



SPOTLIGHT:

a chro education series by the

MEDICARE

american health policy institute

EXTRA FOR ALL

Part Five of Six



AMERICAN
HEALTH
POLICY
INSTITUTE

OBJECTIVES OF THE SERIES

We hope this CHRO Education Series will increase member awareness of the spectrum of potential future health care reforms that may be proposed over the next two years—and will help senior HR leaders assess the implications of various types of reform on their future business and talent strategies. We will also use these papers as the basis for follow up discussions with members in 2019 that will help shape the Association’s work with policymakers.



*Employers and the U.S.
Health Care System*



*The Health Care
Reform Spectrum*



*Spotlight:
Replace the ACA*



*Spotlight: The
Medicare for All Act*

V ■ **Spotlight: Medicare Extra for All**

PART FIVE of SIX

Nearly a decade after the passage of the Affordable Care Act, health care continues to be a top issue among voters in the U.S., with the two major parties offering distinctly different visions of the direction of future reform. To help CHROs, their teams, stakeholders, and the public better understand the health care landscape and the prospects for change, we’re launching a series of short papers that will discuss the various types of reform proposals being discussed among policy makers, political candidates and other key stakeholders.



*Implications for
Employers*

V. Spotlight: Medicare Extra for All

PART FIVE of SIX

Introduction

With Democrats in control of the House of Representatives and the 2020 Presidential campaign already underway, health care is gaining increasing attention among policy makers in Washington and around the country. House Democratic leaders have announced hearings on health care reform, including the prospect of a “single-payer” system, while states explore ways of expanding access and controlling costs.

In Parts I and II of this series, we examined the unique role employers play in the US health care system, and framed the issue by looking at four ways government plays a role in health insurance:

- Provide financial incentives for the purchase of private insurance;
- Provide direct coverage to specific populations (*e.g.*, Medicare, Medicaid);
- Influence supply and demand for insurance, primarily through regulation; and
- Exerts full control (single-payer).

In Part III, we looked at the key elements of reform proposals being discussed by Republicans in Congress, while in Part IV we examined the other end of the reform spectrum -- where government plays the leading role in how individuals get health insurance by acting as the “single-payer” of health care for all citizens.

In this installment of our series, we’ll discuss the range of options that exist between replacing the ACA and moving toward a single-payer system. We’ll do this by taking a look at “Medicare Extra for All,” a reform proposal released in 2018 by the Center for American Progress. Medicare Extra for All is one of several potential reform proposals that would create a “public option” – a government-run plan that is made available to Americans as an alternative to existing private insurance.

The Center for American Progress

The Center for American Progress (CAP) is a public policy research and advocacy organization which presents a progressive viewpoint on economic and social issues. The Medicare Extra for All proposal was released by CAP on February 22, 2018. You can read the full proposal [here](#).

There are many variations of this basic concept of creating a public option for health care coverage; while we won’t cover them all in this paper, we’ll provide a basic overview of the key elements of CAP’s particular approach.

Medicare Extra for All: The Details

There is growing public support for offering Americans an option to “buy-in” to a government-run health plan such as Medicare. A recent pollⁱ by the Kaiser Family Foundation found that 74% of those surveyed would support a national government plan similar to Medicare that would be open to anyone but would allow them to keep their current coverage if they so prefer. Support among Democrats and Independents was strongest, but nearly half of Republicans (47%) also supported such a plan.

