitment to consumers.

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