

Improving Access to Affordable and Comprehensive Health Insurance

Federal Policy Recommendations from the Robert Wood Johnson Foundation

THE ISSUE

Everyone in America should have access to high quality, affordable, and comprehensive care covering the full range of physical and mental health needs. Access to this care should not differ by income, race, ethnicity, immigration status, gender, sexual orientation or disability. To accomplish this, universal health insurance coverage is essential. As both the costs and benefits of medical treatment have increased over time, the consequences of lacking insurance coverage have only grown. Yet our nation has addressed the unmet need for coverage in a piecemeal and inadequate fashion. The consequences affect us all. Nearly thirty million people, disproportionately Black and Latino, are uninsured today.

COVID-19 has not only revealed our coverage problem, but also magnified its consequences. Financial barriers to care, particularly for people of color or those in low-wage jobs is one of our nation's clearest vulnerabilities during this pandemic.¹ Yet perhaps this crisis will also provide the opportunity to effect lasting change. At this most challenging time, policymakers must both maximize existing opportunities for coverage, and lay the foundation for a sustainable system – universal coverage coupled with significant cost containment.



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WHY IT MATTERS

There is a large and growing body of research that demonstrates the positive impact of coverage on health and mortality. For example, a recent study using federal survey data linked to death records found a significant mortality reduction in states that expanded Medicaid. Additionally, coverage has important economic benefits. Studies of recent Medicaid expansions have shown improved economic impacts at the individual and neighborhood level, demonstrating the financial importance of health insurance to low income families and communities.² Additionally, there is growing evidence that affordability barriers can have dire health consequences.³ The uninsured, disproportionately racial and ethnic minorities and low income, are more likely to forgo preventive care, leading to later-stage disease diagnoses, lower life expectancy, and greater risk of hospitalization.⁴ Inequitable access to quality care is driving disturbing increases in pregnancy-related health problems, particularly among women of color.⁵ Financial barriers to care are not only a problem of the uninsured; excessive cost-sharing affects millions of people whose health insurance is inadequate.⁶ Structural racism in our health care system, including differential care, leads to disparate and inequitable outcomes, regardless of insurance status.⁷

The Affordable Care Act (ACA) was a significant step forward, which allowed approximately 20 million people to gain coverage between 2010 and 2016. The uninsurance rate reached a historic low in 2016, and while it has increased somewhat in subsequent years, most of the coverage gains from the ACA have been sustained.⁸ The gap in the uninsurance rate between Blacks and Whites under age 65 has been reduced by half between 2010 and 2020. The uninsurance rate among Latino was reduced by fifty percent during the same period.⁹ Additionally, the ACA reduced income inequality, particularly in expansion states.¹⁰

Yet the potential of the Affordable Care Act was limited in a few important ways. One was that states were able to choose whether or not to expand Medicaid, and twelve states have still not elected to do so. The most egregiously unfair element of our uninsurance problem today is the plight of the more than two million people living in these states, who have fallen into the “Medicaid coverage gap”.¹¹ These are people who have extremely low incomes and are disproportionately Black and Latino and who, simply due to the state in which they reside, have no access to coverage. Another major limitation of the ACA, temporarily addressed in the [American Rescue Plan](#), is the inadequacy of the subsidies for those with moderately higher incomes.¹²

Pre-existing problems with coverage access and affordability have been compounded by the COVID-19 pandemic and its associated economic dislocation. An estimated 10 million workers and their dependents have lost access to employer-sponsored health insurance.¹³ Many are eligible for alternative coverage through a family member, Medicaid, or the ACA marketplace, but the CBO has estimated there was an increase of between .5 and 1.5 million in the number of uninsured in 2020.¹⁴ Even before COVID-19, we had been losing ground on coverage, including for children, for whom the uninsurance rate for children has been rising since 2017.¹⁵

Creating a truly equitable coverage system will require significant eligibility expansion, meaningful cost containment, and additional revenue. There are a number of administrative and legislative actions that can be taken to support coverage in the short term. Many are already underway, or have been included in the [American Rescue Plan Act of 2021](#). Building on that, policymakers should consider additional actions to create a long lasting, equitable and affordable system of health insurance coverage.

CONSIDERATIONS FOR POLICYMAKERS

1. Short Term: During COVID-19, maximize coverage through existing channels

Administrative:

- **Increase enrollment in the ACA marketplace.** We applaud the Administration's decision to hold a special enrollment period and devote needed resources to outreach and enrollment activities. Preliminary data on enrollment are promising, and should increase with the availability of additional premium subsidies. In light of the additional subsidies, the Administration should consider extending the special enrollment period.
- **Reverse policies that limit coverage.** Through a series of Executive Orders (EO) and subsequent actions, the Administration has already begun the process of reversing current policies that have the potential to limit coverage in the ACA Marketplace and Medicaid. More focused executive actions in these areas through the regulatory process are essential to fulfill the promise of the broadly worded EO. The Administration has already withdrawn Medicaid work rules and has stopped enforcing the Department of Homeland Security's "public charge" rule.¹⁶ Other policies that should be reversed include a rule liberalizing the regulation of [short-term, limited-duration plans](#), and waiver [guidance that encourages states to abandon public exchanges](#).