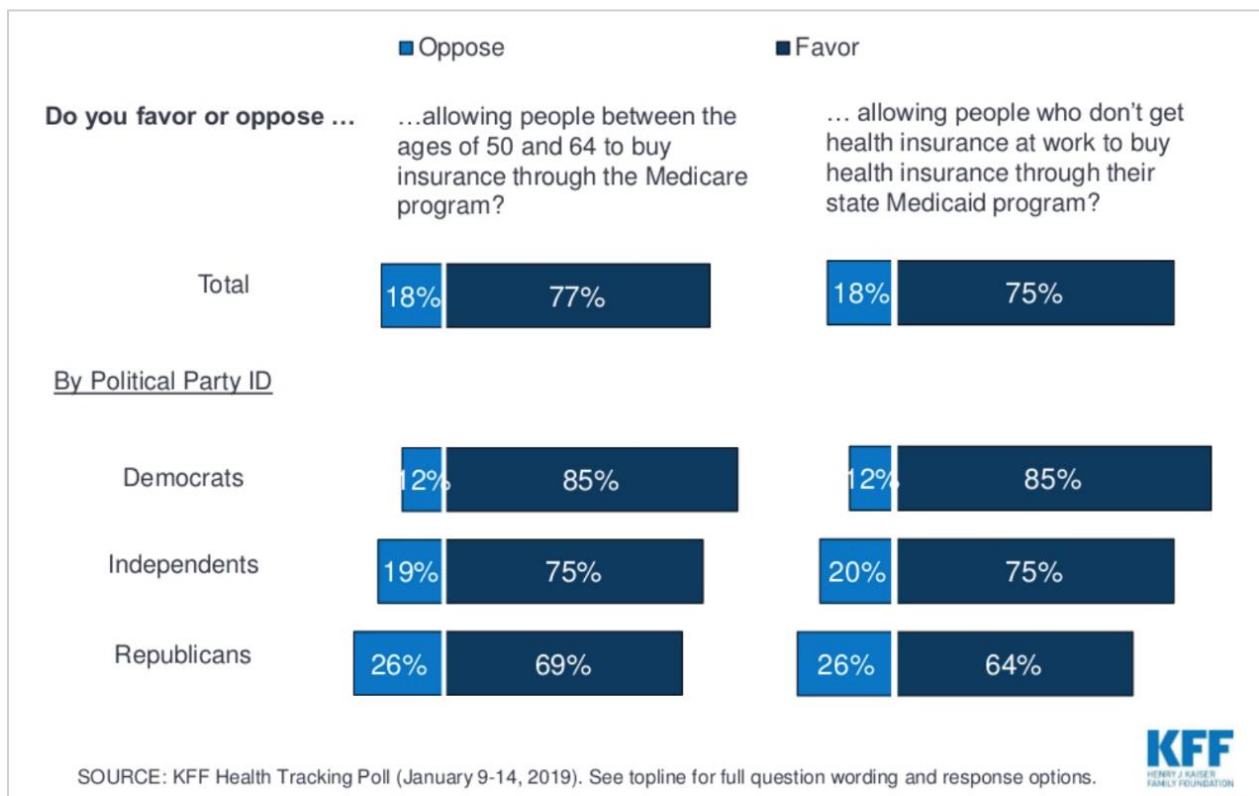
Support is even higher among Republicans (69%) when the plan is limited only to allowing those over age 50 to buy-in to Medicare.

Medicare Extra for All (“Medicare Extra”) would create a new health plan available to

What is a “Public Option?”

While there are many potential ways to describe it, we define a “public option system” as one where a government-financed health plan would be offered to Americans as one of many options, competing with private health insurance plans.

all Americansⁱⁱ, regardless of income, age, health or insurance status. Individual premiums would vary by income, with caps ranging from 0% (for families with incomes less than 150% of the federal poverty level, or FPL) to 10% (for families above 500% of the FPL).



Medicare Extra would not replace employer-sponsored insurance; employers would have the option to continue to offer coverage (subject to new standards) or provide financial support for their employees to get coverage under Medicare Extra. The preservation of employer-sponsored coverage is a key feature of Medicare Extra; in fact, under the proposal employer-sponsored plans are the only type of private insurance that is permitted to duplicate coverage provided by Medicare Extra. Private insurance companies would not be allowed to offer plans that duplicate Medicare Extra benefits, but they could offer “complementary” benefits.

The proposal acknowledges the popularity of employer-sponsored coverage and that most who get coverage from their employer are satisfied with it. However, it also points out that employer plans are becoming increasingly unaffordable and seeks to “balance the desire of most employees to keep their coverage with the need of many employees for a more affordable option.”

Employer Options Under Medicare Extra

Under the proposal, employers would have four options for providing health care coverage to their employees:

- Continue to sponsor their own coverage. Employers could continue to offer coverage, but it would need to provide an actuarial value of at least 80%, and employers would need to contribute at least 70% of the premium. Employers that choose this option would continue to benefit from the tax exclusion of premiums from income and payroll taxⁱⁱⁱ.

- Sponsor Medicare Extra as a form of employer-sponsored insurance. Employers would automatically enroll employees into Medicare Extra and would need to contribute at least 70% of the Medicare Extra premium. The tax benefit of employer-sponsored insurance **would not** apply to employer premium contributions under this option (employers would still be able to deduct the cost of health coverage from their corporate taxes, but the value of such coverage would need to be added to the employee’s taxable income).
- Choose to make maintenance of effort payments. Employers could make payments to Medicare Extra equal to their health spending in the year prior to the law’s enactment, subject to increases linked to consumer medical inflation rates. The tax benefit of employer-sponsored insurance **would not** apply to employer payments under this option^{iv}.
- Make aggregated payments in lieu of premium contributions. Employers could make simpler aggregated payments to Medicare Extra in amounts ranging from 0% to 8% of payroll, depending on employer size. The tax benefit of employer-sponsored insurance **would not** apply to employer payments under this option^v.

Small employers (fewer than 100 FTEs) would not need to make any payments at all, nor would they be required to offer coverage or sponsor Medicare Extra. This means that 98% of all U.S. firms that employ one-third of all workers would not need to make any payments at all.^{vi}

Employee Choice Under Medicare Extra

Under the proposal, employees would have the option to enroll in either their employer-sponsored plan or Medicare Extra. If they did not make a choice, employers would automatically enroll them in the employer plan.

If employees choose Medicare Extra, employers would contribute the same amount to Medicare Extra as they would contribute to their own coverage. The tax benefit for employer-sponsored insurance would not apply to these employer-paid premiums.

Controlling Costs Under Medicare Extra

Reimbursement Rates and Payment Reform

In an effort to lower costs, provider payment rates under Medicare Extra would reflect an average of rates under Medicare, Medicaid and commercial insurance, minus a percentage. Medicare Extra would also increase rates paid for primary care relative to specialty care.

Under the proposal, "the benefits of Medicare Extra rates would extend to employer-sponsored insurance and significantly lower premiums." Out of network providers would be prohibited from charging more than Medicare Extra rates.

Medicare Extra would reform the payment and delivery system by paying hospitals for a bundle of services. It would also make "site-neutral" payments -- the same payment for the same service regardless of where it takes place.

Direct Negotiation

Medicare Extra would seek to control costs by directly negotiating prices for prescription drugs, medical devices, and durable medical equipment.

Leveraging Medicare Advantage: Medicare Choice

Medicare Extra would leverage the success of the Medicare Advantage program, which provides a choice of plans to seniors. Medicare Advantage plans currently account for approximately 34% of total Medicare enrollment.

Medicare Advantage would be reconstituted as Medicare Choice and be made available to all Medicare Extra enrollees. Medicare Extra would solicit bids from insurance plans; the payments to the plans would equal the average bid (but would be no more than 95% of the Medicare Extra premium). Consumers who select a plan that costs less than the average bid would receive a rebate for the difference; those who choose a more expensive plan would pay the difference.

Transition to Medicare Extra

The Medicare Extra proposal envisions an 8-year transition period before the program would be fully implemented. In the first year, a "public option" would be offered in any county that was not served by at least one insurer in the individual market.

By year four, auto-enrollment would begin with those in individual market, the uninsured, newborns, and those turning age 65. Individuals in employer plans and in the current Medicare system would have the option to enroll, and small employers could sponsor Medicare Extra for their employees.

In year six, Medicaid/CHIP beneficiaries would be automatically enrolled, and by year eight large employers could sponsor Medicare Extra for all employees.

Using the four-part framework from Part II of our series, the following chart shows how

Medicare Extra would compare with the current state under the ACA.

Role	Current State	Medicare Extra for All
Financial incentives	<ul style="list-style-type: none"> • Tax policy encourages ESI • Subsidies for low income to purchase coverage on Exchanges 	<ul style="list-style-type: none"> • Allows employer-sponsored coverage to continue with favorable tax treatment • Provides employers the option of offering coverage or financially sponsoring employees in Medicare Extra • Provides employees the choice of private coverage or Medicare Extra • Eliminates Exchanges
Direct coverage to select populations	<ul style="list-style-type: none"> • Medicaid/CHIP • Medicare • Veterans/Armed Forces • Federal Employees 	<ul style="list-style-type: none"> • Replaces Medicaid/CHIP • Those currently enrolled in Medicare can elect to remain • Veterans/Armed Forces/Federal employees can remain in current coverage
Influence Supply and Demand	<ul style="list-style-type: none"> • Employer mandate • “Minimum Essential Coverage” standards 	<ul style="list-style-type: none"> • Preserves employer-sponsored insurance, but eliminates all other private insurance that duplicates Medicare Extra • Employer coverage must deliver 80% actuarial value and employers must pay 70% of premiums • Establishes reimbursement rates based on average of Medicare, Medicaid and commercial insurance • Negotiates prices directly with drug manufacturers, medical device and durable equipment providers • Replicates current Medicare Advantage plans, with competitive bidding to lower costs • Sets caps on Medicare Extra individual premiums based on income
Fully control	n/a	n/a