- **Maintain the protections established under the Public Health Emergency (PHE).** Policies such as continuous coverage requirements have allowed states to keep more people enrolled in Medicaid during the pandemic.¹⁷ These measures should be maintained until no longer needed, and states should be given assistance in transitioning back to conducting eligibility redeterminations. Aiding the ability to execute this recommendation has been the explicit commitment by the Administration to extend the PHE throughout 2021.

Legislative:

The [American Rescue Plan Act of 2021](#) includes a number of provisions to stabilize coverage in the short term:

- **Additional incentives for states to expand Medicaid.** The American Rescue Plan offers to raise the Federal Medical Assistance Percentage (FMAP) by 5 percentage points for two years in an attempt to induce recalcitrant states to expand Medicaid. If the remaining twelve states expand Medicaid eligibility it could cover more than two million people currently in the coverage gap.
- **Increased affordability of marketplace coverage.** Temporarily increasing subsidies and placing a cap on premiums as a share of income makes marketplace coverage far more affordable to millions, especially those whose income exceeds 400% FPL (\$51,040 for an individual). Additionally, the American Rescue Plan addresses subsidy rules to protect families whose incomes are fluctuating during the pandemic and ensure that unemployment insurance payments lower the income basis used to calculate premium tax credits.
- **Subsidies for COBRA.** COBRA (Consolidated Omnibus Budget Reconciliation Act) is a transitional program that allows employees to maintain their job-based coverage for a limited duration after leaving employment. Since it requires the employee to pay both the employee and employer share of the cost of coverage, it is typically very expensive, and is rarely used. As a temporary emergency measure, the American Rescue Plan subsidizes the cost of COBRA payments to help some of those losing jobs keep their employment-based coverage.
- **Expansion of post-partum access to Medicaid.** All women should have a source of insurance coverage before, during, and after pregnancy. Improving access to care in the post-partum period may reduce maternal morbidity and mortality. The American Rescue Plan created a state option to extend Medicaid eligibility for all pregnancy-related and postpartum medical assistance for 12-months. This option would significantly expand pregnancy-related coverage, which currently lasts through 60 days post-partum.

- **Increased funding for Home and Community-Based Services (HCBS) for the elderly and people with disabilities.** There is an institutional bias in the Medicaid program, and a great unmet need for home and community based services. The American Rescue Plan increased the federal matching percentage (FMAP) by 10 percentage points for home and community-based services, so that states can take steps to improve the availability of services that would allow the elderly and disabled to receive care in their homes.

2. Long term: Prioritize permanent policies that provide universal coverage and cost containment

Looking beyond the pandemic, the Administration should build on these short-term measures to prioritize a policy agenda that will lead to sustainable coverage expansion.

Legislative/Administrative:

- **Close the Medicaid coverage gap.** If non-expanding states do not take advantage of increased FMAP, Congress should consider using either the Marketplace or other federal approaches, including but not limited to a public option to close the coverage gap. There should be a fair way for states that have already expanded to avail themselves of these opportunities.
- **Permanently increase the affordability of marketplace plans.** In addition to increasing subsidies, policymakers should consider increasing the actuarial value of the benchmark plan to reduce out of pocket costs. An income-based cap on maximum out of pocket costs should also be considered. Additionally, policymakers should address the “family glitch,” which negatively impacts the way in which affordability for family coverage is determined for purposes of accessing ACA subsidy support.
- **Reduce the cost of prescription drugs.** Address anticompetitive behavior and delays to competition that skew the market prices of prescription drugs. Allow the Medicare program to address costs, including but not limited to use of reference prices or negotiated prices for high-cost drugs. Cap payments to physicians for prescription drugs in Medicare Part B and develop alternative payment approaches to limit excess prices and costs incurred by beneficiaries and taxpayers. Utilize savings to expand coverage and improve Medicare prescription drug benefits.
- **Reform Medicare Part D benefits.** Change the benefit design and establish a maximum out of pocket limit for beneficiaries. This will create incentives for plans and Pharmacy Benefit Managers (PBMs) to better manage the drug benefit and reduce costs for both beneficiaries and taxpayers.¹⁸

- **Implement the No Surprises Act in a manner which maximizes the cost containment potential.** The recently passed No Surprises Act is designed to limit “surprise” billing by out of network providers. An inclusive and timely national data source, such as a national All Payer Claims Data Base (ACPD) will permit active surveillance of trends in health care service prices.¹⁹
- **Promote competition in health care markets.** Address market power and the negative impacts of health system consolidation through active anti-trust and other strategies, including the possibility of rate regulation in persistently uncompetitive markets.²⁰ The recent amendment of the McCarran Ferguson Act means that now health insurers will be subject to the same federal antitrust laws as other industries. This should increase the opportunity for antitrust enforcement of both health insurers and providers and lead to more competition. The impact of vertical integration on health care costs and competition should also receive greater scrutiny. Vigorous implementation of interoperability will also promote competition.
- **Open the firewall between the ACA Marketplace and employer insurance.** Potentially in combination with a new public option that contains costs, permit employees to choose between marketplace plans and their employer’s offering, in a manner that protects against insurance companies dumping patients or adverse selection.
- **Improve opportunities for working people with disabilities to access Medicaid.** Medicaid covers important services that can make it possible for people with disabilities to participate in the workforce. Almost every state permits working individuals with disabilities to buy-in to Medicaid, but the current program is overly complex and under-utilized. Clarifying regulatory guidance and passing legislation to streamline and simplify this program would allow more people to benefit.²¹

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