Other “Public Option” Approaches

While the Medicare Extra proposal has not been translated into actual legislation, there were several bills introduced in the 115th Congress (2017-2018) (See Table 1, below), and one in the current Congress would implement a similar public option approach. These bills are summarized below.

Public Plan Option

Three bills would create a public option similar to Medicare Extra but would differ in one important respect - they would offer the public option on the existing ACA exchanges and would compete with individual private plans. Existing subsidies could be used to purchase coverage, and all three plans would seek to lower costs by leveraging Medicare payment rates and by negotiating drug prices directly with manufacturers.

“Buy-In” for Older Americans

Three bills would take a more limited approach than Medicare Extra, allowing older Americans to “buy in” to Medicare at either age 50 or 55. All would allow exchange subsidies to be used to purchase coverage, and one (H.R. 3748) would allow those eligible for employer coverage to buy in - and would allow employers to contribute to the cost of coverage.

State Medicaid “Buy-In”

The “State Public Option Act” would allow states to create a Medicaid “buy in” option that would be offered via the exchanges and allow ACA subsidies. The plan would cap premiums at 9.5% of income and enhance Medicaid reimbursement rates by referencing Medicaid as a floor.

Is this the Year of “Medicaid Buy-In?”

In the absence of federal action on health care, states are considering ways to allow residents to “buy-in” to Medicaid. According to a Pew Stateline report, at least 10 states are considering this path. “We think 2019 is going to be the year of Medicaid buy-in,” said Allison O’Toole, senior director of state affairs for United States of Care, a nonpartisan group that promotes affordable health care for all.

Legislation has been introduced in eight states; and in Nevada, a Medicaid buy-in was passed by the legislature in 2017 but vetoed by Governor Sandoval.

You can read more about state Medicaid buy-in options [here](#) and [here](#).

Type	Bill	Sponsor(s)
Public Plan Option	H.R. 635 / S. 194, CHOICE Act	Rep. Schakowsky (D-IL), Sen. Whitehouse (D-RI)
Public Plan Option	H.R. 4094 / S. 1970 Medicare-X Choice Act of 2017	Rep. Higgins (D-NY), Sen. Bennett (D-CO)
Public Plan Option	H.R. 6117 / S. 2708 Choose Medicare Act	Rep. Richmond (D-LA), Sen. Merkley (D-OR)
Older American Medicare Buy In	S. 1742 Medicare at 55 Act S. 470 Medicare at 50 Act (introduced in February 2019)	Sen. Stabenow (D-MI)
Older American Medicare Buy In	H.R. 3748 Medicare Buy-In and Health Care Stabilization Act of 2017	Rep. Higgins (D-NY)
State Medicaid Buy-In	H.R. 4129 / S. 2001 State Public Option Act	Rep. Lujan (D-NM), Schatz (D-HI)

Next Up: Implications for Employers

As momentum builds in Washington for a renewed debate around health care reform, innovations at the state level could provide a “laboratory” for experimentation on ways to address America’s health care challenges.

The final installment in our series will examine the potential implications for employers of each of the various reform proposals we’ve highlighted in Parts III, IV and V.

Endnotes

ⁱ <https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/>

ⁱⁱ The Center for American Progress Medicare Extra for All proposal is predicated on the passage of comprehensive immigration reform as coverage is limited to individuals “lawfully residing” in the United States.

ⁱⁱⁱ Under the Center for American Progress (CAP) proposal, the only alternative that does not require the value of healthcare coverage to be included in an employee’s taxable income is where the employer offers an appropriate level of healthcare coverage to all employees and does not offer Medicare Extra as an option to employees.

^{iv} The value of the healthcare coverage provided would be taxable income to the employee.

^v The value of the healthcare coverage provided would be taxable income to the employee.

^{vi} U.S. Census Bureau, 2014 County Business Patterns, https://www2.census.gov/programs-surveys/susb/tables/2014/us_state_totals_2014.xlsx